University Hospitals Bristol
NHS Foundation Trust

PUBLIC TRUST BOARD
Meeting to be held on 31st January 2017, 11:00 - 1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Preliminary Business				
1	Apologies for absence	Information	*Chairman*	Verbal
2	Declarations of Interest	Information	*Chairman*	Verbal
3	Patient Experience Story	Information	*Chief Nurse*	Verbal /3
4	Minutes of the meetings held on: • 29 November 2016 • 22 December 2016	Approval	*Chairman*	6 17
5	Matters arising and Action Log	Approval	*Chairman*	21
6	Chief Executive Report	Information	*Chief Executive*	22
7	Board Assurance Framework 2016/17 (Quarter 3)	Assurance	*Chief Executive*	26
Care and Quality				
8	Independent Review of Children's Cardiac Services progress report	Assurance	*Chief Nurse*	48
9	Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Board Review – Quality, Workforce, Access	Assurance	*Chief Operating Officer*	81
10	Quarterly Complaints Report (Quarter 2)	Assurance	*Chief Nurse*	138
11	Quarterly Patient Experience and Involvement Report (Quarter 2)	Assurance	*Chief Nurse*	172
12	Quality and Outcomes Committee Chair's Report: • 22nd December 2016 • 27th January 2017	Assurance	*Quality & Outcomes Committee Chair*	199 To be tabled

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Organisational and System Strategy and Transformation				
13	Transforming Care Programme Board	Assurance	*Chief Executive*	202
Financial Performance				
14	Finance Report	Assurance	*Director of Finance & Information*	209
15	Finance Committee Chair's Report: • 22nd December 2016 • 27th January 2017	Assurance	*Finance Committee Chair*	237 To be tabled
Governance				
16	Audit Committee Chairs Report	Assurance	*Audit Committee Chair*	239
17	Register of Seals	Assurance	*Chief Executive*	242
18	Fit and Proper Persons Policy	Approval	*Chief Executive*	245
Research and Innovation				
19	Research and Innovation Quarterly Update Report	Assurance	*Medical Director*	282
Items for Information				
20	West of England Academic Health Science Network Board	Information	*Chief Executive*	289
21	Governors' Log of Communications	Information	Chairman	294
Concluding Business				
22	Any Other Urgent Business	Information	*Chairman*	Verbal
23	Date and time of next meeting **Tuesday 28th February 2017, 11-00am- 1:00pm, Conference Room, TrustHQ, Marlborough St, Bristol, BS13NU**		*Chairman*	Verbal

Cover report to the Public Trust Board meeting to be held on Tuesday, 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3
Meeting Title	Public Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Patient Story		
Author	Tony Watkin, Patient and Public Involvement Lead		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6:We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

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

Executive Summary

Purpose

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

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

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

Key issues to note

The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services.

In this context, access to health and social care services by the deaf, deafened and hard of hearing communities in Bristol and South Gloucestershire is a subject of significant interest to local Healthwatch organisations. In December 2016, Trust representatives met with Healthwatch to explore how we can better support people from this community when they are patients in our care.

In this story, Trish Vallance, deaf health promotion officer for Bristol City Council, will reflect on the communication and information needs of people when they are in our hospitals and how this can impact on the quality of care they receive. This includes the experiences of Deaf British Sign Language Users, deaf people who speak/lip read, hard of hearing and Deafblind people.

Recommendations

Members are asked to:

- **Note** the patient story

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

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

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

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

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

Quality	☐	Equality	☒	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

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

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

Minutes of the Public Trust Board Meeting

Held on 29th November 2016 11:00am-1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

Present

Board Members

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

In Attendance

Name	Job Title/Position
Pam Wenger	Trust Secretary
Ian Barrington	Divisional Director, Women's and Children's Services (attended for item 9)
Fiona Reid	Head of Communications
Tony Watkins	Patient and Public Involvement lead
Andeloris Chacon	Patient (attended for Item 3)
Jo Jones	Member of Public
Carole Dacombe	Governor
Mo Schiller	Governor
Flo Jordan	Staff Governor
Bob Bennett	Governor
Malcom Watson	Governor
Rashid Joomun	Governor
Clive Hamilton	Governor

Minutes:

Zainab Gill	Corporate Governance Administrator

The Chair opened the Meeting at 11:00am

Minute Ref	Item Number	Action
127/11/16	**Welcome and Introductions (Item 1)**	
	Apologies were noted from Guy Orpen (Non-Executive) and Paul Mapson (Director of Finance and Information).	
128/11/16	**Declarations of Interest (Item 2)**	
	In accordance with Trust standing orders, all Board members present were required to declare any conflicts of interest with items on the meeting agenda. There were no new declarations made.	
129/11/16	**Patient Experience Story (Item 3)**	
	The meeting began with a patient story, from Andeloris Chacon, the Manager at Bristol Black Carers. Andeloris Chacon spoke about the experiences of carers who have supported patients at UH Bristol and the perceptions the local community has of the Trust and its hospitals. She said her organisation was developing a voice in the Trust through the Trust's Involvement Network. Following on from the story, the Board felt it would be beneficial to the Trust and its patients to learn more about the impact of the work being done by Bristol Black Carers and the Trust's Involvement Network. The Board reflected on the need to become better at listening to carers of patients and the importance of understanding confidentiality and safe handover to carers when discharging a patient. Alison Ryan highlighted to Governors that they could take this opportunity to contact Andeloris Chacon and her organisation outside of the Board meeting, to help build links and improve communication with their constituencies. **Members RESOLVED to:** • **Receive** the patient story.	
130/11/16	**Minutes of the last meeting (Item 4)**	
	The minutes of the meeting held on 31st October 2016 were agreed as a true and accurate record. **Members RESOLVED to:** • **Approve** the minutes from the meeting held on 31st October 2016 as a true and accurate record.	

Minute Ref	Item Number	Action
131/11/16	**Matters arising and Action Log (Item 5)**	
	Members received and reviewed the action log. The progress against the outstanding actions was noted. - *Action 1, Minute ref 105/10/16* – Robert Woolley confirmed that although he remained uncertain about the extent of beefing to North Somerset Health and Wellbeing Board, he would be presenting the Sustainability and Transformation Plan to Bristol, North Somerset and South Gloucestershire councils' Overview and Scrutiny Committees during the next week.	
132/11/16	**Chief Executive's Report (Item 6)**	
	Robert Woolley discussed the highlights from the Chief Executive's report and updated the Board on several further matters which were not covered in the report: <u>Recognising Success</u> Robert Woolley spoke about the recent award ceremony and that it had been a positive evening of recognising and reflecting on achievements of staff and the Trust. He gave special thanks to Above and Beyond for funding the event. <u>Care Quality Commission Inspection</u> Robert Woolley provided a brief update on the recent Care Quality Commission inspection, confirming that the Trust had received positive verbal feedback from inspectors on the pride and confidence of staff and the great focus on care and compassion within the Trust. He confirmed that the inspectors had received consistent positive feedback from patients about the Trust and its staff. The Board noted that the Care Quality Commission had advised there would be written confirmation of the verbal feedback received. It was further noted by the Board that the official visit did not end until 9th December 2016 and inspectors could return unannounced at any time within that time. Robert Woolley advised that a draft report for review of factual accuracy from the Care Quality Commission would be available in February 2017. In relation to this, John Savage reported that he had received positive comments from the Care Quality Commission inspectors in relation to the Non-Executive directors that they had met. <u>NHS Improvement</u> The Board noted that NHS Improvement had published its analysis of quarter two performance showing the following: there was a 648 million pound deficit amongst NHS providers at the end of September; A&E attendances had increased by 6 percent since last year, and there was an increase in delayed transfers of care in comparison to the previous year.	

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	Following on from this, Robert Woolley confirmed that he had received a letter from Jim Mackie, Chief Executive at NHS Improvement congratulating the Trust on delivering its plan and the positive position of the Trust. He further confirmed that the Trust's Operating Plan would be submitted to NHS Improvement by Christmas and that there would be an exceptional Board meeting on 22nd December to sign off the plan. <u>Tenders</u> Robert Woolley updated the Board on the recent successful outcome of the first bid against the tender for Sexual Health Services in Bristol, North Somerset and South Gloucestershire. He said that the Children's Community Health Service tender was still being considered and the partnership that the Trust was a part of was the preferred provider, out the award of the contract had not yet been agreed. The Board noted that North Somerset Community had withdrawn from the partnership. **Members RESOLVED to:** • **Receive** the Chief Executive report for information.	
133/11/16	**Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital. (Item 7)**	
	Sean O'Kelly introduced the report informing the Board that it was an update on the progress and implementation of the recommendations identified by the Verita report which was commissioned by the Trust following the death of a baby at the Bristol Royal Hospital for Children in April 2015. He highlighted that most recommendations had now been indicated as complete, with recommendation 3 and 9 still outstanding. He confirmed that the Trust had commissioned a senior independent clinician (Professor Mike Stevens) to help deliver these two outstanding recommendations. The Board noted that Professor Mike Stevens had met with the family of the baby on four occasions to help define and refine a set of questions to present to the Trust which would need to be addressed by the Trust by January 2017. He confirmed that the family were aware of the progress made in regard to the outstanding recommendations. Emma Woollett stated that it would be helpful to understand what impact the actions arising from the report have had over time. She was particularly interested in recommendation two relating to the child death review process. Alison Ryan confirmed that the Quality and Outcomes Committee and Internal Audit would assist in auditing and reviewing	

Minute Ref	Item Number	Action
	the effectiveness of the agreed actions put in place. **Members RESOLVED to:** • **Receive** progress on the report for assurance.	
134/11/16	**Independent Review of Cardiac Services in Bristol (Item 8)**	
	Members received the report to update the Board on the development of the programme plan to address the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network, as set out in the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children. The Board noted that the assurance framework had been revised slightly to include the terms of reference for the parent's reference group and sign off of the completed projects. The Board agreed to approve the revised assurance framework. Carolyn Mills further confirmed that there were no risks to report in terms of timescales for outstanding actions. Alison Ryan sought assurance on recommendation 24, on page 64 of the report, which related to "developing more effective mechanisms for maintaining dialogue". Carolyn Mills advised that this action was due to be considered at this month's Clinical Quality Group meeting, but due to an exceptional circumstances this item had been delayed. In relation to this, Robert Woolley explained that it was a difficult and broad action which required all parties to be present. Robert Woolley provided an update on the announcement by NHS England of the accelerated national reviews into paediatric critical care and specialised surgery for children. Members discussed the recommendations in the review report and in particular how the Board was seeking assurances in relation to the completion of the actions that were attributed to external bodies. It was noted that Carolyn Mills had been exploring ways to address this issue and it was agreed to write to NHS England in 6 months' time asking for a progress update on the actions they were taking forward. David Armstrong thanked Carolyn Mills for the updated report and in particular he was pleased to note the improvements and that this now provided appropriate assurance and clearly indicated the actions for steering groups as well as the effectiveness of using a RAG rating system as it helped to prompt the Board to ask the right questions. **Members RESOLVED to:** • **Receive** progress on the report for assurance.	

Minute Ref	Item Number	Action
135/11/16	**Interim Annual Report for Children's Services (Item 9)**	
	The Board received the Interim Annual Report for Children's Services from October 2015 to September 2016. Ian Barrington advised that the report covered the key achievements, pressures and opportunities arising over the last 12 months. He confirmed that the full report would be published in the summer of 2017 and would cover the preceding 18 months and then move to an annual cycle of financial year in line with business planning and Trust Annual Report timetables. The highlights from the presentation were noted as follows: - Ian Barrington presented to the Board three stories illustrating the success and continued improvement of the Children's Hospital. The first related to a bone marrow transplant survival and the hospital's high rate of survival in relation to this; the second related to a child's recovery following a procedure to retrieve his leg, which was badly injured in a car accident; and the third was in relation to the successful recovery of a child who had had a life threatening head injury. - The Children's Hospital's strong and well-staffed safeguarding and bereavement team. - The Hospital's Sign up to safety and sepsis screening in Children's emergency department & the development of an inpatient tool. David Armstrong asked a question in relation to processes, and the option of receiving a similar presentation showing the Trust's key achievements and successes for the all hospitals managed by the Trust. Robert Woolley confirmed that this presentation was in relation to specific issues that the Bristol Children's Hospital had been experiencing. However, the Trust would consider the value of a similar report for all of its hospitals. David Armstrong asked for assurance around the commitment to incorporate children's services into the Sustainability and Transformation Plan and the services' involvement in the production of the operational plan. Ian Barrington in response to this question spoke about the existing close working relationships with the key sustainability and transformation areas which would in turn allow them to have an effective input into decision making and confirmed that locally their focus was on urgent care. He confirmed that he was comfortable with their level of oversight of the operational plan and local issues.	

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	Jill Youds commended the Children's Hospital on their Facebook page and its honesty and transparency. She asked for assurance in relation to theatre vacancy issues and following a recent walk around in the hospital an update on the continued challenges around mental health for both patients and staff. Ian Barrington advised that their primary focus was on, recruitment and retention, review of shift patterns, night teams and communication. In relation to the question about the challenges around mental health issues he advised that they had placed a bid with commissioners for approval of a psychiatric liaison team to help address the ongoing challenges. The Board discussed the high agency staff usage across all of its hospitals and how to tackle this issue. The Board noted that premium agency staff are paid more than the Trust can afford and that for a reduction in usage there needs to be an improvement in reporting and communication and a shift in management culture. **Members RESOLVED to:** • **Note** the contents of this report and support its publication to wider stakeholders of Children's Services; and • **Consider** providing the Board with an annual report illustrating the key achievements, pressures and opportunities arising for all hospitals managed by the Trust.	*Chief Executive*
136/11/16	**Quality Performance Report (Item 10)**	
	Owen Ainsley provided an overview of the performance for October 2016. The Board noted that A&E performance was below the national standard and the Trust's trajectory. Owen Ainsley explained the reason for this was a combination of national issues and local issues relating to delayed discharges across the board and an increase in attendances and urgent care capacity across the city. Owen Ainsley advised that work was being done to address these issues at different levels, including work with the Emergency Care Improvement programme, NHS Improvement and through ORLA virtual ward. The Board were pleased to note that progress had been made in recovering performance against the other national access standards this month, in line with the Trust's recovery forecasts, including a reduction in both the number of patients waiting over 18 weeks from Referral to Treatment , and the number of patients waiting over 6 weeks for a diagnostic test as well as an improvement in the 62-day referral to treatment GP. Owen Ainsley concluded by saying that, despite the emergency pressures, the Trust continued to perform well against the majority of the core quality indicators, including the rate of inpatient falls and	

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	pressure ulcers, and the NHS Safety Thermometer composite measure of Harm Free care. **Members RESOLVED to**: • **Receive** the Quality Performance Report for assurance.	
137/11/16	**Quality and Outcomes Committee Chair's Report (Item 11)**	
	Members received the report following the meeting of the Quality and Outcomes Committee held on the 25th November 2016. Alison Ryan, Chair of the Quality and Outcomes Committee, provided a brief update on the issues discussed at the last meeting. Members noted the key highlights from the report, including the continued focus on patient flow and A&E performance. Alison Ryan advised that the Committee were looking forward to receiving more positive workforce KPI's and evidence in the reduction of use of agency staff. John Moore questioned the rise in dissatisfied complainants in the report and queried whether this was a capacity issue. Carolyn Mills advised that this related to individual responses to complaints not meeting the expectations of the complainant and assured the Board that these responses were looked at by herself and Sean O'Kelly. Emma Woollett sought assurance on the risk relating to delays in histopathology and the plans in place to address the delays. Owen Ainsley advised that the Trust continued to work closely with North Bristol Trust on KPI's and processes around this. **Members RESOLVED to:** • **Receive** the Quality and Outcomes Committee Chair's Report for assurance.	
138/11/16	**Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan (Item 12)**	
	Members received the Sustainability and Transformation Plan for Bristol, North Somerset and South Gloucestershire. Members noted that the local Sustainability and Transformation Plan is being organised across three broad, interrelated themes • Prevention, early intervention and self-care • Integrated primary and community care • Acute Care Collaboration Members noted that the Sustainability and Transformation Plan was in its current stage of development which includes: a shared assessment of the service and financial challenges facing the local health and care system, a summary of the case for change and our vision for working together and working differently to meet this challenge.	

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	Members noted that following a 'checkpoint' review by NHS England, the Sustainability and Transformation Plan will now be progressed leading to the development of specific plans and proposals. The further detailed work will be informed through local engagement with local people, patients and carers, and other stakeholders. Robert Woolley said that the scale of the task was enormous and would take time to implement. He talked about the principles of the Sustainability and Transformation Plan helping to empower patients and communities to help shape local care provisions. David Armstrong was pleased with the work in relation to the plan and said that he felt there would be a need for skilled project management to implement the plan. Alison Ryan commented on the provision of the plan and stated that the approach seemed service and not patient focussed. She felt a patient centred approach would be more effective. Robert Woolley confirmed that due to time constraints, this had not been achieved in the current plan, but this was very much the intention going forward. The Board agreed to approve the plan and receive further updates as work progressed. **Members RESOLVED to:** • **Receive** the Sustainability and Transformation Plan; • **Agree** the Sustainability and Transformation Plan in its current stage of development as the basis for further detailed work leading to implementation of relevant portfolios, programmes and projects; and • **Agree** to receive further updates as this work is progressed.	
139/11/16	**Finance Report (Item 13)**	
	Members received the Finance Report and noted that the summary income and expenditure statement showed a surplus of £9.086m (before technical items) for the first seven months of the year. This included £7.014m of sustainability funding – the position represented a surplus of £2.072m without this funding. The operating plan required a surplus of £9.488m at month seven, therefore the Trust was £0.402m adverse against this plan. Kate Parraman confirmed that October had been a better month in terms of activity and the CQUIN achievement. She said nursing pay expenditure continued to be a challenge. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	

Minute Ref	Item Number	Action
140/11/16	**Finance Committee Chair's Report (Item 14)**	
	Members received the report from the meeting of the Finance Committee held in November 2016. Lisa Gardner said their focus continued to be on workforce and reduction of agency costs. She said they had received a positive presentation from Deborah Tunnell, Head of HR Service Centre on the work being done on retention and recruitment. Lisa Gardner confirmed that the Committee had an on-going focus on the Trust's financial position for this year and the achievement of the position utilising non-recurring items. Carolyn Mills said she and Owen Ainsley had been approving out of hour requests for ambulance queue nurses, on behalf of the chief executive, as there had been an increase in demand, which had been above the funded establishment for wards. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's report for assurance.	
141/11/16	**Taking further action to reduce agency spend (Item 15)**	
	Members received the report for assurance and noted that NHS Improvement had written to all Trust Chairs, Chief Executives and Finance Directors to lay out actions needed to reduce agency spend, which include promoting transparency, better data, stronger accountability to Boards and additional reporting of high-cost overrides. Members received an update on the actions that were being taken by the Trust and the improved levels of scrutiny in relation to high cost agency usage. Members agreed to approve the self-certification checklist for onward submission to NHS Improvement. **Members RESOLVED to:** • **Receive** the report for assurance; and • **Approve** the Board self-certification checklist for submission to NHS Improvement.	
142/11/16	**Changes to the Trusts Constitution (Item 16)**	
	Members received the report for approval and noted that the report contained the Trust Constitution proposed by the Governor Constitution Project Focus Group on 1 September 2016 and agreed by the Council of Governors on 31 October 2016. The Board agreed to approve the Trusts Constitution.	

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Receive** the report; and • **Approve** the changes to the Trust Constitution.	
143/11/16	**Governors' Log of Communications (Item 17)**	
	The report provided the Board with an update on governors' questions and responses from Executive Directors. **Members RESOLVED to:** • **Note** the Governors' Log of Communications.	
144/11/16	**Any Other Business (Item 18)**	
	The Board had no other urgent business.	
145/11/16	**Date of Next Meeting (Item 19)**	
	Thursday 22nd December 2016, 9-10am, Conference Room, Trust HQ, Marlborough St, Bristol,BS1 3NU	

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

Minutes of the Public Trust Board Meeting

Held on 22nd December 2016 09:00am-10:00am, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

Present
Board Members

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

In Attendance

Name	Job Title/Position
Garry Williams	Patient Governor
Kate Hanlon	Interim Head of Membership & Governance

Minutes:

Zainab Gill	Corporate Governance Administrator

The Chair opened the Meeting at 09:00am

Minute Ref	Item Number	Action
146/12/16	**Welcome and Introductions (Item 1)**	
	Apologies were noted from Owen Ainsley, Interim Chief Operating Officer and Pam Wenger, Trust Secretary.	
147/12/16	**Declarations of Interest (Item 2)**	
	In accordance with Trust standing orders, all Board members present were required to declare any conflicts of interest with items on the meeting agenda. There were no new declarations made.	

Minute Ref	Item Number	Action
148/12/16	**Operating Plan 2017/18 (Item 3)**	
	The Board received the draft two year Trust Operational Plan for review and formal approval. Paula Clarke confirmed to the Board that the draft two year Operational Plan had already been summited to NHS Improvement in November and that the Board were being asked to approve the final narrative plan and the self -certification. The Board noted the key points detailed in the plan, which included the following: - Alignment with the aspirations and relevant specific actions of the developing Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan (BNSSG STP); - A reflection of the Trust's leadership role within the Sustainability and Transformation Plan based on the Trust's record of delivery of sustainable, affordable, quality care and our intent to bring this experience into the system including our support for and engagement in the adoption of an open book approach through joint contract meetings with our commissioners; - Clarity and ownership of stretching quality priorities delivered through enabling quality improvement frameworks; - Workforce plans aligned to finance, activity and quality and addressing robust accountability for managing agency and locum expenditure; - A commitment to deliver improvements in core access and NHS Constitution standards aligned to proposed performance trajectories; - Detailed financial plans for 2017/18 with 2018/19 plan included as a best estimate. The Trust's position for 2017/18 reflects rejecting of the 2017/18 Control Total advised by NHS Improvement of £22.8m net surplus. This results in the forfeit of Sustainability & Transformation (S&T) funding of £13.3m and the Trust being subject to national core penalties currently assessed at £2.5m and contributes to a 2017/18 deficit plan of £10.2m. Given the Trust's track record of delivering a surplus plan for the last fourteen years, the Trust still wishes to discuss with NHS Improvement how a surplus plan can be created and delivered for 2017/18 and beyond.	

Minute Ref	Item Number	Action
	The self-certification attached at Appendix 1. Paula Clarke drew the Board's attention to a required change in the wording on page 5, section 5.6 of the plan in relation to commissioners accepting the need to derogate. She explained that commissioners were not in a position to do this, however recognised that without investment the Trust would not be in a position to meet the required standard set by them. The Board went on to discuss the agreed approach in relation the financial position and the deficit plan. Paula Clarke said that the decision to reject the control total was unavoidable, but reassured the Board that the focus now continued to be on addressing savings challenges identified in the plan, alongside absorbing new cost pressures, including the junior doctors' contract for which the cost was still unknown and addressing the loss in the baseline CQUIN funding. She went on to confirm that the plan recognised the need for alignment with the Sustainability and Transformation Plan and where possible identified specific actions that helped progress implementation of the Sustainability and Transformation Plan. Paul Mapson advised that some of the risks highlighted in the plan relating to the financial position were national issues. He further confirmed that in relation to the commissioner contracts the Trust is unable to commit to many service developments as commissioners have confirmed that they are unable to fund any additional service developments in 17/18. He reassured the Board that he was hopeful that there would be a national CQUIN review and an opportunity to address the challenges around the Trust's Control Total with NHS Improvement. The Board agreed that the earlier deadline for contract sign off was positive as it would allow additional time in 2017 to focus on developing a robust delivery plan. Alison Ryan referred to the workforce section of the plan and asked for additional narrative to be included around the workforce race equality scheme. Alex Nestor and Paula Clarke agreed to include suggested addition. In response to a query from David Armstrong, Paula Clarke confirmed that the Trust will work closely with both internal and external enablers as outlined in the Sustainability and Transformation Plan though not detailed in this plan due to the limited word count. Jill Youds endorsed the decision taken by the Board to reject the	

Minute Ref	Item Number	Action
	control total and expressed her disappointment with the lack of transparency in how the Control Total is set. She reaffirmed concerns around agency spend and actions being taken to tackle this. Paul Mapson advised that the self-certification included in the plan was key confirming that he believed that the Trust was presenting a credible plan that demonstrates good governance. Emma Woollett supported the decision to reject the control total, and the need to focus on the underlying divisional shortfalls and not on non-transparent figures relating to the Control Total. John Savage commented on the hard work involved in producing the plan and asked that the Board's gratitude be passed on to all those involved. **Members RESOLVED to:** • **Approve t**he 2017 – 19 Operational Plan for submission to NHS Improvement by Noon on 23 December 2016.	
149/12/16	**Any Other Business (Item 4)**	
	The Board had no other urgent business.	
150/12/16	**Date of Next Meeting (Item 5)**	
	31st January 2017 11:00am-1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol,BS1 3NU	

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

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Board of Directors meeting held in Public 29 November 2016 and 22 December 2016
Action tracker

Completed actions following the meetings held on the 29 November 2016 and 22 December 2016					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	**135/11/16**	**Interim Annual Report** Consider providing the Board with an interim annual presentation illustrating the key achievements, pressures and opportunities arising over the last twelve months for all hospitals managed by the Trust.	Chief Executive	January 2017	**Complete** The Trust's Annual Report provides this summary for the last 12 months and is presented at the Annual Members' meeting.
2.	**105/10/16**	**Chief Executives Report** Confirm the position of the North Somerset Health and Wellbeing Boards briefing on the Sustainability and Transformation Plan.	Chief Executive	January 2017	**Complete** The North Somerset People and Communities Board were briefed on the Sustainability and Transformation Plan at their meeting on 6 September 2016.
3	**107/10/16**	**Board Assurance Framework Report Q2 2016-17** Receive further assurance on the controls in place around access targets	Chief Executive	January 2017	**Complete** Agenda Item.
4	**114/10/16**	**Transforming Care Programme Board** Receive an evaluation on the benefits experienced from use of the Happy App.	Director of Strategy and Transformation	January 2017	**Complete** Agenda Item.

Cover report to the Trust Board meeting to be held on Tuesday, 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	6
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Chief Executive Report		
Author	Robert Woolley, Chief Executive		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

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

Executive Summary

Purpose

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

Key issues to note

The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in December 2016 and January 2017.

Recommendations
The Trust Board is recommended to note the key issues addressed by the Senior Leadership Team in the month and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda. Members are asked to: • **Note** the report.

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

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

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

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

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

Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

N/A

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

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

Date papers were previously submitted to other committees

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

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – JANUARY 2017

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in December 2016 and January 2017.

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

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

3. STRATEGY AND BUSINESS PLANNING

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

The group **agreed** proposals for internal revenue cost pressures for 2017/2018.

The group **agreed,** in principle, to pursue a proposal in respect of the patient catering service, noting the need to agree how best to design the approach for implementation and mobilisation of the plan.

The group **noted** an update on the junior doctors' 2016 contract implementation.

The group **supported** a proposal for a Clinical Lead for Strategy and Productivity, with the caveat that it be appropriately focussed on key areas.

The group **supported** a proposal for additional discharge capacity.

4. RISK, FINANCE AND GOVERNANCE

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

The group received and **noted** the Quarter 2 Complaints and Patient Experience Reports for ongoing submission to the Quality and Outcomes Committee and Trust Board.

The group received and **noted** the Quarter 3 2016/2017 Themed Serious Incident Report, prior to submission to the Quality and Outcomes Committee.

The group received and **noted** the Quarter 3 2016/2017 update on Corporate Quality Objectives.

The group **received** the Board Assurance Framework 2016/2017 Quarter 2 update prior to onward submission to the Trust Board.

The group **approved** changes to the Corporate Risk Register.

The group **approved** revised terms of reference for the Trust Research Group.

The group **received** two medium impact Internal Audit Reports in relation to Financial Stability and Cost Improvement Plans and Datix Implementation.

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

The group **noted** the Internal Audit Protocol for information.

The group **noted** the overview of the Trust's performance against key national access and quality standards relative to national and regional providers for Quarter 2 2016/2017. This briefing provides an overview of the Trust's performance against key national access and quality standards relative to national and regional providers for Q2 2016/17.

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
January 2017

Cover report to the Trust Board meeting to be held on Tuesday, 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	7
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Board Assurance Framework 2016-17 (Quarter 3)		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☒	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☒
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☒

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

Executive Summary

Purpose

To provide assurance that the organisation is on track to achieve its strategic and annual objectives for the current year. Importantly, the Board Assurance Framework describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks so as to ensure delivery is not compromised.

The Board Assurance Framework (BAF) forms part of the Trust's risk management strategy and is the framework for identification and management of strategic risks. The BAF provides detail on key activities underway to achieving each annual objective; progress as it currently stands in-year; risks to achieving objectives; actions and controls in place to mitigate those risks; and internal and external sources of assurance to ensure the risks are being mitigated appropriately.

Key Changes

STRATEGIC PRIORITY 1:
We will consistently deliver high quality individual care, delivered with compassion
Principal Risk 1 - Failure to maintain the quality of patient services.

- Second line of assurance robust forms of assurance, some gaps in controls around business continuity arrangements.
- Action Plan to address the issues around business continuity is ongoing.
- Further development has been made to the Quality Impact Assessment process to cover and support changes to service provision and the stopping of services.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- 14 associated Corporate Risks - Addition of *Risk 910 - Risk to the provision of timely and efficient care and patient experience due to being held in the ambulance queue.*

Principal Risk 3 - Failure to act on feedback from patients, staff and our public.

- First Line level of assurance but gaps due to lack of real time patient feedback system.
- The 'Happy App' has been successfully rolled out across clinical areas.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- No associated Corporate Risks.

STRATEGIC PRIORITY 2:
We will ensure a safe, friendly and modern environment for our patients and our staff
Principal Risk 2 - Failure to develop and maintain the Trust estate.

- Second line level of assurance in relation to Health and safety issues, third line in respect of Internal Audit work programme.
- Gaps in assurance around roof and drain maintenance being addressed via operational and capital work programme for 2016/17, the impact of roof and drain issues on bed capacity and flow have reduced in year.
- Previous Risk Rating 8, Current Risk Rating 8, static trajectory.
- No associated Corporate Risks.

STRATEGIC PRIORITY 3:
We will strive to employ the best staff and help all our staff fulfil their individual potential
Principal Risk 4 - Failure to recruit, train and sustain an engaged and effective workforce.

- First & second line assurance around reporting arrangements and agency action plan now in place.
- Metrics continue to highlight risk around staff retention, although improving (see corporate risk 674).
- Previous Risk Rating 12, Current Risk Rating 12, static trajectory.
- 3 associated Corporate Risks.

STRATEGIC PRIORITY 4:
We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.
Principal Risk 5 - Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.

- Second line assurance in place but gaps identified Trust wide around supporting innovation and improvement, to be addressed by implementation of Innovation Strategy.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- No associated Corporate Risks.

STRATEGIC PRIORITY 5:
We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.

Principal Risk 6 - Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.

- Second line assurance currently in place with potential for feedback via STP from BNSSG.
- Bid for research funding from NIHR successful.
- Partnership meetings now in place with NBT, UoB, UWE and memorandum of understanding in place with UoB.
- Senior staff involvement in North Somerset sustainability board programme
- Previous Risk Rating 6, Current Risk Rating 6, static trajectory.
- No associated Corporate Risks.

STRATEGIC PRIORITY 6:
We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.

Principal Risk 7 - Failure to sustain financial sustainability

- Second line assurance in place via internal reporting and divisional reporting arrangements, weak controls and gaps in assurance identified.
- Previous Risk Rating 9, Current Risk Rating 9 static trajectory.
- 3 associated Corporate Risks - Addition of *Risk 1843 - Trust's 2016/17 Operational Plan Control Total surplus of £15.9m*

STRATEGIC PRIORITY 7:
We will ensure we are soundly governed and are compliant with the requirements of our regulators

Principal Risk 8 - Failure to comply with targets, statutory duties and functions

- Robust second level assurance in place and third level in respect of NHS Improvement returns and CQC inspections.
- No significant gaps identified in either controls or assurance,
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- 6 associated corporate risks, reduction of one risk *1413 Risk of non-compliance with IG Toolkit at level 2 2016/17*, due to improvement in essential training compliance.

Summary

The current scores for principal risks are summarised in the following heat map - there has been no movement in Q3.

	Likelihood				
Impact	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic					
4 Major					
3 Moderate			1, 3, 5, 7, 8	4	
2 Minor			6	2	
1 Negligible					

Recommendations

Members are asked to:

- **Review** the information contained within the report

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

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☒
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☒	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☒
Failure to maintain financial sustainability.	☒	Failure to comply with targets, statutory duties and functions.	☒

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

Impact Upon Corporate Risk
None identified.

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Risk Management Group**
16/01/2017				10/01/2017

University Hospitals Bristol NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

Q3 2016-17

1. Board Assurance Framework for the delivery of Objectives.

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process. The Board achieves this, primarily through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.

2. The Trust Strategy

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

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

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

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

2.1 Trust Strategic Priorities

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

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

3. 2016/17 Priorities

The following priorities are outlined in our 2016/17 annual NHS Improvement Operational Plan.

	1. Care and Quality
1.1	Delivery of 12 Quality Objectives as follows; • Reducing cancelled operations; • Ensuring patients are treated in the right ward for their clinical condition; • Improving management of sepsis; • Improving timeliness of patient discharge; • Reducing patient-reported in-clinic delays for outpatient appointments, and keeping patients informed about how long they can expect to wait; • Reducing the number of complaints received where poor communication is identified as a root cause; • Ensuring public-facing information displayed in our hospitals is relevant, up-to-date, standardised and accessible; • Ensuring inpatients are kept informed about what the next stage in their treatment and care will be, and when they can expect this to happen; • Fully implementing the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted; • Increasing the proportion of patients who tell us that, whilst they were in hospital, we asked them about the quality of care they were receiving; • Reducing avoidable harm to patients; and • Improving staff-reported ratings for engagement and satisfaction.
1.2	Achievement of our 'Sign up to Safety' priorities as follows; • Early recognition and escalation of deteriorating patients to include early recognition and management of sepsis and acute kidney injury; • Medicines safety at the point of transfer of care with cross system working with healthcare partners; • Developing our safety culture to help us work towards, for example, zero tolerance of falls; and • Reducing never events for invasive procedures.
1.3	Delivery of the two objectives identified in the Medical Royal Colleges 2014 "*Guidance for taking responsibility: Accountable clinicians and informed patients" as follows;*

	"*A patient's entire stay in hospital should be coordinated and caring, effective and efficient with an individual named clinician – the Responsible Consultant/Clinician – taking overall responsibility for their care whilst retaining the principles of multidisciplinary team working"; and* "*Ensuring that every patient knows who the Responsible Consultant/Clinician, with this overall responsibility for their care is and also who is directly available to provide information about their care – the Named Nurse".*
1.4	Participate in the annual publication of avoidable deaths.
1.5	Demonstrate affordable progress towards delivery of the four key seven day services standards by 2020.
1.6	Further embed hosted Operational Delivery Networks (ODN), including paediatric neurosciences, Congenital Heart Disease and Critical Care.
1.7	Delivery of agreed specialised and local CQUIN targets.
	2. Non-Financial Performance
2.1	Deliver the agreed performance trajectories for Referral To Treatment (RTT), 6 week diagnostic, Cancer and the Accident and Emergency (A&E) four hour waiting standard.
2.2	Effective cross sector and patient flow remains a challenge due to external system wide factors. Work actively with our partners and through the STP, Better Care Programme and Urgent Care Network to develop and implement plans to improve flow and materially reduce the number of patients with a delayed discharge.
2.3	Successful implementation of the Orla Healthcare community based 'virtual ward'.
	3. IM&T and Estates
3.1	Continue with the necessary upgrading of the Estate along with medical equipment replacement.
3.2	During the coming year we will continue to deploy new digital capability throughout the Trust, further embedding and extending existing functions with particular emphasis on: • Rolling out digital case notes across our other hospital sites together with the implementation of e-forms and workflow automation; • Commencing delivery of a new nursing e-observations and replacement e-rostering systems; • Going live across the Trust with electronic prescribing and medicines administration; • Providing more convenient access to our systems and services through the wider use of mobile technology and telehealth techniques; and • Delivering the objectives of the Clinical Utilisation Review (CUR) by using existing systems rather than purchasing duplicate systems which are not supported by Clinicians or the IT function.
3.3	Development of our innovation and technology strategy
	4. Financial Performance
4.1	Maintain sound financial control working to a surplus plan for the 14th year running, albeit caveated with significant remaining risks – both from Commissioner SLAs and internal pressures.
4.2	Delivery of 16/17 income plans and Cost Improvement Programme.
4.3	Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital.

	5. Organisational and System Strategy and Transformation
5.1	Complete a full refresh of our Trust strategy in Autumn 2016, along with the development of a new governance structure for strategic planning and implementation, to ensure that we are aligned to the system wide Sustainability and Transformation Plan (STP) and maintain the recommendations of the Well Led Governance Review.
5.2	Further evaluate opportunities to continue to develop our specialised services portfolio throughout 2016/17.
5.3	Development of the system Sustainability and Transformation Plan - take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.
	6. Workforce and Engagement
6.1	Further development and implementation of strategic workforce plans, linked to the evolving STP.
6.2	Achieve NHS Improvement's locum and agency expenditure requirements.
6.3	Successful implementation of workforce recruitment and retention plan.
6.4	Delivery of agreed workforce KPIs.
6.5	Development and delivery of staff engagement plan, linked to the learning from the results of the 2015 staff survey.

4. Principal Risks

- **Principal Risk 1:** Failure to maintain the quality of patient services.
- **Principal Risk 2**: Failure to develop and maintain the Trust estate.
- **Principal Risk 3:** Failure to act on feedback from patients, staff and our public.
- **Principal Risk 4:** Failure to recruit, train and sustain an engaged and effective workforce.
- **Principal Risk 5:** Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.
- **Principal Risk 6:** Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.
- **Principal Risk 7:** Failure to maintain financial sustainability.
- **Principal Risk 8:** Failure to comply with targets, statutory duties and functions.

Risk scoring = consequence x likelihood

	Likelihood				
score	**1**	**2**	**3**	**4**	**5**
Consequence	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 – 6	Moderate risk
8 – 12	High risk
15 – 25	Very High risk

The current scores for principal risks are summarised in the following heat map.

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic					
4 Major					
3 Moderate			1, 3, 5, 7, 8	4	
2 Minor			6	2	
1 Negligible					

University Hospitals Bristol Control Framework

Vision, organisational priorities and outcomes, aims, values and behaviours, policies and procedures, budget and budget control, performance measures and trajectories and management of associated risks

Leadership → Staff → Systems and Processes → Finances → Technology

Controls and Assurance Mechanisms

High Quality Care

***Controls*: evidenced within**

- Operational Plan 2016/17 – Strategic and annual objectives
- Commissioning
- Annual Quality Objectives
- intentions and plans
- Capital and Estates Strategy
- Quality Impact Assessment protocol
- Equality Impact Assessment

***Assurance*: gained via**

- Quality and Outcome Committee
- Divisional Quality Groups
- Senior Leadership Team
- Annual Quality Statement
- Annual Report and Annual Governance Statement
- Chairs Reports
- Visits and Inspections

Performance Management

***Controls*:**

- Objectives and Appraisals
- Performance targets
- Performance Dashboards and monthly reporting
- Regular Performance and Quality reports
- Concerns and Patient Experience Reports
- Serious Incident Reporting

***Assurance*: gained via**

- Divisional Boards, Service/Ward levels
- Escalation arrangements
- Audits, visits
- Executive Director and Senior Leadership Team meetings
- Quality and Outcomes, Finance and Audit Committees
- Internal/External Audits

Risk Management

***Controls*:**

- Risk management strategy and Policy
- Board Assurance Framework
- Corporate Risk Register
- Divisional Risk Register

Reports to the Board, Senior Leadership Team and sub committees

Policies and Procedures

Scheme of Delegation

***Assurance*: gained via**

- Divisional Boards, Service/Ward levels
- Escalation arrangements
- Internal/External Audits, visits
- Executive Director and Senior Leadership Team meetings
- Quality and Outcomes, Finance and Audit Committees
- Risk Management Group

Levels of Assurance

VISION AND CORPORATE PRIORITIES

First Line
Operational

- Organisational structures – delegation of responsibility through line Management arrangements
- Appraisal process
- Policies and Procedures
- Incident reporting and thematic reviews
- Risk Management processes and systems
- Performance Reports, Complaints and Patient Experience Reports, Workforce Reports, Staff Nursing Report, Finance Reports

Second Line
Risk and Compliance

Assurance and Oversight Committees

- Audit Committee
- Finance Committee
- Quality and Outcomes Committee
- Remuneration Committee
- Risk Management Group, Clinical Quality Group, Health and Safety Groups etc

Findings and/or reports from inspections, Friends and Family Test, Annual Reporting through to Committees, Self-Certification NHS Improvement

Third Line
Independent

- Internal Audit Plan 2016-17
- External Audits (eg. Annual Accounts and Annual Report)
- CQC Inspections/NHS Improvement
- Visits by Royal Colleges
- Independent Reviews – Verita Investigations
- Independent Review Paediatric Cardiac Surgery
- Well Led Governance Review

REGULATORS

EXTERNAL AUDIT

Key

The Assurance Framework has the following headings:

Principal Risk	What could prevent the objective from being achieved? Which area within organisation does this risk primarily impact on – clinical, organisational or financial?
Key Controls	What controls / systems do we have in place to assist secure delivery of the objective?
Form of Assurance	How are the controls monitored?
Level of Assurance	What does the evidence tell us in relation to the effectiveness of the controls / systems which are being relied on
Gaps in Controls	Gaps in control: Are there any gaps in the effectiveness of controls/ systems in place?
Gaps in assurance	Where can we improve evidence about the effectiveness of one or more of the key controls / systems which we are relying on?
Actions Agreed for any gaps in controls or assurance	Plans to address the gaps in control and / or assurance
Current Risk Rating	Assessment of the risk taking into account the strength of the controls currently in place to manage the risk
Direction of travel	Are the controls and assurances improving? ↑ ↓ ↔
Ref	This should include the reference to the Strategic Priorities and also align with the top corporate risk register

STRATEGIC PRIORITY 1 :
We will consistently deliver high quality individual care, delivered with compassion

OPERATIONAL PLAN 2016/17 PRIORITIES	**Quality and Care** • Delivery of 12 Quality Objectives • Achievement of our 'Sign up to Safety' priorities • Delivery of the two objectives identified in the Medical Royal Colleges 2014 "*Guidance for taking responsibility: Accountable clinicians and informed patients* • Participate in the annual publication of avoidable deaths. • Demonstrate affordable progress towards delivery of the four key seven day services standards by 2020. • Further embed hosted Operational Delivery Networks (ODN), including paediatric neurosciences, Congenital Heart Disease and Critical Care. • Delivery of agreed specialised and local CQUIN targets.				**Non-Financial Performance** • Deliver the agreed performance trajectories for Referral To Treatment (RTT), 6 week diagnostic, Cancer and the Accident and Emergency (A&E) four hour waiting standard. • Effective cross sector and patient flow remains a challenge due to external system wide factors. Work actively with our partners and through the STP, Better Care Programme and Urgent Care Network to develop and implement plans to improve flow and materially reduce the number of patients with a delayed discharge. • Successful implementation of the Orla Healthcare community based 'virtual ward'.				
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Principal Risk 1 - *Failure to maintain the quality of patient services.*	Serious Incident process Risk Management Strategy and Policy Professional Standards and Code of Practice/Clinical Supervision Whole system approach being delivered through the Urgent Care Network. QIA process for savings schemes meeting specific criteria Trust Values Quality Objectives Productive theatre initiative to reduce the number of cancelled Operations. Sign up to Safety Campaign Business Continuity and Emergency planning arrangements NICE guidelines self-assessments/ Clinical Audit Programme. NICE guidelines self-assessments/ Clinical Audit Programme. Monitoring of RTT Performance Monitoring of Access Performance: • RTT Operations Group / RTT Steering Group • Cancer PTL Meetings / Cancer Performance Improvement Group / Cancer Steering Group • Emergency Access Steering Group • Divisional Access performance scorecards • Divisional Monthly Reviews with Executive Team	Reports to Quality and Outcomes Committee. Annual Governance Statement providing assurance on the strength of Internal Control regarding risk management processes, review and effectiveness Annual Report. Quality metrics demonstrate that despite operational pressures, our patients are receiving good quality care despite delays in their discharge. Quality Account. Quality Strategy Reports to Clinical Quality Group. External - EPRR assessment (NHSE) Internal - self assessment Clinical Quality Group/Clinical Audit Group reporting mechanisms. Reports to SDG, SLT Trust Board	Internal performance reports form first line assurance. Reports to: • Trust Board, • Service Delivery Group • Senior Leadership Team • Audit Committee • Quality & Outcomes Committee • Clinical Quality Group Form second line assurance External audit/review forms third line assurance. Formal confirmation received from NHSE of improved EPRR position (from non-compliant to partially compliant).		Emergency Preparedness, Resilience and Response (EPRR) externally assessed as partially compliant.	Ongoing action Plan in place to address the issues around business continuity Further development of the Quality Impact Assessment process to cover /support changes to service provision/stopping of services	Chief Nurse & Chief Operating Officer **Quality and Outcomes Committee**	Possible x Moderate 9	↔

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Principal Risk 3 - *Failure to act on feedback from patients, staff and our public.*	**Stakeholder feedback:** Participation in the national patient surveys. Comments cards available on wards and in clinics. The Friends and Family Test administered at discharge in day case, inpatient and Emergency Department settings Teams of volunteers visit wards to interview patients whilst at UH Bristol A monthly post-discharge inpatient, outpatient, parent and maternity survey is undertaken and volunteers who undertake the 15 Step Challenge in wards. Patient Stories are a monthly item on the Trust Board agenda. **Staff feedback:** National Staff Survey Regular staff workshops are held to gather feedback and views from staff members in an informal setting. The Staff Friends and Family Test. Other, local or more specific surveys/focus groups also take place sickness and turnover). Monitoring of progress in the achievement of KPI's. Happy App in clinical areas initially.	Programme of regular quality reports and reporting to committees and Board including: patient safety, workforce; patient experience; serious incidents; complaints; and trust wide learning Quality meetings with commissioners and information shared as part of the annual quality schedule; including serious incident investigation outcomes. Regular attendance of Trust staff at local authority overview and scrutiny committee meetings. Appointed governors on the Council of Governors from partner organisations including the local authority and universities. Council of Governor meetings Governor focus groups Non-Executive Director Counsel meetings Governors log of queries and concerns Internal Audit of Staff Engagement	Regular reports and KPI's form first line assurance. Reports to: • Trust Board, • Quality & Outcomes Committee • Meeting with Commissioners • Local Authority Overview & Scrutiny Committee • Council of Governor Meetings • Governor Focus Groups • NED Counsel Form second line assurance Internal Audit forms third line assurance.	Happy App not in all areas.	Although some of the patient feedback collected corporately is made available directly to inpatient wards (e.g. via posters and circulation of spreadsheets), there is an opportunity to make this more rapidly available and more accessible to ward staff.	The Patient Experience & Involvement Team is continuing to explore a solution to this, with a focus on responsiveness to patients' needs. Funding has been identified to procure a new patient feedback system during 2016/17. Roll out Happy App across whole organisation.	Chief Nurse & Director of Human Resources and Organisational Development **Quality and Outcomes Committee**	Possible x Moderate 9	↔

STRATEGIC PRIORITY 2 :
We will ensure a safe, friendly and modern environment for our patients and our staff

OPERATIONAL PLAN 2016/17 PRIORITIES	**IM&T and Estates** • Continue with the necessary upgrading of the Estate along with medical equipment replacement • During the coming year we will continue to deploy new digital capability throughout the Trust, further embedding and extending existing functions with particular emphasis on: ○ Rolling out digital case notes across our other hospital sites together with the implementation of e-forms and workflow automation; ○ Commencing delivery of a new nursing e-observations and replacement e-rostering systems; ○ Going live across the Trust with electronic prescribing and medicines administration; ○ Providing more convenient access to our systems and services through the wider use of mobile technology and telehealth techniques; and ○ Delivering the objectives of the Clinical Utilisation Review (CUR) by using existing systems rather than purchasing duplicate systems which are not supported by Clinicians or the IT function.

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Principal Risk 2 - *Failure to develop and maintain the Trust estate*	Incident reporting and risk assessments at Divisional and Departmental level. Regular inspections Internal Audit work programme. Recent PLACE (Patient-led assessments of the care environment) inspection reports did not surface any key risks.	Reports to Audit Committee, Risk Management Group, Divisional Boards and Health and Safety Groups Findings from inspections are included in reports to assurance committees. External audit of the Trust's Annual Accounts and Annual Report. Findings from independent assessments are included in reports to assurance committees.	Regular inspections form first line assurance. Reports to: • Trust Board, • Audit Committee • Divisional Boards Form second line assurance External assessment and audit forms third line assurance.	No significant gaps in controls.	Incident reporting in relation to aspects of estate, reveal limited assurance in respect of drain blockages and roofs	Operational and capital works programme for 16/17 provides resources to address issues in relation to drains and roofs (both to improve controls and mitigate future risks).	Chief Operating Officer **Service Delivery Group**	Major x Unlikely 8	↔

STRATEGIC PRIORITY 3 : **We will strive to employ the best staff and help all our staff fulfil their individual potential**									
OPERATIONAL PLAN 2016/17 PRIORITIES	**Workforce and Engagement** • Further development and implementation of strategic workforce plans, linked to the evolving STP. • Achieve NHS Improvement's locum and agency expenditure requirements. • Successful implementation of workforce recruitment and retention plan. • Delivery of agreed workforce KPIs. • Development and delivery of staff engagement plan, linked to the learning from the results of the 2015 staff survey.								
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Principal Risk 4 - *Failure to recruit, train and sustain an engaged and effective workforce.*	HR Policies and Procedures Clear accountability at Divisional level Trust wide learning opportunities Monthly compliance reports on Essential Training are sent to Divisions and include trajectories to achieve compliance. Appraisal Process/Personal Development Plan Corporate and Local Induction Quality objective on staff engagement Agency Controls Group. Divisional Reviews including performance against workforce plans Health and Wellbeing Programme (to include delivery of the NHS Staff Health and Wellbeing CQUIN 2016/17). Comprehensive development plans at Divisional and trust wide level. Staff Recognition Awards.	Metrics in relation to key controls are reviewed by the Senior Leadership Team, QOC and Trust Board: Staff survey results/ Exit Interviews. Review of ET compliance. Annual learning and development report. Health and Safety Reports. Friends and Family Test. Weekly returns agency staffing. Agency action plan.	Regular internal reports form first line assurance. Reports to: • Trust Board, • Senior Leadership Team • Quality Outcome Committee Form second line assurance .	Metrics indicate we have a risk around staff retention, although improving.	Limited assurance primarily around achieving compliance with essential training rates.	Refresh of the Workforce and Retention Strategy. Mid-year review of workforce KPIs to understand forecast out turn.	Director of Workforce and Organisational Development **Trust Board**	Major x Possible 12	↔

STRATEGIC PRIORITY 4 : We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.									
OPERATIONAL PLAN 2016/17 PRIORITIES	• Development of our innovation and technology strategy								
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Principal Risk 5 - *Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.*	Memorandum of agreement with University of Bristol. Joint Posts. Clinical Networks. Research Standing Operating Procedures. Process in place for corrective and preventative actions where breaches of GCP/protocol are identified to support learning by PI/CI and research team. Regular review of research recruitment on a trust-wide level. Key Performance Indicators at divisional level (bed holding only) finalised for regular divisional review. Staff engagement embedded in planning service improvement and transformation work via direct involvement and variety of communication mechanisms. Transformation and other service improvement leads networked across the divisions – role includes identifying and supporting local innovation. Partnership with the Academic Health Science Network to train a cohort of improvement coaches to add capacity to this support network. Programmes such as Bright Ideas. During 16/17 review of approach to supporting innovation across the Trust planned (take stock of current work, identify gaps in support, develop solutions). Research grants, Research Capability Funding, commercial and delivery income maintained. SPAs recognised in consultant job plans.	Trust Research Group. Divisional research committees/groups. Regular reports to the Board KPI reviews (trust wide & divisional) Board metrics. Audit/inspections. Education and Training Annual Report Project steering groups /reporting to Transformation Board & Senior Leadership Team. Regular reports to the Trust Board. Evidence of wide range of innovation and improvement programmes completed/underway. Good response to Bright Ideas/Trust Recognising Success awards. NIHR award £21m over 5 years for Biomedical Research Centre to Trust and UoB partnership	Regular reviews form first line assurance. Reports to: • Trust Board, • Quality & Outcomes Committee • Divisional Groups • Transformation Board Form second line assurance Internal/External Audit/inspections forms third line assurance.	Medicine divisional research meetings now in place; Surgery, Head and Neck divisional research committee/group under review, but due to change in Clinical Chair timelines to be revisited during Q4 Need to better connect scope of activity underway across all aspects of improvement and innovation and clarify routes to support for proposals. Consider provision of access to basic improvement toolkit via e-learning. Better communication and promotion of improvement priorities required to provide mechanisms for increased staff input to these priorities (e.g. Happy App).	Clear mechanism for protecting time for non-medical PIs recruiting to National Institute of Health Research portfolio trials not in place. Additional methods of assurance to be identified in review of innovation.	Work in progress to address the divisional research committee's gaps. Review of Trust approach to supporting innovation and improvement to identify and address specific gaps. (Sept 2016) Workshops held in May and June to establish degree of connectedness of wide range of innovation/improvement work underway, identify gaps/duplication and develop proposals for further testing. Plan/strategy to be developed for consideration at Transformation Board with final approval by end of October 2016. Plan for supporting Innovation & Improvement presented to Transformation Board in October. Recommendations were fully supported, and team given go ahead for implementation. Action plan agreed and mobilisation of work now underway.	Medical Director **Trust Board**	Moderate x Possible 9	↔

STRATEGIC PRIORITY 5 : We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.

OPERATIONAL PLAN 2016/17 PRIORITIES	**Organisational and System Strategy and Transformation** • Complete a full refresh of our Trust strategy in Autumn 2016, along with the development of a new governance structure for strategic planning and implementation, to ensure that we are aligned to the system wide Sustainability and Transformation Plan (STP) and maintain the recommendations of the Well Led Governance Review. • Further evaluate opportunities to continue to develop our specialised services portfolio throughout 2016/17. • Development of the system Sustainability and Transformation Plan - take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Principal Risk 6 - *Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.*	Executive to Executive meetings with NBT. Partnership Programme Board with NBT. Partnership meeting and MOU in place with UoB 4 way Partnership meeting with NBT, UoB, UWE Chief Executive agreed as local system leader for STP for BNSSG with other Executives playing lead roles within the STP processes. Range of senior staff involvement in NS Sustainability Board programme Staff involved in wide range of external activities e.g. Bristol Health Partners, Better Care Bristol, CLAHRC West, BNSSG System Leadership Group.	Board Partnership Reports. Reports to Trust Board. Staff survey feedback. Appraisal process KPI. "Critical Friend" approach being considered within STP process. Tender Framework in place from April 2016 explicitly addressing partnership opportunities. Evidence in recent tenders that Trust is a sought after partner - Children's Community Services; Sexual Health National feedback on Sustainability and Transformation Plan processes and leadership. Bristol Research Centre successful bid for NIHR funding 2016 No indication in current self-assessment within STP of adverse perceptions.	Internal reviews and monitoring of KPI's form first line assurance. Reports to: • Trust Board, Form second line assurance	Complete visibility of scope of staff engagement in external activities challenging and not necessarily required.	No significant gaps. Ability to harness soft information.	None.	Director of Strategy and Transformation **Trust Board**	Moderate x Unlikely 6	↔

STRATEGIC PRIORITY 6 : We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal									
OPERATIONAL PLAN 2016/17 PRIORITIES	**Financial Performance** • Maintain sound financial control working to a surplus plan for the 14th year running, albeit caveated with significant remaining risks – both from Commissioner SLAs and internal pressures. • Delivery of 16/17 income plans and Cost Improvement Programme • Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital.								
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Principal Risk 7 - *Failure to sustain financial sustainability*	Budgetary control systems in place. Scheme of delegation and agreed budget holders. Financial Control Procedures. Standing Financial Instructions. Monthly Divisional CIP reviews. Monthly Finance & Operational Divisional Performance reviews. Divisional Board monthly scrutiny of operational and financial performance. Monthly review of financial performance with Divisional budget holders. Monthly Divisional contract income and activity reviews, savings reviews. Monthly savings work stream reviews. Monthly review by Savings Board Divisional control of vacancies and procurement monitored at monthly performance meetings. Income and Expenditure performance, capital expenditure, the statement of financial position and cash flow statement scrutiny at the Finance Committee.	Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital. Regular Reporting to the Finance Committee and Trust Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board. Monthly Pay Controls Group, Non Pay Controls Group and Nursing Controls Group scrutiny of Divisions performance. Detailed monthly submission of financial performance submitted to the Regulator, NHS Improvement. Capital expenditure for year to date at 85% within the 85% to 115% tolerance specified by the Regulator. Strong statement of financial position. Liquidity metric of 4 (highest) and FSRR of 4 (highest rating) for 2016/17 year to date.	Regular divisional board scrutiny and reviews form first line assurance. Reports to: • Trust Board, • Finance Committee • NHSI Form second line assurance External review of financial position forms third line assurance.	Evidence that staffing controls are weak in some areas Evidence that income and activity performance controls are weak e.g. inpatient and outpatient activity planning and delivery performance. . Underperformance, shortfall in savings delivery and high levels of nursing and medical expenditure.	Lack of assurance that pay expenditure controls are fully effective. Lack of assurance that activity capacity planning and income performance controls are fully effective. Lack of assurance that new savings ideas will be developed. Lack of assurance that capital expenditure controls for operational capital and major medical equipment are fully effective Limited assurance that all controls are effective in light of continued spend above plan in some areas e.g. agency spend. Weak assurance in Divisions given adverse positions to Operating Plans largely due income.	Prioritised Executive review at Divisional Reviews. Transformation Board and productivity review process via Savings Board to identify further savings. Trust Capital Group has been established to scrutinise delivery of capital plans and has met during November, December and January.	Chief Operating Officer **Finance Committee**	Moderate x Possible 9	↔

STRATEGIC PRIORITY 7 : We will ensure we are soundly governed and are compliant with the requirements of our regulators									
OPERATIONAL PLAN 2016/17 PRIORITIES	• Implementation of the recommendations from the Well Led Governance Review								
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Principal Risk 8 - *Failure to comply with targets, statutory duties and functions*	Trust Board and all committees have an annual forward plan aligned to their terms of reference, Trust's Standing Orders and Standing Financial Instructions to ensure appropriate annual reporting against plans is in place. Regular reporting to NHS Improvement following Board approval. Monitoring of CQC inspection action plans via Clinical Quality Group, Senior Leadership Team, QOC	Annual Report, Annual Governance Statement, and Annual Quality Report, Annual Account submitted to Trust Board. NHS Improvement returns signed off by the Trust Board. Internal Audit Reports on Governance, risk management and financial accounts reported to Audit Committee. Self-assessment. Monthly Board Reports. Performance and Finance Reports at each Board Meeting. Committee Reports at each Board Meeting. Independent reports from CQC on Inspection Visits.	Regular reviews form first line assurance. Reports to: • Trust Board, • Quality & Outcomes Committee • Audit Committee Form second line assurance CQC Inspection Report provides third level assurance into areas inspected.	No significant gaps in control.	Partial assurance of effectiveness of controls, in light of on-going failure of some standards.	None.	Chief Executive **Trust Board**	Moderate x Possible 9	↔

Appendix 2: Links to the Corporate Risk Register

Strategic Objective	Principal Risk	Corporate Risk Register	Current Risk Rating
STRATEGIC PRIORITY 1: We will consistently deliver high quality individual care, delivered with compassion.	**Principal Risk 1:** Failure to maintain the quality of patient services.	**423 -** Risk that length of stay does not reduce in line with planning assumptions resulting in an increase in bed occupancy. **588** - Risk of patients coming to harm or having sub-optimal outcomes due failure to recognise and respond to deterioration. **674 -** Risks of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff. **856 -** Risk that the emotional & Mental Health needs of children and young people are not being fully met. **888** - Risk of failure to deliver the agreed recovery trajectories for all RTT standards **910** - Risk to the provision of timely and efficient care and patient experience due to being held in the ambulance queue **919 -** Risk that the Trust does not meet the national standard for cancelled operations. **932 -** Risk of failure to deliver care that meets National Cancer Waiting Time Standards. **949 -** Risk that perinatal mental health services are not adequate to the needs of those requiring to access the service. **961 -** Risk of harm to patients awaiting discharge, once medically fit **1497 -** Risk of Delays in transfer of North Somerset patients due to temporary closure of Clevedon Hospital. **1595 -** Risk that patients detained under s136 may be brought to ED due to lack of capacity in community provision **1598 -** Risk of Patients Falls Resulting in Harm. **1640 -** Risk of poorer quality service for patients due to delays with reporting of histology samples following service transfer.	9
	Principal Risk 3: Failure to act on feedback from patients, staff and our public.	No corporate risk identified	9
STRATEGIC PRIORITY 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	**Principal Risk 2:** Failure to develop and maintain the Trust estate.	No corporate risk identified	8
STRATEGIC PRIORITY 3: We will strive to employ the best staff and help all our staff fulfil their individual potential**.**	**Principal Risk 4:** Failure to recruit, sustain an engaged and effective workforce.	**674 -** Risks of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff. **793 -** Risk of work related stress affecting staff across the organisation. **921 -** Risk of not achieving 90% compliance for Essential Training for all Trust staff.	12
STRATEGIC PRIORITY 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	**Principal Risk 5:** Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	No corporate risk identified	9
STRATEGIC PRIORITY 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	**Principal Risk 6:** Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	No corporate risk identified	6
STRATEGIC PRIORITY 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	**Principal Risk 7:** Failure to sustain financial sustainability.	**674 -** Risks of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff. **959 -**Risk that Trust does not Deliver 2016/17 financial plan due to Divisions not achieving their current year savings target **1843** - Trust's 2016/17 Operational Plan Control Total surplus of £15.9m	9
STRATEGIC PRIORITY 7: We will ensure we are soundly governed and are compliant with the requirements of our regulators.	**Principal Risk 8:** Failure to comply with targets, statutory duties and functions.	**801 -** Risk that the Trust does not maintain a GREEN Monitor Governance Rating **869 -** Risk of Reputational Damage Arising From Adverse Media Coverage of Trust Activities **919 -** Risk that the Trust does not meet the national standard for cancelled operations **932 -** Risk of failure to deliver care that meets National Cancer Waiting Time Standards **970 -** Potential risk of non-compliance with some of Monitor's core 4-hour Wait Clinical Indicator **1530 -** Risk of adverse operational impact arising from unplanned closure of Weston Emergency Department due to staffing shortages	9

Cover report to the Trust Board meeting to be held on Tuesday, 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	8
Meeting Title	Trust Board	Meeting Date	Tuesday, 31 January 2017
Report Title	Independent Review of Children's Cardiac Services progress report		
Author	Carolyn Mills, Chief Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential.	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

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

Executive Summary

This paper provides an update to Board members on the programme plan to deliver the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network as set out in the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and a CQC expert review of clinical outcomes of the children cardiac service published on 30 June 2016.

<u>Key issues to note:</u>

The closure of recommendation 8

- There are no risks to delivery of the recommendations detailed in the report
- Parent representatives have been appointed and attended their first steering group meeting in January (see appendix one)
- The Cardiac Families Reference Group has also begun to actively review work underway within the services to meet the Independent Review Recommendations,

prior to these actions being submitted to the Steering Group for closure (see appendix two).
Recommendations
Members are asked to: • **Receive** report for Assurance

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

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

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

Impact Upon Corporate Risk
Nil

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

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

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

1.0 Introduction

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

2.0 Programme management

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

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	
Sept '16	0	0	16	1	11	4	0 of 32
Oct '16	0	0	26	5	1	0	0 of 32
Nov'16	0	5	19	8	0	0	0 of 32
Dec'16	0	5	19	8	0	0	1 of 32

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

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	
Sept '16	0	0	13	1	4	0	0 of 32
Oct '16	0	0	15	3	0	0	0 of 32
Nov'16	0	3	9	6	0	0	0 of 32
Dec'16	0	3	9	6	0	0	1 of 32

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

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	
Sept '16	0	0	1	0	1	3	0 of 32
Oct '16	0	0	5	0	0	0	0 of 32
Nov'16	0	0	5	0	0	0	0 of 32
Dec'16	0	0	5	0	0	0	0 of 32

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

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	
Sept '16	0	0	1	0	4	0	0 of 32
Oct '16	0	0	5	0	0	0	0 of 32
Nov'16	0	2	3	0	0	0	0 of 32
Dec'16	0	2	3	0	0	0	0 of 32

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

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	
Sept '16	0	0	1	0	2	1	0 of 32
Oct '16	0	0	1	2	1	0	0 of 32
Nov'16	0	0	2	2	0	0	0 of 32
Dec'16	0	0	2	2	0	0	0 of 32

3.0 Risks to Delivery

No risks to report to the Board.

4.0 Assurance Framework

The parent representatives have now been appointed to act as the parent voice on the steering group (see Roles and Responsibility document, appendix 1). The Cardiac Families Reference Group has also begun to actively review work underway within the services to meet the

Independent Review Recommendations, prior to these actions being submitted to the Steering Group for closure (see Terms of Reference, appendix 2).

The January Steering Group meeting was attended by 4 parent representatives who provided robust challenge, advice and assurance around the progress of the review actions and the recommendations made to the steering group to close.

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

- Four parent representatives attended the steering group meeting on 9th January 2017.
- The Virtual Parents Reference Group is in place and has been used to review evidence as part of the assurance process prior to recommendation actions for closure.
- There are 15 projects in the action plan that have had, or will have, family involvement in the associated service developments.
- A young person's involvement consultation has commenced to explore how they would like to get involved and feedback on where and how the Trust could further develop/ improve service provision. The initial feedback indicated there are a range of ways young people would like to be involved in the Independent Review and ongoing service improvement work. An action plan is being developed to meet these requirements

6.0 Wider Communications

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

A 6-month review document will be produced in January 2017 to provide a simple overview of progress to date for staff, families and members of the public.

7.0 Recommendations closed

The January 2017 Steering Group approved Recommendation 8 for closure

The Trust Board is recommended to:

- Receive the progress report

Appendix 1

Parent Representative Role and Responsibility
Independent Review of Children's Cardiac Services Steering Group

1. Introduction

The Trust is responsible for the delivery of 32 recommendations from the Independent Review of Children's Cardiac Services and CQC report (http://www.uhbristol.nhs.uk/about-us/reports-and-findings-relating-to-the-children's-hospital/). A Steering Group has been set up, chaired by Carolyn Mills, Chief Nurse and Executive Lead for Children's Hospital, to ensure that the recommendations are delivered in a timely and comprehensive manner.

Parents have played an important role in bringing about significant changes and in improving the care we provide. We would like to work in partnership with parents to help deliver the recommendations of these reports. There are a number of ways we are engaging and involving parents and families in this work, and this includes inviting parent representatives on the Steering Group. Parent representative on the Steering Group will play an important part in supporting and informing the implementation of the recommendations from a parent and family perspective.

2. What is a parent representative?

A parent representative is a member of a group or committee who has personal experience of using health or care services. They offer a different point of view from people who provide or commission health care services.

Parent Representatives are appointed by the hospital to promote openness and transparency by involving and consulting the public in its work.

Parent representatives are not expected to represent the views of the wider community but rather bring a different, lay perspective to the work of the group, which professionals hear and take seriously. They are not constrained by professional protocols and can speak out, but also know how to listen and engage in constructive debate.

Parent Representatives are not paid for their work but are entitled to claim reimbursement of travel costs including mileage or public transport fees and parking.

3. What will I be asked to do?

The role of the parent representative will be to;

- Act as the voice of the parent on the Steering Group, ensuring the *interests of the families of cardiac services in the Children's hospital are represented in the implementation and sign off of the recommendations.*
- *Provide advice guidance and challenge to the Steering Group to help ensure that the family involvement in the implementation has been appropriate, relevant and effective.*

- *Be part of the virtual parents reference group (please see Cardiac Families Group Terms of Reference for more detail) and* to be the link and liaison between the Steering Group and the parents reference group – disseminating information and updating both groups as required.
- Support the assessment of whether a recommendation, should be signed off as effectively completed from a parent/family perspective.

- *To engage in the monthly meetings of the Independent Review Steering Group meeting by reviewing the meeting papers and providing input/comments prior to the meeting taking place or by attending the meeting if possible (Times and dates of meeting currently being reviewed).*

- Maintain confidentiality at all times and to comply with UH Bristol Health & Safety Policy, Information Governance policy, Safeguarding and Equalities legislation and other relevant policies. These will be provided at the commencement of your role.

- As Parent Representatives you <u>are not</u> responsible for the delivery of the recommendations or the delivery of any specific actions.

4. What skills and qualities will I need?

As a parent representative you will need the following skills:

- Willingness to develop an understanding of the work of the steering group and the role it plays in the Trust
- The ability to process and consider detailed information in the form of reports
- The ability to participate confidently in meetings
- The ability to focus on other individuals or on groups and organisations outside of one's own experiences.
- Empathy and the capacity to consider the needs and feelings of others
- Able to give an appropriate time commitment.
- The ability to maintain confidentiality.
- Good communications skills including respect for the views of others and the ability to listen and take part in constructive debate.

5. How will I be supported?

As a Parent Representative you will receive support from the Cardiac Review Programme Manager and the Family Involvement Working Group members. This will include:

- An initial induction to Trust policies and processes.

- Sending of papers for the Steering Group meeting plus the opportunity to discuss these prior to the meeting with the Cardiac Review programme manager

- Individual support to deliver the role, as required, including preparation for meetings and claiming your travel costs.

- A named individual to represent your views when you are unable to attend meetings and to give you feedback on the outcomes

- Ongoing support to identify development opportunities to allow you to develop in this role

You will also have the opportunity to be actively involved in the Congenital Heart Disease Network and other Children's hospital groups should you be interested.

6. Terms of Engagement

To act as a Parent Representative it would be important that you:

- Are able to commit to undertaking the responsibilities above
- Be willing to act in the best interests of all service users, independent of specific personal interests

We will ask you to complete a simple Expression of Interest form to let us know why you are interested in the role and what you would hope to gain from it. We will also ask you to complete a Disclosure and Barring form according to our standard procedures.

7. Duration

This is flexible and can be adapted to suit the individual circumstances. The implementation programme for the review is due to complete in June 2017 with a period of evaluation post implementation which we would expect to conclude by the end of the year.

We anticipate that there will then be further opportunities within the Congenital Heart Disease (CHD) Network to continue in a similar role for any parents who wish to do so.
The CHD network links together all the healthcare providers, patients and families in the South Wales and South West region. The networks vision is to ensure high quality, equitable access to care across the region; providing excellent information to patients, families and staff; collaborating to improve quality; and ensuring that there is a strong collective voice for CHD services.

We are aware that circumstances may change which may influence your ability to be part of this work. We hope that we would be able to support you with any changes or adjustments necessary but should you feel unable to continue with the role at any point, please advise the programme manager

If you would like to become a parent representative, please contact the LIAISE team on 0117 342 7444 or email bchinfo@UHBristol.nhs.uk and we will be happy to contact you to discuss this further.

Appendix 2

Terms of Reference – Cardiac Families Reference Group

Document Data		
Corporate Entity	Cardiac Reference Group	
Document Type	Terms of Reference	
Document Status	Final version 1.0	
Hospital Lead	Clinical Chair, Women and Children's Division	
Document Owner	Cardiac Review Programme Manager	
Approval Authority	Women and Children's Cardiac Review Delivery Group	
Next Review Date:	**Date of First Issue:**	**Date Version Effective From:**
	FINAL v1.0, 29/11/16	01/12/2016
Estimated Reading Time	5 mins	

Document Abstract
This document provides the Terms of reference for the Cardiac Family Reference Group, giving guidance on the purpose and makeup of the group and identifying duties carried out by the group.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
3/11/16	V0.1	Cardiac Review Family Involvement Group	Content	Content additions/deletions and amendments
17/11/16	V0.3	Cardiac Families	Content	Content additions/deletions and amendments
29/11/16	V1.0	Cardiac Review Family Involvement Group	Content	Content additions/deletions and amendments

What is the Group for?

This group is for supporting developments and improvements in the cardiac service both in Bristol and the wider South West Network.

Who can join this group?

The group is open to patients who are currently accessing or have accessed the cardiac service and their families. This includes both patients seen by a Cardiologist, and those who have undergone cardiac surgery.

How do you become a member?

Please let us know if you would like to become a member by emailing bchinfo@UHBristol.nhs.uk with your name and a contact number. We will telephone you to confirm the additional details we need and then send you the link to join the group. By accepting the invitation you are agreeing to the **Group Guidelines** detailed below.

What does the group do?

- Acts as a voice of the family and provides an objective "sounding board" for the cardiac service to understand their views.
- Brings together families from a wide geographic area to participate in service development where attending meetings and focus groups may be a barrier to engagement.
- Provides a forum to discuss ideas about how to develop and improve the services offered.
- Works together to reach a consensus on the best way to progress specific projects or activities.
- Supports the development of documents such as patient information leaflets, policy and guidance documents and electronic information resources.
- Helps form and facilitate task groups for various activities as and when required
- Reviews and approves, from a family perspective, actions taken as a result of any reports or reviews of the cardiac service either by internal or by external organisations

Where will the outcomes of this group be shared?

Outcomes will be shared on the hospital and Congenital Heart Disease (CHD) network website, via the hospital facebook page, and through the cardiac support groups. They will be included in the CHD network newsletter which will be distributed across the region. The CHD network links together all the healthcare providers, patients and families in the South Wales and South West region. The networks vision is to ensure high quality, equitable access to care across the region; providing excellent information to patients, families and staff; collaborating to improve quality; and ensuring that there is a strong collective voice for CHD services.

How will the group work?

This is a virtual group which uses facebook as a platform for communication. The group will only be visible to group members in order to protect your privacy. Invitations to join the group will be offered

patients who are currently accessing or have access the cardiac service and their families, which will be verified by the clinical team. Your profile will be visible to other group members according to your own personal privacy settings. We will post when we would like you to get involved in pieces of work which may have a specific deadline for responses. There is no obligation or expectation for any of the group members to be involved in any pieces of work that is sent to them. We appreciate that members of the group have many other important commitments and may not be able to participate or get involved in the work at any given time. We respect every group member's right to withdraw their involvement at any time. Access to the group will be limited to group members and the hospital staff that are leading on involving families in this work, namely the Clinical Chair, Specialist Clinical Psychologist, LIAISE team manager and the Cardiac Review Programme Manager. Feedback from the group will be anonymised before sharing wider. Group members can get involved in a variety of different types of work; from reviewing documents to helping design and improve a specific process.

Group Guidelines

1. Any reporting of the discussions that take place in the group will be anonymised and will not contain any information that will identify members.
2. We expect that participants only post comments and commentary that is relevant to the group and the discussions taking place. Members should be respectful to the group community. Administrators will not accept vulgarity, personal attacks or insulting posts and all discussions must remain civil and courteous.
3. Members are expected to respect the privacy of other members of the group and treat any discussions within the group as confidential.
4. The group is not a means of communication with the cardiac team and should not be used to ask questions about diagnosis or treatment. Please speak to your clinical team should you have any questions. Any complaints or comments relating to the service for which you require a response should be directed through LIAISE or the Patient Support and Complaints Team. The group will not act as a support group however it may signpost people to relevant support groups if appropriate.
5. Only upload images or graphics that are owned by yourself and do not upload anything that encourages illegal activity.
6. The administrators reserve the right to remove members, posts, photos and comments from the group. This may be with or without explanation.
7. If any posts are identified which cause concern for an individual's safety the administrator will escalate this concern according to the Trust safeguarding policy.
8. Your participation in this group is at your own risk and you will take full responsibility for your comments and any information you choose to provide.
9. Be careful when providing personal information online. We would strongly advice that you do not upload the following information; full address, DOB, telephone no. national insurance no, school/workplace/birth place/previous addresses.
10. Please be aware that the views of members do not necessarily represent or reflect the opinions of University Hospital Bristol and the wider Congenital Heart Disease Network.
11. Please abide by Facebooks Statement of Rights and Responsibilities (www.facebook.com)

How can I unsubscribe from the group?

At any point you can remove yourself from the online group. Should you wish to re-join at a later date you can contact us on bchinfo@UHBristol.nhs.uk

Who will be the administrator for the group?

The Cardiac Review Programme Manager will be responsible for administrating and overseeing this group. This is a hospital employee whose responsibility is to lead and coordinate the implementation of the Cardiac Review and CQC recommendations.

I want to be involved, but not part of this group?

We have a range of options for engagement and participation. Please contact us on bchinfo@UHBristol.nhs.uk or telephone 0117-3427444 and we will be happy to discuss these further.

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

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

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
2	That the Trust should review the adequacy of staffing to support NCHDA's audit and collection of data.	Deputy Divisional Director	Apr '17	**Blue- on target**	None		Review of staffing	Assistant General Manager for Paediatric Cardiac Services	Sept '17	**Green- complete**	Staffing review report
							Results and recommendations reported at Women's and Children's Delivery Group in Sept. '16.	Assistant General Manager for Paediatric Cardiac Services	Sept '17	**Green- complete**	Women's and Children's Delivery Group Agenda and minutes 20.09.16
							Requirement for additional staff will feed into business round 2016-17	Assistant General Manager for Paediatric Cardiac Services	Apr' 17	**Blue- on target**	Expression of interest form and Women's and Children's Operating Plan
3	That the Trust should review the information given to families at the point of diagnosis (whether antenatal or post-natal), to ensure that it covers not only diagnosis but also the proposed pathway of care. Attention	Specialist Clinical Psychologist	Apr '17	**Blue- on target**			Information given to families at the point of diagnosis reviewed by the clinical team and the cardiac families – remaining information for Catheter Procedures and Discharge leaflet. Website and leaflets updated to reflect improvements	Clinical Team & Cardiac Families	Jan' 16	**Green- complete**	Revised patient information leaflets
							Links to access relevant information to be added to the bottom of clinic letters for patients.	Specialist Clinical Psychologist	Dec '16	**Blue- on target**	Clinic letter with links
							Review and amendment of Catheter and Discharge leaflet	Cardiac CNS team	Feb' 17	**Blue- on target**	Revised Catheter and Discharge leaflet

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	should be paid to the means by which such information is conveyed, and the use of internet and electronic resources to supplement leaflets and letters.						Enhance existing information with a visual diagram displaying pathways of care (FI).	Specialist Clinical Psychologist	Apr' 17	**Blue- on target**	Pathway of Care accessible visual
							Website proposal to be written for new Children's website including cardiac information similar to Evelina to improve accessibility of our information. *This will be additional and not essential for delivery of the recommendation* (FI).	LIAISE Team Manager and Specialist Clinical Psychologist	tbc	**Started**	
							Smart phone App proposal to be written for Cardiac Services to enable patient/families to access information electronically (FI). *This will be additional and not essential for delivery of the recommendation*	LIAISE Team Manager and Specialist Clinical Psychologist	tbc	**Not started**	
4	That the Commissioners and providers of fetal cardiology services in Wales should review the availability of support for women, including for any transition to Bristol or other specialist tertiary centres. For example, women whose fetus is diagnosed with a cardiac anomaly and are delivering their	CHD Network Clinical Director	Apr '17	**Amber – behind plan**	Risk that we are unable to get commitment / agreement on the changes that are required across the two hospitals / commissioning bodies Risk that operational challenges	Jun 17 due to delay in engagement with UHW and the operational challenges in their fetal cardiology service	Meeting arranged for 18th November with English and Welsh commissioners as well as Bristol and Cardiff trusts to establish: 1. Commissioner oversight of network 2. Commissioner support for IR actions (4,5 &11) 3. Establishment of working group(s) to address the specific changes in practices required	CHD Network Clinical Director and Network Manager	Nov '16	**Green - complete**	Agreed pathway of care in line with new CHD standards and in line with patient feedback
							Ahead of the meeting: define specifics of recommendation (e.g. approaches to diagnosis and counselling); options for patient involvement (survey then focus group); CHD standards that relate to this recommendation; examples of practice from other centres	CHD Network Clinical Director and Network Manager	Nov '16	**Green- complete**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	baby in Wales should be offered the opportunity, and be supported to visit the centre in Bristol, if there is an expectation that their baby will be transferred to Bristol at some point following the birth				in delivery of the fetal cardiology service in UHW prevent focus on the achievement of this recommendation business plan		University Hospital Wales to define how additional fetal sessions will be delivered and who from fetal cardiology will lead the recommendation implementation and collaborate with Bristol to set up working group in January	Clinical Director for Acute Child Health, university hospital wales	Dec '16	**Blue- on target**	
							Fetal working group to define changes / new pathways, taking account of patient feedback	Working group	Jan '17	**Blue- on target**	
							Undertake patient survey and focus groups (FI).	CHD Network Manager	~~Jan '17~~ Revised to Feb 17 due to delay in engagement with UHW and the operational challenges in their fetal service	**Amber – behind plan**	
							Co-design the offer with patient representatives for women whose fetus has been diagnosed with cardiac anomaly and deliver agreed model.	CHD Network Manager	Apr 17	**Blue- on target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							New pathways in place	CHD Network Clinical Director and Network Manager	~~Apr '17~~ Revised to Jun 17	**Amber – behind plan**	Summary paper showing previous and new ways of working, detailing an assessment of the benefits
5	The South West and Wales Network should regard it as a priority in its development to achieve better co-ordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol.	CHD Network Clinical Director	Apr '17	**Amber – behind plan**	Risk that we are unable to get commitment / agreement on the changes that are required across the two hospitals / commissioning bodies Risk that lack of paediatric cardiology lead in UHW delays the ability to undertake actions	Final completion delayed to May 17 due to initial delay getting engagement from UHW	Network Manager and Network Clinical Director to contact Welsh Commissioners and University of Hospital of Wales to meet to discuss and agree process including method of monitoring its implementation	CHD Network Manager	Nov 16	**Green- complete**	
							Set up joint working group set up with Network Team facilitating. UHB, UHW and commissioners to deliver the relevant actions and improvements required for service.	CHD Network Manager	Dec 16	**Blue- on target**	
							To define the opportunities for improvement in coordination and the actions to achieve this	CHD Network Manager	Dec 16	**Blue- on target**	
							To undertake a patient engagement exercise (e.g. focus group, survey, online reference group) to test the proposed options for improvement	CHD Network Manager	Jan 17	**Blue- on target**	
							Deliver actions to improve coordination	CHD Network Manager	May 17	**Blue- on target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
7	The paediatric cardiac service in Bristol should carry out periodic audit of follow-up care to ensure that the care is in line with the intended treatment plan, including with regards to the timing of follow-up appointments.	Deputy Divisional Director	Jan '17	**Green-complete**	None		Audit proposal submitted to the audit facilitator for inclusion on the Children's annual audit plan	Patient Safety Manager	Aug '16	**Green-complete**	Audit proposal
							Conduct 1st annual audit into follow up care for cardiac patients as per recommendation	Patient Safety Manager	Nov '16	**Green-complete**	Audit report
							Report findings of the audit	Patient Safety Manager	Jan '17	**Green-complete**	Audit presentation and W&C delivery group Agenda and minutes November meeting
							System developed for the regular reporting and review of follow up waiting lists at monthly Cardiac Business meeting.	Assistant General Manager for Paediatric Cardiac Services	Aug '16	**Green-complete**	Follow up backlog report, Cardiac Monthly Business meeting standard agenda
8	The Trust should monitor the experience of children and families to ensure that improvements in the organisation of outpatient clinics have been effective.	Nurse Project Lead	Oct '16	**Approved as closed by Steering Group (09/01/17)**			Baseline assessment (monthly outpatient survey) of current experience of children and families in outpatients reviewed)	Outpatients Experience working group	Aug '16	**Green-complete**	1.Outpatients and Clinical Investigations Unit Service Delivery Terms of Reference
							Gap analysis of current monitoring vs monitoring required to understand patients experience of the organisation of outpatient's completed	Outpatients Experience working group	Sept '16	**Green-complete**	2. Outpatients and Clinical Investigations Unit Service Delivery Group

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							Systems in place for regular and specific monitoring, and reviewing and acting on results (FI)	Outpatients & CIU Service Delivery Group	Oct '16	**Green- complete**	Agenda(3.10.16) 3. Outpatients and Clinical Investigations Unit Service Delivery minutes of meeting (3.10.16) 4. OPD Patient Experience Report (October 2016) 5. Paediatric Cardiology – Non-Admitted RTT Recovery (Appendix 1) 6. Cardiology Follow-Up backlog update (Appendix 7. Project on a Page: Outpatient Productivity at BRHC (Appendix 7)
9	In the light of concerns about the continuing pressure on cardiologists and the facilities and	Divisional Director	Jan'17	**Blue- on target**	Risk that other sites are unable to share data		Undertake benchmarking exercise with other CHD Networks, reviewing a defined list of criteria including aspects such as: job planning, IT and imaging links, information governance. To include site visits as appropriate	CHD Network Manager	Jan '17	**Blue- on target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	resources available, the Children's Hospital should benchmark itself against comparable centres and make the necessary changes which such an exercise demonstrates as being necessary.				required to complete a comprehensive benchmarking exercise Dependent on the action required to address the gaps it may not be possible to have implemented all the changes in the timescale.		Identification of actions required to address the gaps	CHD Network Manager	Jan '17	**Blue- on target**	
							Progress to implementing any changes in practice that are deemed necessary	CHD Network Manager and Divisional Director	Jan '17	**Blue- on target**	
11	That the paediatric cardiac service benchmarks its current arrangements against other comparable centres, to ensure that its ability, as a tertiary 'Level 1' centre under the NCHD Standards, to communicate with a 'Level 2' centre, are adequate and sufficiently resourced. Benchmarking would require a study both of the technical resources	CHD Network Clinical Director	Jan'17	**Blue- on target**	Linked to recommendation no.9. Actions detailed under recommendation no. 9 will also achieve recommendation no. 11. Risks to delivery, timescales, progress against delivery and evidence will be the same as per recommendation no. 9						

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	underpinning good communication, and the physical capacity of clinicians to attend planning meetings such as the JCC (Links to recommendation no. 5)										
16	As an interim measure pending any national guidance, that the paediatric cardiac service in the Trust reviews its practice to ensure that there is consistency of approach in the information provided to parents about the involvement of other operators or team members.	Clinical Lead for Cardiac Services and Consultant Paediatric Cardiac Surgeon	Dec '16	**Blue- on target**			Enhance existing guidance to describe team working and in particular the involvement of other operators and team members in patient care. Review by the Trust wide consent group and Cardiac Clinical Governance for approval and then implement.	Consultant Paediatric Surgeon and Specialist Clinical Psychologist	Dec '16	**Blue- on target**	
18	That steps be taken by the Trust to review the adequacy of the procedures for assessing risk in in relation to reviewing cancellations and the timing of re-scheduled procedures within paediatric cardiac services.	Deputy Divisional Director	Nov '16	**Green- complete**			Assessment of current process of risk assessing patients who have been cancelled and the timing of their rescheduled procedure	Cardiac Review Programme Manager	Aug '16	**Green- complete**	Current process review report
							Develop new and improved process for risk assessing cancelled patients ensuring outcomes of this are documented	Consultant Paediatric Surgeon and Cardiac Review Programme Manager	Nov '16	**Green- complete**	JCC performance review meeting agenda and cancelled operations report

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
20	That the Trust should set out a timetable for the establishment of appropriate services for end-of-life care and bereavement support.	Deputy Divisional Director	Nov '16	**Green-complete**	None		End-of-life care and bereavement support pathway developed (FI)	Deputy Divisional Director	Sept '16	**Green-complete**	End-of-life and bereavement support pathway
							Implementation and roll out of new pathway	Deputy Divisional Director	Nov '16	**Green-complete**	Communication and presentations to roll out
21	Commissioners should give priority to the need to provide adequate funds for the provision of a comprehensive service of psychological support	Commissioners		**Green-complete (provider actions)**			Previous submission to commissioners for psychological support updated	Head of Psychology Services	Sept '16	**Green-complete**	Submission to Commissions
							Expression of Interest for increased resource to be submitted as part of business planning	Head of Psychology Services / Deputy Divisional Director	Mar'17	**Green-complete**	Expression of interest and W&C Business plan
23	That the BRHC confirm, by audit or other suitable means of review, that effective action has been taken to ensure that staff possess a shared understanding of the nature of patient safety incidents and how they should be ranked.	Deputy Divisional Director	Dec '16	**Blue- on target**	None		Review results of Trust wide Manchester Patient Safety (MAPSAF) to understand current baseline for both team level and divisional staff views on patient safety incident reporting and management	Deputy Divisional Director	Sept '16	**Green-complete**	
							Annual programme- Targeted approach to all staff groups to be developed with implementation of bespoke training and regular updates to clinical staff	Deputy Divisional Director	Dec '16	**Blue- on target**	
CQ C.2	Provision of a formal report of transoesophageal or epicardial echocardiography performed during surgery	Clinical Lead for Cardiac Services	Nov '16	**Amber-behind target**		Jan '17 *Slippage due to capacity constraints*	ECHO form for reporting in theatres implemented	Consultant Paediatric Cardiologist	Aug '16	**Green-complete**	
							Audit to assess implementation (Nov'16) and request to Steering Group to close	Patient Safety Manager	Nov '16	**Amber-behind target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
CQ C. 3	Recording pain and comfort scores in line with planned care and when pain relief is changed to evaluate practice	Ward 32 Manager	Aug '16	**Green- complete** **22/11/16- approved for closure by W&C delivery group**			Documentation developed to record pain scores more easily	Ward 32 Manager	Jan'16	**Green- complete**	Nursing documentation
							Complete an audit on existing practise and report findings	Ward 32 Manager	Aug '16	**Green- complete**	Audit of nursing documentation
CQ C. 4	Ensuring all discussions with parents are recorded to avoid inconsistency in communication. This includes communications with the Cardiac Liaison Nurses, who should record contacts with families in the patient records (links with review recommendation 12)	Head of Nursing	Dec '16	**Blue- on target**			Work with Cardiac Nurse Specialists to improve recording communication in the patients' medical records and review option of Medway proforma's to support recording in notes	Head of Nursing	Dec '16	**Blue- on target**	
CQ C. 5	Providing written material to families relating to diagnosis and recording this in the records. (links to review recommendation 3)	Clinical Lead for Cardiac Services	Apr '17	**Blue- on target**	Linked to recommendation no. 3. Actions detailed under recommendation no. 3 will also achieve CQC recommendation no. 5						
CQ C.6	Ensuring that advice from all professionals involved with individual children is	Head of Allied Health Professionals and Clinical	Jan '17	**Blue- on target**		Agreed mechanism for including AHP	Assessment of current Allied Health Professionals input into discharge planning for Cardiac Services Audit completed and results to be formulated 27th October 2016.	Head of Allied Health Professionals	Oct '16	**Green- complete**	Assessment documentation

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	included in discharge planning to ensure that all needs are addressed.	Lead for Cardiac Services				advice into discharge planning for children within Cardiac Services	Agree with Cardiac Services Team an effective mechanism for including Allied Health Professionals into discharge planning for Cardiac Services. Meeting setup for 4th November.	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Nov'16	**Blue – on target**	Agreed mechanism for including AHP advice into discharge planning for children within Cardiac Services
							Implement agreed mechanism for including Allied Health Professionals into discharging planning for Cardiac Services	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Jan 17	**Blue – on target**	Implementation plan delivery report

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

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

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
26.	That the Trust should explore urgently the development of an integrated process for the management of complaints and all related investigations following either a death of a child or a serious incident, taking account of the work of the NHS England's Medical Directorate on this matter. Clear guidance should be given to patients or parents about the function and purpose of each element of an investigation, how they may contribute if they so choose, and how their contributions will be reflected in reports. Such guidance should also draw attention to any sources of support which they may draw upon.	Chief Nurse	Jan '17	**Amber- behind target**		Jun'17 additional and amended actions to fulfil recommendation	**26.1** Develop an appendix to the Serious Incident (SI) policy defining "link" between Child Death Review (CDR), complaints and SI investigations / reporting, includes adults and children.	Women and Children's Head of Governance	July '16	**Green- Complete** ***Approved by delivery group 15.11.16***	Link between serious incidents and other investigatory procedures (e.g. Complaints and Child Death Review) July 2016
							26.2 Develop and implement guidance for staff in **children's services** on standards procedures / practices that need to be followed to provide a high quality and equitable service for all patients / families in the event of bereavement.	Women and Children's Head of Governance	Dec '16	**Blue- on target**	
							26.3 Develop and implement guidance for staff in **adult services** on standards procedures / practices that need to be followed to provide a high quality and equitable service for all patients / families in the event of bereavement.	Head of Quality (Patient Safety)	Jul '16	**Green- Complete**	Guidance for Supporting and Working with patients/families after unexpected death of an adult or a serious incident involving an adult, July 2016 (latest version)
							26.4 Develop 'guidance' / information for **families** in **children's services** how the x3 processes of Child Death Review (CDR) / Serious Investigation (SI) / Root Cause Analysis (RCA) investigation inquests and complaints are initiated / managed and integrate ***(FI)***	Women and Children's Head of Governance	April '17	**Blue- on target**	

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							26.5 Develop 'guidance' / information for **staff** in **children's services** on how the x3 processes of CDR / SI / RCA investigation inquests and complaints are initiated / managed and integrate.	Women and Children's Head of Governance	Dec '16	**Blue- on target**	
							26.6 Develop the above **staff** guidance for **adult** patients and families (minus CDR)	Head of Quality (Patient Safety)	Dec '16	**Blue- on target**	
							26.7 Develop the above **family** guidance for **adult** patients and families (minus CDR) **(FI).**	Head of Quality (Patient Safety)	Apr '17	**Blue- on target**	
							26.8 Review options for how patients / families can participate (if they want to) with the SI RCA process implement preferred options **(FI).**	Head of Quality (Patient Safety)	Jun '17	**Blue- on target**	
							26.9 Implement a process for gaining regular feedback from patients / families involved in a SI RCAs process to understand what it felt like for them and how we can improve the process for them **(FI)**	Head of Quality (Patient Safety)	Jun '17	**Blue- on target**	
27	That the design of the processes we refer to should take account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue.	Chief Nurse	Jun '17	**Blue- on target**			**27.1** Guidance developed for staff for the preparation and conduct of meetings with parents/families to discuss concerns and/or adverse event feedback	Medical Director	Jun '16	**Green- complete**	Guidance for the Preparation and Conduct of Meetings with Parents/Families to discuss concerns and/or adverse event feedback, June 2016
							As per actions 26.4 and 26.5, included in recommendation no. 26 to develop guidance for staff				

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							27.2 Develop a framework for training staff to support them to effectively and sensitively manage processes relating to CDR/SI's and complaints. Develop and pilot session. Existing complaints training materials to be reviewed and updated to include guidance on supporting families in circumstances where a complaint is being investigated alongside a CDR or SI. January 2017. Other bespoke training opportunities to be considered in light of development of staff guidance by Children's Services (see 26.5), due April 2017.	Head of Quality (Patient Experience and Clinical Effectiveness) And Head of Quality (Patient Safety)	Jun '17	**Blue- on target**	
28	That guidance be drawn up which identifies when, and if so, how, an 'independent element' can be introduced into the handling of those complaints or investigations which require it.	Chief Nurse	Dec '16	**Blue- on target**			**28.1** To review UHBristol's previous use of independent review / benchmarking from other trusts to inform above. - Complaints - RCA's	Patient Support and Complaints Manager and Patient Safety Manager	Nov '16 Nov '16	**Green- complete**	Reports of the Reviews undertaken
							28.2 Develop guidance for when to access 'independent advise / review' for - Complaints - SI RCAs	Head of Quality (Patient Experience and Clinical Effectiveness) And Head of Quality (Patient Safety)	Oct '16 Dec '16	**Blue- on target**	Complaints policy Serious Incident Policy (appendix 9, pg. 33)
							28.3 The Trust has entered into exploratory discussions with the Patients Association about developing a model for exceptional independent investigation/review. This work will commence with a focus group of previous dissatisfied complainants in	Head of Quality (Patient Experience and	Mar '17		

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							February 2017.	Clinical Effectiveness			
29	That as part of the process of exploring the options for more effective handling of complaints, including the introduction of an independent element, serious consideration be given to offering as early as possible, alternative forms of dispute resolution, such as medical mediation.	Chief Nurse	Apr '17	**Blue- on target**			**29.0** Consider how an independent review can be introduced for 2nd time dissatisfied complainants / involve users in developing a solution. 29.1 Visit the Evelina to understand their model for mediation and possible replication at UHBristol. A report will be presented following the visit to consider next steps and possible resource implications.	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green- complete**	Complaints policy
30	That the Trust should review its procedures to ensure that patients or families are offered not only information about any changes in practice introduced as a result of a complaint or incident involving them or their families and seek feedback on its effectiveness, but also the opportunity to be involved in designing those changes and overseeing their implementation.	Chief Nurse	Dec '16	**Amber- behind target**		Apr '17 Revised to allow for family involvement	**30.1** Develop a clear process with timescales trust-wide for feedback to families / patients outcomes involved in SI panels / review and actions ongoing from this and staff **(FI).**	Head of Quality (Patient Safety) and Clinical Effectiveness)	Apr '17	**Blue- on target**	
							30.2 Ensure complainants are routinely asked whether and how they would like to be involved in designing changes in practice in response to the concerns they have raised **(FI)**	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green- complete**	

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							30.3 Use of process for asking patients how they would like to be involved in designing changes in practice in response to the concerns they have raised to be audited at the end of February 2017, including review of survey replies.	Head of Quality (Patient Experience and Clinical Effectiveness)	Feb '17	**Blue – on target**	
							30.4 Regular complainant focus groups to be held from April 2017 onwards as part of routine follow-up of people's experience of the complaints system. Ambition is for these focus groups to eventually be facilitated by previous complainants.	Head of Quality (Patient Experience and Clinical Effectiveness)	April '17	**Blue – on target**	

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

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

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
12	That clinicians encourage an open and transparent dialogue with patients and families upon the option of recording conversations when a diagnosis, course of treatment, or prognosis is being discussed.	Medical Director	Dec '16	**Blue on target**			**12.1** Guidance developed to medical staff to ensure patients and families are given the option to record conversations when a diagnosis, course of treatment, or prognosis is being discussed	Medical Director	Aug '16	**Green-completed**	Medical Staff Guidance
							12.2 Review of new existing guidance to reflect the recommendation and include recommendation in updated consent policy , guidance notes and e-learning	Deputy Medical Director	Nov '16	**Green-Completed**	Consent policy Guidance on consent policy e-learning for consent
							12.3 Incorporate new guidance into existing Children's Consent pathway (existing letter that goes to families before their surgical appointment) (FI)	Consultant Paediatric Cardiac Surgeon	Dec '16	**Blue- on target**	Letter to families
13	That the Trust review its Consent Policy and the training of staff, to ensure that any questions regarding the capacity of parents or carers to give consent to treatment on behalf of their children are identified and appropriate advice sought	Deputy Medical Director	Jan '17	**Blue-on target**	E-learning lead is currently on learn term sick which has led to a delay in updating e-learning material		**13.1** Trust wide Consent delivery group set up	Deputy Medical Director	Sept '17	**Green-Completed**	Terms of reference for Trust Wide Consent Group Minutes and actions from meetings
							13.2 Review the consent policy and agree a re-write policy or amend existing policy to ensure patients and clinicians are supported to make decisions together	Consent Group	Nov'16	**Green Completed**	Revised consent policy ratified by CQC December 2016
							13.3 Develop training and communication plan	Deputy Medical Director	Dec '16	**Amber behind but no impact on completion date**	Training and communications plan

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							13.4 Advice from legal team and safeguarding on revised consent policy and e-learning	Deputy Medical Director	Nov '16	**Amber**	Legal and safeguarding assurance confirmation
							13.5 Update e-learning for any changes to consent policy and process	Deputy Medical Director	Jan '17	**Amber**	Updated E-learning package for consent
14	That the Trust reviews its Consent Policy to take account of recent developments in the law in this area, emphasising the rights of patients to be treated as partners by doctors, and to be properly informed about material risks	Deputy Medical Director	**Linked to recommendation no. 13, actions, timescales and status as detailed under this recommendation – Blue on target, date completion scheduled Jan '17**								
17	That the Trust carry out a review or audit of (I) its policy concerning obtaining consent to anaesthesia, and its implementation; and (ii) the implementation of the changes to its processes and procedures	Deputy Medical Director	May'17	**Blue-on target**			**17.1** Anaesthetic group to be set up to review current practise in pre-op assessment in relation to consent for anaesthesia and how they can implement a consent for anaesthesia process trust wide (FI)	Consultant Paediatric Cardiac Anaesthetist	Dec '16	**Blue on target**	Minutes and actions from meeting
							17.2 Liaise with Royal College of Anaesthesia and other appropriate professional bodies with regarding national policy	Paediatric Anaesthesia consent group	Jan' 17	**Blue-on-target**	Correspondence with Royal College of Anaesthetists and Associations
							17.3 Implementation plan for trust wide consent process	Paediatric Anaesthesia consent group	May '17	**Not started**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	relating to consent										
CQC. 1	Recording the percentage risk of mortality or other major complications discussed with parents or carers on consent forms	Deputy Medical Director	Jan' 17	**Blue- on target**			**1.1** Review trust wide consent form in use to agree whether they should be amended to improve recording of risk	Consent Group	Dec '17	**Blue- on target**	Updated / amended trust consent forms
							1.2 Paediatric Cardiac Services to agree whether service would benefit from a bespoke cardiac consent form that includes percentage risk	Consultant Paediatric Cardiac Surgeon	Nov '16	**Amber**	Agreement of Paediatric Consent Group to utilise bespoke consent forms where appropriate
							1.3 Cardiac Services- agree and implement process for discussing percentage risk with families (FI)	Consultant Paediatric Cardiac Surgeon	Nov '16	**Green**	Information and consent forms available to parents

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

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
22	That the Trust review the implementation of the recommendation of the Kennedy Report that a member of the Trust's Executive, sitting on the Board, has responsibility to ensure that the interests of children are preserved and protected, and should routinely report on this matter to the Board.	Trust Secretary	Sept '16	**Green- complete**			Review of current arrangements and processes (Sept '16)	Trust Secretary	Sept '16	**Green- complete**	Executive Lead Role description
24	That urgent attention be given to developing more effective mechanisms for maintaining dialogue in the future in situations such as these, at the level of both the provider and commissioning organisations.	Commissioners and Trust	Jan '16	**Blue- on target**			Discussion with commissioners about the issues and agreement to mitigate a similar occurrence	Commissioners and Trust	Jan '16	**Blue- on target**	
31	That the Trust should review the history of recent events and the contents of this report, with a view to acknowledging publically the role which parents have played in bringing about significant changes in practice	Chief Nurse	Oct '16	**Green- complete**			Trust board paper presented in July acknowledging the role which parents have played in bring about significant changes in practice and in improving the provision of care	Chief Executive	July '16	**Green- complete**	Trust Board Paper and Trust Board Agenda, July '16
							Presentation to Health and Overview Scrutiny Committee	Chief Executive, Medical Director, Chief Nurse and Women's and	Aug '16	**Green- complete**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	and in improving the provision of care.							Children's Divisional Director			
							Presentation to the Bristol Safeguarding Children's Board	Chief Nurse	Oct '16	**Green- complete**	
32	That the Trust redesignate its activities regarding the safety of patients so as to replace the notion of "patient safety" with the reference to the safety of patients, thereby placing patients at the centre of its concern for safe care.	Medical Director	Dec '16	**Blue- on target**			Adoption of the term "Safety of Patients" in place of "Patient Safety" going forward and communication of preferred term Trust wide	Medical Director	Dec '16	**Blue- on target**	

Key	
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Cover report to the Trust Board meeting to be held on Tuesday, 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	9
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Quality and Performance Report		
Author	• Xanthe Whittaker, Associate Director of Performance/Deputy COO • Anne Reader, Head of Quality (Patient Safety) • Heather Toyne, Head of Workforce Strategy & Planning		
Executive Lead	Owen Ainsley, Interim Chief Operating Officer		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1:We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☒

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

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

Recommendations
Members are asked to: • **Note** report for Assurance

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

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

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

Impact Upon Corporate Risk
N/A

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		27/1/17		

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

January 2017

Executive Summary

Progress continued to be made in recovering performance against the national access standards in December, with performance in two key areas ahead of the recovery forecasts. This included a further month's achievement of the 92% national standard for the percentage of patients waiting under 18 weeks from Referral to Treatment (RTT), and achievement of the 85% standard for the percentage of patients receiving cancer treatment within 62 days of urgent referral by their GP. Performance against the 99% national standard for the percentage of patients waiting under 6 weeks for a diagnostic test dipped below target due to a staff sickness related loss of capacity, and disappointingly, performance against the A&E 4-hour standard continued to be below the in-month performance trajectory. The Overview page of this report provides further details of the priorities, risks and threats for the coming months, along with noteworthy successes in the period.

The number of patients on the new outpatient waiting list has fallen, as has the number of patients on the elective waiting list, the latter likely as a result of the usual seasonal decline in attendances. The fall in the outpatient waiting list is in part being driven by a seasonal reduction in GP referrals. Consistent with the reduction in the size of the outpatient waiting list, the number of patients waiting over 18 weeks RTT on non-admitted (outpatient) pathways has decreased. The same progress is not being made in reducing the number of long waiters on admitted (elective) pathways, due to a combination of reduced capacity, the level of cancellations of operations due to reduced bed availability remaining high, and high levels of patient choice. Reduced bed availability due to emergency pressures poses a risk to sustained achievement of the 92% national RTT standard in January. There are also ongoing risks to restoring achievement of the 6-week wait for a diagnostic test due to specific capacity constraints in January in Sleep Studies and high levels of demand following the usual high levels of patient choice to defer tests over the Christmas/New Year period.

Whilst emergency pressures eased slightly, the overall level of emergency admissions into the Bristol Children's Hospital in December was 6.5% higher than in December last year. Performance against the A&E 4-hour performance therefore continued to be below the site-level seasonal norm. Levels of emergency admissions into the BRI remained similar to that of the previous month, and same period last year. However, the number of bed-days consumed by Green to Go (delayed discharge) patients remained high, as did the number of over 14 days stays in hospital. Bed occupancy remained above the seasonal norm as a result, impacting on patient flow and 4-hour performance and also increasing the percentage of operations cancelled at last-minute. Despite these bed pressures there was a significant reduction in the number of days patients spent outlying from their correct specialty ward.

Even against this continued backdrop of emergency pressures, the Trust continues to perform well against the majority of the core quality indicators including the rate of inpatient falls and pressure ulcers, and the NHS Safety Thermometer composite measure of Harm Free care. The improved performance against the National Early Warning Scores (NEWS) measure of our management of deteriorating patients also continues to be sustained, as does the low rate of missed doses of critical medication. Particularly noteworthy this month are the improvements in performance against the 72-hour food chart review, nutrition screening within 24 hours of admission and the number of complainants dissatisfied with the Trust's response. Performance against the metrics related to the management of patients who have sustained a fractured neck of femur continues to be disappointing, and the focus of significant attention.

System pressures continue to provide context to the ongoing workforce challenges, especially bank and agency usage. The high levels of staff sickness have continued, and pose risks to sustained recovery of access standards and further bank and agency spend. Last month's vacancy and turn-over rates have been sustained reflecting the continued strong internal focus on recruitment and retention of staff. We continue to work in partnership with other organisations within the community to mitigate these system risks, and improve the responsiveness of the Trust's services.

Performance Overview

External views of the Trust

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

Care Quality Commission

Ratings for the main University Hospitals Bristol NHS Foundation Trust sites

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

NHS Choices

Website

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

Site	User ratings	Recommended by staff	Mortality rate (within 30 days)	Food choice & Quality
BCH	5 stars	OK	OK	✓ 98.5%
STM	4 stars	OK	OK	✓ 98.4%
BRI	3.5 stars	OK	OK	✓ 96.5%
BDH	3 stars	OK	OK	Not avail
BEH	4.5 Stars	OK	OK	✓ 91.7%

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

NHS Improvement Single Oversight Framework

For the latest month reported the Trust failed to achieve the trajectory for two of the four access standards in the Single Oversight Framework (SOF). The 85% national standard for the percentage of patients receiving cancer treatment within 62-day of urgent GP referral was met in November, for first time since December 2015. The 92% Referral to Treatment (RTT) was also achieved for a second consecutive month. However, the 6-week diagnostic wait standard failed to be met following achievement in the previous month. The A&E 4-hour standard recovery Sustainability & Transformation Fund (STF) trajectory continues not to be met.

The Trust has been off trajectory for the A&E 4-hour standard for greater than two consecutive months. Under the rules of the SOF this means that NHS Improvement (NHSI) may consider providing additional support to the Trust to recover performance. NHSI has recently undertaken a Critical Friend visit, for which the Trust is expecting a written report shortly.

Access Key Performance Indicator		Quarter 1			Quarter 2			Quarter 3		
		April 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
A&E 4-hours	Actual	87.2%	91.7%	89.0%	89.3%	90.0%	87.3%	82.9%	78.5%	79.6%
	STF trajectory	81.9%	84.4%	85.9%	87.6%	88.4%	92.2%	93.3%	90.0%	89.3%
62-day GP cancer	Actual	77.2%	70.5%	70.8%	72.9%	84.5%	80.5%	79.5%	85.2%	
	STF trajectory*	72.7%	73.2%	81.8%	84.7%	81.7%	85.0%	85.0%	85.1%	86.9%
Referral to Treatment Time (RTT)	Actual	92.3%	92.6%	92.1%	92.0%	90.5%	90.4%	91.2%	92.0%	92.0%
	STF trajectory*	92.6%	92.6%	92.8%	93.2%	93.2%	93.4%	93.4%	93.4%	92.8%
6-week wait diagnostic	Actual	98.3%	98.6%	96.3%	96.1%	95.5%	96.9%	98.9%	99.0%	98.2%
	STF trajectory*	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%

*minimum requirement is achievement of the national standard

Summary Scorecard

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

Key changes in indicators in the period:

RED to GREEN:

- Complaints response
- Cancer waiting times
- Outliers

AMBER to RED

- Outpatient appointments cancelled

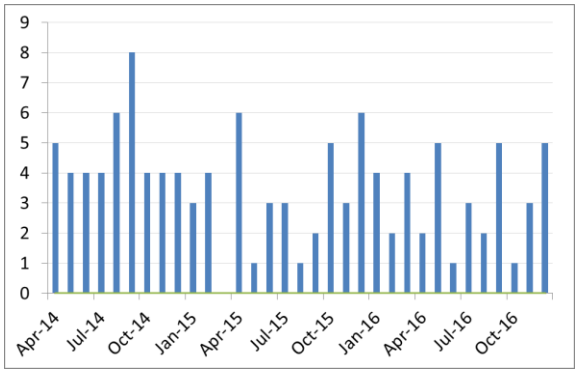
GREEN to RED:

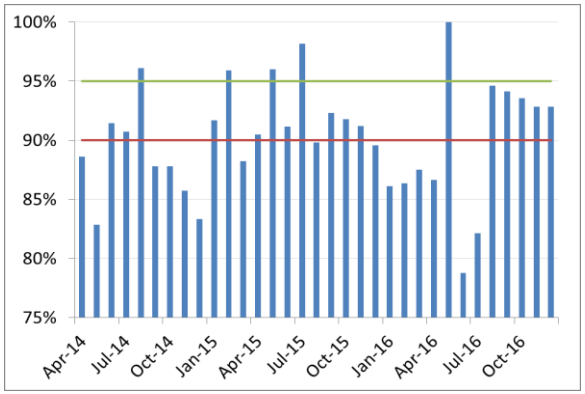
- Diagnostic waits
- Heart reperfusion times

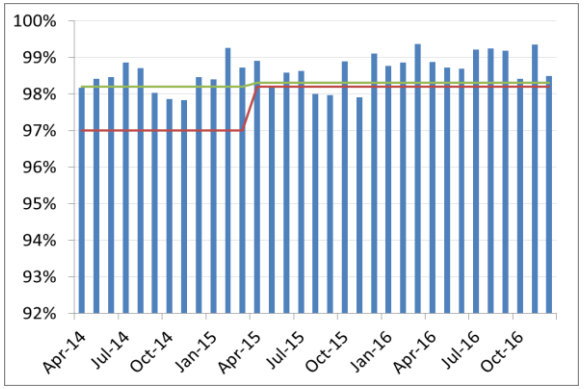
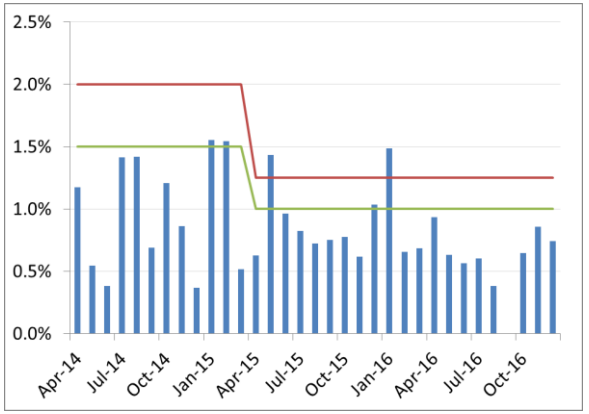
Overview

The following summarises the key successes in December 2016, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 4 2016/17.

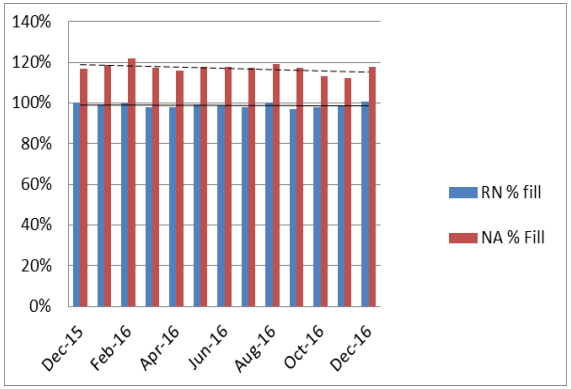
Successes	Priorities
• In December 2016, there was a 30% reduction in outliers bed-days relative to November; • To date (13th January 2017), there have been no dissatisfied replies to the thirty nine compliant responses sent out in October. This is the first time since April 2015 that 0% has been achieved; • Improvements in the 72 hour food chart review 94.3% in December compared to 87.1% in November; • Over seventy-seven percent (5025) of frontline staff have received the flu vaccination, exceeding the CQUIN target; • Agency usage reduced by 31.2 FTE during December, despite periods of black escalation and high levels of sickness absence; • The 62-day GP cancer standard was met for greater than 85% of patients in November, despite continued high level of late referrals from other providers; • The 92% national standard for the percentage of patients waiting under 18 weeks from Referral to Treatment was met for a second consecutive month.	• Improvement in the care of patients with fractured neck of femur, during quarter 4 2016/17, including timeliness to theatre; • Continued focus on the reduction of agency usage and sickness absence; this will be an ongoing priority in the 2017/18 operating plans; • Further reduction in the number of patients waiting over 18 weeks Referral to Treatment (RTT), by delivering additional activity in each month in quarter 4; • Sustained improvement in performance against the 62-day GP cancer waiting times standard during quarter 3.
Opportunities	**Risks & Threats**
• Piloting and training has commenced on the new Rostering system, which goes live in April, bringing the opportunity for improved booking and rostering; • The E-Appraisal system which will go live in March 2017; this is in response staff feedback from the staff survey and our commitment to ensuring appraisals are of real value and quality;	• There were four reported falls with harm in December 2016. This is the highest reported figure since May 2016; • Data quality issues in reported WHO checklist performance due to a new system being introduced; • Sickness absence has reached the highest level for more than six years at 4.9%. Achieving target KPI of 3.9% is now very unlikely, as it would require performance of 3.5% or lower to be sustained for each of the next three months; • Ongoing emergency pressures could make sustained achievement of the 92% RTT national waiting times standard challenging; • Late referrals from other providers continue to impact on achievement of cancer waiting times standards.

<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 case of Clostridium difficile (C. diff) attributed to the Trust in December 2016. This was attributed to divisions as shown in the table below.
<table>
<tr><th></th><th>C. difficile</th></tr>
<tr><td>Surgery, Head and Neck</td><td>1</td></tr>
<tr><td>Specialised Services</td><td>2</td></tr>
<tr><td>Medicine</td><td>2</td></tr>
</table>
</td>
<td>Total number of C. diff cases
 

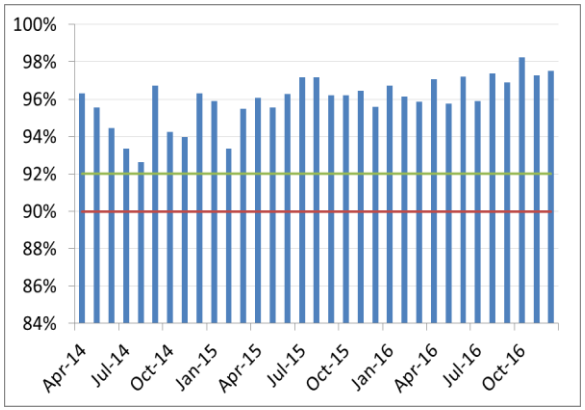
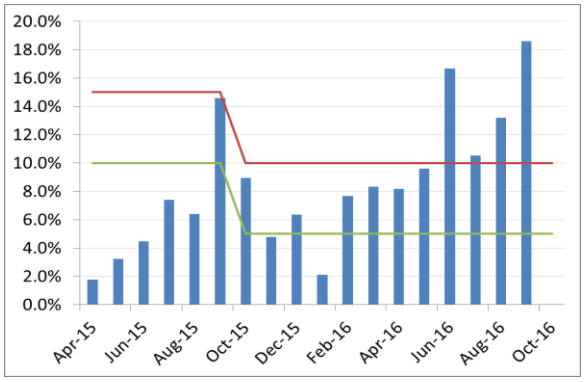
A total of 27 cases (unavoidable + avoidable) have been reported in the year to date against a limit of 45 for April 2016 to March 2017.</td>
<td>The annual limit for the Trust for 2016/17 is 45 avoidable cases. The monthly assessment of cases continues with the Clinical Commissioning Group. The total number of cases to date attributed to the Trust is twenty seven. Fourteen cases have been assessed as unavoidable, and eight cases assessed as avoidable. The cases for December are still to be assessed.</td>
</tr>
<tr>
<td>Deteriorating patient
National early warning scores (NEWS) acted upon in accordance with the escalation protocol (excluding paediatrics). This is an area of focus for our Sign up to Safety Patient Safety Improvement Programme. Our three year goal is sustained improvement above 95%.</td>
<td>Performance in December was 93% (two breaches) against a three year improvement goal of 95%. This is the same as November's performance.
Two breaches occurred in December, one in each of the Divisions of Specialised Services, and Surgery, Head & Neck. One breach was due to the patient's triggers not being revised; the clinically optimised patient's low blood pressure was "normal" for them and this is why the patient was not escalated. One breach was due to the patient being seen by the F1 doctor but not the Registrar as the escalation protocol indicates. There was a phone discussion with the Registrar. Neither patient came to harm as a result of the breaches.</td>
<td>Deteriorating patient: percentage of early warning scores acted upon
 
</td>
<td>Work continues in the deteriorating patient work-stream of our patient Safety Improvement Programme and is reported in detail to the Programme Board.
Details of the actions being taken are described in the actions section (Actions 1A to 1G).</td>
</tr>
</table>

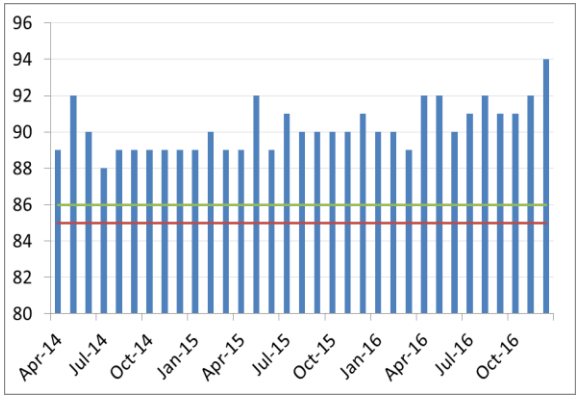
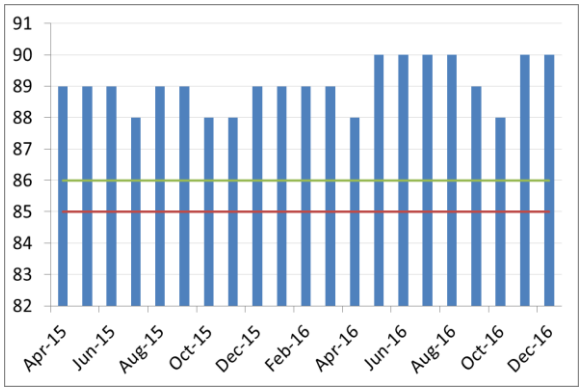
Description	Current Performance	Trend	Comments
Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.	In December 2016, the percentage of patients with no new harms was 98.5% (12 patients had new harms), against an upper quartile target of 98.26% (GREEN threshold) of the NHS Improvement patient safety peer group of trusts.	**The percentage of patients surveyed showing No New Harm each month** 	The December 2016 Safety Thermometer point prevalence audit showed two new catheter associated urinary tract infections, five falls with harm, three new pressure ulcers and three new venous thrombo-emboli. One patient had two new harms.
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 December 2016, 0.74% of patients reviewed (7 out of 941) had one or more omitted critical medications in the past three days. The target for omitted doses is no more than 1%, the average for the year to date is 0.62%. The 0.74% for December 2016 is a slight deterioration from the November 2016 figure of 0.86% (10 out of 1168).	**Percentage of omitted doses of listed critical medicines** 	Month-on-month this figure has remained below the target for omitted doses of no more than 1%. Actions being taken are described in the actions section (Actions 2A and 2B)

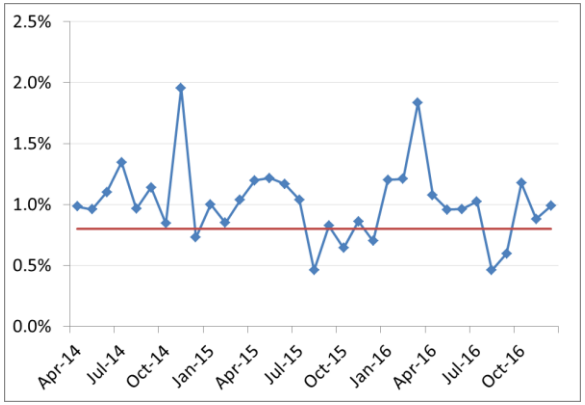
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Achievement of the Green threshold depends on all categories of Essential Training achieving 90%, and Information Governance achieving 95%. Overall compliance is 88% (excluding Child Protection Level 3), the same as last month. Compliance with each of the reporting categories is provided below.
<table>
<tr><th>December 2016</th><th>UH Bristol</th></tr>
<tr><td>Total</td><td>88%</td></tr>
<tr><td>Three Yearly (14 topics)</td><td>89%</td></tr>
<tr><td>Annual (Fire)</td><td>81%</td></tr>
<tr><td>Annual (IG)</td><td>76%</td></tr>
<tr><td>Induction</td><td>96%</td></tr>
<tr><td>Resuscitation</td><td>83%</td></tr>
<tr><td>Safeguarding</td><td>90%</td></tr>
</table>
</td>
<td>There are four graphs which are included in Appendix 2, which show performance against the new trajectories for Fire and Information Governance (IG).</td>
<td>Action plan 3 provides details of the ongoing work to achieve compliance across all topics.</td>
</tr>
<tr>
<td>Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.</td>
<td>The report shows that in December 2016 the Trust had rostered 223,256 expected nursing hours, with the number of actual hours worked of 232,546.

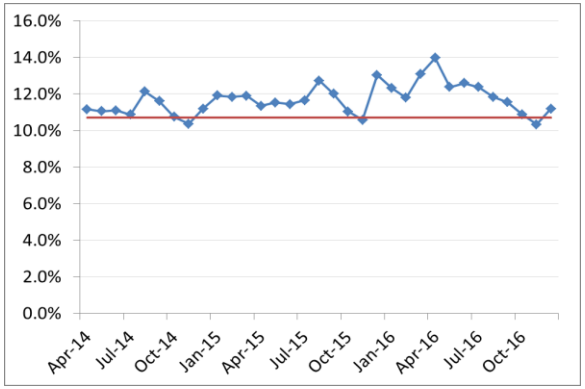
This gave a fill rate of 104%
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>64,545</td><td>58,111</td><td>+6,434</td></tr>
<tr><td>Specialised Services</td><td>40,953</td><td>40,561</td><td>+392</td></tr>
<tr><td>Surgery Head & Neck</td><td>44,188</td><td>42,531</td><td>+1,657</td></tr>
<tr><td>Women’s & Children’s</td><td>82,860</td><td>82,053</td><td>+807</td></tr>
<tr><td>Trust - overall</td><td>232,546</td><td>223,256</td><td>+9,290</td></tr>
</table>
</td>
<td>The percentage overall staffing fill rate by month
 
</td>
<td>Overall for the month of December 2016, the trust had 100% cover for RN’s on days and 100% RN cover for nights. The unregistered level of 111% for days and 122% for nights reflects the activity seen in December. This was due primarily to NA specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night.

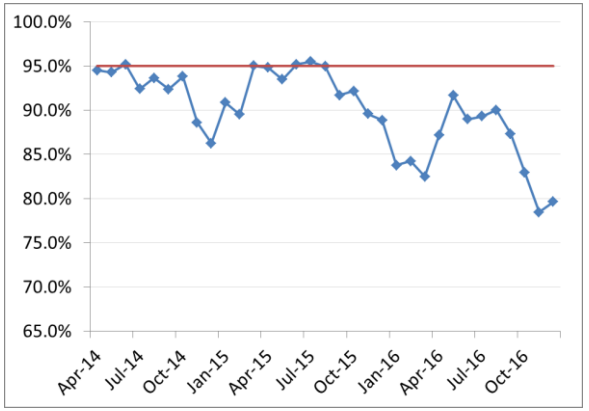
See also Action 4.</td>
</tr>
</table>

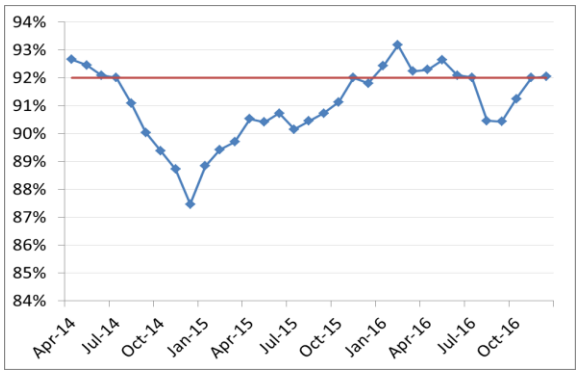
Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for December 2016 was 97.5%. This metric combines Friends & Family Test scores from inpatient and day-case areas of the Trust, for both adult and paediatric services. Division and hospital-level data is provided to the Trust Board on a quarterly basis in the quarterly Patient Experience and Involvement report.	**Inpatient Friends & Family scores each month** 	The scores for the Trust are in line with national norms. A very high proportion of the Trust's patients would recommend the care that they receive to their friends and family. These results are shared with ward staff and are displayed publically on the wards. Division and hospital-level data is provided to the Trust Board and is explored within the Quarterly Patient Experience report.
Dissatisfied Complainants. By October 2015 we are aiming for less than 5% of complainants to report that they are dissatisfied with our response to their complaint by the end of the month following the month in which their complaint response was sent.	Following an agreed change, dissatisfied cases are now measured as a proportion of complaints responses and reported two months in arrears. This means that the latest data in the board dashboard is for the month of October 2016. Performance for October was 0% against a green target of 5%. As of 13th January 2017, none of the 39 responses sent out in October had resulted in dissatisfied replies.	**Percentage of compliantaints dissatisfied with the complaint response each month** 	Our year to date performance is 11.1% compared with 6.2% for 2015/16, as reported in the Trust's 2014/15 Quality Report. Informal Benchmarking with other NHS Trusts suggests that the rates of dissatisfied complainants are typically in the range of 8% to 10%. Actions continue as previously reported to the Board (Actions 5A to 5D).

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 December 2016, the score was 94 out of a possible score of 100, and 92 for Q3 as a whole. Divisional level scores are provided on a quarterly basis to ensure sample sizes are sufficiently reliable. Trust: Q2 2016/2017: 91; Q3 2016/2017: 92 Medicine: 88; 90 Surgery, Head & Neck: 92; 92 Specialised Services: 92; 92 Women's & Children's (Bristol Royal Hospital for Children): 92; 94 Women's & Children's Division (Postnatal wards): 92; 91	**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 score for the Trust as whole was 90 in December 2016 (out of score of 100). Divisional scores for quarter 3 are provided as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful. Trust: Q2 2016/2017: 90; Q3 2016/2017: 90 Medicine: 89; 89 Specialised Services: 87; 89 Surgery, Head & Neck: 92; 88 Women's & Children's (Bristol Royal Hospital for Children): 89; 85 Diagnostics & Therapies: 94; 96	**Outpatient Experience Scores (maximum score 100) each month** 	The Trust's performance is in line with national norms in terms of patient-reported experience. This metric would turn red if outpatient experience at UH Bristol began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the Trust score remains green. Divisional scores are examined in detail in the Trust's Quarterly Patient Experience Report.

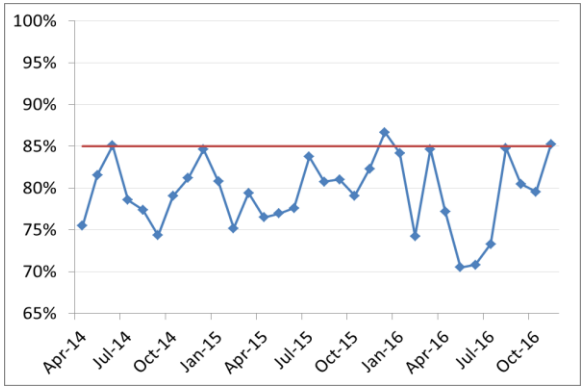
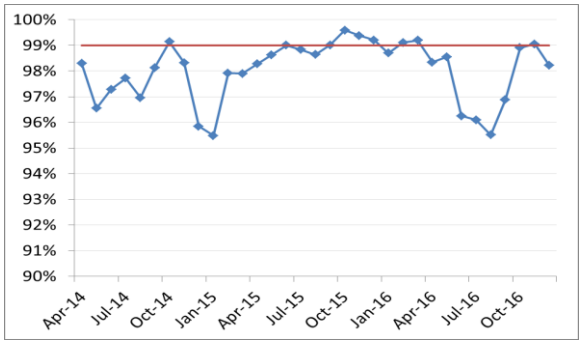
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In December the Trust cancelled 58 (0.99% of) operations at last-minute for non-clinical reasons. The reasons for the cancellations are shown below:
<table>
<tr><th>Cancellation reason</th><th></th></tr>
<tr><td>Emergency patient prioritised</td><td>15 (26%)</td></tr>
<tr><td>No ward bed available</td><td>13 (22%)</td></tr>
<tr><td>No HDU/ITU bed available</td><td>7 (12%)</td></tr>
<tr><td>Clinically complicated patient in theatre</td><td>6 (10%)</td></tr>
<tr><td>Surgeon taken ill/unavailable</td><td>5 (9%)</td></tr>
<tr><td>Other causes (8 different breach reasons - no themes)</td><td>12 (21%)</td></tr>
</table>
Four patients cancelled in November were readmitted outside of 28 days. This equates to 93.0% of cancellations being readmitted within 28 days, which is below the former national standard of 95%.</td>
<td>Percentage of operations cancelled at last-minute
 

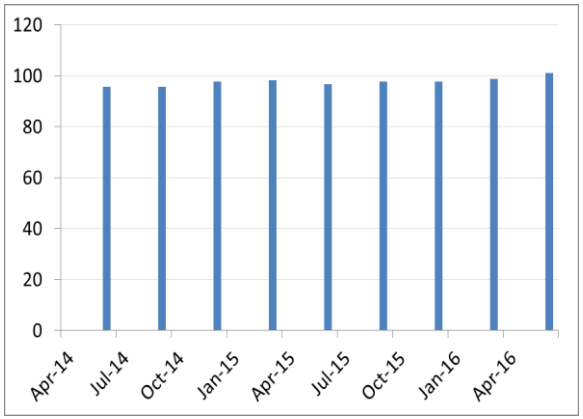
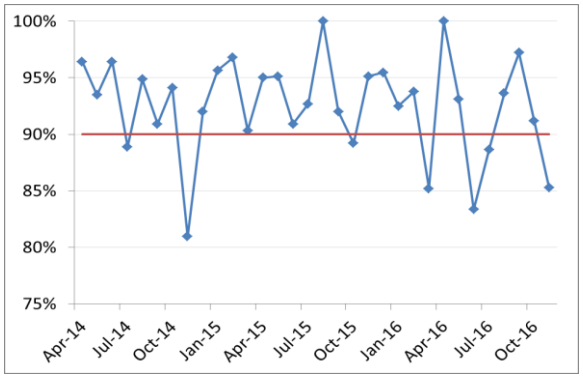
The national 0.8% standard is currently not forecast to be met in January due to emergency pressures.</td>
<td>Emergency pressures continues to be the predominant cause of cancellations this month, with emergency patients needing to be prioritised, ward bed availability, and a lack of High Dependency / Intensive Therapy Unit beds (due to these being occupied by emergency patients), making-up 60% of all cancellations. An action plan to reduce elective cancellations continues to be implemented (Actions 6A and 6B). However, please also see actions detailed under A&E 4 hours (8A to D) and outlier bed-days (13).</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 December 11.2% of outpatient appointments were cancelled by the hospital, which is above the Red threshold of 10.7%. This is first month since June that there has been an increase in the outpatient hospital cancellation rate. However, the rate of cancellation this month remains below the monthly average cancellation rate for the last two years.</td>
<td>Percentage of outpatient appointments cancelled by the hospital
 
</td>
<td>Ensuring outpatient capacity is effectively managed on a day-to-day basis is a core part of the improvement work overseen by the Outpatients Steering Group. The improvement plan for this key performance indicator was recently refreshed, prioritising those actions that are likely to reduce the current underlying rate of cancellation by the hospital (Actions 7A to C).</td>
</tr>
</table>

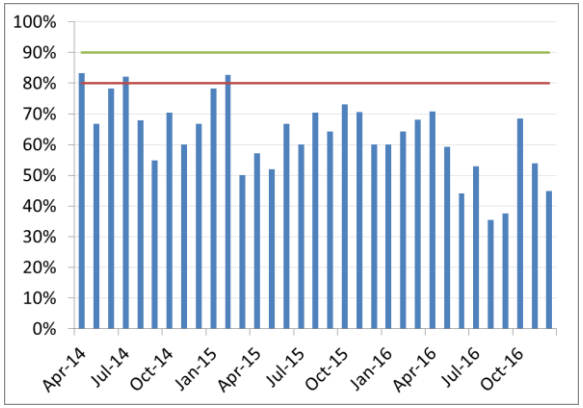
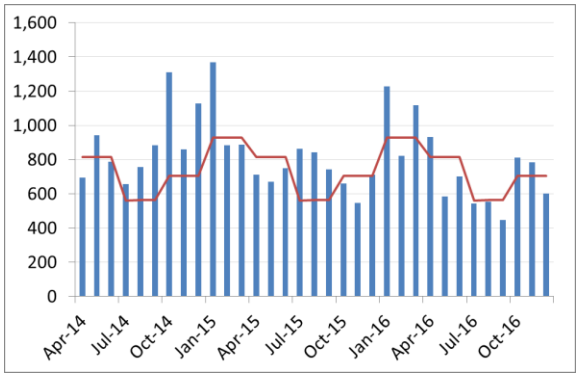
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% national standard was not achieved in December. Trust-level performance at 79.6% was also below the in-month trajectory (89.3%). Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Dec 2015</th><th>Nov 2016</th><th>Dec 2016</th></tr>
<tr><td>Attendances</td><td>5,490</td><td>5,574</td><td>5,439</td></tr>
<tr><td>Emergency Admissions</td><td>1,943</td><td>1,950</td><td>1,957</td></tr>
<tr><td>Patients managed < 4 hours</td><td>4767
86.8%</td><td>3996
71.7%</td><td>3996
73.5%</td></tr>
<tr><th>BCH</th><th>Dec 2015</th><th>Nov 2016</th><th>Dec 2016</th></tr>
<tr><td>Attendances</td><td>3,444</td><td>4,051</td><td>3,652</td></tr>
<tr><td>Emergency Admissions</td><td>904</td><td>1,033</td><td>963</td></tr>
<tr><td>Patients managed < 4 hours</td><td>2986
86.7%</td><td>3184
78.6%</td><td>2899
79.4%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments
 

The trajectory of 88.5% is not forecast to be met in January.</td>
<td>There was a 6.5% increase in emergency admissions into the BCH during December relative to the same period last year. Levels of emergency admissions into the BRI remained consistent with those seen in November and the previous year. The number of over 14 day stays decreased slightly, but remained significantly above the average for last winter. Bed occupancy for the first three weeks of December also remained high, impacting on patient flow. Actions continue to be taken to manage demand and reduce length of stay (Actions 8A to 8H).</td>
</tr>
<tr>
<td>Referral to Treatment (RTT) is a measure of the length of wait from referral through to treatment. The target is for at least 92% of patients, who have not yet received treatment, and whose pathway is considered to be incomplete (or ongoing), to be waiting less than 18 weeks at month-end.</td>
<td>The 92% national standard was met at the end of December, with reported performance of 92.0% against the recovery forecast of 91.6% (see Appendix 3). The number of patients waiting over 40 weeks RTT at month-end increased in December, mainly due to continued theatre capacity pressures in the Division of Women's & Children's. There was one over 52-week waiter, which was a patient that wasn't added to the dermatology elective waiting list when they should have.
<table>
<tr><th></th><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>53</td><td>78</td><td>93</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>0</td><td>1</td><td>1</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 

Recovery forecast for January remains achievement of the 92% standard.</td>
<td>The number of patients waiting over 18 weeks on a non-admitted (outpatient) pathway has decreased, as has the total size of the outpatient waiting list. There has, however, been a small increase in the number of patients waiting over 18 weeks on admitted pathways, as a result of elective cancellations due to emergency pressures and patient choice to delay treatment until January. The recovery plan continues to be implemented and monitored through weekly meetings with Divisions (Action 9).</td>
</tr>
</table>

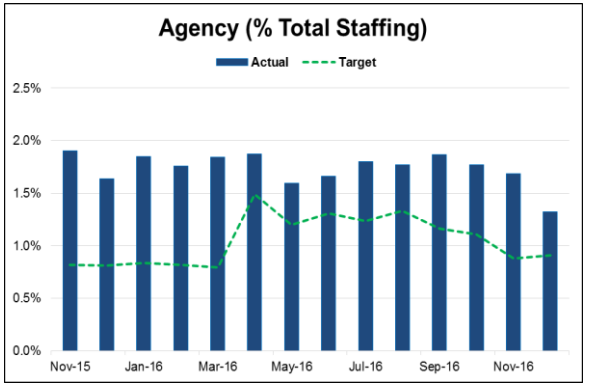
Description	Current Performance	Trend	Comments
Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.	November's performance was 85.2% against the 85% 62-day GP standard, and a trajectory of 85.1%. The 85% standard was met for internal pathways with performance at 90.8%. The main reasons for failure to achieve the 85% 62-day GP standard for individual patients is shown below. **Breach reason** / **Nov 16** Late referral by/delays at other provider: 6.5 Medical deferral/clinical complexity: 2.5 Delayed radiology diagnostic: 2.0 Patient choice: 1.0 Pathway management/admin issues: 2.0 Other reason: 2.5 **TOTAL: 16.5**	**Percentage of patients treated within 62 days of GP referral**  Performance against the 90% 62-day screening standard in November was 83.3%, with one breach of standard due to patient choice.	Performance continues to be impacted by factors outside of the control of the Trust, including late referrals and medical deferrals. Despite this the 85% standard was achieved, mainly due to a high number of treatments in the month. A CQUIN came into effect on the 1st October, along with a national policy for 'automatic' breach reallocation of late referrals. Adjusted performance based upon the reallocation rules would have been 88.2%. An improvement plan continues to be implemented to minimise avoidable delays (Action 10).
Diagnostic waits – diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end.	Performance against the 99% national standard was 98.2% in December. The number and percentage of over 6-week waiters at month-end, is shown below: **Diagnostic test** / **Oct** / **Nov** / **Dec** MRI: 1 / 2 / 1 Ultrasound: 0 / 0 / 1 Sleep: 20 / 1 / 9 Endoscopies: 40 / 42 / 30 CT: 25 / 29 / 22 Echo: 0 / 4 / 63 Other: 1 / 1 / 10 **TOTAL: 87 / 79 / 136** Percentage: **98.9%** / **99.0%** / **98.2%** Recovery trajectory: 98.5% / 99.0% / 99.0%	**Percentage of patients waiting under 6 weeks at month-end**  Achievement of the 99% at the end of January is at risk due to factors detailed in the section to the right.	There was an increase in the number of patients waiting over 6 weeks for a diagnostic test between November and December, mainly due to staff sickness within the echo service. Achievement of the 99% standard at the end of January is dependent upon enough extra capacity being established to address the bulge in demand due to patient choice to delay tests over the Christmas period, and also service capacity lost within Sleep Studies, due to the physical move of the service (Action 11A to 11C).

Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator is the ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors. This is nationally published quarterly, six months in arrears.	Summary Hospital Mortality Indicator (SHMI) for the last 12 months ending June 2016 was 101.2. This represents 21 more actual deaths than expected deaths in the 12 month period up to June 2016. The lower confidence limit of this indicator for the Trust is below 100 and the Trust is in the "As expected" category for SHMI. The Hospitalised Standardised Mortality Ratio (HSMR) remains well below 100 with 152 fewer actual deaths than expected deaths within the 12-month period up to June 2016.	**Summary Hospital Mortality Indicator (SHMI) for in hospital deaths each month** 	This latest SHMI data will be reviewed in detail to understand the reasons for the increase and identify any action the Trust needs to take.
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 November (latest data), 29 out of 34 patients (85.3%) were treated within 90 minutes of arrival in the hospital. Performance for the year as a whole remains above the 90% standard at 91.8%.	**Percentage of patients with a Door to Balloon Time < 90 minutes by month** 	Routine monthly analysis of the causes of delays in patients being treated within 90 minutes continues. Four of the five breaches of standard in November were a result of the Catheter Lab already being in use when the patient arrived for emergency treatment.

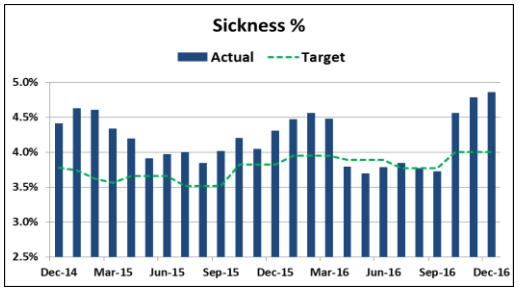
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In December 2016 we achieved 44.8% (13/29 patients) overall performance in Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 51.7% (15/29 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number of patients</th></tr>
<tr><td>Lack of theatre capacity.</td><td>3</td></tr>
<tr><td>Priority given to other surgical trauma cases.</td><td>4</td></tr>
<tr><td>Medically unfit for surgery.</td><td>3</td></tr>
<tr><td>Patient died.</td><td>1</td></tr>
<tr><td>Delayed diagnosis.</td><td>1 – MRI not reported on the same day.</td></tr>
<tr><td>Awaiting surgical specialist.</td><td>1 - Awaiting specialist in hip fractures.</td></tr>
<tr><td>Non-availability of radiographer.</td><td>1</td></tr>
</table>
</td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.
 
</td>
<td>Four patients did not receive any ortho-geriatrician review due to sickness and planned annual leave.
Actions are being taken to establish a future service model across Trauma & Orthopaedics, and ensure that consistent, sustainable cover is provided (Actions 12A to 12D).</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 December 2016 there were 602 outlier bed-days against a target of 705 outlier bed days. Performance showed a significant improvement in December with a decrease of 182 bed-days over November’s figure of 784.
<table>
<tr><th>Outlier bed-days</th><th>December 2016</th></tr>
<tr><td>Medicine</td><td>357</td></tr>
<tr><td>Surgery, Head & Neck</td><td>118</td></tr>
<tr><td>Specialised Services</td><td>110</td></tr>
<tr><td>Women's & Children's Division</td><td>13</td></tr>
<tr><td>Diagnostics and Therapies</td><td>4</td></tr>
<tr><td>Total</td><td>602</td></tr>
</table>
</td>
<td>Number of days patients spent outlying from their specialty wards
 
</td>
<td>In quarter 3 the target is set at 705 and actual outlier bed-days were 103 fewer than this. This is an improvement on the previous month where the target was exceeded by 79 bed days.
Ongoing actions are shown in the action plan section of this report. (Action 13).</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 31.2 FTE, reducing from 1.7% to 1.3% of total staffing. Levels dropped across all Divisions except Diagnostic & Therapies and Facilities & Estates. Nursing agency usage reduced by 21.7 FTE.	**Agency usage as a percentage of total staffing by month**	The agency action plans continue to be implemented and the headlines are in the improvement plan (Action 14). A summary of compliance with agency caps is attached in Appendix 2.
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2015/16. The red threshold is 0.5% over the monthly target.	Sickness absence has increased from 4.8% to 4.9%. The main reason for the exceptionally high levels during the last three months are the combination of the seasonal increase in colds and flu (22% in month) combined with a spike in absence due to psychological reasons.	**Sickness absence as a percentage of full time equivalents by month**	Average monthly sickness absence for the year to date stands at 4.1%. Action 15 describes the ongoing programme of work to address sickness absence.

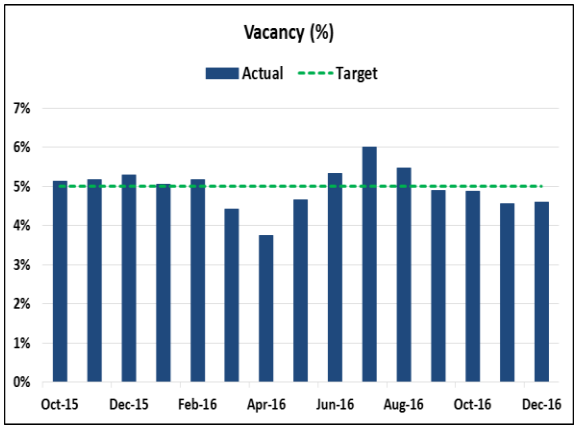
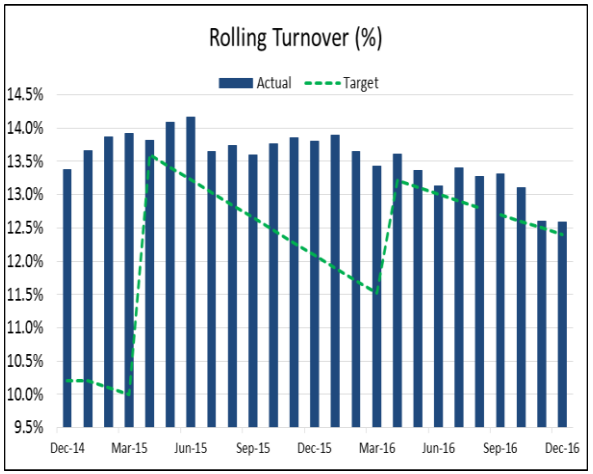
December 2016	FTE	Actual %	KPI
UH Bristol	**111.5**	**1.3%**	**0.9%**
Diagnostics & Therapies	6.6	0.7%	0.5%
Medicine	34.7	2.7%	1.8%
Specialised Services	11.1	1.2%	1.2%
Surgery, Head & Neck	19.4	1.1%	0.4%
Women's & Children's	14.7	0.8%	0.5%
Trust Services	11.8	1.7%	2.1%
Facilities & Estates	13.3	1.7%	1.0%

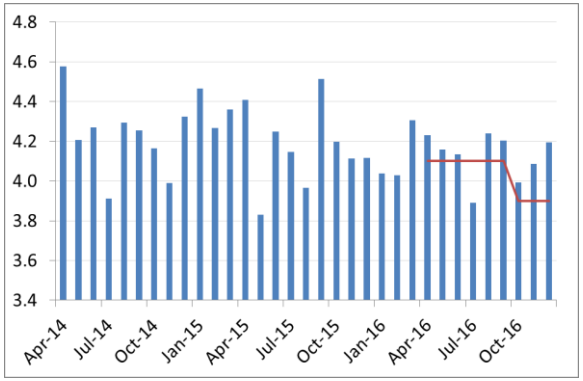


December 2016	Actual	KPI
UH Bristol	**4.9%**	**4.0%**
Diagnostics & Therapies	4.0%	2.8%
Medicine	5.1%	4.5%
Specialised Services	4.1%	3.7%
Surgery, Head & Neck	4.4%	3.7%
Women's & Children's	5.0%	4.1%
Trust Services	4.3%	3.5%
Facilities & Estates	7.7%	6.0%



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

Description	Current Performance	Trend	Comments
Vacancies - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.	Overall vacancies remain the same as last month, at 4.6%. Registered nursing vacancies increased from 3.1% (75.6 FTE) to 3.7% (89.4 FTE). Ancillary vacancies reduced from 6.8% (58.3FTE) to 5.9% (50.1 FTE). **December 2016 / Rate** **UH Bristol: 4.6%** Diagnostics & Therapies: 5.9% Medicine: 4.8% Specialised Services: 5.3% Surgery, Head & Neck: 5.0% Women's & Children's: 1.7% Trust Services: 6.9% Facilities & Estates: 5.8%	**Vacancies rate by month** 	The recruitment action plan is summarised in Action 16. Appendix 2 details progress in reducing specialist nursing vacancies (Heygroves Theatres and Coronary Care Intensive Care Unit - CICU). Heygroves has four new starters before March, leaving two vacancies unfilled. CICU are off trajectory as a result of higher than forecast turnover, but have ten new starters planned for Q4.
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 12.1% by the end of 2016/17. The red threshold is 10% above monthly trajectory**.**	Turnover has remained the same as last month, at 12.6%.Registered nurse turnover increased slightly from 11.9% to 12.1%. **December 2016 / Actual / Target** **UH Bristol: 12.6% / 12.5%** Diagnostics & Therap.: 11.2% / 12.6% Medicine: 14.8% / 13.6% Specialised Services: 11.8% / 13.0% Surgery, Head & Neck: 12.4% / 12.7% Women's & Children's: 11.5% / 10.8% Trust Services: 13.2% / 12.7% Facilities & Estates: 14.6% / 13.6%	**Staff turnover rate by month** 	Programmes to support staff recruitment remain a key priority for the Divisions and the Trust (Action 17).

Description	Current Performance	Trend	Comments
Length of Stay (LOS) measures the number of days inpatients on average spent in hospital. This measure excludes day-cases. LOS is measured at the point at which patients are discharged from hospital.	In December the average length of stay for inpatients was 4.19 days, which is above the quarter 3 RED threshold of 3.90 days. This is a further 0.10 day increase on the previous month. The percentage of patients discharged in December who were long-stay stay patients increased significantly relative to previous months. This in part explains the increase in reported length of stay in December. The number of long stay patients in hospital at month-end decreased slightly, but did not return to the levels seen in quarter 3 2015/16. This suggests that length of stay will remain high.	**Average length of stay (days)**  Length of stay is forecast to remain above the RED threshold in January and to materially increase when the existing cohort of long-stay patients are discahrged.	The number of bed-days consumed by Green to Go delayed discharges fell slightly during December, although total numbers of patients remain at circa 65. The jointly agreed planning assumption of 30 patients continues to not be met. Work to reduce delayed discharges and over 14 days stays continues as part of the emergency access community-wide resilience plan and additional exceptional actions being taken (Actions 8A to 8H and 13).

Improvement Plan

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Safe					
Deteriorating patient Early warning scores for acted upon.	1A	Further targeted teaching for areas where NEWS incidents have occurred.	Commenced February 2016 and on-going	Monthly progress reviewed in the deteriorating patient work stream and quarterly by the Patient Safety Improvement Programme Board, Clinical Quality Group and Quality and Outcomes Committee	Sustained improvement to 95% by 2018.
	1B	Accessing doctor education opportunities to assist with resetting triggers safely	Commenced April 2016 and on-going	As above	Sustained improvement to 95% by 2018.
	1C	Conduct 1:1 debriefs to further understand the reasons why nurses and doctors are unable to escalate or respond to escalation and address these accordingly. Also please see 1E below.	Underway aiming for completion January2017. This will now not be completed until March 2017	As above	Sustained improvement to 95% by 2018.
	1D	Spreading point of care simulation training in adult general ward areas to address human factors elements of escalating deteriorating patients and use of structured communication.	September 2016 and on-going	As above	Sustained improvement to 95% by 2018.
	1E	Additional time allocated for patient safety in doctors' induction to train new appointees on resetting triggers safely and	From September 2016 and ongoing	As above	Sustained improvement to 95% by 2018.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		human factors awareness of escalation conversations.			
	1F	Mapping exercise of coverage of responders to escalation calls out of hours	February 2017	As above	Sustained improvement to 95% by 2018.
	1G	Procurement of e observations system to enable automatic calculation of NEWS and notification of elevated NEWS to responder	TBC	As above	Sustained improvement to 95% by 2018.
Non-purposeful omitted doses of critical medication	2A	Datix dashboard being developed to capture omitted doses, to allow detailed thematic analysis.	Commenced October 2016 and ongoing	Improvement under development	Maintain current improvement and sustain performance below 1%
	2B	Trust-wide bulletin on medicines for Parkinson's disease. Information to be sent to Matrons for dissemination to ward staff.	Commenced October 2016 and ongoing	Highlight this issue and the drug availability.	Maintain current improvement and sustain performance below 1%
Essential Training	3	Continue to drive compliance including increasing e-learning.	Ongoing	Oversight by Workforce and OD Group via the Essential Training Steering Group	Divisional Trajectories show compliance by the end of March 2017. Information Governance is required to achieve 95%. The target for all other essential training is 90%.
		Detailed plans and trajectories focus on improving the compliance of Safeguarding Resuscitation, Information Governance and Fire Safety.	Ongoing	Oversight of safeguarding training compliance by Safeguarding Board/ Workforce and Organisational Development Group. Monthly and quarterly Divisional Performance	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
				Reviews.	
Monthly Staffing levels	4	Continue to validate temporary staffing assignments against agreed criteria.	Ongoing	Monitored through agency controls and action plan.	Action plan available on request.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Caring					
Dissatisfied complainants	5A	Response writing training continues to be rolled-out to Divisions	Ongoing	Completion of training signed-off by Patient Support & Complaints Team and Divisions.	Achieve and maintain a green RAG rating for this indicator.
	5B	Upon receipt of written response letters from the Divisions, there is a thorough checking process, whereby all letters are firstly checked by the case-worker handling the complaint, then by the Patient Support & Complaints Manager. The Head of Quality for Patient Experience & Clinical Effectiveness also checks a selection of response letters each week. All responses are then sent to the Executives for final approval and sign-off.	Ongoing	Senior Managers responsible for drafting and signing off response letters before they leave the Division are named on a Response Letter Checklist that is sent to the Executives with the letter. Any concerns over the quality of these letters can then be discussed individually with the manager concerned and further training provided if necessary.	
	5C	Dissatisfied responses are now routinely checked by the Head of Quality (Patient Experience & Clinical Effectiveness) to identify learning where appropriate. All cases where a complaint is dissatisfied for a second time are escalated to and reviewed by the Chief Nurse. In early January 2017, the Head of Quality and Acting Patient Support and Complaints Manager will	Implemented September 2015 and ongoing January 2017	Learning identified and shared with Divisions	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		conduct a detailed review of the 15 dissatisfied cases from July and August to identify any themes and learning.			
	5D	The Trust will be establishing a new complaints review panel in 2017, the terms of reference for which will be developed by the end of January.	Terms of Reference established by January 2017		
Last minute cancelled operations	6A	Continued focus on recruitment and retention of staff to enable all adult BRI ITU beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited and in post. Development and implementation of a strategy for managing ITU/HDU beds across general adult and cardiac units, to improve ability to manage peaks in demand.	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 Clinical Strategy Group.	Improvement to be evidenced by a reduction in cancellations in Q4. Achievement of quality objective on a quarterly basis.
	6B	Specialty specific actions to reduce the likelihood of cancellations.	Ongoing	Monthly review of plan with Divisions by Associate Director of Operations.	As above.
Outpatient appointments cancelled by hospital	7A	Produce summary analysis of first month's use of the new cancellation codes, and test the reasonableness of the target	Complete	Report provided for Outpatient Steering Group;	Outpatient Steering Group to identify any new actions arising from this analysis, which may alter performance trajectory.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		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.			
	7B	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 December (revised from end of November)	Report provided for Outpatient Steering Group	Amber threshold expected to be achieved again by the end of March.
	7C	Confirm that no leave is being agreed within six weeks (or timescale locally agreed).	Ongoing	Report provided for Outpatient Steering Group	See action 7B

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Responsive					
A&E 4-hours	8A	Medically expected patients managed via Acute Care Unit (ACU) to avoid adding to ED queue	End of December	Actions expected to reduce and/or smooth demand. Monitoring of expected improvement in relevant KPI through the Emergency Access Improvement Group (AEPIG)	Improvement expected in Q4 performance, relative to monthly trajectory.
	8B	Additional medical Senior Registrar cover for twilight shifts to support ED	End of January		
	8C	Extended escalation capacity (A518) likely to end of quarter 4, and continued use of ORLA	End of December		
	8D	Three additional consultant-led discharge teams on the ground	Continuing until the end of January.		
	8E	Two Acute physicians commencing in post	Mid-February		
	8F	Flexible use of community beds via system partners	Duration of quarter 4 2016/17	Progress monitored through daily ALAMAC calls.	
	8G	Additional GPSU and Urgent care capacity	Duration of quarter 4 2016/17		
	8H	Alternative transport to smooth flow of medically expected patients	From mid-January		
Referral to Treatment Time (RTT)	9	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory. Continued weekly review of	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review	Reduction in over 18 week RTT pathways through to the end of December (achieved), with achievement of 92% in each

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		management of longest waiting patients through RTT Operations Group.		meetings.	month in quarter 4.
Cancer waiting times	10	Implementation of Cancer Performance Improvement Plan, including ideal timescale pathways, and reduced waits for 2-week wait appointments.	Ongoing	Oversight of implementation by Cancer Performance Improvement Group, with escalation to Cancer Steering Group.	Achieve monthly recovery trajectory submitted for quarter 3 2016/17 (achieved in November and achieved for each month with reallocation/CQUIN rules applied).
Diagnostic waits	11A	Increase adult endoscopy capacity by recruiting to the Nurse Endoscopist post, completing the in-house training of a nurse endoscopist, booking additional waiting list initiatives and sessions through Glanso, and outsourcing as much routine work as possible to a private provider through the contract which has recently been agreed.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Recovery of 99% standard for endoscopy by end of January (revised from October).
	11B	Additional Sleep Studies waiting list sessions being undertaken to help address the bulge in demand;	End February	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Recovery of 99% standard by end of October - achieved for October and November, but not in December. Additional sessions now being booked in January and February.
	11C	Additional echocardiography sessions to be established to catch-up on capacity lost in December.	End January	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review	Achievement of 99% standard again for this diagnostic modality by the end of

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
				meetings as required.	January.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Effective					
Fracture neck of femur Best Practice Tariff (BPT)	12A	Build and submit case for middle grade medical ortho-geriatric support (1.0 WTE 1-year fixed term with focus on quality/pathway work relating to Fractured Neck of Femur). This will enable consistent and regular ortho-geriatric cover across orthopaedic wards, and avoid breaches due to annual leave etc.	September 2016	Successful funding bid and subsequent recruitment to post.	Post on hold pending completion of business case of investment to service following BOA report and recommendations
	12B	Build and submit case for specialist acute fracture nurse support (Band 6 permanent).	April 2017	Successful funding bid and subsequent recruitment to post.	Expected to form part of investment proposal for the 2017/18 operating plan.
	12C	Review the ward structure to see whether separate wards with protected beds and capacity for fractured neck of femurs will allow additional focus to meet patient's needs	April 2017	Focussed care consolidated in each ward, suitable to meet the patients' needs. Improved recruitment and retention of ward staff.	Proposals have been submitted to split the wards into one elderly trauma and fractured neck of femur ward (A604), and one young trauma and elective ward (A602). Awaiting full feedback, but the initial reaction was positive.
	12D	Review and make the case to increase physiotherapy services to support fractured neck of femurs patients on the trauma and orthopaedic wards across seven days	April 2017	Earlier physiotherapy and nutritional support, earlier mobilisation and better chest management.	Post on hold pending completion of business case of investment to service following BOA report and recommendations

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Outlier bed-days	13	Ward processes to increase early utilisation of discharge lounge to facilitate patients from Acute Medical Unit getting into the correct speciality at point of first transfer.	Ongoing	Oversight in Ward Processes Project Group	Linked to increased and timely use of discharge lounge

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Efficient					
Agency Usage	14	**Effective rostering**: "Allocate" implementation will provide: • Acuity and dependency to match staffing with demand. • Improved rostering/booking for ward managers and staff • Robust management information	Pilot November 2016, go live April 2017	Nursing agency: oversight by Savings Board through its sub group (Nursing Controls Cost Improvement Group). Medical agency: oversight through the Medical Efficiencies Group.	The mid-year review forecast an out turn in March 2017 of 1.5% compared with the 2016/17 KPI of 1.1% as a percentage of total staffing. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance reviews.
		Controls and efficiency: • Increased rigour to escalation processes requiring Executive approval for all high cost agency usage • Procurement of nurse and AHP agency supplier arrangements is underway for contracts to be awarded in April 2017	Ongoing		
		• Operating plan agency trajectories monitored through divisional reviews	Monthly and quarterly reviews		
		Enhancing bank provision: • Ongoing marketing drive	Ongoing		
		• Bank shifts available on "Allocate", allowing shifts to be viewed from home	End January		
		• Pilot to extend opening hours of the Temporary Staffing Bureau	End January		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Sickness Absence	15	**Review of Supporting Attendance Policy:** Draft policy to Policy Group February 2017; implementation April 2017, managers training from April 2017	Dec 2016 – April 2017	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. In order to achieve the KPI, sickness would have to be 3.7% or lower for each of the remaining months of 2016/17.
		Supporting Attendance Surgeries: To expedite cases where possible	Ongoing		
		Musculo-skeletal: Interventions by Occupational Health, Physio direct, and Manual Handling Team	Ongoing		
		Staff Health and Well Being: Action plan includes staff health checks	January 2016 to January 2018		
		Staff Health and Well Being CQUIN 2016/17: • Physiotherapist, Associate Counsellor and Administrative and Clerical support.	Funded until March 2017	CQUIN short term working group (Peer review Bristol Clinical Commissioning Group)	
		2017/19 Staff Health and Wellbeing CQUIN: Includes the following 3 indicators: **1.** Improvement in staff survey wellbeing questions **2.** Healthy food (staff/visitors/ Patients) builds on 2016 CQUIN **3.** Flu vaccination programme: ○ 2018: 70% uptake	End of March 2018 and March 2019 End of February	Workplace Wellbeing Steering Group (quarterly) /CQUIN Delivery Group	

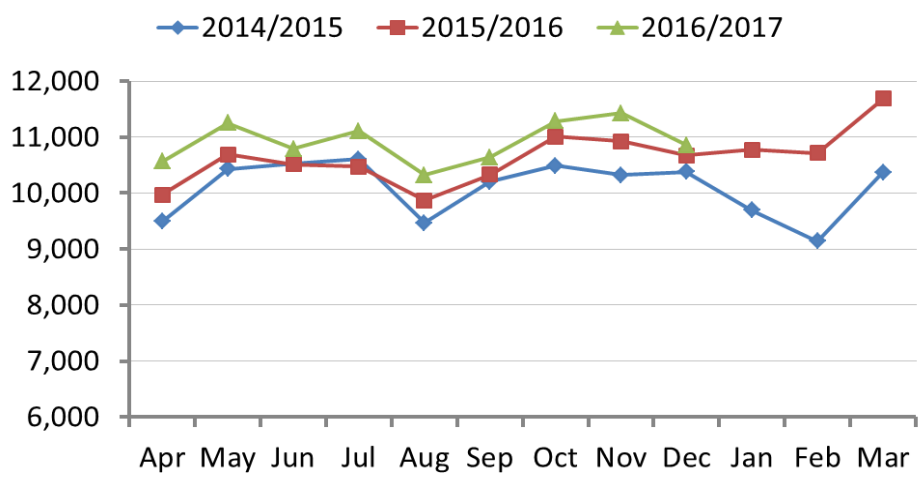
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		○ 2019 75% uptake	2018/19		
Vacancies	16	Recruitment action plan includes the following activities. **Recruitment Performance:** • Divisional Performance and Operations Meetings monitor ongoing vacancy levels and performance against the agreed KPI of 45 days to recruit. **Marketing and advertising:** • A new nursing recruitment website as part of the Nurse Marketing Strategy went live in November 2016 supported by digital and social media led advertising campaigns **Support for recruitment and retention initiatives in specialist areas**: - • Heygroves Theatres and CICU. Trajectories are shown in appendix 3.	Review quarterly Ongoing Reviewed monthly	Workforce and OD Group /Recruitment Sub Group. Divisional Performance and Operational Reviews	Detailed trajectories are in place for key recruitment hotspots, including theatres; critical care, haematology and ancillary staff
Turnover	17	**Complete review of appraisal**: Including: • Revised policy • E-Appraisal • Engaging staff Future actions include: • Communication plan	March 2017 Communication plan launched	Transformation Board	The KPI for 2016/17 has been set at 12.1%. The forecast out turn for March 2017, based on the mid-year review, was 12.4%.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		• Further pilots for improved E appraisal system in 2017	January 2017		
		Targeted leadership and management development programme: Evaluation of the first programme - end February 2017.	End February 2017		
		Team building and local decision making: Options appraisal to be considered by Senior Leadership team.	Evaluation in February 2017	Senior Leadership Team	
		Staff experience workshops: Divisions have incorporated actions with detailed milestones into their operating plans.	November 2015 - March 2017	Divisional Boards/ Senior Leadership Team/Workforce and OD Group.	
		Transformational Engagement and retention: Leadership Behaviours to be developed and implemented in the first quarter 2017/18.	Workshops December 2016 to January 2017.	Senior Leadership Team/Board	
		Staff Survey: Staff survey closed December 2nd Results available in March/April.	March/April 2017	Workforce and OD Group	

Operational context

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

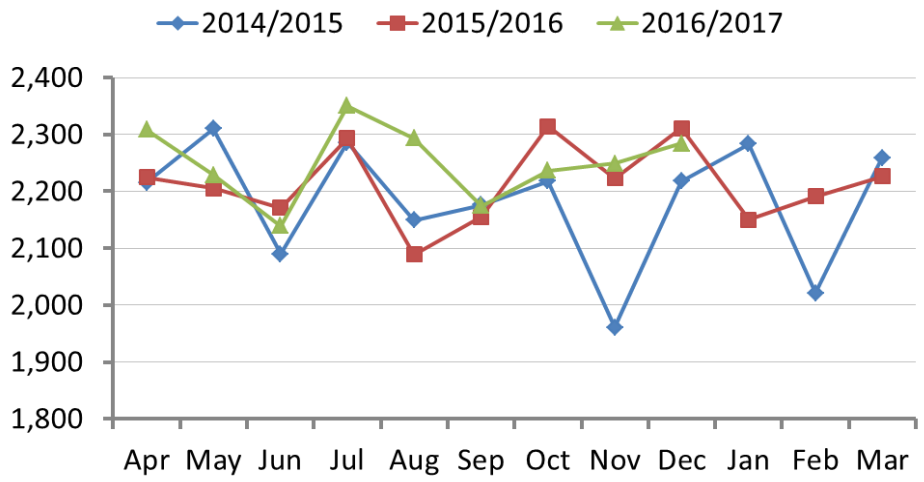
Emergency Department (ED) attendances



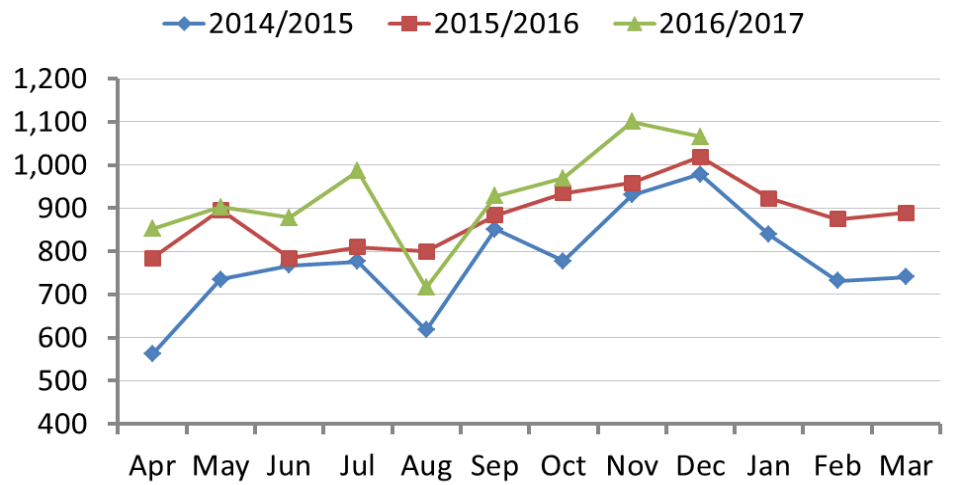
Summary points:

- Emergency attendances have fall to a similar level to the same period last year;
- The total number of emergency admissions into the BRI remain around the seasonal norm, but the number of emergency admissions into the BCH continued to be above the same period last year;
- The number of new outpatient attendances decreased back to the level of the seasonal norm; the outpatient waiting list has significantly decreased in size;
- The number of elective admissions also decreased back to the level of the seasonal norm, in part due to higher cancellations due to emergency pressures; consistent with this, the number of patients waiting over 18 weeks for treatment on an admitted pathway, has risen (see Assurance and Leading Indicators section).

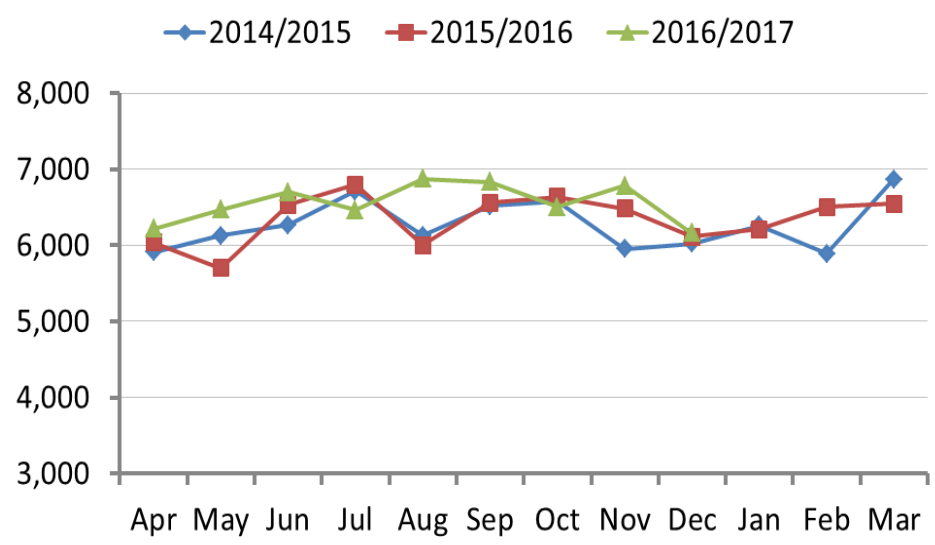
Emergency admissions (BRI)



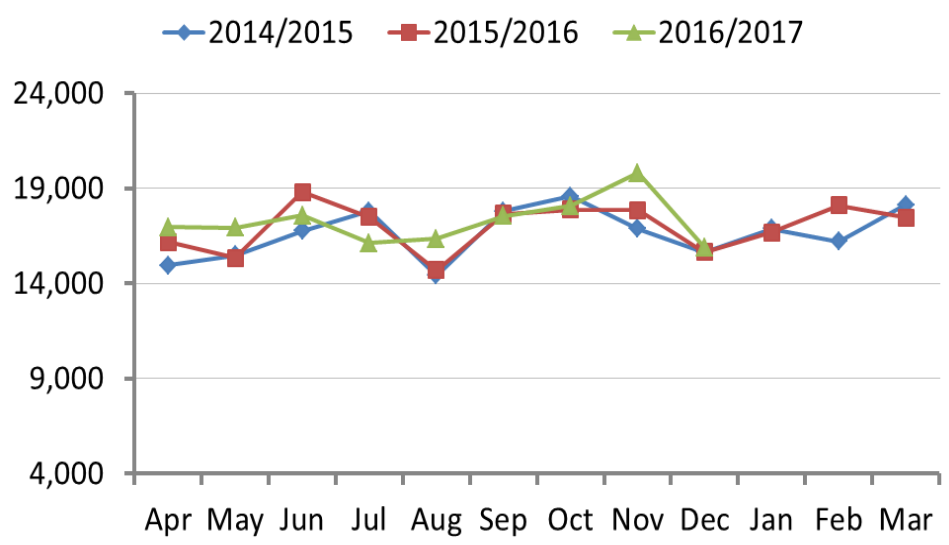
Emergency admissions (BCH)



Elective admissions



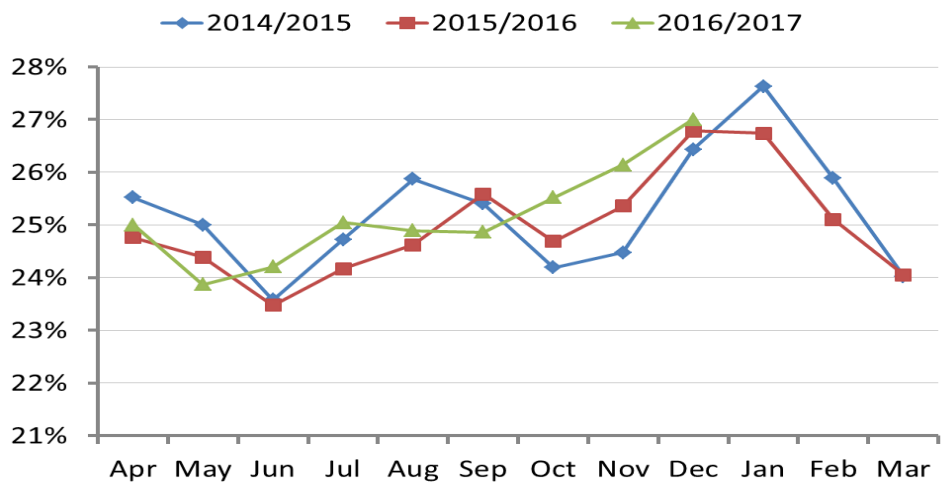
New outpatient attendances



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.

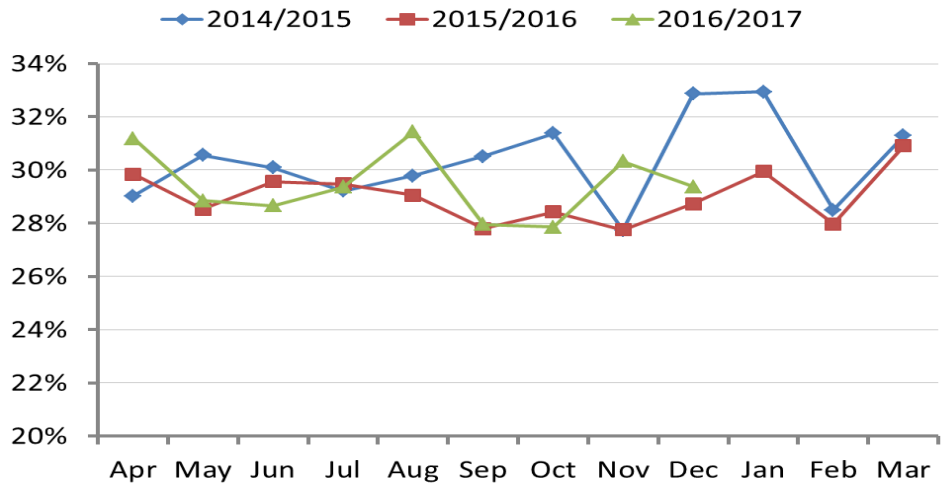
Percentage ED attendances resulting in admission



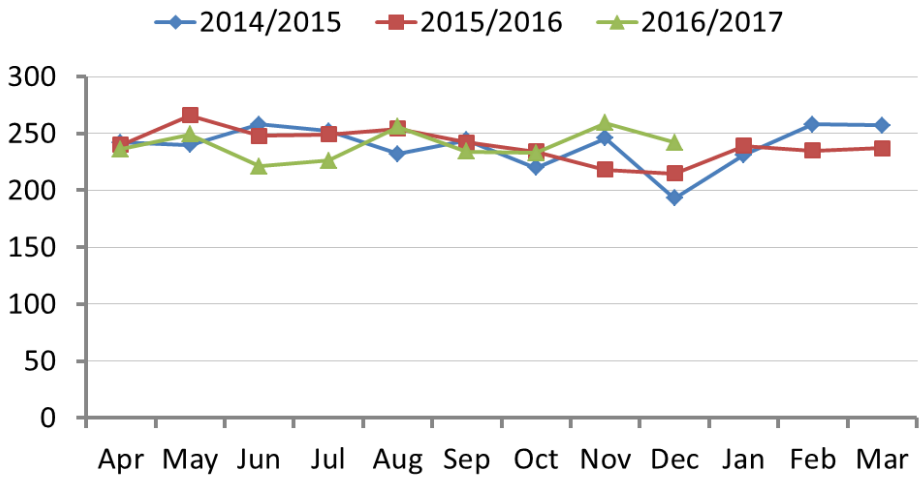
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission continues to show the usual seasonal rise, and is similar to the same period last year; the percentage of patients admitted aged 75 years and over is slightly above the same period last year;
- The number of bed-days consumed by delayed discharges remains significantly above last year's level, as does BRI bed occupancy, despite the usual fall due to increased discharges pre-Christmas;
- The number of patients on the outpatient waiting list has decreased; consistent with this, the number of patients waiting over 18 weeks RTT on a non-admitted pathway has decreased, but the numbers on admitted pathway have not (see Appendix 3);
- The number of patients referred by their GP with a suspected cancer (2-week waits) remains significantly above the same period last year.

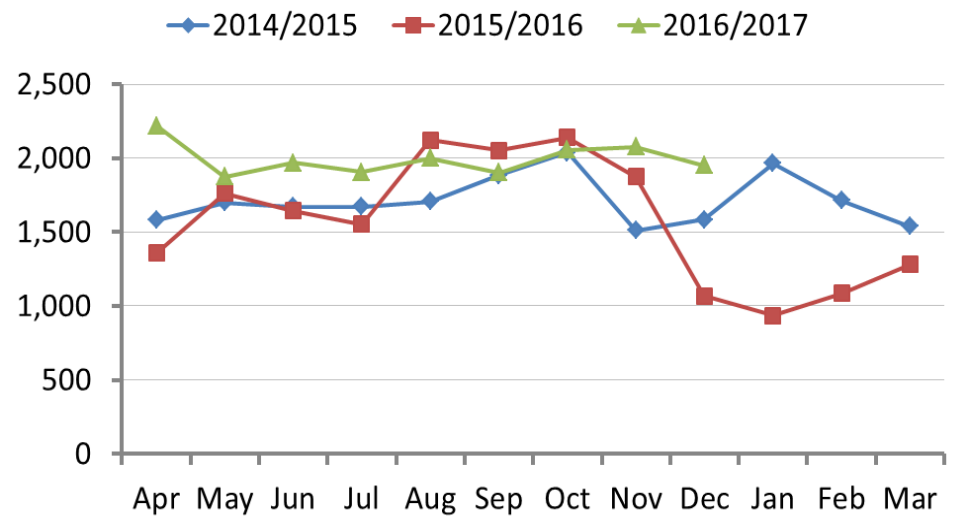
Percentage of Emergency BRI spells patients aged 75 years and over



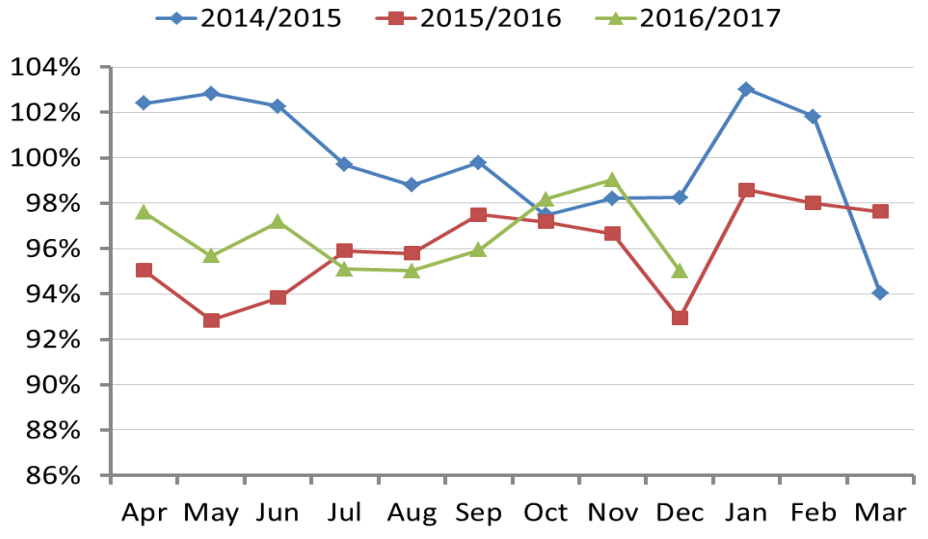
Over 14 day stays



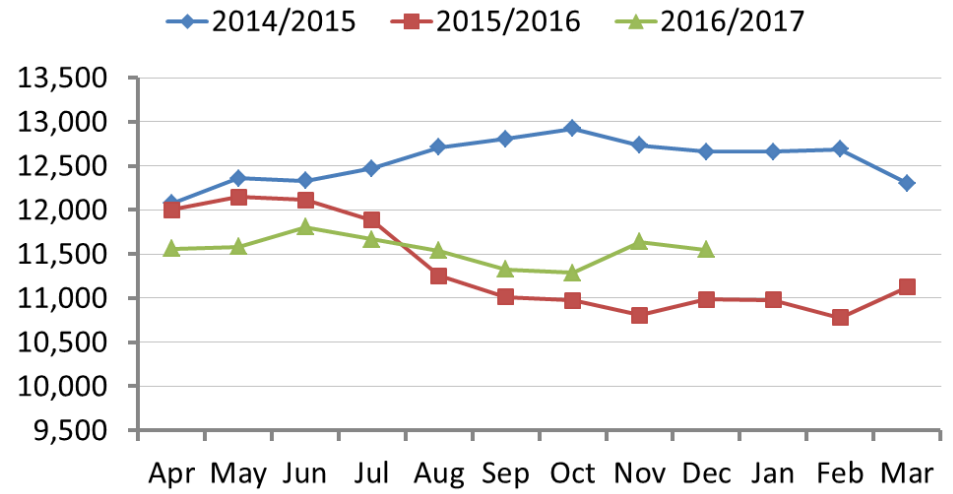
Delayed discharges (Green to Go) – bed-days consumed



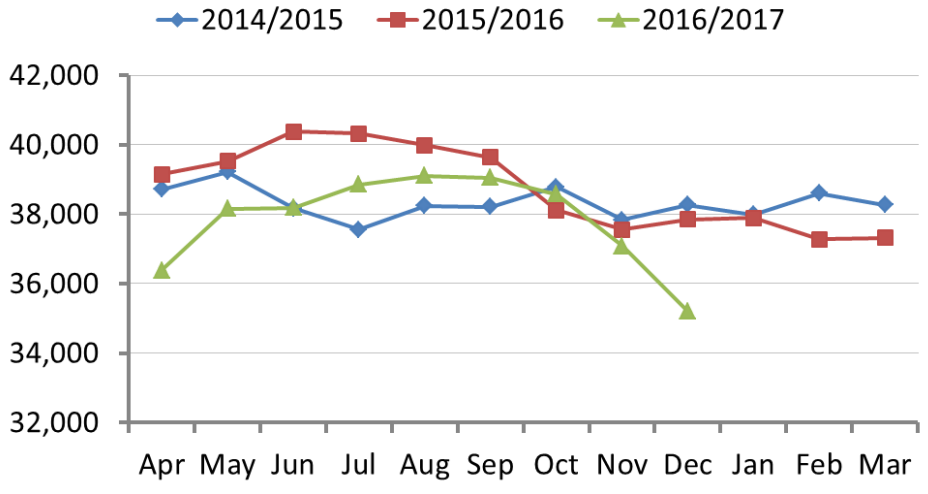
BRI Bed Occupancy



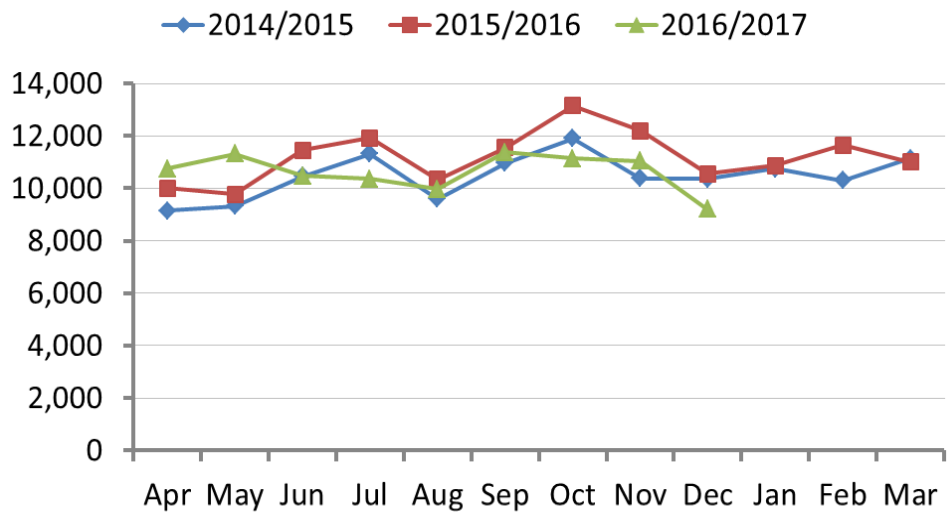
Elective waiting list size



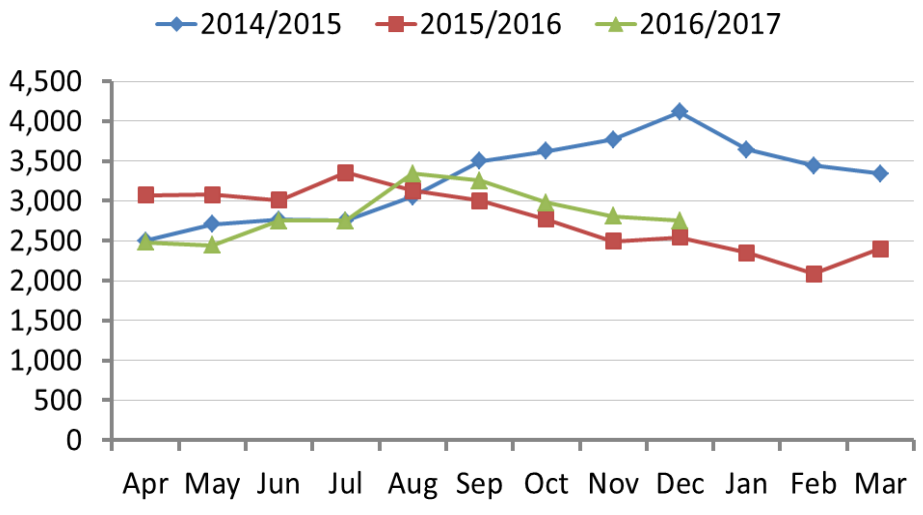
Outpatient waiting list size



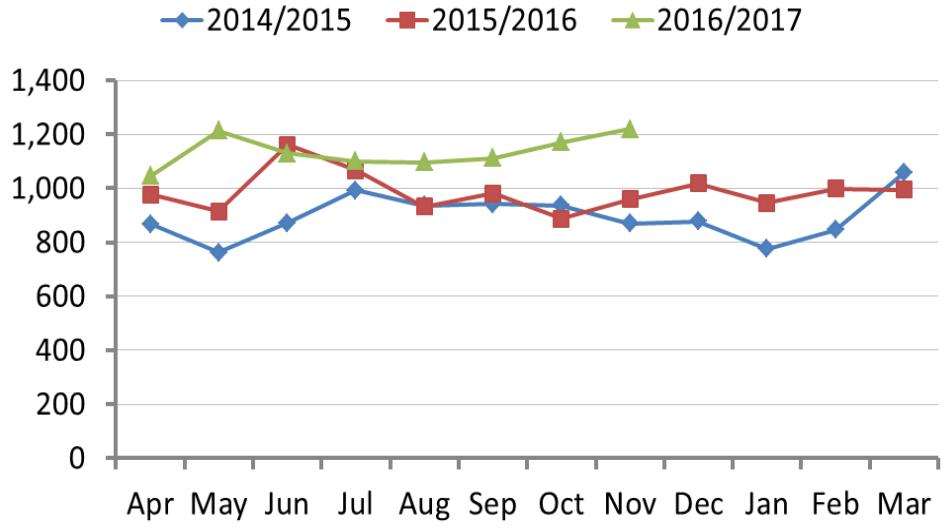
Number of RTT pathways stopped (i.e. treatments)



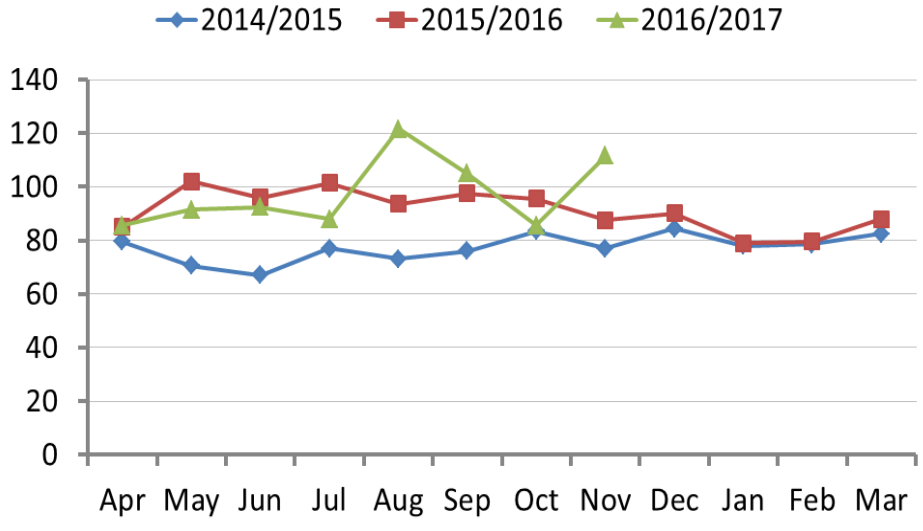
Number of RTT pathways over 18 weeks



Cancer 2-week wait – urgent GP – referrals seen



Cancer 62-day GP referred treatments



Trust Scorecards

SAFE, CARING & EFFECTIVE

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	3	3	3	0	0	0	0	0	0	0	1	0	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	3	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
	DA03	C.Diff Cases - Monthly Totals	40	27	4	2	4	2	5	1	3	2	5	1	3	5	10	8	10	9
	DA02	MSSA Cases - Monthly Totals	26	29	2	1	0	2	3	3	7	4	2	0	6	2	3	8	13	8
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	12	14	17	0	1	2	3	4	5	5	-	-	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.3%	96.8%	96.4%	97.7%	96.8%	96.6%	97.3%	98%	96.9%	98.4%	94.9%	97%	96.5%	95.7%	97%	97.3%	96.8%	96.4%
	DB02	Antibiotic Compliance	87.6%	87.6%	86.5%	88.2%	86.1%	84.4%	85.3%	83.9%	88.2%	86.5%	86.8%	90.9%	90.3%	91.2%	86.9%	84.5%	87.4%	90.8%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	94%	95%	94%	95%	95%	95%	96%	97%	95%	95%	96%	96%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	97%	98%	98%	98%	98%	98%	98%	98%	98%	97%	97%	97%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	95%	96%	95%	96%	96%	96%	96%	97%	97%	96%	96%	97%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	69	40	6	4	10	3	8	2	6	8	1	4	5	3	20	13	15	12
	S02a	Number of Confirmed Serious Incidents	55	27	5	4	5	3	7	2	5	7	1	2	-	-	14	12	13	2
	S02b	Number of Serious Incidents Still Open	5	11	1	0	0	0	1	0	0	0	0	2	5	3	1	1	0	10
	S03	Serious Incidents Reported Within 48 Hours	84.1%	92.5%	100%	100%	100%	66.7%	100%	100%	83.3%	87.5%	100%	100%	100%	100%	100%	92.3%	86.7%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	-	87.5%	-	-	-	66.7%	100%	100%	100%	87.5%	100%	75%	80%	66.7%	-	92.3%	93.3%	75%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	74.1%	97.4%	60%	63.6%	100%	100%	100%	100%	100%	100%	100%	100%	100%	75%	66.7%	100%	100%	93.3%
Never Events	S01	Total Never Events	3	2	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	13787	9803	1190	1196	1226	1145	1216	1258	1173	1139	1263	1220	1389	-	3612	3619	3575	2609
	S06b	Patient Safety Incidents Per 1000 Beddays	44.75	42.4	44.65	48.26	46.78	45.19	46.88	50.22	45.32	44.67	50.77	45.61	52.93	-	46.52	47.41	46.88	33.18
	S07	Number of Patient Safety Incidents - Severe Harm	97	63	5	6	3	2	8	9	10	10	2	10	12	-	14	19	22	22
Patient Falls	AB01	Falls Per 1,000 Beddays	3.95	4.26	3.56	3.59	4.16	4.26	3.93	4.59	4.6	3.84	4.42	4.86	4.04	3.74	3.77	4.26	4.29	4.22
	AB06a	Total Number of Patient Falls Resulting in Harm	30	25	2	3	5	1	4	3	3	3	3	2	2	4	10	8	9	8
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	-	0.195	-	-	-	-	-	-	-	-	-	-	-	0.195	-	-	-	0.195
	DE02	Pressure Ulcers - Grade 2	-	31	-	-	-	-	-	-	-	-	-	-	-	5	-	-	-	9
	DE03	Pressure Ulcers - Grade 3	-	2	-	-	-	-	-	-	-	-	-	-	-	0	-	-	-	1
	DE04	Pressure Ulcers - Grade 4	-	0	-	-	-	-	-	-	-	-	-	-	-	0	-	-	-	0
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.2%	99.1%	97.1%	95.6%	96.9%	99.3%	99.1%	99%	99.1%	99.1%	99%	99%	99.4%	99%	96.5%	99.2%	99.1%	99.1%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.6%	96.1%	93.6%	96%	94.5%	94.8%	96.3%	96.6%	97.3%	95.7%	94.1%	97%	96.5%	97%	94.7%	95.8%	95.8%	96.8%
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	90.4%	89.1%	90.4%	89.9%	91.4%	83.6%	94%	86.3%	89.4%	89.8%	89.7%	86.5%	87.1%	94.3%	90.6%	88.5%	89.6%	89.4%
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	-	84.5%	-	-	-	-	-	80.8%	-	-	88%	-	-	91%	-	80.8%	88%	91%
Safety	Y01	WHO Surgical Checklist Compliance	99.9%	99.5%	99.9%	99.9%	100%	99.8%	100%	98.9%	99.6%	99.9%	100%	99.6%	-	97.7%	99.9%	99.6%	99.9%	98.7%

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3
Patient Safety																				
Medicines	WA01	Medication Incidents Resulting in Harm	0.8%	0.49%	1.28%	0.42%	0.41%	0%	0.51%	0%	0.55%	0%	1.01%	0.55%	1.19%	-	0.7%	0.16%	0.51%	0.92%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.87%	0.62%	1.49%	0.66%	0.69%	0.93%	0.63%	0.56%	0.6%	0.38%	0%	0.65%	0.86%	0.74%	0.92%	0.73%	0.33%	0.75%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.1%	97.9%	97.2%	96.7%	97.3%	97.1%	97.7%	98.3%	98.4%	98.6%	98.6%	97.6%	97.5%	97.4%	97.1%	97.7%	98.6%	97.5%
	AK04	Safety Thermometer - No New Harms	98.6%	98.9%	98.8%	98.9%	99.4%	98.9%	98.7%	98.7%	99.2%	99.2%	99.2%	98.4%	99.3%	98.5%	99%	98.8%	99.2%	98.7%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	90%	91%	86%	86%	88%	87%	100%	79%	82%	95%	94%	94%	93%	93%	86%	89%	90%	93%
Out of Hours	TD05	Out of Hours Departures	10.7%	7.7%	11%	9.6%	9.6%	8.1%	7.5%	7.2%	7.8%	8.7%	7.3%	7.1%	7.6%	7.9%	10.1%	7.6%	7.9%	7.5%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	20.3%	22.4%	21.9%	22.4%	23.3%	23%	22.3%	23.4%	23.1%	21.1%	22.3%	21.9%	22.3%	22.3%	22.5%	22.9%	22.1%	22.2%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	10444	8655	911	926	990	970	952	989	1004	909	939	978	971	943	2827	2911	2852	2892
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.1%	103.6%	105.9%	103.2%	103.1%	104.7%	104%	103.1%	104.3%	102.7%	101.9%	102.6%	105.3%	104.2%	104.1%	103.9%	103%	104%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	97.7	101.2	-	-	98.7	-	-	101.2	-	-	-	-	-	-	98.7	101.2	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	90	83	97.7	97	95.9	78.9	80	83.5	92.6	81.9	81.6	83.1	-	-	96.8	80.7	85.5	83.1
Readmissions	C01	Emergency Readmissions Percentage	2.74%	1.78%	2.67%	2.66%	1.5%	1.74%	1.56%	1.7%	1.76%	2%	2.29%	1.48%	1.7%	-	2.27%	1.67%	2.01%	1.59%
Maternity	G04	Percentage of Spontaneous Vaginal Deliveries	62.1%	60.7%	62.7%	60.1%	62.5%	66.6%	60.9%	56.4%	62.1%	61.5%	59.4%	58.8%	62.8%	58.2%	61.8%	61.2%	61%	59.9%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	75.9%	68.6%	76%	78.6%	80%	87.5%	74.1%	72%	73.5%	61.3%	58.3%	73.7%	69.2%	51.7%	78.2%	77.6%	65.2%	63.5%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	82.5%	75.7%	80%	78.6%	84%	83.3%	81.5%	72%	79.4%	64.5%	58.3%	89.5%	69.2%	86.2%	80.8%	78.9%	68.5%	81.1%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	63.5%	51%	60%	64.3%	68%	70.8%	59.3%	44%	52.9%	35.5%	37.5%	68.4%	53.8%	44.8%	64.1%	57.9%	42.7%	54.1%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	50.2	47.5	40.5	35.8	61.4	44.1	44.4	72.2	53.5	49.4	51.7	53.2	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	61.5%	62.3%	62.5%	77.4%	60.6%	69.2%	67.6%	65.9%	59%	51.4%	63.4%	56.8%	61.8%	-	66.1%	67.7%	58.3%	59.2%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	93.5%	90.8%	91.7%	96.8%	84.8%	88.5%	88.2%	93.2%	92.3%	85.7%	92.7%	97.3%	88.2%	-	91.1%	90%	90.4%	93%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.4%	69.9%	71.4%	80%	80%	58.3%	68.8%	61.5%	76.5%	71.4%	80%	60%	65.2%	81.8%	77.3%	63.4%	76.5%	68.2%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	91.6%	93.7%	93.4%	94.7%	96.7%	94.5%	95.8%	94.1%	98%	96.3%	93.2%	93.1%	88.9%	89.1%	94.9%	94.8%	96%	90.2%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	95.8%	97.5%	95.7%	96.3%	96.8%	96.8%	97.8%	98.1%	98.1%	97.8%	100%	96.8%	94.1%	97.6%	96.2%	97.5%	98.6%	96.3%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	92.3%	93.9%	100%	100%	100%	95.2%	100%	100%	100%	100%	85.7%	100%	100%	71.4%	100%	97.2%	92.3%	88.2%
	AC04	Percentage of Dementia Carers Feeling Supported	88.3%	75%	-	93.8%	100%	75%	-	-	-	-	-	-	-	-	96.2%	75%	-	-
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	9666	5961	1228	822	1117	933	583	702	545	554	447	811	784	602	3167	2218	1546	2197

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	90	90	89	92	92	90	91	92	91	91	92	94	90	91	91	92
	P01g	Patient Survey - Kindness and Understanding	-	-	95	94	93	96	96	94	93	96	96	95	96	97	94	95	95	95
	P01h	Patient Survey - Outpatient Tracker Score	-	-	89	89	89	88	90	90	90	90	89	88	90	90	89	89	90	90
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	19.5%	35.8%	21.9%	22%	26.3%	35.2%	42.4%	40.5%	36.5%	36.8%	30.7%	33.7%	35.9%	30.6%	23.3%	39.4%	34.6%	33.5%
	P03b	Friends and Family Test ED Coverage	13%	15.5%	15.8%	16.7%	12.3%	14.8%	13.5%	15.5%	12%	16.8%	15.5%	17.3%	18.9%	15.4%	14.9%	14.6%	14.7%	17.2%
	P03c	Friends and Family Test MAT Coverage	22.7%	21.3%	15.7%	24%	33.7%	16.2%	26.3%	19%	24.4%	20.4%	21.1%	22.6%	22.1%	19.8%	24.3%	20.5%	21.9%	21.6%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	96.3%	97%	96.7%	96.1%	95.9%	97.1%	95.8%	97.2%	95.9%	97.4%	96.9%	98.2%	97.3%	97.5%	96.2%	96.6%	96.7%	97.7%
	P04b	Friends and Family Test Score - ED	75.4%	77.4%	77.7%	73.7%	71.5%	80.2%	78.1%	74.4%	71.8%	79.6%	78.6%	79.3%	78.9%	74.1%	74.4%	77.5%	77.1%	77.6%
	P04c	Friends and Family Test Score - Maternity	96.6%	96.6%	94.9%	97.6%	95.8%	96.6%	98.9%	95.5%	96.2%	97.8%	97.3%	97.7%	94.3%	94.5%	96.2%	97.2%	97%	95.6%
Patient Complaints	T01	Number of Patient Complaints	1941	1434	143	183	150	176	146	198	200	155	162	140	139	118	476	520	517	397
	T01a	Patient Complaints as a Proportion of Activity	0.252%	0.24%	0.225%	0.268%	0.221%	0.272%	0.218%	0.296%	0.315%	0.246%	0.24%	0.204%	0.19%	0.19%	0.238%	0.262%	0.266%	0.195%
	T03a	Complaints Responded To Within Trust Timeframe	75.2%	86.1%	68.1%	71.8%	86.1%	81.6%	73.1%	73.8%	86.8%	90.6%	86%	92.3%	93.4%	97.4%	74.6%	76.2%	88.1%	94.2%
	T03b	Complaints Responded To Within Divisional Timeframe	91.3%	88.5%	91.5%	84.6%	100%	87.8%	92.3%	95.2%	89.5%	94.3%	81.4%	92.3%	85.2%	76.9%	91.8%	91.6%	88.8%	84.9%
	T04c	Percentage of Responses where Complainant is Dissatisfied	6.15%	11.08%	2.13%	7.69%	8.33%	8.16%	9.62%	16.67%	10.53%	13.21%	18.61%	0%	-	-	5.74%	11.19%	14.18%	0%
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.03%	0.9%	1.2%	1.21%	1.84%	1.08%	0.96%	0.96%	1.03%	0.46%	0.6%	1.18%	0.88%	0.99%	1.42%	1%	0.69%	1.01%
	F01a	Number of Last Minute Cancelled Operations	713	503	68	71	108	63	59	61	63	30	39	73	57	58	247	183	132	188

Please note: *The reduction in the WHO checklist compliance is a recording issue following the switch to the new BlueSpier theatre system in November. The new system allows staff to override a warning that a mandatory field has not been completed, and save the theatre episode even if the WHO checklist field remains incomplete. This is being addressed via the "Key Training Messages" for staff who use the BlueSpier system. A development for the system is already planned to flag an incomplete mandatory WHO checklist field at the end of the theatre list to the person reviewing. Clinical staff report they are confident that the previous high level of use of the WHO checklist in theatres continues in practice.*

RESPONSIVE

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 15/16	Annual 16/17 YTD	Monthly Totals Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Quarterly Totals 15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.3%	91.6%	92.4%	93.2%	92.2%	92.3%	92.6%	92.1%	92%	90.5%	90.4%	91.2%	92%	-	92.6%	92.3%	91%	91.6%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	2349	2083	2397	2480	2442	2753	2749	3344	3256	2978	2805	-	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	8	2	2	0	0	0	0	0	0	0	1	0	1	-	2	0	1	1
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	471	278	15	14	26	24	22	14	27	33	27	53	78	-	55	60	87	131
	A09	Referral To Treatment Ongoing Pathways 35+ Weeks	-	-	1738	1051	75	68	77	80	80	85	117	113	179	209	188	-	220	245	409	397
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	95.9%	94.3%	93.7%	98%	96.6%	94.5%	94.6%	93.5%	95.4%	93.7%	91.6%	94.4%	96.2%	-	96.1%	94.2%	93.6%	95.3%
	E01c	Cancer - Urgent Referrals Stretch Target	93%	93%	-	65.9%	-	-	-	64.8%	68%	65.3%	67.6%	68.4%	67%	55.4%	71%	-	-	66.1%	67.6%	63.2%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	97.5%	96.8%	98.5%	97%	97.7%	91.5%	96.2%	96.7%	99.1%	96.5%	97.4%	98.2%	98.3%	-	97.8%	94.9%	97.6%	98.2%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.9%	98.3%	96.1%	100%	99%	97.7%	100%	97.3%	97.5%	97.7%	99.1%	97.4%	100%	-	98.3%	98.3%	98.1%	98.7%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	96.8%	94.3%	97.6%	97.9%	95%	80%	94%	97.7%	97.1%	92.6%	98.4%	96.4%	98%	-	96.9%	90.2%	96.1%	97.1%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.1%	96.3%	97.9%	96.7%	98.6%	97.9%	98.4%	96.8%	96.7%	95.2%	92%	95.5%	98.1%	-	97.8%	97.7%	94.5%	96.9%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	80.6%	78.2%	84.2%	74.2%	84.7%	77.2%	70.5%	70.8%	73.3%	84.8%	80.5%	79.5%	85.2%	-	81.1%	72.7%	80.1%	82.7%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	68.6%	62.1%	50%	60%	70%	41.7%	35.3%	85.7%	66.7%	55.6%	44.4%	100%	83.3%	-	64.6%	47.2%	55.6%	91.7%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	91.1%	89.4%	81%	92.9%	100%	75.9%	86.6%	96.9%	89.3%	91.1%	92.5%	87.8%	92.5%	-	92.1%	86.8%	90.8%	90.1%
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	1.03%	0.9%	1.2%	1.21%	1.84%	1.08%	0.96%	0.96%	1.03%	0.46%	0.6%	1.18%	0.88%	0.99%	1.42%	1%	0.69%	1.01%
	F01a	Number of Last Minute Cancelled Operations	-	-	713	503	68	71	108	63	59	61	63	30	39	73	57	58	247	183	132	188
	F02c	Number of LMCs Not Re-admitted Within 28 Days	27	27	76	47	1	6	12	23	2	2	4	3	0	3	6	4	19	27	7	13
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.28%	1.48%	1.86%	1.36%	1.68%	1.35%	1.82%	1.14%	1.5%	1.12%	1.33%	2.11%	1.61%	1.38%	1.63%	1.43%	1.31%	1.7%
	F07a	Number of Admissions Cancelled Day Before	-	-	887	831	105	80	99	79	112	72	92	73	87	131	104	81	284	263	252	316
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	75.4%	70.8%	75%	59.4%	63%	83.8%	55.2%	66.7%	70.5%	76.6%	75%	73.5%	58.8%	-	66.7%	69.8%	74%	66.2%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	93.3%	91.8%	92.5%	93.8%	85.2%	100%	93.1%	83.3%	88.6%	93.6%	97.2%	91.2%	85.3%	-	90.9%	92.7%	92.9%	88.2%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	98.97%	97.52%	98.69%	99.11%	99.2%	98.34%	98.55%	96.25%	96.09%	95.51%	96.88%	98.91%	99.05%	98.23%	99.01%	97.68%	96.17%	98.74%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	11.9%	11.9%	12.3%	11.8%	13.1%	14%	12.4%	12.6%	12.4%	11.8%	11.6%	10.9%	10.3%	11.2%	12.4%	13%	11.9%	10.8%
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	19	33	31	34	23	22	29	31	25	30	28	28	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	5	5	10	3	6	4	5	6	5	4	2	3	-	-	-	-
Green To Go List	AQ01	Numbers on the Green to Go List (Acute)	-	-	-	-	42	49	48	59	48	50	46	60	45	56	56	51	-	-	-	-
	AQ02	Numbers on the Green to Go List (Non-Acute)	-	-	-	-	7	9	16	8	10	10	6	9	15	6	7	8	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.16	4.12	4.04	4.03	4.31	4.23	4.16	4.13	3.89	4.24	4.2	3.99	4.09	4.19	4.12	4.17	4.11	4.09

RESPONSIVE (continued)

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 15/16	Annual 16/17 YTD	Monthly Totals Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Quarterly Totals 15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3
Emergency Department Indicators																						
ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	90.43%	86.11%	83.76%	84.23%	82.49%	87.17%	91.66%	88.99%	89.33%	90.01%	87.33%	82.94%	78.45%	79.64%	83.47%	89.32%	88.89%	80.35%
		This is measured against the national standard of 95%																				
ED - Time in Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	-	-	90.43%	86.11%	83.76%	84.23%	82.49%	87.17%	91.66%	88.99%	89.33%	90.01%	87.33%	82.94%	78.45%	79.64%	83.47%	89.32%	88.89%	80.35%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	87.4%	79.62%	75.72%	79.13%	75.11%	79.8%	87.73%	81.8%	83.73%	83.71%	80.78%	73.39%	71.69%	73.47%	76.61%	83.17%	82.77%	72.85%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	90.56%	89.77%	89.12%	84.67%	85.59%	93.02%	93.84%	95.11%	93.58%	97.29%	91.57%	90.65%	78.6%	79.38%	86.39%	94.01%	93.94%	82.63%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	99.48%	98.99%	99.83%	99.6%	98.94%	99.33%	99.54%	99.24%	98.65%	98.61%	99.26%	98.06%	99.06%	99.15%	99.44%	99.37%	98.84%	98.74%
		This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets																				
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	12	16	6	0	6	0	1	0	0	0	1	2	1	11	12	1	1	14
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	99%	97.3%	98.8%	99.3%	97.5%	96.2%	98.2%	94.7%	97%	97.9%	97.3%	98.3%	97.9%	97.9%	98.5%	96.4%	97.4%	98%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	93%	92.5%	92.7%	92.9%	94.1%	93.3%	94.2%	92.1%	91.7%	91.8%	91.2%	91.8%	92.7%	93.7%	93.2%	93.2%	91.6%	92.7%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.8%	52.5%	52.6%	45.3%	45.8%	55.2%	51.7%	51.7%	51.1%	56.5%	55.2%	52.8%	48.2%	50.5%	47.8%	52.8%	54.2%	50.5%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.9%	98.5%	98.7%	98.6%	98.6%	98.8%	98.9%	98.5%	98.3%	98.9%	98.5%	98%	98.5%	98.3%	98.7%	98.7%	98.6%	98.3%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	3%	2.5%	3%	3.7%	3.1%	3%	2.4%	2.3%	2.2%	2.2%	2.3%	2.4%	2.5%	3.3%	3.3%	2.6%	2.3%	2.7%
	B05	ED Left Without Being Seen Rate	5%	5%	2.4%	2.3%	2.6%	2.7%	2.5%	2.1%	2%	2.5%	2.9%	1.8%	2.2%	2.6%	2.2%	2.4%	2.6%	2.2%	2.3%	2.4%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1102	984	236	153	140	62	72	114	77	125	140	161	119	114	529	248	342	394
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	4.5%	4%	2.8%	2.6%	2.1%	4.2%	3.1%	6.2%	5.1%	6.2%	4.8%	5.6%	2.8%	3.1%	3.1%	5.8%	4.4%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	49.5%	36.4%	53.6%	55%	63.2%	56.3%	29%	52.4%	29.2%	25%	37.2%	30.3%	52.6%	33.3%	56.7%	42.6%	30.5%	40.2%

EFFICIENT

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3
Sickness	AF02	Sickness Rate	4.2%	4.1%	4.5%	4.6%	4.5%	3.9%	3.7%	3.8%	3.8%	3.8%	3.7%	4.6%	4.8%	4.9%	4.5%	3.8%	3.7%	4.9%
		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	8407.6	8224.1	8229.4	8258.8	8241.7	8239	8304	8334.2	8364.5	8364.5	8393.1	8402.2	8407.6	8258.8	8304	8364.5	8407.6
	AF09A	Actual Staff FTE (Including Bank & Agency)	8319.4	8412.7	8233.9	8246.6	8319.4	8339.7	8277.5	8315.7	8322.1	8398.3	8436.4	8427.7	8468.8	8412.7	8319.4	8315.7	8436.4	8412.7
	AF13	Percentage Over Funded Establishment	0.7%	0.1%	0.1%	0.2%	0.7%	1.2%	0.5%	0.1%	-0.1%	0.4%	0.9%	0.4%	0.8%	0.1%	0.7%	0.1%	0.9%	0.1%
		Green is below 0.5%. Amber is 0.5% to below 1% and Red is 1% or above																		
Bank Usage	AF04	Workforce Bank Usage	350.9	358.5	342.8	361.7	350.9	337.2	370	394.7	429.9	437.9	410.7	376.3	387	358.5	350.9	394.7	410.7	358.5
	AF11A	Percentage Bank Usage	4.2%	4.3%	4.2%	4.4%	4.2%	4%	4.5%	4.7%	5.2%	5.2%	4.9%	4.5%	4.6%	4.3%	4.2%	4.7%	4.9%	4.3%
		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	111.5	152.1	144.9	153.4	156.4	131.9	138.3	149.8	148.5	157.4	149.1	142.7	111.5	153.4	138.3	157.4	111.5
	AF11B	Percentage Agency Usage	1.8%	1.3%	1.8%	1.8%	1.8%	1.9%	1.6%	1.7%	1.8%	1.8%	1.9%	1.8%	1.7%	1.3%	1.8%	1.7%	1.9%	1.3%
		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	383.7	412	422.3	361	305.8	380	439.2	494.8	452.7	404.5	404.5	379.6	383.7	361	439.2	404.5	383.7
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.4%	4.6%	5.1%	5.2%	4.4%	3.8%	4.7%	5.3%	6%	5.5%	4.9%	4.9%	4.6%	4.6%	4.4%	5.3%	4.9%	4.6%
		For 2015/16, target is below 5% for Green, 5% or above for Red																		
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	148	116	137	154	148	229	191	137	169	367	205	128	109	116	148	137	205	116
	AF10	Workforce Turnover Rate	13.4%	12.6%	13.9%	13.6%	13.4%	13.6%	13.3%	13.1%	13.4%	13.3%	13.3%	13.1%	12.6%	12.6%	13.4%	13.1%	13.3%	12.6%
		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%	-	92%	92%	91%	-	-	-	-	-	-	-	-	-	91%	91%	-	-
		Green is above 90%, Red is below 85%, Amber is 85% to 90%																		
Essential Training 2016/17	AF21a	Essential Training Compliance - Three Yearly Training	-	89%	-	-	-	-	88%	88%	88%	85%	88%	88%	88%	89%	-	88%	88%	89%
	AF21b	Essential Training Compliance - Annual Training (Fire & IG)	-	-	-	-	-	-	56%	63%	66%	67%	73%	75%	-	-	-	63%	73%	-
	AF21f	Essential Training Compliance - Fire Safety		81%	-	-	-	-	-	-	-	-	-	-	80%	81%			-	81%
	AF21g	Essential Training Compliance - Information Governance		76%	-	-	-	-	-	-	-	-	-	-	76%	76%			-	76%
	AF21c	Essential Training Compliance - Induction	-	96%	-	-	-	-	96%	95%	96%	94%	96%	96%	96%	96%	-	95%	96%	96%
	AF21d	Essential Training Compliance - Resuscitation Training	-	83%	-	-	-	-	78%	79%	79%	77%	81%	81%	81%	83%	-	79%	81%	83%
	AF21e	Essential Training Compliance - Safeguarding Training	-	90%	-	-	-	-	88%	88%	89%	86%	88%	89%	90%	90%	-	88%	88%	90%
		Green is above 90%, Red is below 85%, Amber is 85% to 90%																		

Appendix 1

Glossary of useful abbreviations, terms and standards

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

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

Appendix 2

Breakdown of Essential Training Compliance for November 2016:

All Essential Training

	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Three Yearly	89%	90%	90%	89%	91%	89%	88%	87%
Annual Fire	81%	88%	78%	77%	84%	76%	88%	82%
Annual IG	76%	85%	78%	74%	80%	66%	84%	76%
Induction & Orientation	96%	98%	99%	95%	96%	95%	97%	95%
Resuscitation	83%	79%	N/A	84%	85%	84%	87%	82%
Safeguarding	90%	92%	89%	91%	91%	89%	91%	86%

Safeguarding Adults and Children

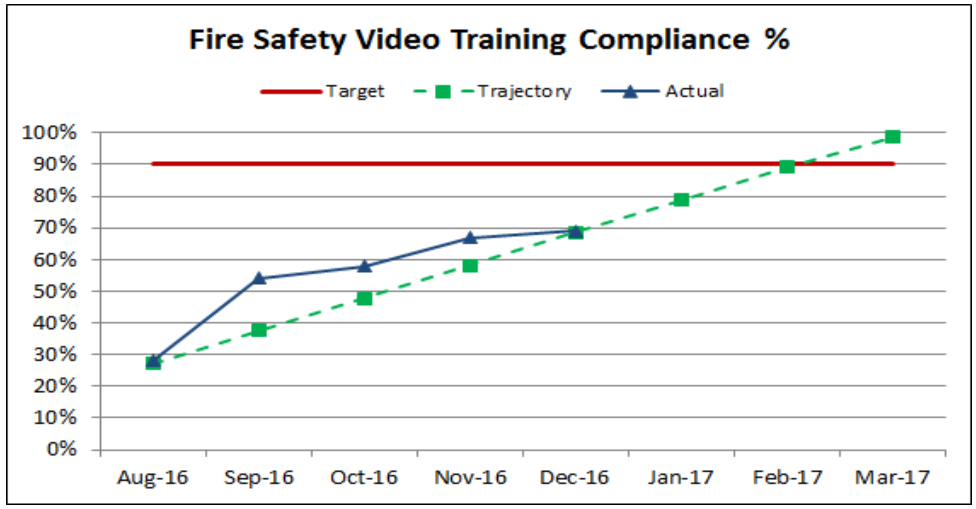
	UH Bristol	Diagnostics and Therapies	Facilities And Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Safeguarding Adults L1	91%	93%	92%	91%	91%	84%	92%	89%
Safeguarding Adults L2	89%	93%	80%	93%	93%	91%	87%	85%
Safeguarding Adults L3	69%	75%	-	73%	83%	57%	82%	38%
Safeguarding Children L1	91%	93%	90%	93%	94%	86%	92%	-
Safeguarding Children L2	90%	90%	83%	91%	89%	90%	86%	93%

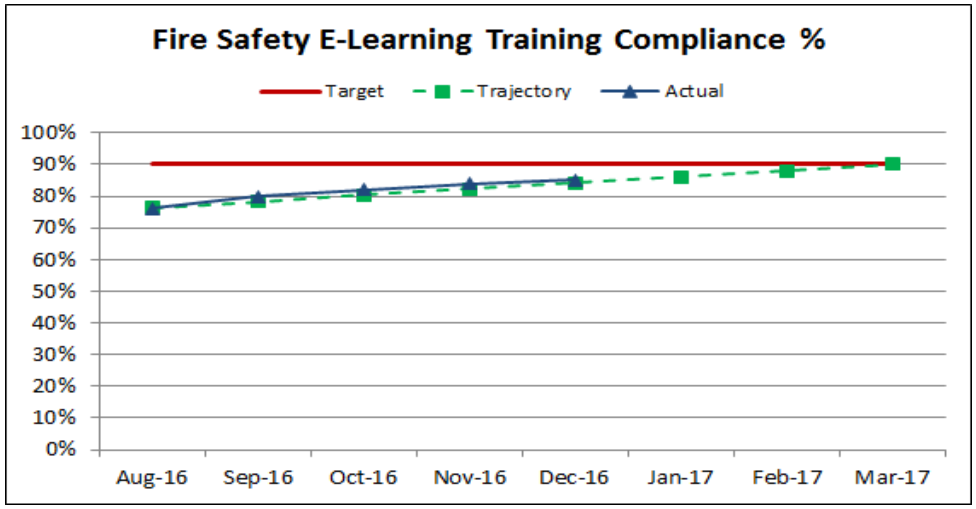
Child Protection Level 3

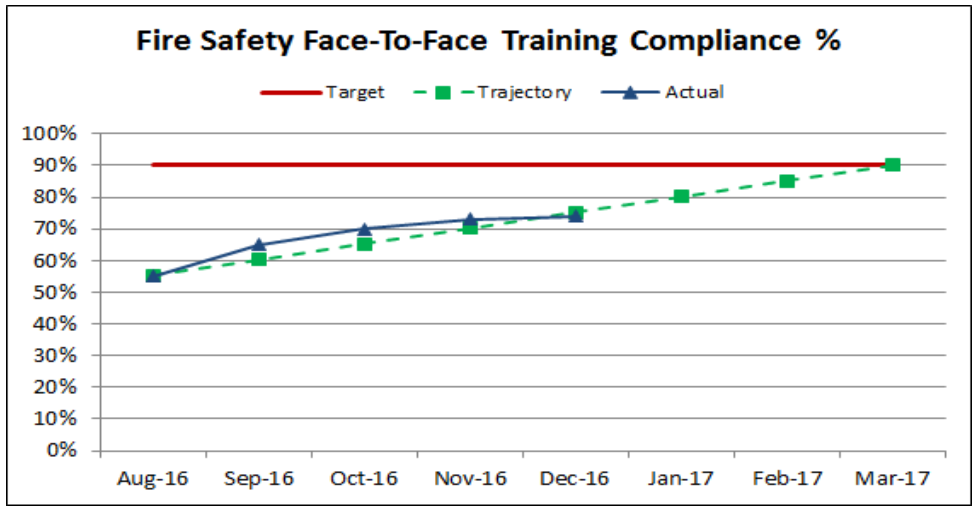
	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Core	76%	77%	63%	48%	65%	100%	78%
Specialist	75%	-	-	-	-	100%	74%

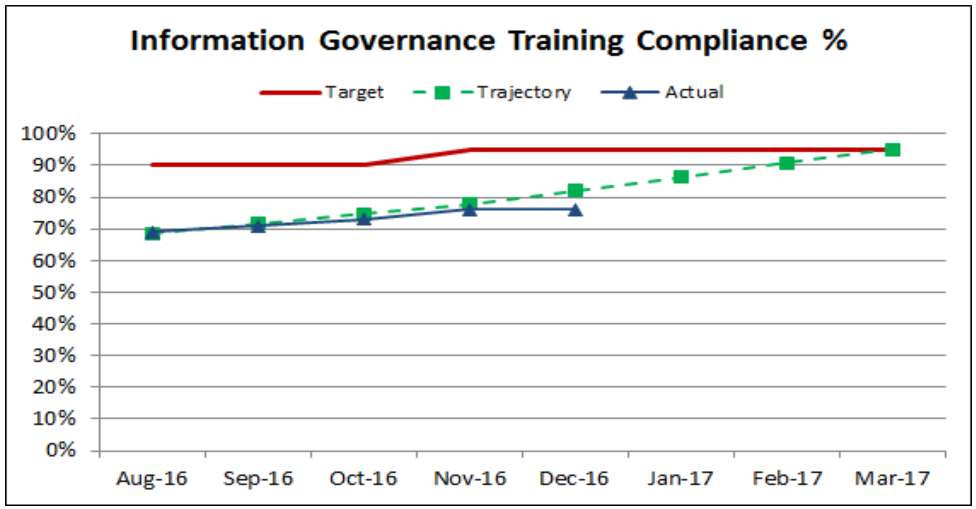
Appendix 2 (continued)

Performance against Trajectory for Fire and Information Governance









Please note: there are two types of fire training represented in these trajectories, two yearly and annual fire training, with different target audiences. In addition, there are a fixed number of staff who require an additional training video under the previous fire training requirements. This will not be a requirement in the future once all are trained. The starting point for the trajectories is the same as the actual compliance figure for August 2016. The agreed Trust target for all essential training continues to be 90%, except Information Governance, which has a national target of 95%.

Appendix 2 (continued)

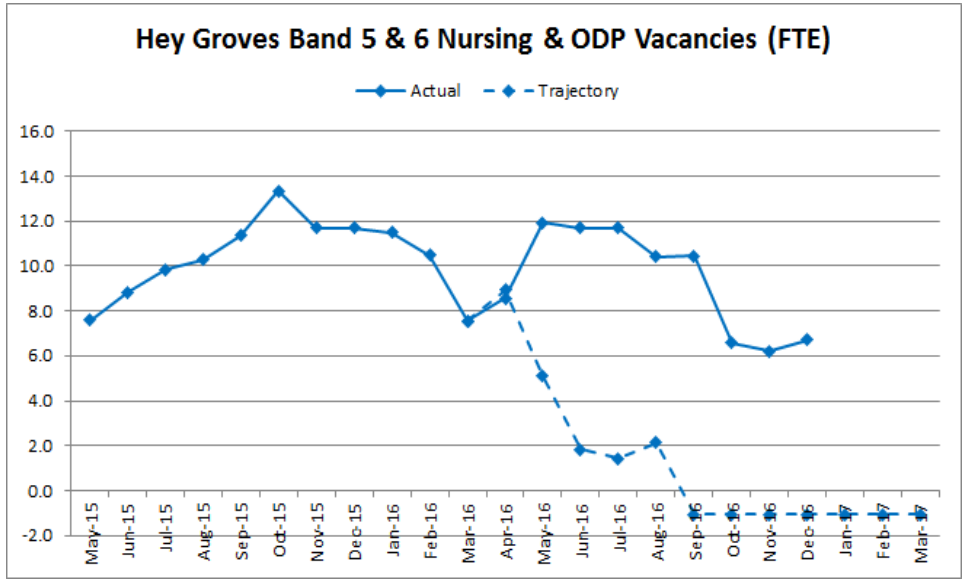
Agency shifts by staff group for 21st November to 18th December 2016

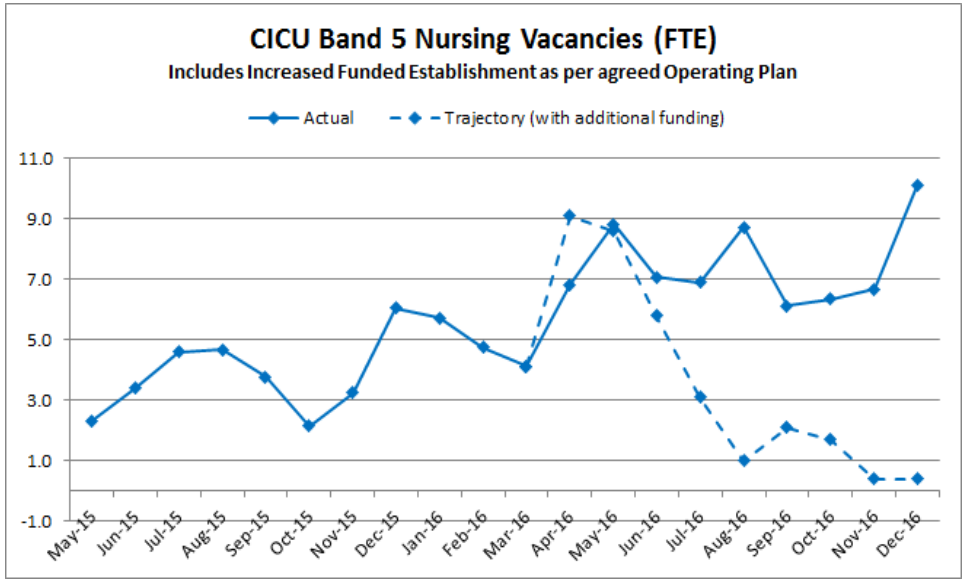
This report provides the Trust with an opportunity to do a retrospective submission to NHS Improvement of all our agency activity for the preceding four calendar week period, confirming over-rides with agency rates, worker wage rates and frameworks.

Staff Group	Within framework and price cap	Exceeds price cap	Exceeds wage cap	Non framework and above both price and wage cap	Exceeds price and wage cap	Total
Nursing and Midwifery	0	44	0	302	994	**1340**
Health Care Assistant & other Support	17	26	68	12	27	**150**
Medical & Dental	0	0	0	0	56	**56**
Scientific, therapeutic / technical Allied Health Professional (AHP) & Healthcare Science	0	0	0	0	32	**32**
Administrative & Clerical and Estates	1210	0	0	0	0	**1210**

Appendix 2 (continued)

Recruitment compared with trajectory for Heygroves Theatres and CICU





Appendix 3

Access standards – further breakdown of figures

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

Tumour Site	UH Bristol	Internal operational target	National
Brain	-	-	-
Breast†	100%	-	94.7%
Gynaecology	58.3%	85%	76.1%
Haematology (excluding acute leukaemia)	70.6%	85%	78.1%
Head and Neck	94.1%	79%	73.4%
Lower Gastrointestinal	82.1%	79%	70.1%
Lung	80.0%	79%	72.2%
Other	71.4%	-	71.2%
Sarcoma*	75.0%	-	67.4%
Skin	97.1%	96%	95.2%
Upper Gastrointestinal	78.1%	79%	76.4%
Urology*†	100%	-	77.5%
Total (all tumour sites)	**85.2%**	**85.0%**	**82.1%**
Improvement trajectory	**85.0%**		
Performance for internally managed pathways	**90.8%**		
Performance for shared care pathways	**65.3%**		
Performance with breach reallocation/CQUIN applied	**88.2%**		

*3 or fewer patients treated in accountability terms

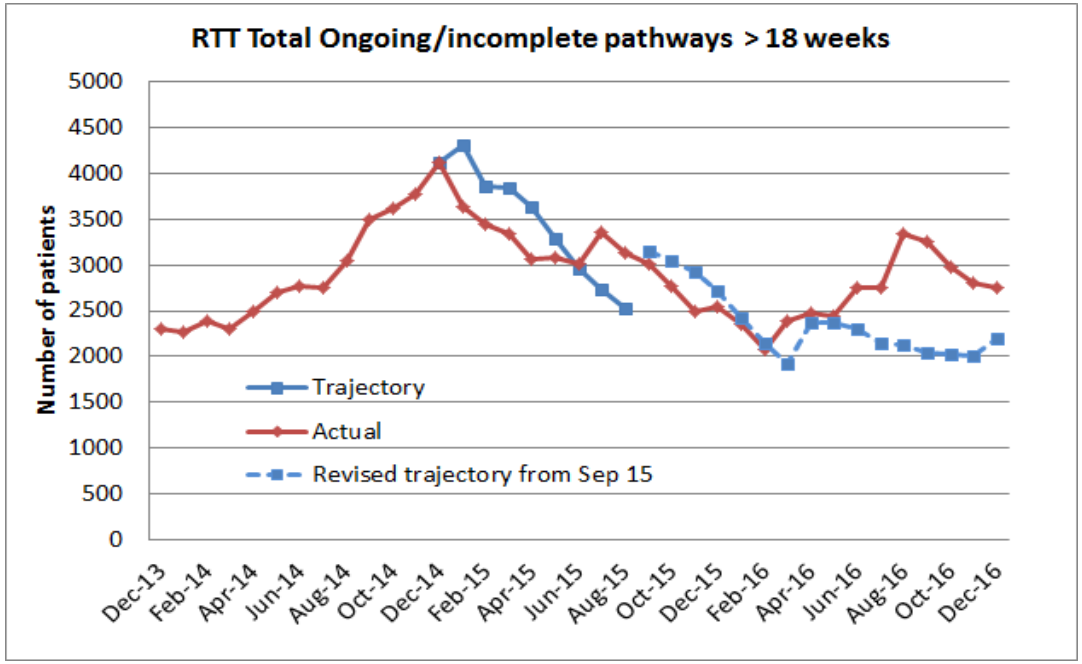
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

Appendix 3 (continued)

Access standards – further breakdown of figures

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

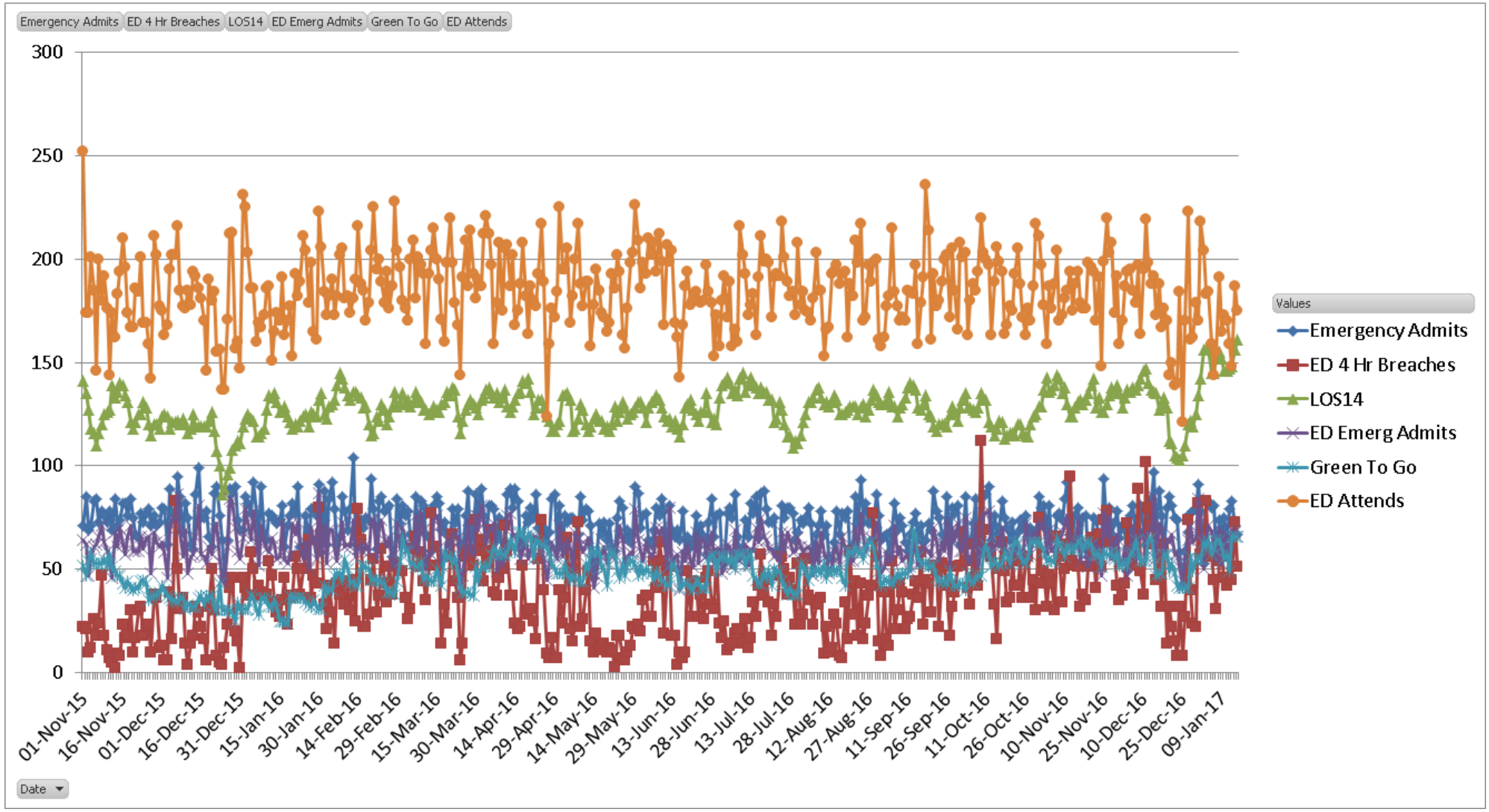
RTT Specialty	Ongoing Over 18 Weeks	Ongoing Pathways	Ongoing Performance
Cardiology	174	1,908	90.9%
Cardiothoracic Surgery	8	251	96.8%
Dermatology	122	2,138	94.3%
E.N.T.	50	2,393	97.9%
Gastroenterology	25	381	93.4%
General Medicine	0	56	100.0%
Geriatric Medicine	9	182	95.1%
Gynaecology	139	1,532	90.9%
Neurology	113	481	76.5%
Ophthalmology	202	5,394	96.3%
Oral Surgery	159	1,913	91.7%
Other	1,637	15,329	89.3%
Rheumatology	17	533	96.8%
Thoracic Medicine	20	821	97.6%
Trauma & Orthopaedics	76	1,248	93.9%
Grand Total	**2,751**	**34,560**	**92.0%**



	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Non-admitted pathways (target/actual)	1364/1480	1364/1796	1202/1741	1185/2189	1106/2060	1140/1852	1123/1677	1306/1594
Admitted pathways (target/actual)	1004/962	940/957	940/1008	940/1155	940/1196	890/1126	890/1128	890/1157
Total pathways (target/actual)	2368/2442	2304/2753	2142/2749	2125/3344	2046/3256	2030/2978	2013/2805	2196/2751
Target % incomplete < 18 weeks	92.6%	92.8%	93.2%	93.2%	93.4%	93.4%	93.4%	92.8%
Actual target % incomplete < 18 weeks	92.6%	92.1%	92.0%	90.5%	90.4%	91.2%	92.0%	92.0%
Recovery forecast	N/A	N/A	N/A	N/A	N/A	90.8%	91.4%	91.6%

Appendix 3 (continued)

BRI Flow metrics



Cover report to the Trust Board meeting to be held on Tuesday, 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	10
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Quarterly Complaints Report (Quarter 2)		
Author	Carolyn Mills, Chief Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☒	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential.	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

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

Executive Summary

Purpose

To summarise complaints data for Quarter 2 (July-September 2016) and to share learning from this important source of service-user feedback.

Key points to note

Improvements in Quarter 2 (Q2):

- The number of complaints received in Q2 represents a very slight decrease of 0.6% compared to Q1, but a more significant 7.7% decrease on the corresponding period one year previously.

- In Q2, 88.1% of responses were posted within the agreed timescale, compared to 76.2% in Q1 and 74.6% in Q4 (2015/16).
- The majority of complaints continue to be resolved by the Trust informally.
- Complaints about the following reduced in Q2: staff attitude and communication; cancelled and delayed operations; lower GI surgery; ear nose and throat surgery; gastroenterology and hepatology; paediatric plastic surgery; and Ward 78 at St Michael's Hospital.
- The long-term downwards trend in complaints about Bristol Eye Hospital also continued in Q2.

However:

- The proportion of complainants who tell us that they are dissatisfied with our formal complaint investigation response has deteriorated – a pattern which continued into Q3.
- Complaints about the following increased in Q2: trauma and orthopaedics; and the division of specialised services including the GUCH (Grown up congenital heart disease) service.

Corporate plans include:

- The Head of Quality (Patient Experience and Clinical Effectiveness) and Acting Patient Support and Complaints Manager met in early January to review dissatisfied responses to complaints responses sent our during August and September for any themes and learning.
- Establishing a new complaint review panel in early 2017, incorporating learning from Salford Royal.
- Working with the Patients Association to develop a potential model for exceptional external investigation or review of high-risk complaints. This work will commence in early 2017 with an invited focus group of previous dissatisfied complainants.

Recommendations

Members are asked to:

- **Note** the report.

Intended Audience

(please select any which are relevant to this paper)

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

Board Assurance Framework Risk

(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

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

Impact Upon Corporate Risk
N/A

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		22nd December 2016		Senior Leadership Team; Patient Experience Group

University Hospitals Bristol NHS
NHS Foundation Trust

Complaints Report

Quarter 2, 2016/2017

(1st July 2016 to 30th September 2016)

Authors: Tanya Tofts, Patient Support and Complaints Manager
Louise Townsend, Acting Patient Support and Complaints Manager
Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)

Overview

Successes	Priorities
• The number of complaints received in Q2 represents a very slight decrease of 0.6% compared to Q1 but a more significant 7.7% decrease on the corresponding period one year previously. • In Q2, 88.1% of responses were posted within the agreed timescale, compared to 76.2% in Q1 and 74.6% in Q4 (2015/16). • The majority of complaints continue to be resolved by the Trist informally. • Complaints about the following reduced in Q2: staff attitude and communication; cancelled and delayed operations; lower GI surgery; ear nose and throat surgery; gastroenterology and hepatology; paediatric plastic surgery; and Ward 78 at St Michael's Hospital. • The long-term downwards trend in complaints about Bristol Eye Hospital also continued in Q2.	• To continue to implement learning arising from the complaints and incidents delivery group following the independent review of children's cardiac services, including strengthening the patient/family voice within the complaint process. • To retain an ongoing focus on delivery of training to senior divisional staff about conducting complaints investigations and writing effective responses. • To review coding procedures within the Patient Support and Complaints Team to ensure that complaints are consistently assigned to the most appropriate categories and sub-categories.
Opportunities	**Risks & Threats**
• To establish a new complaint review panel in early 2017, incorporating learning from Salford Royal and NBT. This panel will include retrospective review of a proportion of dissatisfied complaints in order to improve shared learning from these cases. • To work with the Patients Association to develop a potential model for exceptional external investigation or review of high-risk complaints. This work will commence in early 2017 with an invited focus group of previous dissatisfied complainants. • To apply further learning from: the recent NHS Improvement review of the complaints service (report awaited); the recent Care Quality Commission inspection (report awaited) and the forthcoming internal audit of learning from complaints.	• The proportion of complainants who tell us that they are dissatisfied with our formal complaint investigation response has been above (worse than) our amber performance threshold for three consecutive reporting months. Although this amounts to small numbers of cases in absolute terms (in July, we breached our amber target by one case; in August, by two cases), it does not represent the level of performance that we are striving to achieve. • Complaints about the following increased in Q2: trauma and orthopaedics; and the division of Specialised Services including the GUCH (Grown up congenital heart disease) service.

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 517 complaints in Q2, which equates to 0.27% 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 Q2 represents a very slight decrease of 0.6% compared to Q1 and a 7.7% decrease on the corresponding period one year previously.

Figure 1 shows the pattern of complaints received in the last 15 months. 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 Q2, 88.1% of responses were posted within the agreed timescale, compared to 76.2% in Q1 and 74.6% in Q4 (2015/16). This represents 16 breaches out of 134 formal complaints which were due to receive a response during Q2[2]. Figure 4 shows the Trust's performance in responding to complaints since July 2015.

[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

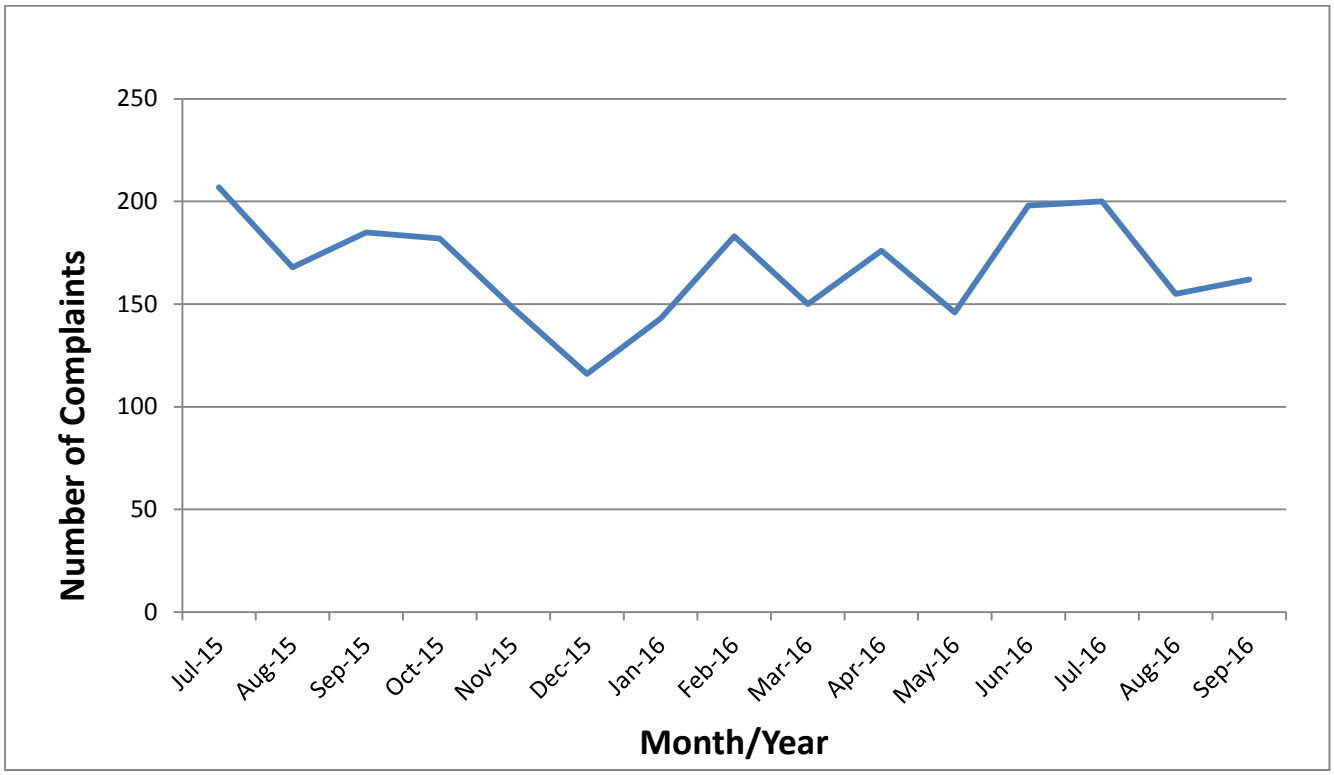


Figure 2: Complaints received, as a percentage of patient activity

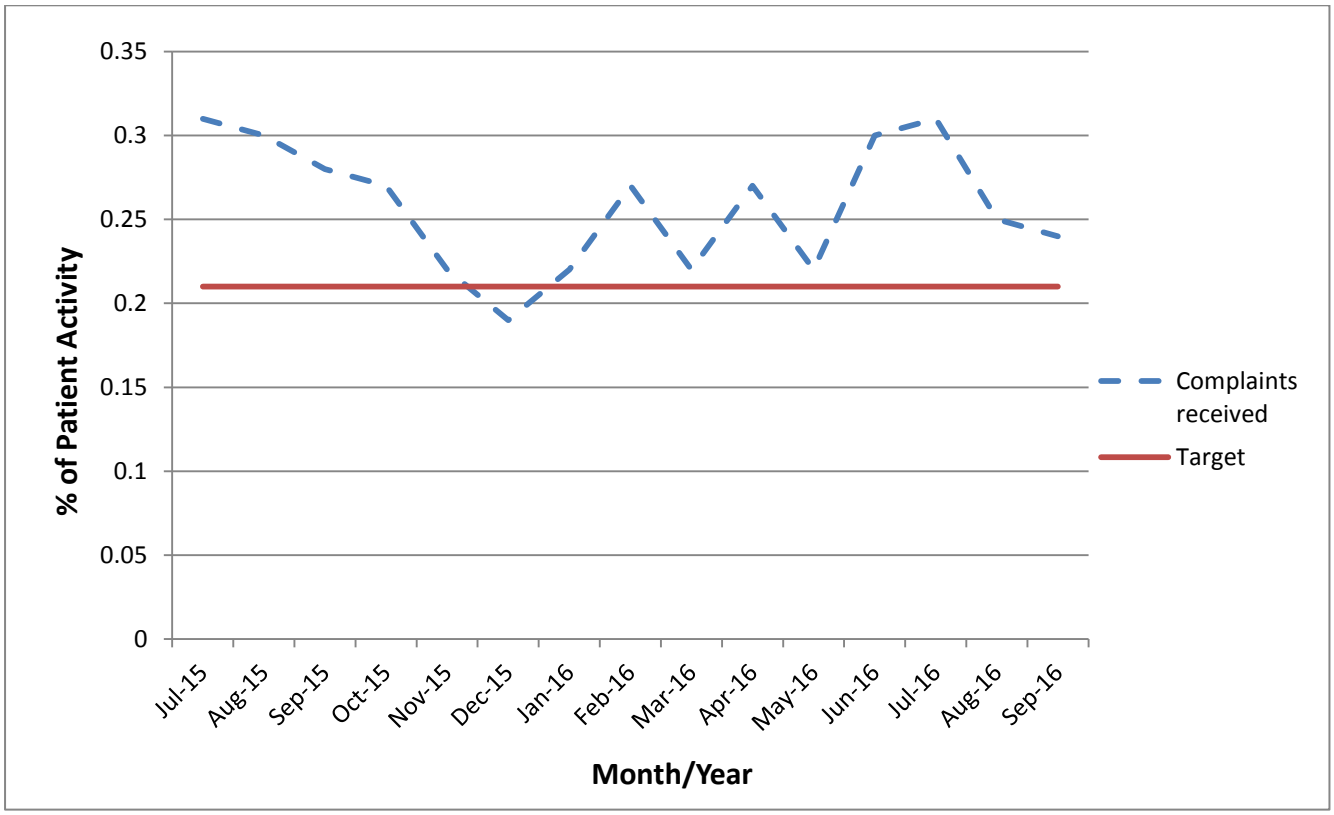


Figure 3: Numbers of formal v informal complaints

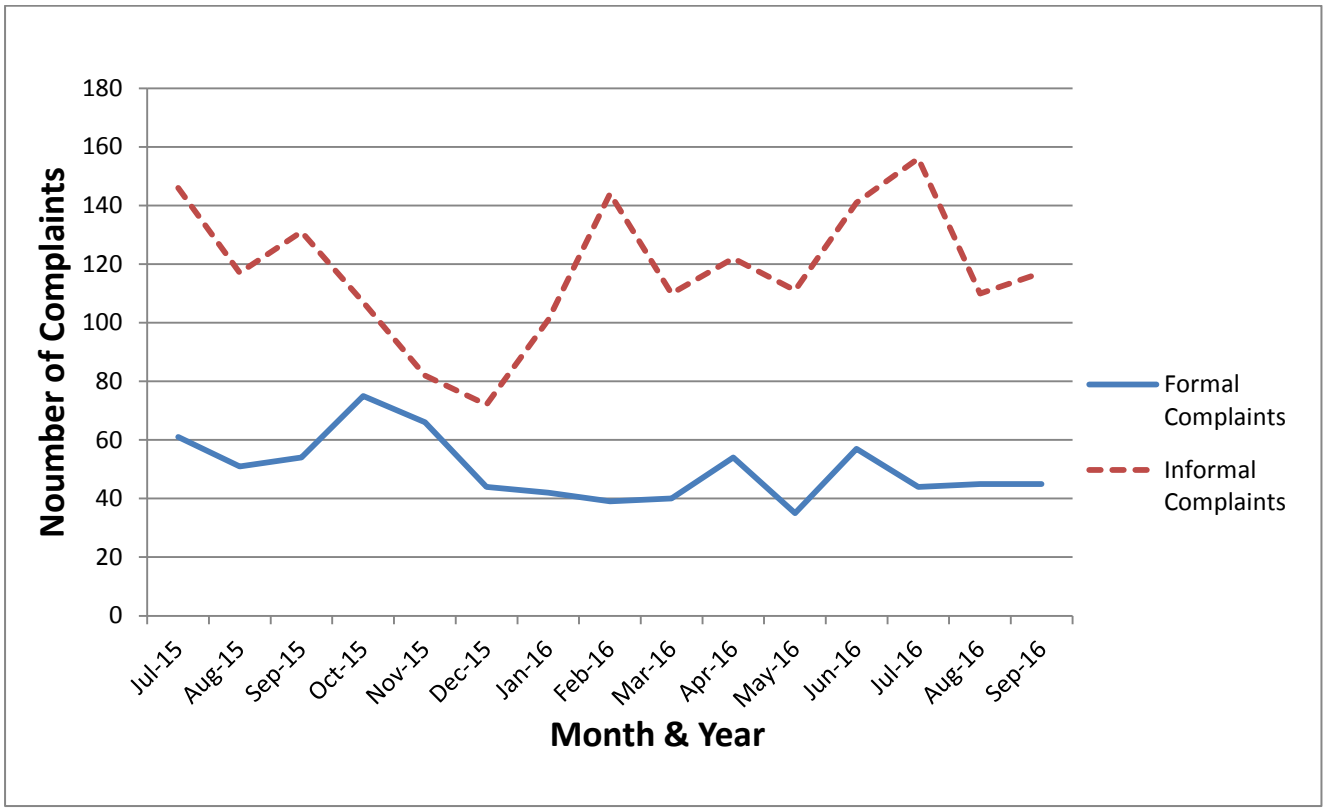


Figure 4: Percentage of complaints responded to within agreed timescale

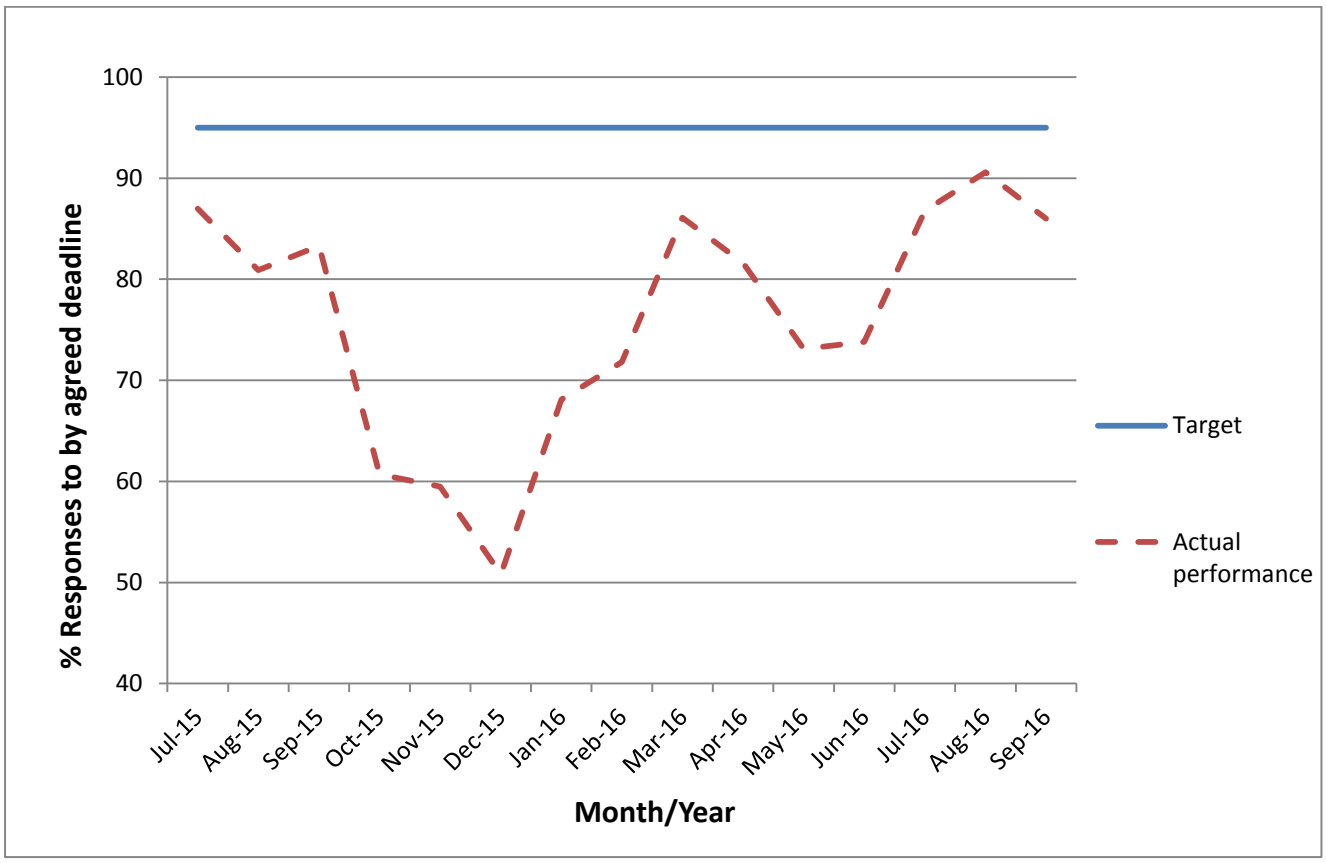


Table 1: Complaints performance

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

		Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total complaints received (inc. TS and F&E from April 2013)	TOTAL	185	182	148	116	143	183	150	176	146	198	200	155	162
	Formal	54	75	66	44	42	39	40	54	35	57	44	45	45
	Informal	131	107	82	72	101	144	110	122	111	141	156	110	117
Number and % of complaints per patient attendance in the month	%	0.28%	0.27%	0.22%	0.19%	0.22%	0.27%	0.22%	0.27%	0.22%	0.30%	0.31%	0.25%	0.24%
	Complaints	185	182	148	116	143	183	150	176	146	198	200	155	162
	Attendances	66,285	68,131	67,434	61,126	63,582	68,391	67,932	64,750	66,973	66,816	63,580	63,073	67,371
% responded to within the agreed timescale (i.e. response posted to complainant)	%	83.3%	60.7%	59.5%	50.8%	68.1%	71.8%	86.1%	80.0%	73.1%	73.8%	86.8%	90.6%	86.0%
	Within timescale	40	34	25	32	32	28	31	40	38	31	33	48	37
	Total	48	56	42	63	47	39	36	49	52	42	38	53	43
% responded to by Division within required timescale for executive review	%	95.8%	80.4%	81.0%	90.5%	91.5%	84.6%	100%	86.0%	92.3%	92.9%	89.5%	94.3%	81.4%
	Within timescale	45	45	34	57	43	33	36	43	48	39	34	50	35
	Total	48	56	42	63	47	39	36	50	52	42	38	53	43
Number of breached cases where the breached deadline is attributable to Division	Attributable to Division	2	7	7	20	12	10	5	3	8	7	4	4	4
	Total Breaches	8	22	17	31	15	11	5	9	14	11	5	5	6
Number of extensions to originally agreed timescale (formal investigation process only)		10	23	13	26	21	14	25	21	8	11	15	18	12
% of complainants dissatisfied with response and case re-opened	%	16.7%	10.7%	4.8%	7.9%	6.4%	7.7%	8.3%	8.0%	9.6%	16.7%	10.5%	13.2%	-
	Reopened Dissatisfied	8	6	2	5	3	3	3	4	5	7	4	7	-
	Total Responses Due	48	56	42	63	47	39	36	50	52	42	38	53	-

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 in 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].

An additional level scrutiny of dissatisfied cases has been incorporated into the process for dealing with cases where the complainant is unhappy with our response. This involves the Head of Quality (Patient Experience and Clinical Effectiveness) reviewing all dissatisfied responses before they are sent to the Executives for sign-off. This additional review ensures that we are learning from these cases, i.e. is there anything we could or should have done differently in our original response. This learning is then shared with the Division responsible for the response.

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. This data is now reported two months' in arrears in order to capture the majority of cases where complainants tell us they were not happy with our response.

In Q2, we are only able to report on the months of July and August, as the September data had not yet been confirmed at the time of writing this report. Of the 91 responses sent out in July and August 2016, and by the cut-off point of mid-November 2016 (the date on which the dissatisfied data for August 2016 was finalised); 11 people had contacted us to say they were dissatisfied. This represents 12.1% of the responses sent out during this period.

In Q1, a total of 143 responses were sent out. By the cut-off point of mid-September 2016 (the date on which the dissatisfied data for June 2016 was finalised), 16 people had contacted us to say they were dissatisfied with our response. This represented 11.2% of the responses sent out and was an increase on the 7.4% (10 of 161) reported in Q4.

Figure 5 shows the percentage of complainants who were dissatisfied with aspects of our complaints response up until August 2016.

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

- On rare occasions, a letter may be 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

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

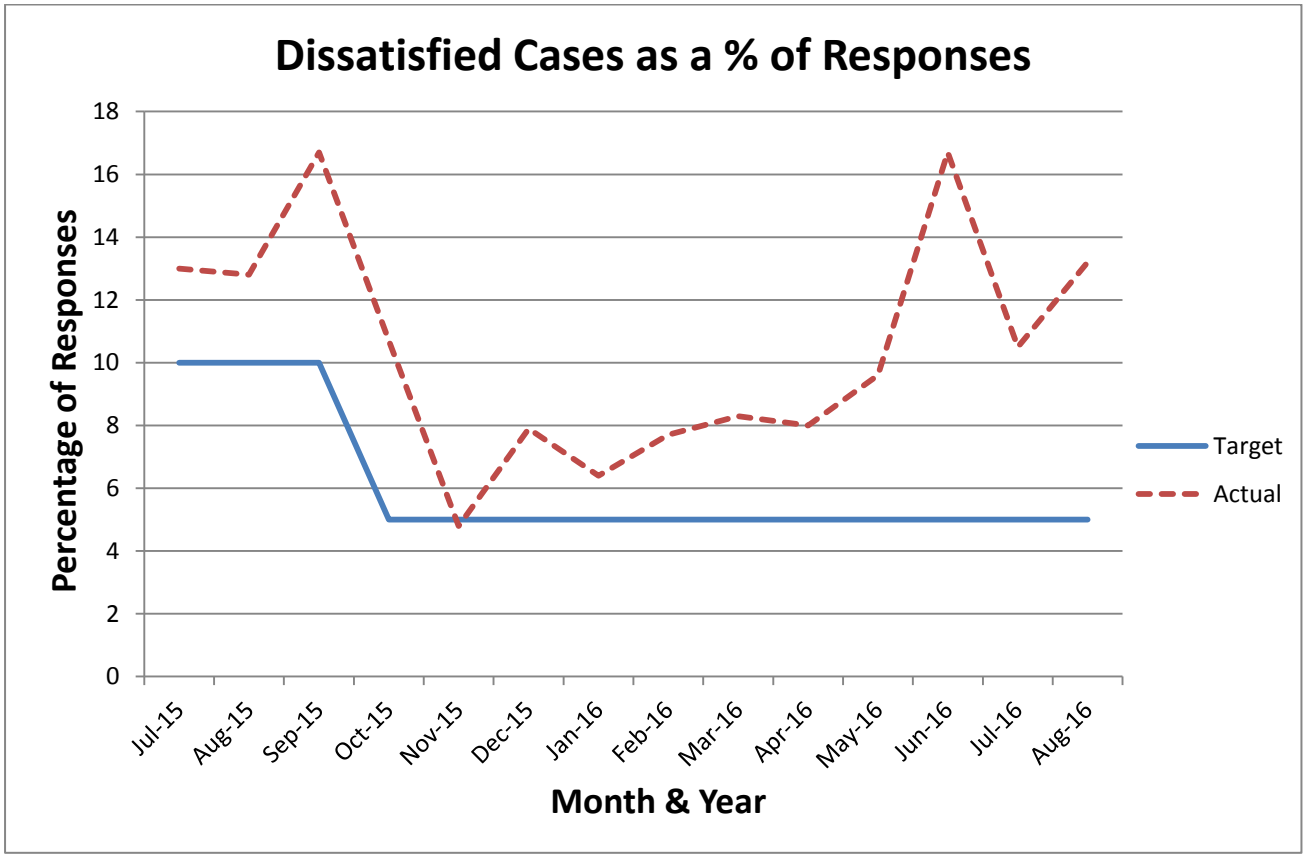
review their complaint. This option might be appropriate if, for example, if a complainant was disputing certain events that had been captured on CCTV and were therefore incontrovertible.

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.

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 eight major categories, or themes. Table 2 provides a breakdown of complaints received in Q2 2016/17 compared to Q1 2016/17. The only noteworthy change compared to Q1 was a reduction in complaints about staff attitude and communication (135 to 116). Changes in all other categories were either marginal or the numbers involved were small. Complaints about access increased from 5 in Q1 to 10 in Q2. This category includes complaints about physical access to our hospitals, services not being available and dissatisfaction with visiting hours.

Table 2: Complaints by category/theme

Category/Theme	Number of complaints received in Q2 (2016/17)	Number of complaints received in Q1 (2016/17)
Access	10 (1.9% of total complaints) ↑	5 (0.9% of total complaints) ↓
Appointments & Admissions	170 (32.9%) ↑	169 (32.5%) ↑
Attitude & Communication	116 (22.4%) ↓	135 (26%) ↓
Clinical Care	132 (25.5%) ↑	128 (24.7%) ↑
Discharge/Transfer/Transport	28 (5.4%) ↑	26 (5%)
Documentation	3 (0.6%) ↑	2 (0.4%)
Facilities & Environment	26 (5%) ↑	22 (4.2%) ↓
Information & Support	32 (6.2%) ↓	33 (6.3%) ↑
Total	**517**	**520**

Each complaint is also assigned to a more specific sub-category, for which there are over 100. Table 3 lists the ten most consistently reported sub-categories. In total, these sub-categories account for approximately two thirds of the complaints received in Q2 (336/517).

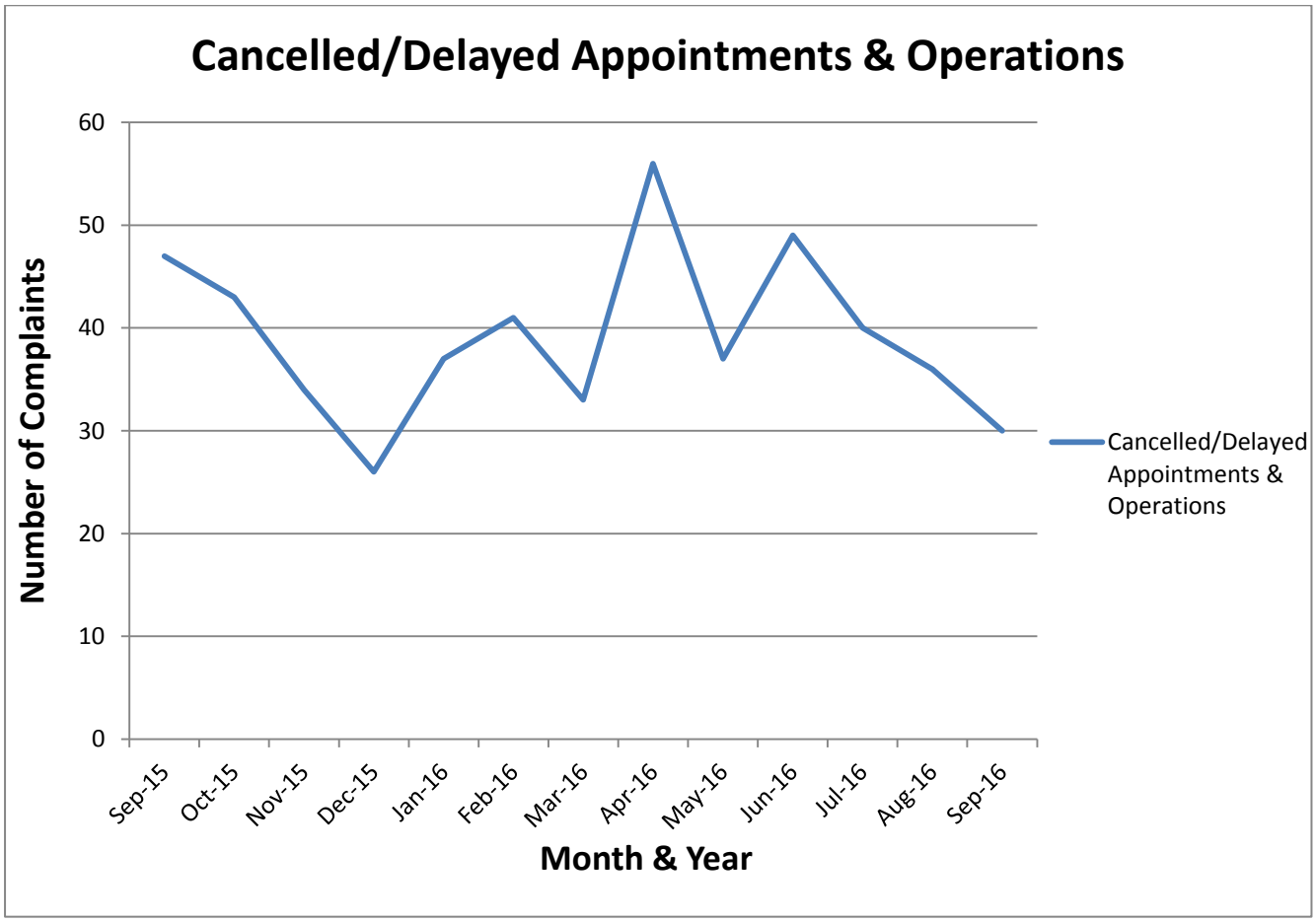
Table 3: Complaints by sub-category

Sub-category	Number of complaints received in Q2 (2016/17)	Q1 2016/17	Q4 2015/16	Q3 2015/16
Cancelled/delayed appointments and operations	106 (25.4% decrease compared to Q1) ↓	142	111	103
Communication with patient/relative	23 (32.4% decrease) ↓	34	62	41
Clinical Care (Medical/Surgical)	60 (14.3% decrease) ↓	70	41	54
Failure to answer telephones/failure to respond	27 (20.6% decrease) ↓	34	29	17
Clinical Care (Nursing/Midwifery)	19 (13.6% decrease) ↓	22	25	18
Attitude of Medical Staff	24 (4.3% increase) ↑	23	18	16
Attitude of Admin/Clerical Staff	11 (31.3% decrease) ↓	16	13	9
Attitude of Nursing Staff	17 (41.7% increase) ↑	12	8	13
Appointments Administration Issues *(new sub-category)*	38 (90% increase) ↑	20	-	-
Transport (Late/Non Arrival/Inappropriate)	11 (83.3% increase) ↑	6	2	8

Complaints about 'cancelled or delayed appointments or operations/procedures' have decreased from 142 in Q1 to 106 in Q2[4].

Figures 6, 7, and 8 show the four most commonly recorded sub-categories of complaint as detailed above, tracked since July 2015. These graphs suggest a recovering pattern of complaints about cancelled or delayed appointments and operations since December 2015, and an improving pattern of complaints about communication with patients/relatives.

Figure 6: Cancelled or delayed appointments and operations



[4] In Q2, a new theme of 'Appointment Administration Issues' was added to Datix as a sub-category of 'Appointments and Admissions'. 38 complaints were assigned to this sub-category. This explains why the total number of complaints in the parent category has risen marginally, even though complaints in the major sub-category (cancelled/delayed appointments and operations) have fallen significantly.

Figure 7: Clinical care – medical/surgical

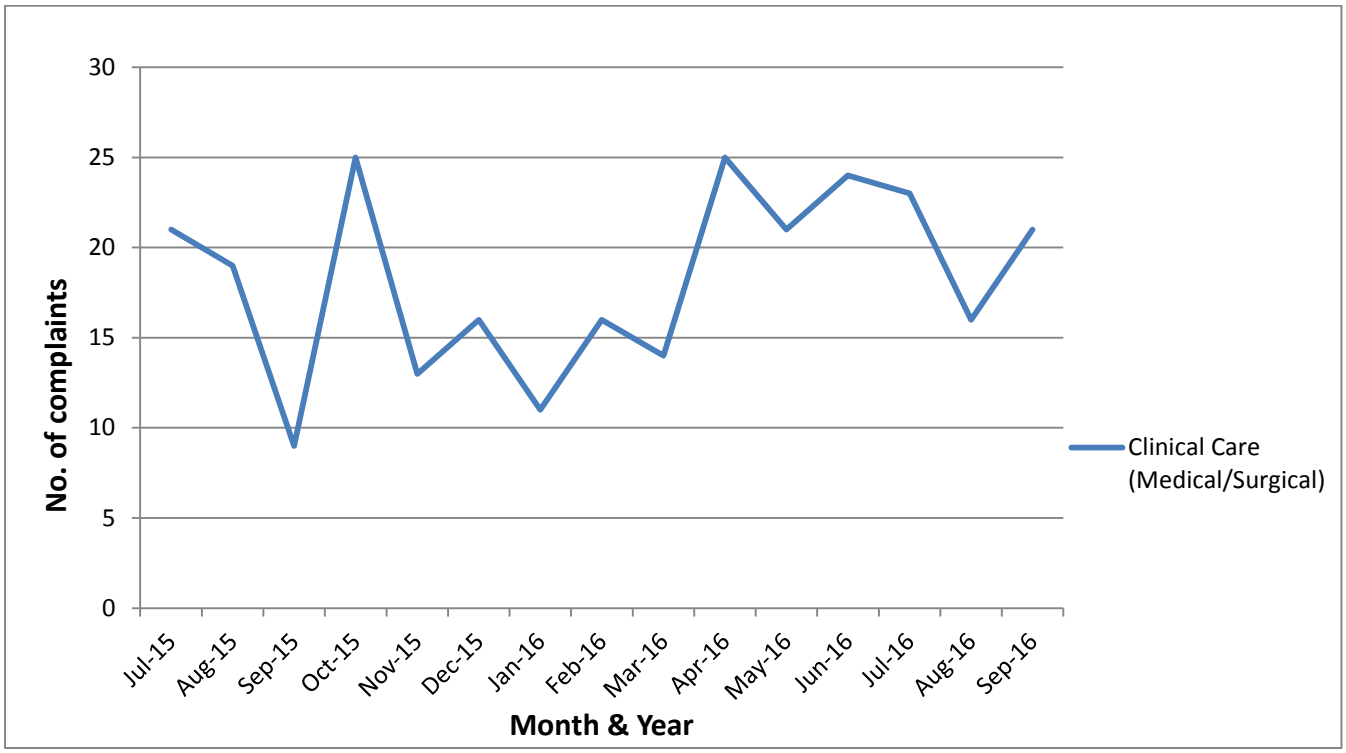
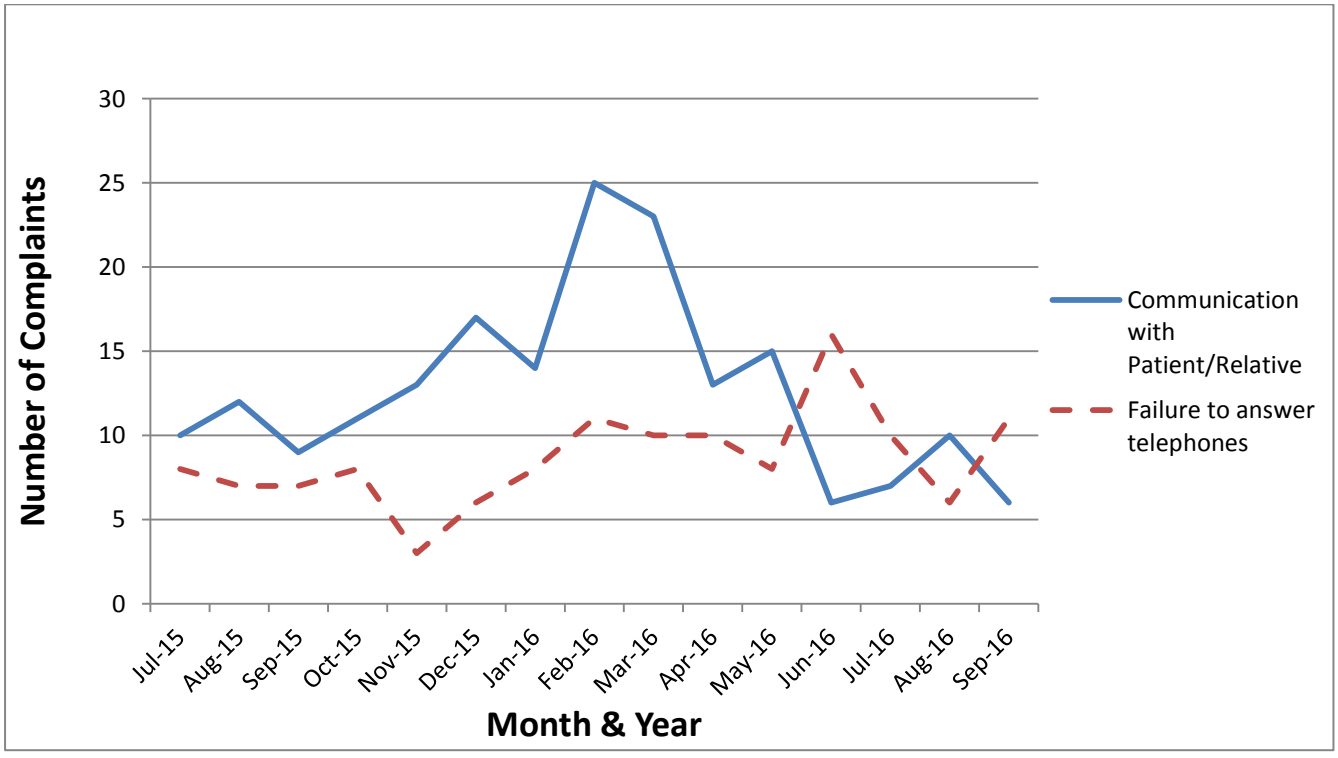


Figure 8: Communication with patient/relative and telephone answering

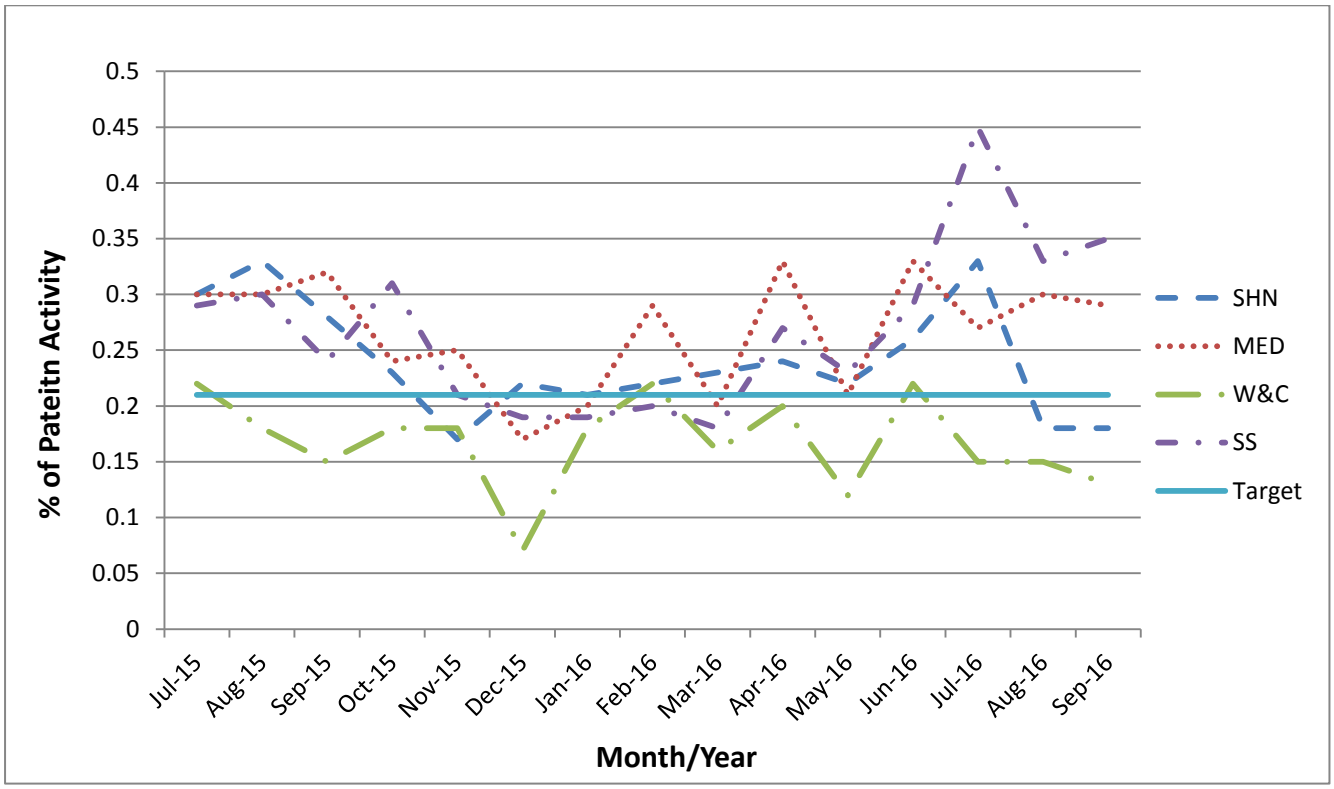


3. Divisional performance

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. Since July 2015, the number of complaints received by the division has been as follows:

Table 4: Complaints received by Division of Diagnostics and Therapies

	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16
No. of complaints received	10	4	5	12	5	7	5	13	6	5	7	12	4	9	6

3.2 Divisional analysis of complaints received

Table 5 provides an analysis of Q2 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 (198) ↓	123 (122) ↑	95 (66) ↑	62 (84) ↓	19 (24) ↓
Total complaints received as a proportion of patient activity	0.23% (0.24%) ↓	0.29% (0.29%) =	0.38% (0.26%) ↑	0.14% (0.18%) ↓	N/A
Number of complaints about appointments and admissions	87 (93) ↓	26 (26) =	27 (18) ↑	18 (28) ↓	6 (7) ↓
Number of complaints about staff attitude and communication	32 (53) ↓	34 (38) ↓	22 (22) =	15 (17) ↓	3 (6) ↓
Number of complaints about clinical care	37 (40) ↓	29 (32) ↓	32 (18) ↑	19 (31) ↓	6 (7) ↓
Area where the most complaints have been received in Q2	Bristol Eye Hospital – 40 (46) Bristol Dental Hospital – 34 (46) Trauma & Orthopaedics – 47 (21) ENT – 10 (17) Upper GI – 10 (15)	Emergency Department (BRI) – 22 (25) Gastroenterology & Hepatology – 11 (20) Dermatology – 18 (14) Ward A300 (AMU) – 7 (9)	BHI Outpatients – 11 (8) GUCH Services – 21 (8) Chemo Day Unit/Outpatients – 5 (7) Ward C708 – 11 (7) Ward D603 – 10 (6)	Paediatric Orthopaedics – 5 (7) Ward 73 (Maternity) – 5 (8) Ward 78 – 3 (12)	Radiology – 8 (8) Audiology – 4 (6) Pharmacy – 3 (5) Physiotherapy – (4)
Notable deteriorations compared to Q1	Trauma & Orthopaedics – 47 (21)	None	GUCH Services – 21 (8)	None	None
Notable improvements compared to Q1	Lower GI – 4 (12) ENT – 10 (17)	Gastroenterology & Hepatology – 11 (20)	None	Paediatric Plastic Surgery – 1 (7) Ward 78 – 3 (12)	Physiotherapy – 1 (4)

[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

In Q2, the Division of Surgery Head & Neck had a notable reduction in complaints about attitude and communication (down from 53 to 32, consolidating the improvement in the previous quarter). Complaints about discharge transfer and transport increased, but the numbers involved were small. Complaints about trauma and orthopedics increased significantly (from 21 to 47), whilst complaints about Lower GI surgery and Ear Nose and Throat surgery reduced. The long-term downwards trend in complaints about Bristol Eye Hospital has continued.

Table 6: Complaints by category type

Category Type	Number and % of complaints received – Q2 2016/17	Number and % of complaints received – Q1 2016/17
Access	2 (1.1% of total complaints)	0 (0% of total complaints) ↓
Appointments & Admissions	87 (47.8%) ↓	90 (45.6%) ↑
Attitude & Communication	32 (17.6%) ↓	53 (26.7%) ↓
Clinical Care	37 (20.3%) ↓	40 (20%) ↑
Facilities & Environment	3 (1.6%) ↑	2 (1.1%) ↓
Information & Support	6 (3.3%) ↓	8 (3.8%) ↑
Discharge/Transfer/ Transport	12 (6.6%) ↑	5 (2.8%)
Documentation	3 (1.6%) ↑	0
Total	**182**	**198**

Table 7: Top sub-categories

Category	Number of complaints received – Q2 2016/17	Number of complaints received – Q1 2016/17
Cancelled or delayed appointments and operations	49 ↓	73 ↑
Clinical Care (Medical/Surgical)	16 ↓	18 ↑
Communication with patient/relative	7 ↓	10 ↓
Attitude of Medical Staff	4 ↓	6 ↓
Attitude of Nursing/Midwifery	3 ↓	4 ↑
Attitude of Admin/Clerical Staff	4 ↓	5 ↑
Clinical Care (Nursing/Midwifery)	2 ↓	4 ↑
Failure to answer telephones	13 ↓	18 ↑

Table 8: Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
Complaints about Trauma and Orthopedics increased significantly (from 21 to 47). Of these 47 complaints received, 28 were in respect of appointment and admission issues. Eight complaints were in respect of attitude and communication and seven complaints were in respect of clinical care. There were no other discernible trends identified for the remaining four complaints.	A large number of these complaints were about phoning the department: patients were either not able to get through, or were put through to a voicemail message. The problem is due to the sheer volume of calls, being received, exacerbated by staff vacancies, which are actively being recruited to. A senior registrar in the department is on long term sick leave, which has limited the availability of appointments.	Call use data is being gathered to inform a business case for the purchase of call centre software, which would enable patients to queue instead of receiving an engaged message. Since July 2016, the department has been in the process of employing more staff to help answer the calls and make appointments.

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

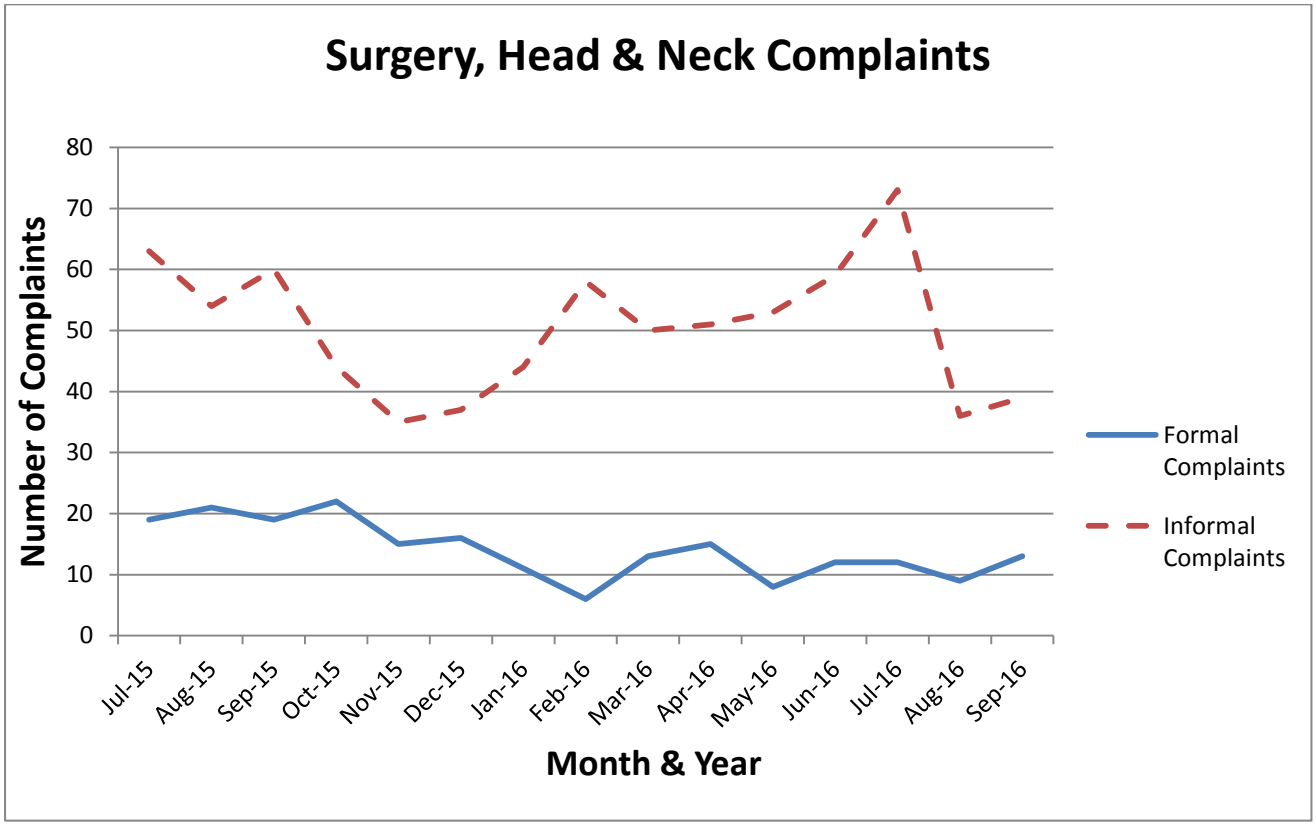
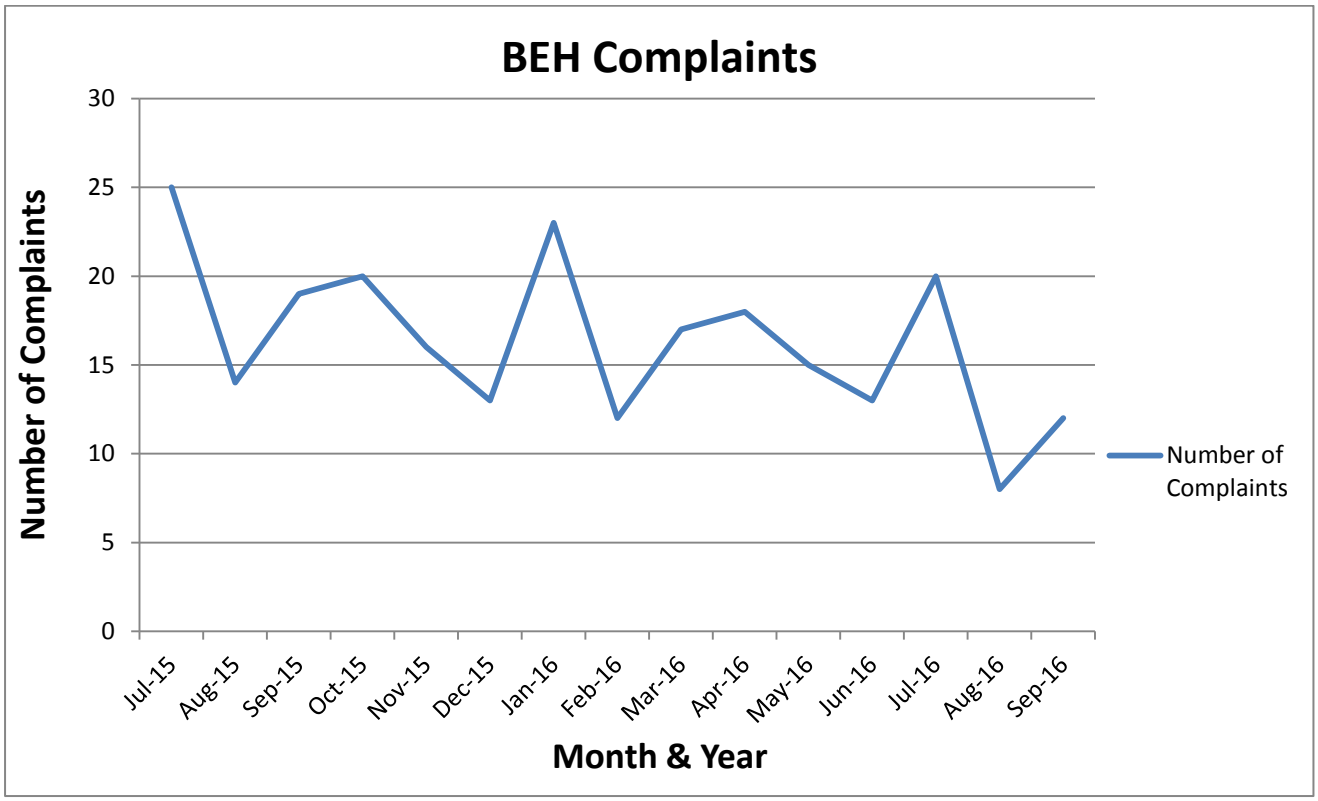


Figure 11: Complaints received by Bristol Eye Hospital



3.2.2 Division of Medicine

In Q2, the thematic pattern of complaints received by the Division of Medicine was unchanged from Q1. A consistent positive pattern of informal resolution in preference to formal resolution was established in Q2. Complaints about Gastroenterology & Hepatology, which had risen in Q1, returned to previously reported levels in Q2.

Table 9: Complaints by category type

Category Type	Number and % of complaints received – Q2 2016/17	Number and % of complaints received – Q1 2016/17
Access	2 (1.6% of total complaints) ↑	1 (0.8% of total complaints) =
Appointments & Admissions	26 (21.1%) ↓	28 (23.1%) ↑
Attitude & Communication	34 (27.6%) ↓	38 (31.1%) ↓
Clinical Care	29 (23.6%) ↓	32 (26.2%) ↑
Facilities & Environment	9 (7.3%) ↑	7 (5.7%) ↓
Information & Support	9 (7.3%) ↑	3 (2.5%) ↓
Discharge/Transfer/ Transport	11 (8.9%) ↓	12 (9.8%)
Documentation	3 (2.4%) ↑	1 (0.8%)
Total	**123**	**122**

Table 10: Top sub-categories

Category	Number of complaints received – Q2 2016/17	Number of complaints received – Q1 2016/17
Cancelled or delayed appointments and operations	17 =	17 ↑
Clinical Care (Medical/Surgical)	14 ↓	17 ↑
Communication with patient/relative	5 ↓	12 =
Attitude of Medical Staff	9 ↑	8 ↑
Attitude of Nursing/Midwifery	7 ↑	5 ↑
Attitude of Admin/Clerical Staff	4 ↓	5 ↑
Clinical Care (Nursing/Midwifery)	5 =	5 ↑
Failure to answer telephones	6 ↑	5 ↓

Figure 12: Medicine – formal and informal complaints received

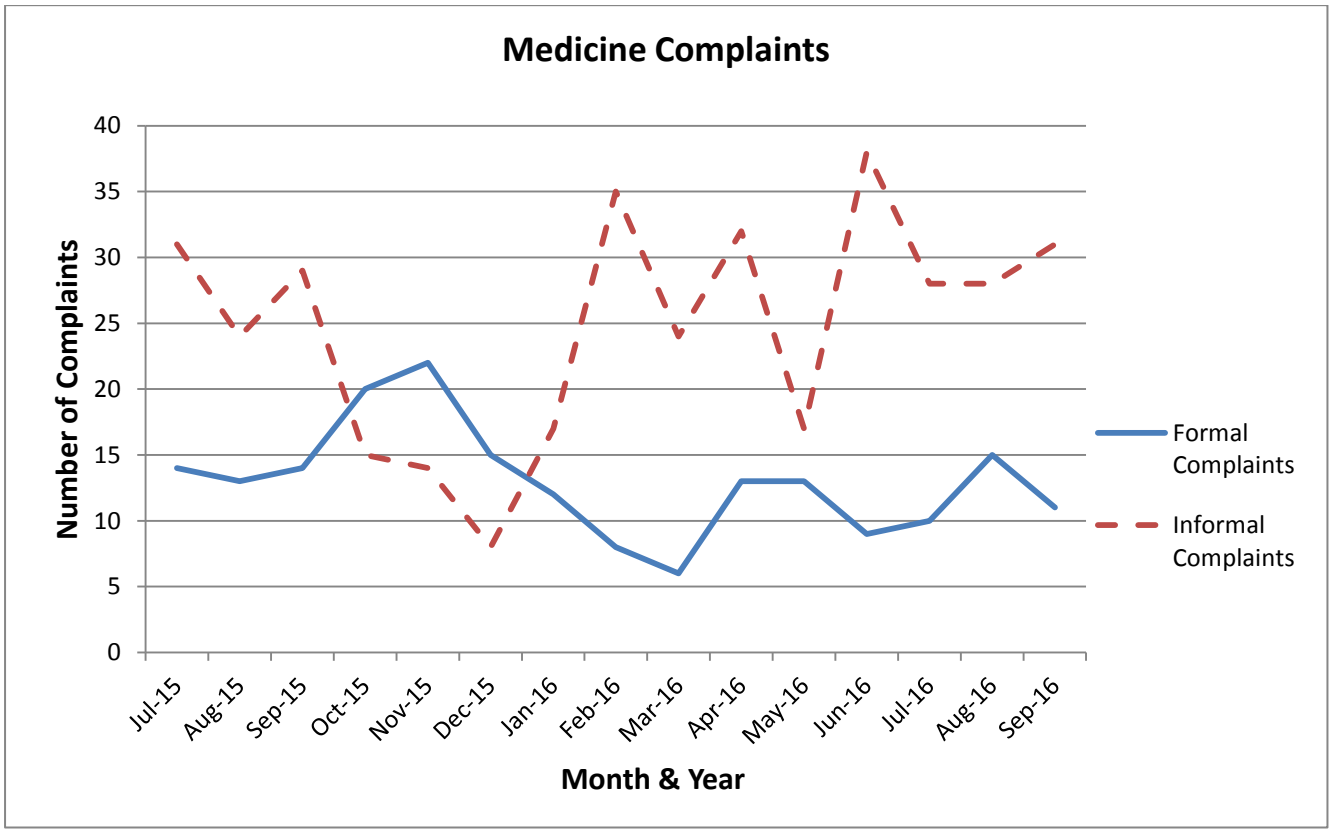
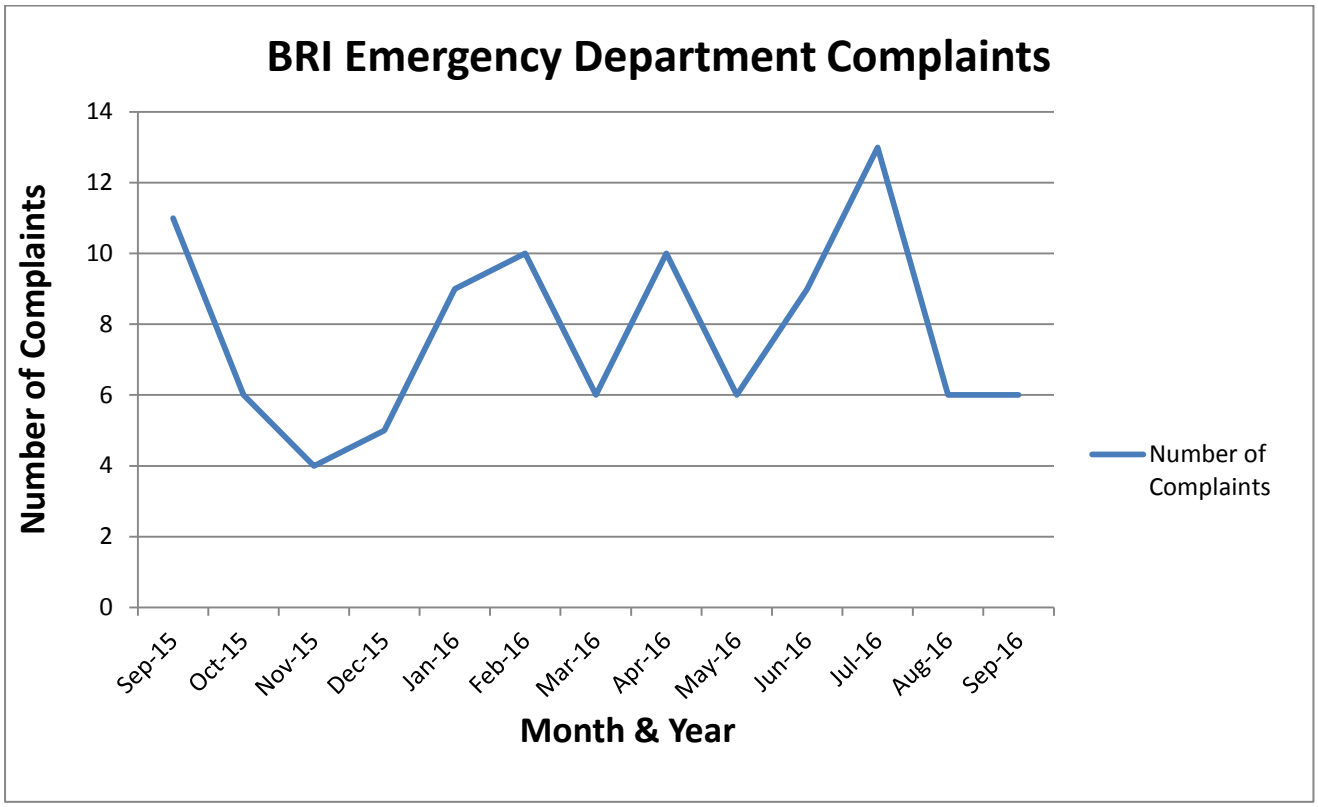


Figure 13: Complaints received by BRI Emergency Department



3.2.3 Division of Specialised Services

In Q2, the Division of Specialised Services experienced a 50% increase in complaints about appointments and admissions, and a similar increase in complaints about clinical care. Complaints about information and support increased, but the numbers involved were small. Overall, complaints increased significantly from 66 to 95. Complaints about GUCH (Grown up congenital heart disease) increase from eight to 21.

Table 12: Complaints by category type

Category Type	Number and % of complaints received – Q2 2016/17	Number and % of complaints received – Q1 2016/17
Access	2 (2.1% of total complaints) ↑	0 (0% of total complaints) =
Appointments & Admissions	27 (28.4%) ↑	18 (27.3%) ↓
Attitude & Communication	22 (23.2%) =	22 (33.3%) ↑
Clinical Care	32 (33.7%) ↑	18 (27.3%) ↑
Facilities & Environment	3 (3.2%) ↑	1 (1.5%) ↑
Information & Support	7 (7.4%) ↑	1 (1.5%) ↓
Discharge/Transfer/Transport	1 (1.1%) ↓	5 (7.6%)
Documentation	1 (1.1%) =	1 (1.5%)
Total	**95**	**66**

Table 13: Top sub-categories

Category	Number of complaints received – Q2 2016/17	Number of complaints received – Q1 2016/17
Cancelled or delayed appointments and operations	27↑ 17 =	17 ↑
Clinical Care (Medical/Surgical)	17 ↑	9 ↑
Communication with patient/relative	5 ↓	8 ↑
Attitude of Medical Staff	5 ↑	1 ↑
Attitude of Nursing/Midwifery	2 =	2 ↑
Attitude of Admin/Clerical Staff	1 ↑	0 ↓
Clinical Care (Nursing/Midwifery)	4 ↑	3 =
Failure to answer telephones	5 =	5 ↑

Table 14: Divisional response to concerns highlighted by Q2 data

Concern	Explanation	Action
Complaints about clinical care increased from 14 in Q4 and 18 in Q1 to 32 in Q2. Of these 32 complaints, 17 were in respect of clinical care provided by medical/surgical staff and four complaints were about care received by nursing staff. There were no other discernible patterns for the remaining 11 complaints.	Some of the 32 cases in Q2 may not have been assigned to the most appropriate complaint category. The division's view is that the core theme in five of these complaints was delay to, or cancellation of procedures and appointments. Similarly, three complaints were about delays in communicating test results and three were patients asking clinical questions following discharge. Local analysis of the remaining 21 complaints has identified the following themes: • questions or concerns highlighted by patients and relatives following the death of a patient both across the Bristol Heart Institute (BHI) and the Bristol Haematology and Oncology Centre (BHOC) • queries and concerns surrounding the diagnosis and treatment of cancer • management of cardiac surgery patients and the patient's experience as a result of delays or	The Division is currently: • exploring ways in which staff can provide further support and information to families following the death of their loved one so that they feel that they have the opportunity to ask questions earlier on in their journey. • reviewing the way in which the patient information and support centre at the BHOC is promoted • embarking upon a *Patient Experience at Heart* project in early 2017 to improve the patient experience across cardiac surgery and cancer pathways specifically.

	cancellation of their procedures	
Complaints about GUCH (Grown up congenital heart disease) increase from eight in Q1 to 21 in Q2. Of these 21 complaints, eight were in respect of cancelled or delayed appointments or operations. There were no other discernible trends identified for the remaining 13 complaints.	The Division experienced significant challenges with patient flow towards the end of Q2 which led to an increased number of cancelled operations.	The Division has allocated specific patient flow responsibilities to a matron within the BHI; processes are currently being reviewed with a view to reducing cancelled operations.

Figure 14: Specialised Services – formal and informal complaints received

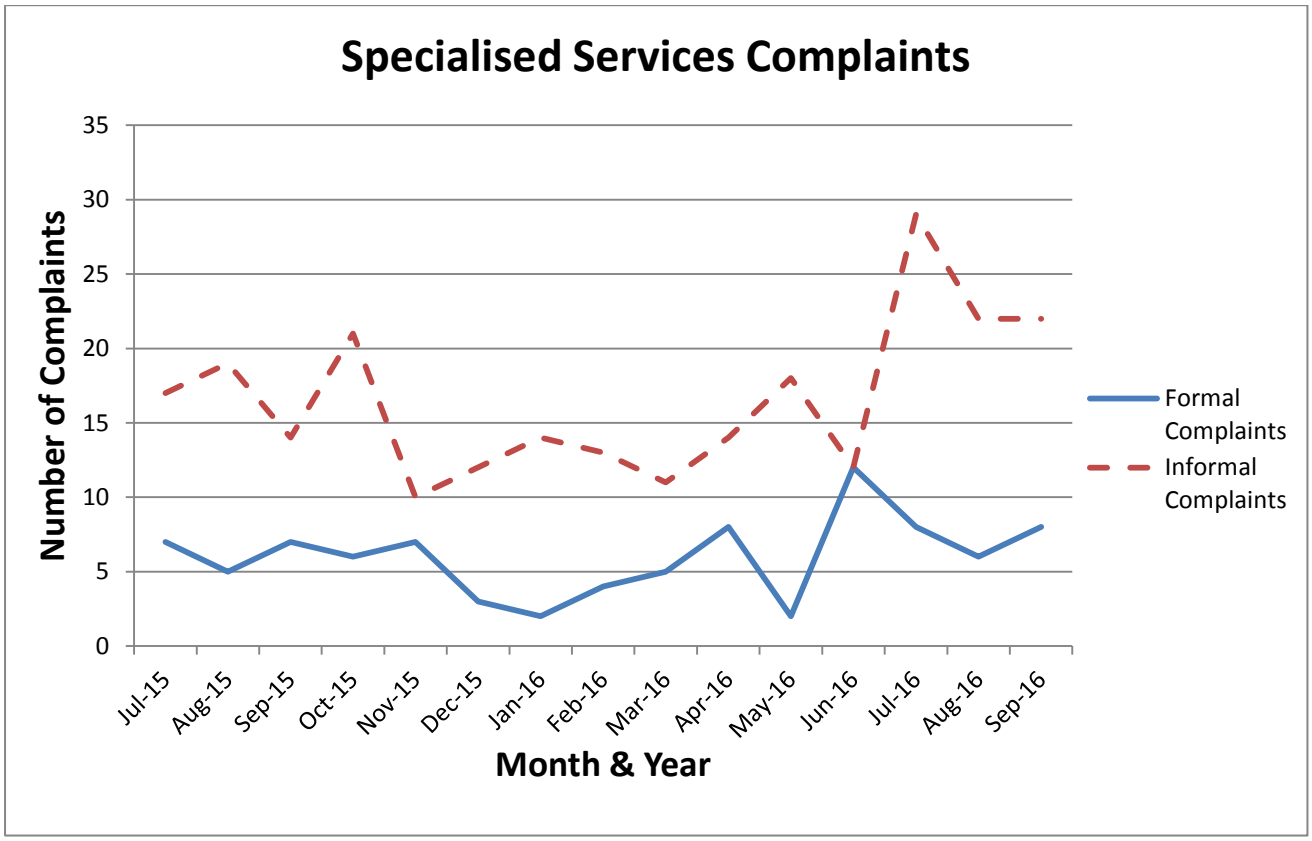
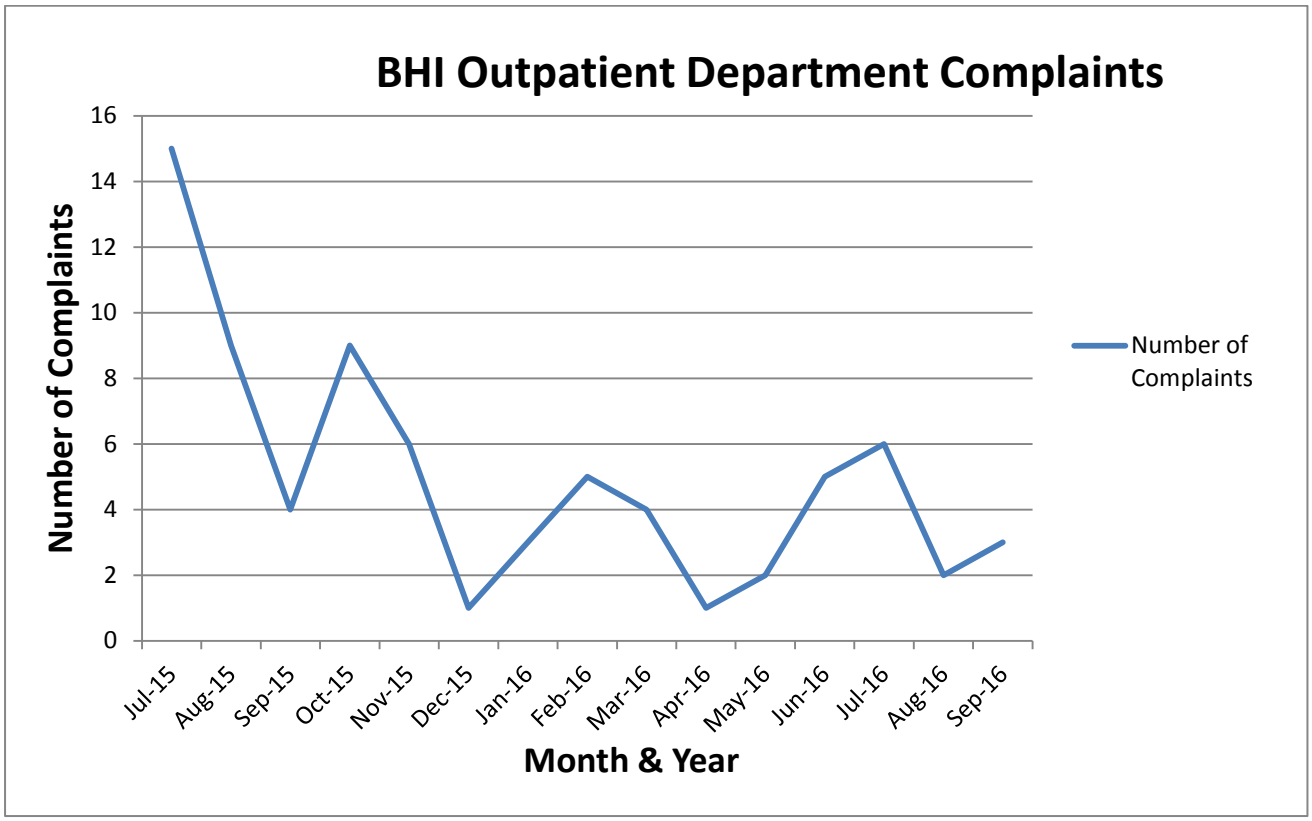


Figure 15: Complaints received by BHI Outpatients



3.2.4 Division of Women's and Children's Services

In Q2, the Division of Women's and Children's Services received fewer complaints about appointments and admissions than in Q1 (18 compared to 29), following a previous increase. Complaints about clinical care also fell in Q2 (from 31 to 19). Paediatric plastic surgery received only one complaint in Q2, following seven complaints in Q1. Ward 78 also saw a notable reduction in complaints, from 12 in Q1 to three in Q2.

Table 15: Complaints by category type

Category Type	Number and % of complaints received – Q2 2016/17	Number and % of complaints received – Q1 2016/17
Access	1 (1.6% of total complaints) ↑	0 (0% of total complaints) =
Appointments & Admissions	18 (29%) ↓	29 (34.5%) ↑
Attitude & Communication	15 (24.2%) ↓	17 (20.2%) ↓
Clinical Care	19 (30.6%) ↓	31 (36.9%) ↑
Facilities & Environment	2 (3.2%) ↑	1 (1.2%) ↓
Information & Support	3 (4.8%) ↓	4 (4.8%) ↑
Discharge/Transfer/Transport	2 (3.2%) =	2 (2.4%)
Documentation	2 (3.2%) ↑	0 (0%)
Total	**62**	**84**

Table 16: Top sub-categories

Category	Number of complaints received – Q2 2016/17	Number of complaints received – Q1 2016/17
Cancelled or delayed appointments and operations	11 ↓	27 ↑
Clinical Care (Medical/Surgical)	7 ↓	15 ↑
Communication with patient/relative	4 ↑	3 ↓
Attitude of Medical Staff	6 ↑	5 ↑
Attitude of Nursing/Midwifery	4 ↑	1 ↓
Attitude of Admin/Clerical Staff	0 ↓	2 ↑
Clinical Care (Nursing/Midwifery)	7 ↑	5 ↓
Failure to answer telephones	1 ↓	2 ↑

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

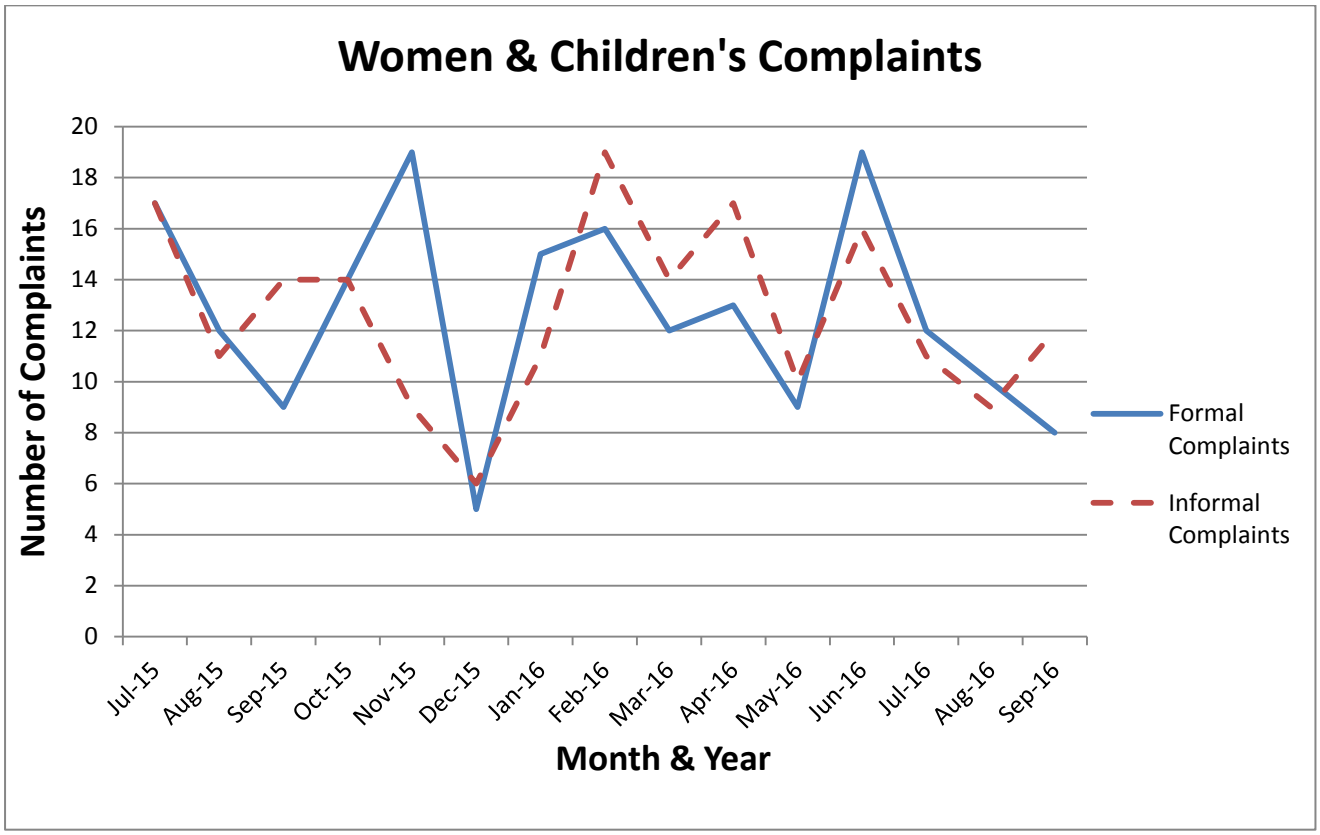
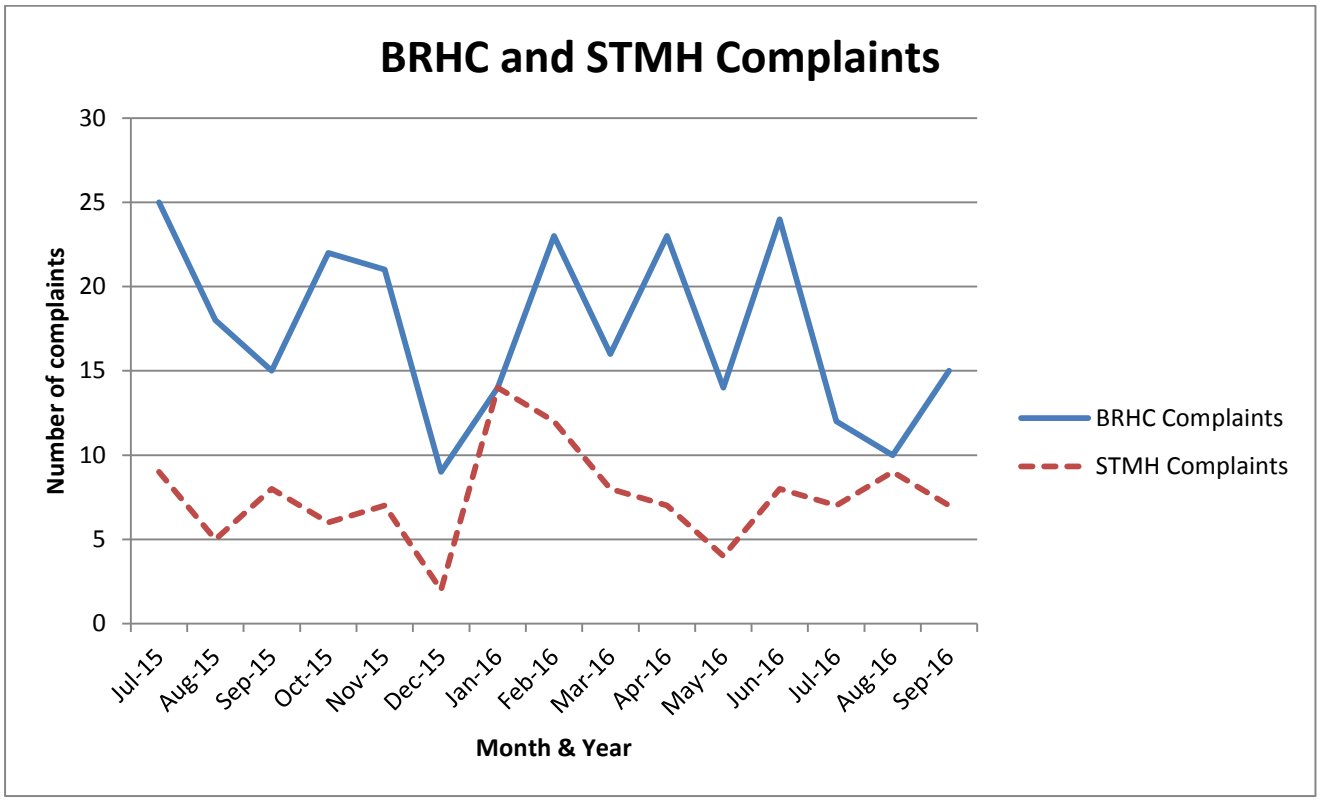


Figure 17: Complaints received by Bristol Royal Hospital for Children and St Michael's Hospital



3.2.5 Division of Diagnostics & Therapies

In Q2, complaints received by the Diagnostics and Therapies Division fell from 24 to 19. The physiotherapy service received only one complaint in this three month period and there were no significant themes or patterns within the divisional data.

Table 18: Complaints by category type

Category Type	Number and % of complaints received – Q2 2016/17	Number and % of complaints received – Q1 2016/17
Access	2 (10.5% of total complaints) ↑	1 (4.2% of total complaints) ↑
Appointments & Admissions	6 (31.6%) ↓	7 (29.2%) ↑
Attitude & Communication	3 (15.8%) ↓	6 (25%) ↓
Clinical Care	6 (31.6%) ↓	7 (29.2%) ↑
Facilities & Environment	1 (5.3%) ↓	3 (12.5%) ↑
Information & Support	0 (0%) =	0 (0%) ↓
Discharge/Transfer/Transport	1 (5.3%) ↑	0 (0%)
Documentation	0 (0%) =	0 (0%)
Total	**19**	**24**

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

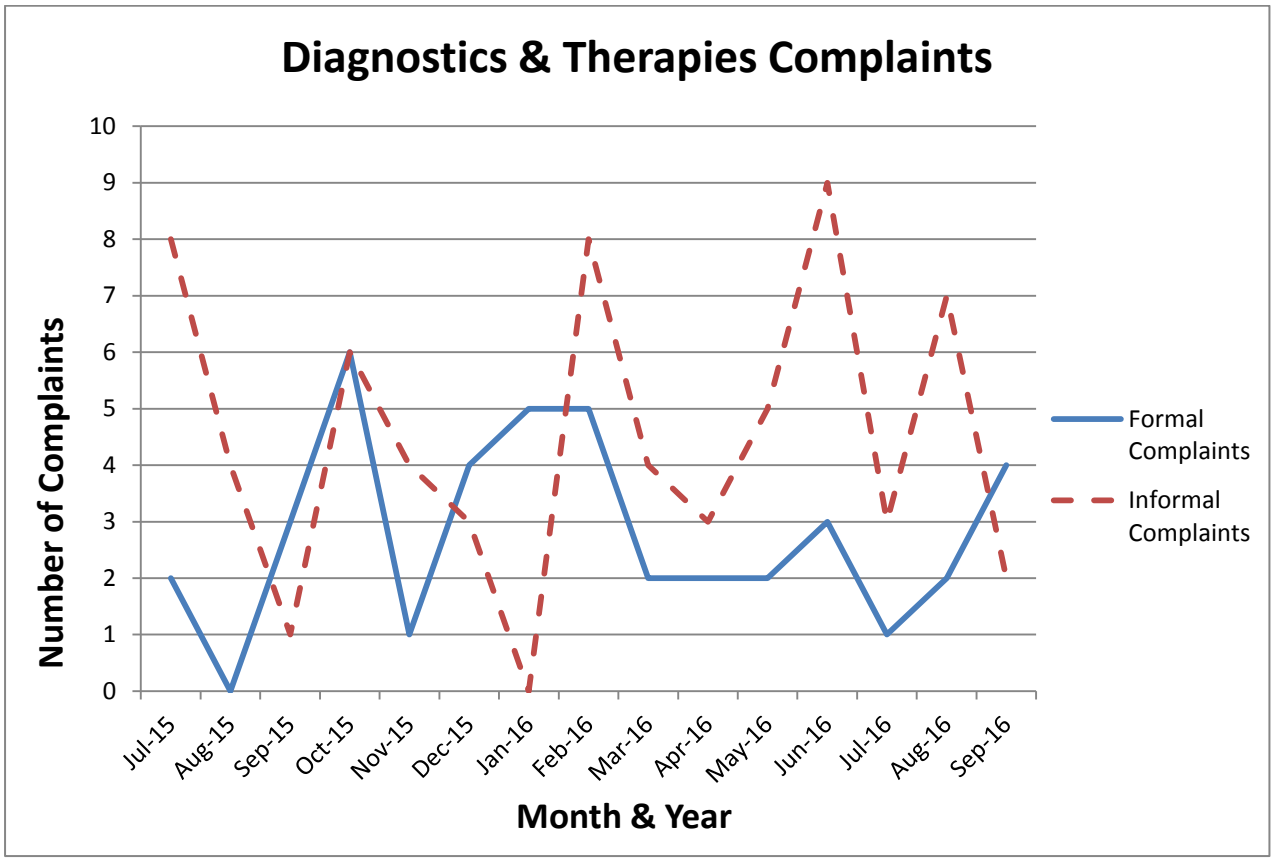
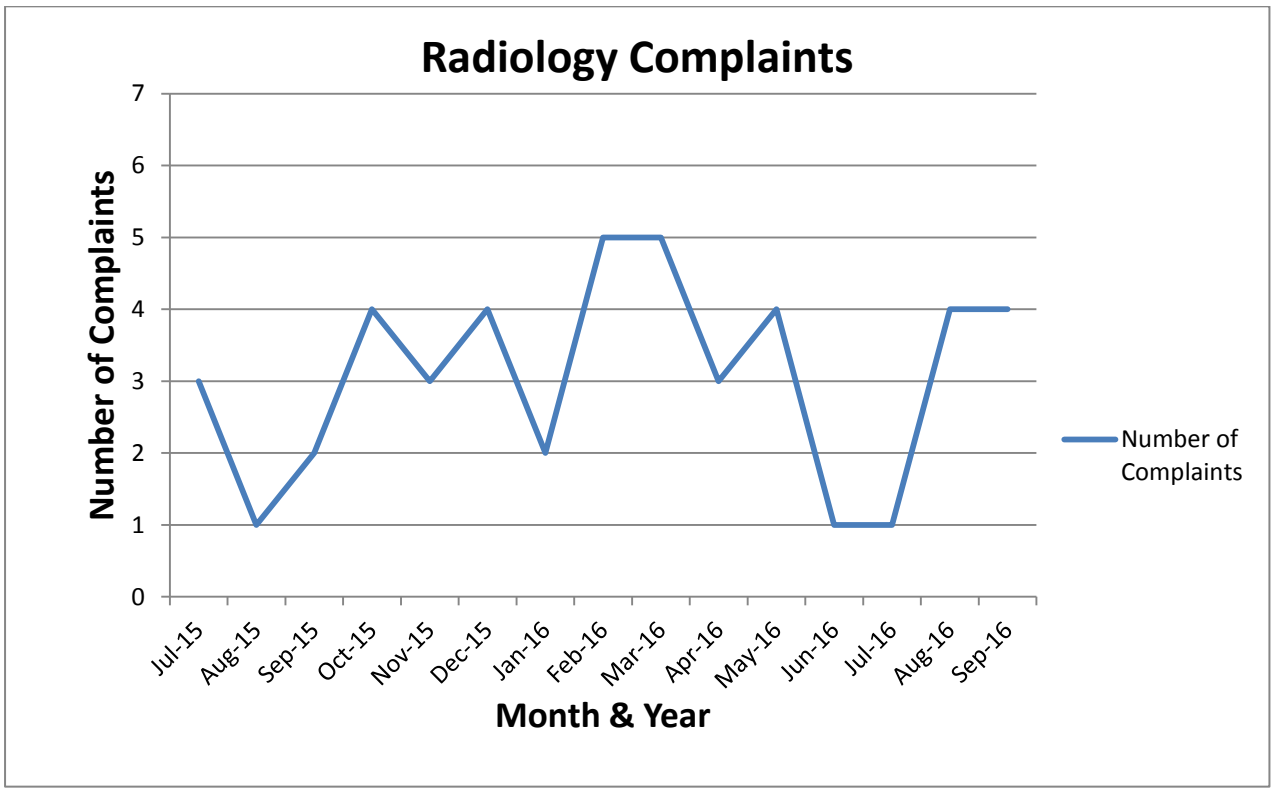


Figure 19: Complaints received by Radiology (Trust-wide)



3.3 Complaints by hospital site

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

Table 19: Breakdown of complaints by hospital site

Hospital/Site	Number and % of complaints received in Q2 2016/17	Number and % of complaints received in Q1 2016/17
Bristol Royal Infirmary (BRI)	300 (58.0%)	228 (43.8% of total complaints)
Bristol Eye Hospital (BEH)	41 (7.9%)	46 (8.9%)
Bristol Dental Hospital (BDH)	34 (6.6%)	46 (8.9%)
St Michael's Hospital (StMH)	40 (7.3%)	47
Bristol Heart Institute (BHI)	17 (3.3%)	50 (9.6%)
Bristol Haematology & Oncology Centre (BHOC)	35 (6.8%)	22 (4.2%)
Bristol Royal Hospital for Children (BRHC)	38 (7.3%)	62 (11.9%)
South Bristol Community Hospital (SBCH)	12 (2.3%)	10 (1.9%)
Total	**517**	**520**

Table 20 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 Q2, the BRI accounted for 31.16% of all attendances and 58.0% of all complaints.

Table 20: Complaints rates by hospital site

Site	No. of complaints	No. of attendances	Complaints rate	Proportion of all attendances	Proportion of all complaints
BRI	300	60,473	0.49%	31.16%	58.0%
BEH	41	31,551	0.13%	16.2%	7.9%
BDH	34	18,732	0.18%	9.65%	6.6%
StMH	40	21,816	0.18%	11.24%	7.3%
BHI	17	4,978	0.34%	2.7%	3.3%
BHOC	35	18,872	0.12%	9.7%	6.8%
BRHC	38	30,511	0.18%	15.73%	7.3%
SBCH	12	6,633	0.18%	3.42%	2.3%
Total	**517**	194,024	0.27%		

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

The Divisions of Medicine, Specialised Services and Women and Children, and Trust Services reported breaches in Q2, totalling 12 breaches, which is a significant decrease on the 34 breaches

recorded in Q1. Table 21 shows a quarterly pattern of reductions in breached deadlines across all clinical divisions.

Table 21: Breakdown of breached deadlines

Division	Q2 (2016/17)	Q1 2016/17	Q4 2015/16	Q3 2015/16
Surgery, Head & Neck	0 (0%)	6 (14.6%)	10 (24.4%)	16 (31.4%)
Medicine	4 (11.1%)	12 (36.4%)	10 (28.6%)	18 (48.6%)
Specialised Services	1 (4.5%)	2 (15.4%)	3 (23.1%)	8 (36.4%)
Women & Children	5 (16.7%)	12 (30.8%)	8 (34.8%)	21 (65.6%)
Diagnostics & Therapies	0 (0%)	2 (18.2%)	0 (0%)	2 (22.2%)
Trust Services	2 (0.1%)	0 (0%)	0 (0%)	0 (0%)
All	**12 breaches**	**34 breaches**	**31 breaches**	**65 breaches**

(So, as an example, there were five breaches of timescale in the Division of Women and Children in Q2, which constituted 16.67% of the complaints responses, had been due in that Division in Q2).

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; any delays during the sign-off process itself; and/or responses being returned for amendment. Sources of delay are shown in the table below.

Table 22: Source of delays

	Source of delays in Q2 2016/17				Totals
	Division	PSCT	Executive sign-off	Other	
Surgery, Head & Neck	0	1	0	1	**2**
Medicine	4	1	0	0	**5**
Specialised Services	1	0	0	1	**2**
Women & Children	5	0	0	0	**5**
Diagnostics & Therapies	0	0	0	0	**0**
Trust Services	2	0	0	0	**2**
All	**12**	**2**	**0**	**2**	**12 breaches**

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 of 2015/16, the process was changed to allow seven working days for the review and sign-off process.

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 Q2, the team dealt with 212 such enquiries, compared to 257 in Q1. These enquiries can be categorised as:

- 124 requests for advice and information (121 in Q1)
- 80 compliments (129 in Q1)[6]
- 8 requests for support (7 in Q1)

The table below shows a breakdown of the 124 requests for advice, information and support dealt with by the team in Q2.

Table 23: Enquiries by category

Category	Number of enquiries
Information about patient	31
Hospital information request	13
Emotional support	11
Medical records requested	9
Clinical information request	8
Signposting	7
Bereavement Support	4
Clinical care	3
Accommodation enquiry	3
Communication with patient/relative	3
Wayfinding	3
Freedom of information request	2
Support with access	2
Transport request	2
Employment and volunteering	2
Benefits and social care	2
Discharge arrangements	2
Follow-up treatment	2
Expenses claim	1
Transfer arrangements	1
Attitude of staff	1

[6] This figure includes compliments added directly to the Datix system by Divisions.

Car parking	1
Appointments administration issues	1
Personal property	1
Waiting time for correspondence	1
Patient choice information	1
Aids and Appliances	1
Confidentiality	1
Delayed appointment	1
Failure to answer phone	1
Privacy and Dignity	1
Referral errors	1
Services not available	1
Total	**124**

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 Q2, 49% were received in writing.

493 complaints (95.4%) were acknowledged within two working days. The remaining 24 cases were all acknowledged within four working days.

6. PHSO cases

During Q2, the Trust was advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in two complaints. During Q2, four existing cases were closed, two of which were not upheld and two of which were partially upheld. Actions and learning from the two partially upheld cases are described below.

As of 30th September (i.e. the end of Q2), eight other cases remained open with the PHSO, four of which have since been closed as not upheld and two of which have been partially upheld.

Table 24: complaints opened by the PHSO during Q2

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
3983	AG	LCY	29/9/15 [7/9/16]	BRI	Trauma and Orthopaedics	Surgery, Head and Neck
Copy of complaint file and medical records sent to the PHSO. (note: since the end of Q2, the Trust has been advised that the PHSO has decided not to uphold this complaint)						
4841	AJ		9/11/15 [30/9/16]	BEH	Outpatients	Surgery, Head and Neck
Copy of complaint file and medical records sent to the PHSO on 17 November 2016. Currently awaiting PHSO response.						

Table 25: complaints closed by the PHSO during Q2

16474		CM	5/8/14	BRI	Ward A604	Surgery, Head & Neck
PHSO final report received 30 August 2016 – not upheld						
19541	AA	LA	13/8/15	BRI	Gastroenterology & Hepatology	Medicine
PHSO final report received 21 September 2016 – not upheld						
10977	ST	ST	7/6/12 [8/12/14]	BRCH	PICU	Women and Children

The PHSO advised the Trust on 1 August that they were partially upholding this complaint. The PHSO found service failure in some aspects of the patient's post-operative care and treatment, but not in other aspects of the patient's care and treatment which were raised by the complainants. The PHSO found that the complainants suffered significant injustice as a consequence of the service failure they have identified, but did not find that the service failure resulted in the injustice the complainants described.

The PHSO also found maladministration in the Trust's handling of the complaint, concluding that the Trust did not provide an "open and accountable" response to some of the complainants' questions about the patient's care.

The PHSO directed the Trust to write to the complainants by 1 September 2016 with an open and honest acknowledgement of the failings identified in the report and an apology for the impact these failings had on the patient and the complainants. The PHSO also advised that by no later than 1 February 2017, the Trust should write to the complainants, setting out:

- the lessons the Trust has learned from the failings the PHSO identified in the patient's care;
- the lessons the Trust has learned from the failings in complaint handling identified by the PHSO;
- the action the Trust has taken and the changes the Trust has made to avoid a recurrence of these failings care and complaint handling; and
- tangible evidence of the impact of the changes made by the Trust.

11453	SJ	LJ	1/8/12 [24/2/15]	BRCH	Cardiac Surgery	Women and Children
The PHSO advised the Trust on 1 August that they were partially upholding this complaint. The PHSO found that there was service failure in the patient's post-operative care and treatment, but they did not conclude that the service failure led to the patient's death, as alleged by the complainant. The PHSO also found maladministration in the Trust's complaint handing, which led to an unresolved injustice to the complainants. The PHSO directed the Trust to write to the complainant by 1 September 2016 with an open and honest acknowledgement of the failings identified in the report with respect to the patient's care and treatment and the Trust's complaint handling. The PHSO added that the Trust should also apologise for the impact these failings had on the patient and the complainants. By the same date, the PHSO instructed the Trust to pay the complainants the sum of £2000 by way of a tangible acknowledgement of the added distress the complainants have suffered. Finally, the PHSO directed the Trust to write the complainants no later than 1 February 2017 setting out: • the lessons the Trust has learned from the failings the PHSO identified in the patient's care; • the lessons the Trust has learned from the failings the PHSO identified in its complaint handling; • the action the Trust has taken and the changes the Trust has made to avoid a recurrence of these failings in the care and in complaint handling; and • tangible evidence of the impact of the changes made by the Trust.						

Table 26: complaints ongoing with PHSO as at 30th September 2016

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received Trust [and date notified by PHSO]	Site	Department	Division
14561	HB	PB	5/12/13 [15/6/16]	STMH	ENT	Surgery, Head & Neck
Note: since the end of Q2, the Trust has received the PHSO's final report - not upheld						
18315	SOC		19/3/15 [13/1/16]	BRI	Rheumatology	Medicine
Note: since the end of Q2, the Trust has received the PHSO's final report - not upheld						
18318	SOC		27/3/15 [13/1/16]	BRI	Adult Therapy	Diagnostics & Therapies
Note: Case handled by PHSO in conjunction with 18315 Since the end of Q2, the Trust has received the PHSO's final report - not upheld						
17763	AP-S	CW	16/1/15 [6/4/16]	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
The PHSO's report was received by the Trust on 3 June 2016 however the 'partially upheld' judgement was subsequently challenged by the Trust. Note: since the end of Q2, following discussion between UH Bristol consultants and the PHSO's						

clinical advisor, the 'partially upheld' judgement has been retracted and the case has not been upheld.						
18479	NK		9/4/15 [8/6/16]	BEH	Outpatients	Surgery, Head & Neck
Note: since the end of Q2, the PHSO has decided to partially uphold this complaint, pertaining to the adequacy of a pre-operative assessment prior to eye surgery and how the risks associated with the surgery were shared with the patient. Actions and learning from this case will be described in the Q3 report.						
15534	AN		22/4/14 [12/4/16]	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Note: since the end of Q2, the PHSO has decided to partially uphold this complaint, pertaining to how the Trust responded to a patient's concerns about pain they were experiencing following wisdom tooth extraction surgery. Actions and learning from this case will be described in the Q3 report.						
17173	DF	DJ	29/10/14 [21/9/15]	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Currently awaiting further contact from the PHSO.						
18856	SC	VP	22/5/15 [15/2/16]	BRI	Ward B501	Medicine
Information relating to this case was most recently submitted to the PHSO in July 2016. Currently waiting to hear further from PHSO.						

Cover report to the Trust Board meeting to be held on 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	11
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Quarterly Patient Experience and Involvement Report (Quarter 2)		
Author	Carolyn Mills, Chief Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☒	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

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

Executive Summary

Purpose

To share insight and learning from patient-reported experience generated from patient surveys and patient and public involvement activities.

Key points to note

- All of the UH Bristol's headline patient satisfaction survey measures in Quarter 2 were above [better than] target, at Trust, Divisional and hospital level - demonstrating the continued provision of a high quality inpatient and outpatient experience.
- A number of patient and public involvement activities are noted in the report. In particular,

at the invitation of the Trust, Healthwatch carried out an "enter and view" of South Bristol Community Hospital inpatient areas, primarily in response to relatively low survey scores being achieved in this setting. Analysis of these survey results in previous Quarterly Patient Experience and Involvement Reports, suggested that they reflect the real challenges in effectively communicating with patients who have complex health and social care needs, and are in line with survey trends seen at a national level. The enter and view provided an opportunity to independently test this analysis. The findings of the report were very positive about the care being provided at South Bristol Community Hospital. A number of suggestions were put forward by Healthwatch to enhance patient experience, in particular recognising that many patients have a relatively long stay and therefore, as far as possible, efforts should be made to ensure access to magazines, activities and the café. A summary of the Trust's response to these recommendations will be provided in the next Quarterly Patient Experience and Involvement Report (due at Trust Board in March 2017).

- The following wards received relatively low survey scores in Quarter 2:
  - Ward 37 (paediatric renal) received relatively low scores on both the "inpatient experience tracker" and "kindness and understanding" survey measures. Further analysis was carried out by the Patient Experience and Involvement Team and the Head of Nursing, but the results did not correlate with other quality metrics reviewed by the Bristol Royal Hospital for Children, including complaints. Therefore, this result may have been a "statistical blip" and survey scores for Ward 37 will continue to be monitored closely (they are more positive in Quarter 3 to date).
  - A400 (older people's assessment unit) had the lowest score on the headline "kindness and understanding" measure, although this appeared to primarily be due to low sample sizes affecting the data and did not correlate with the Friends and Family Test or other quality metrics reviewed by the Division of Medicine for this ward.
  - Ward C808 (care of the elderly) has received relatively low "inpatient tracker" survey scores for several quarters. Our analysis has shown that this correlates with trends seen at a national level and is likely to reflect the real challenges of communicating with patients who have complex health and social care needs. The care of the elderly service nevertheless recognises that there is an opportunity to improve patient experience and a number of service development actions are outlined in the Quarterly report. This includes a focus by the Patient Experience and Involvement Team on understanding the experience of patients in care of the elderly services in Quarter 1 (April-June 2017), utilising the Trust's Involvement Network and *Face2Face* volunteer interview programme.

- In outpatient settings, the Trust receives relatively low survey scores in respect of ensuring patients are kept informed about any delays in clinic. A recent development has seen the installation of new, standardised clinic information boards in a number of clinics. This issue will continue to be a focus for the Trust as improving this survey score is a corporate quality objective for 2016/17.

Recommendations

Members are asked to:

- **Note** the report.

Intended Audience

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

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

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

Impact Upon Corporate Risk
N/A

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		22nd December 2016		Senior Leadership Team; Patient Experience Group

University Hospitals Bristol NHS
NHS Foundation Trust

Quarterly Patient Experience and Involvement Report

Incorporating current Patient and Public Involvement activity and patient survey data received up to Quarter 2 2016/17

Author: **Paul Lewis, Patient Experience and Involvement Team Manager**

Patient Experience and Involvement Team

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Anna Horton, Patient Experience and Regulatory Compliance Facilitator (anna.horton@uhbristol.nhs.uk)

1. Overview of patient-reported experience at UH Bristol: update since the last Quarterly Report

Successes	Priorities
• Approval of the Trust's new Quality Strategy by the Trust Board, incorporating plans for a step-change in the way that UH Bristol collects and uses service-user feedback • The launch of the Trust's new Welcome Guide on adult inpatient wards • Healthwatch carried out an "enter and view" of inpatient services at South Bristol Community Hospital, with positive feedback received from Healthwatch about the care provided there • The Trust expanded opportunities for patients to give feedback about the Bristol Royal Infirmary Emergency Department by introducing a new SMS (text-message) based Friends and Family Test survey	• For 2017/18, the Trust has been set a challenging response rate target for the outpatient Friends and Family Test by the Bristol Clinical Commissioning Group. An options appraisal to identify the best methodology has been undertaken by the Patient Experience and Involvement Team, which points to an SMS-based approach (possibly via an extension of the Trust's SMS appointment reminder system). This has support in principle from the Trust's Outpatient Steering Group and funding options are now being considered.
Opportunities	**Risks & Threats**

• In light of the Trust's new Quality Strategy, to enhance the collection and use of patient feedback via the procurement of a new "real-time feedback" IT system. A working group re-convened in early December 2016 to agree the procurement specification (this will be shared with the Senior Leadership Team for review).
• To extend the text-message Friends and Family Test to the Bristol Royal Hospital for Children Emergency Department (commenced in Quarter 3).
• To share the positive patient feedback in this Quarterly Report with staff delivering care and users of our services
	• The following wards received relatively low survey scores (a full exploration of these results is provided in Section 3 of the current report):
	  • Ward 37 (paediatric renal) received relatively low scores on both the "inpatient experience tracker" and "kindness and understanding" survey measures. This did not correlate with other quality metrics reviewed by the Bristol Royal Hospital for Children, so may be a "statistical blip". These survey scores will continue to be monitored closely (they are more positive in Quarter 3 to date)
	  • A400 (older people's assessment unit) had the lowest score on the headline "kindness and understanding" measure, although this appeared to primarily be due to low sample sizes affecting the data and did not correlate with the Friends and Family Test or other quality metrics reviewed by the Division of Medicine for this ward
	  • Ward C808 (care of the elderly) has received relatively low "inpatient tracker" survey scores for several quarters. Our analysis has shown that this correlates with trends seen at a national level and is likely to reflect the real challenges of communicating with patients who have complex health and social care needs. The care of the elderly service nevertheless recognises that there is an opportunity to improve patient experience and a number of service development actions are outlined in Section 3 of the current report

2. Update on recent and current Patient and Public Involvement (PPI) Activity

The UH Bristol Patient Experience and Involvement Team carries out a range of activities to ensure that patients and the public influence and shape the services that the Trust provides. There are three broad areas of work in this respect:

- The corporate Patient and Public Involvement (PPI) programme (principally the Involvement Network, *Face2Face* patient interviews, Patient Experience at Heart staff workshops, and the "15 steps challenge" – see Appendix B for a summary)
- Service-level PPI activity
- Engagement with partner organisations (e.g. Healthwatch, Patient's Association, local health and social providers)

This section of the Quarterly Report provides a summary of notable PPI activity that has recently been undertaken by the Trust.

Face2Face volunteer interview programme

The volunteer interview team was involved in two recent projects that aimed to understand the experience of specific patient groups:

- In the Adult Congenital Heart Disease clinical nurse specialist service, a dedicated volunteer interviewer was assigned to talk to patients about their experience of care. Conversations took place over several weeks as patients attended appointments. A relatively high proportion of patients in this service have a learning disability and so the volunteer interviewer was trained specifically for this task. The feedback received from patients is currently being collated, but was generally very positive. Insight from this work will also inform the Trust's response to the national Congenital Heart Disease public consultation planned for early 2017.
- In conjunction with the Trust's Transformation Team and the Bristol Clinical Commissioning Group, members of the *Face2Face* interview team talked to inpatients in the Trust's care who were homeless or vulnerably housed. This proved to be a challenging task for the team, particularly because the patients had often left the Trust's care by the time the interviewer arrived to talk to them, and on some occasions it wasn't appropriate for the volunteer to interview the patient. Although limited feedback was elicited from this work, it was a useful learning experience in terms of the *Face2Face* programme itself. The Trust will continue to work with its partners in this project to find ways of engaging with our patients who are homeless or vulnerably housed.

The Involvement Network

The Trust's Involvement Network is currently engaged in discussions about the "Butterfly End of Life Improvement Project", which is being led by the Trust's Palliative Care Team. This project aims to improve the identification of patients on palliative care pathways on the wards and to provide better individualised care planning for these patients. In addition to consultation with the Involvement Network, the Patient Experience and Involvement Team has worked with the Palliative Care Team to carry out focus groups with staff who provide end of life care and also patient representatives.

A representative from Bristol Black Carers (a group that is part of the Involvement Network) talked at a recent meeting of the Trust Board about the experience of carers and the importance of ensuring that carers are partners in care.

A timetable of Involvement Network activity in 2017 is currently being developed and the first event will be the annual "Quality Counts" meeting in January, the outcomes of which will inform the Trust's corporate quality objectives for 2017/18.

Engaging with partner organisations – Healthwatch enter and view

As noted in the previous Quarterly Report, the Trust invited Healthwatch to carry out an "enter and view" of inpatient areas at South Bristol Community Hospital. This was in response to a consistent trend of lower patient survey scores for this hospital. The Patient Experience and Involvement Team's analysis had suggested that these results were consistent with the challenges in caring for patients with complex / long-term health and social care needs, and reflect similar survey trends seen nationally and also for UH Bristol's care of the elderly wards. The enter and view, which took place in October 2016, provided an opportunity to further test this theory. The outcomes report from this visit was recently received from Healthwatch. This put forward a number of service improvement suggestions, which the hospital management team are currently reviewing, but on the whole the findings were positive as the following summary from the report demonstrates:

"Inpatient wards 100 and 200 at South Bristol Community Hospital are to be commended for providing a friendly, caring, clean and functional environment for stroke and rehab' patients to recover in. It was clear that the staff team were happy in their work, treated well by UHB and dedicated to aiding patient recovery. Patients and visitors said very complimentary things about the staff team."

(Healthwatch, South Bristol Community Hospital enter and view report, December 2016)

A summary of the Trust's formal response to this enter and view will be provided in the next Quarterly Patient Experience and Involvement Report.

3. Patient survey data

3.1 Trust-level patient reported experience

The Trust's Patient Experience and Involvement Team is also responsible for measuring patient-reported experience, primarily via the Trust's patient survey programme[1]. This ensures that the quality of UH Bristol's care, as perceived by service-users themselves, can be monitored on an ongoing basis to ensure that high standards are maintained. It should be noted that the postal survey methodology changed in April 2016 (to provide the data a month earlier than had previously been the case): this appears to have had a marginally positive effect on the scores, so caution is needed in directly comparing 2016/17 data with previous years. The key messages from Quarter 2 are:

- All of the UH Bristol's headline patient survey measures remained above target, at Trust, Divisional and hospital level - demonstrating the continued provision of a high quality inpatient and outpatient experience (Charts 1-6)
- As noted in previous Quarterly Reports, it has not been possible to set a target for the Emergency Department Friends and Family Test scores in 2016/17 (Chart 5). This is because of the ongoing trialling

[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. The postal survey target thresholds are set to detect a deterioration of around two standard deviations below the Trust's average (mean) score, so that these measures can act as an "early warning" if the quality of patient experience significantly declines, and action can be taken in response.

of different approaches to collecting this feedback, all of which have varying effects on the score, making it difficult to establish a baseline from which we can set targets. This will continue to be the case until the effects of SMS surveying on the scores are assessed, but the aim remains to put a target in place for this survey from 2017/18.

- The Trust continued to meet its inpatient and day case Friends and Family Test response rate targets in Quarter 2 (Chart 7). However, these rates had started to decline during Quarter 2, to be just above target by the end of the quarter. The Heads of Nursing have therefore reminded their teams about the importance of this feedback process.
- The Trust met its Emergency Department Friends and Family Test response rate in August and September 2016, having achieved this inconsistently during the year to date (Chart 9). This was helped by the introduction of an SMS (text messaging) version of this survey, which is sent to Bristol Royal Infirmary Emergency Department patients after their discharge from the Department. This is being utilised alongside the cards and touchscreens available in the department itself and has proved successful both in terms of generating insightful feedback and supporting achievement of the response rate targets. A trial of this technology is now underway in the Bristol Royal Hospital for Children Emergency Department.

Chart 1 - Kindness and understanding on UH Bristol's wards

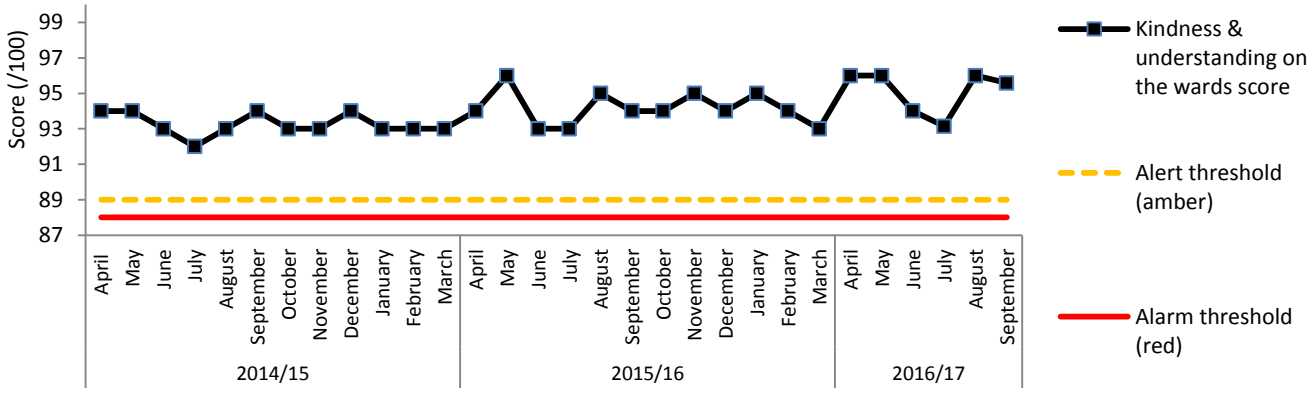
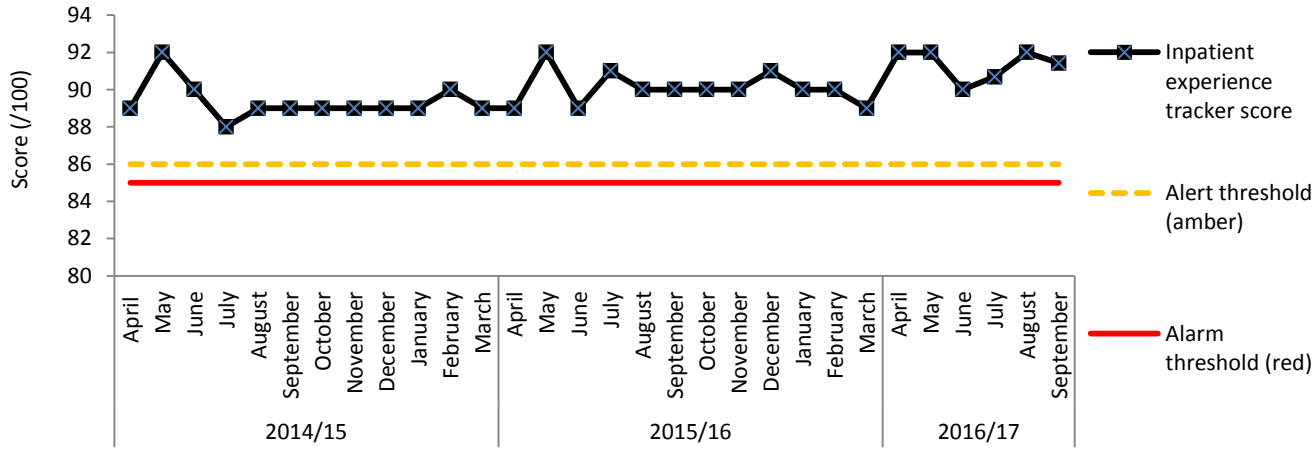


Chart 2 - Inpatient experience tracker score



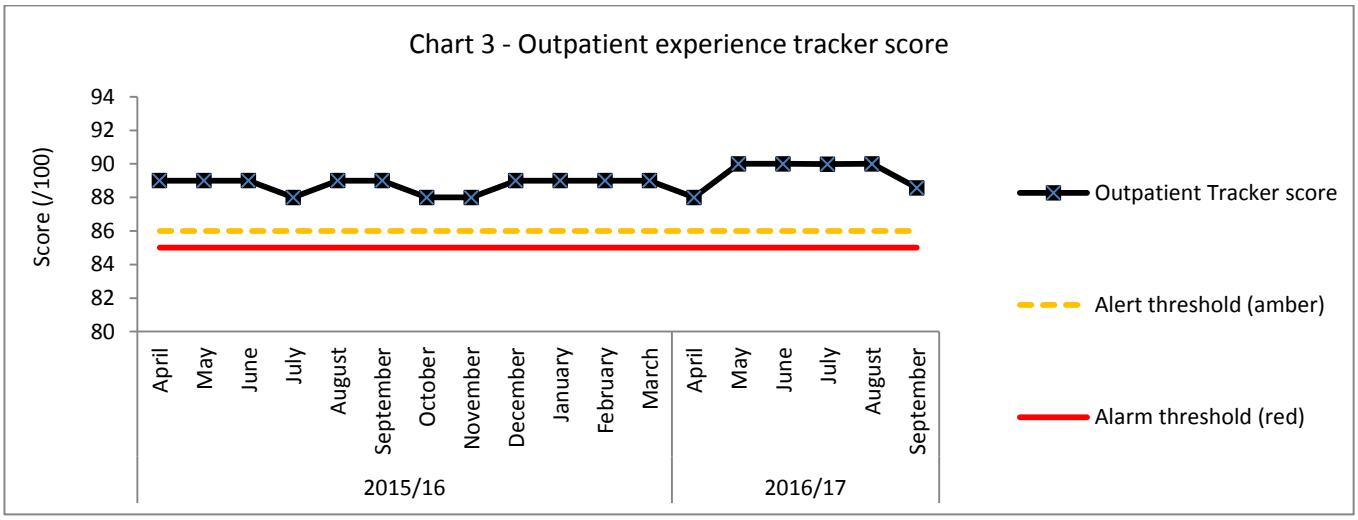


Chart 3 - Outpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April
May
June
July
August
September
October
November
December
January
February
March
April
May
June
July
August
September
2015/16
2016/17
Outpatient Tracker score
Alert threshold (amber)
Alarm threshold (red)

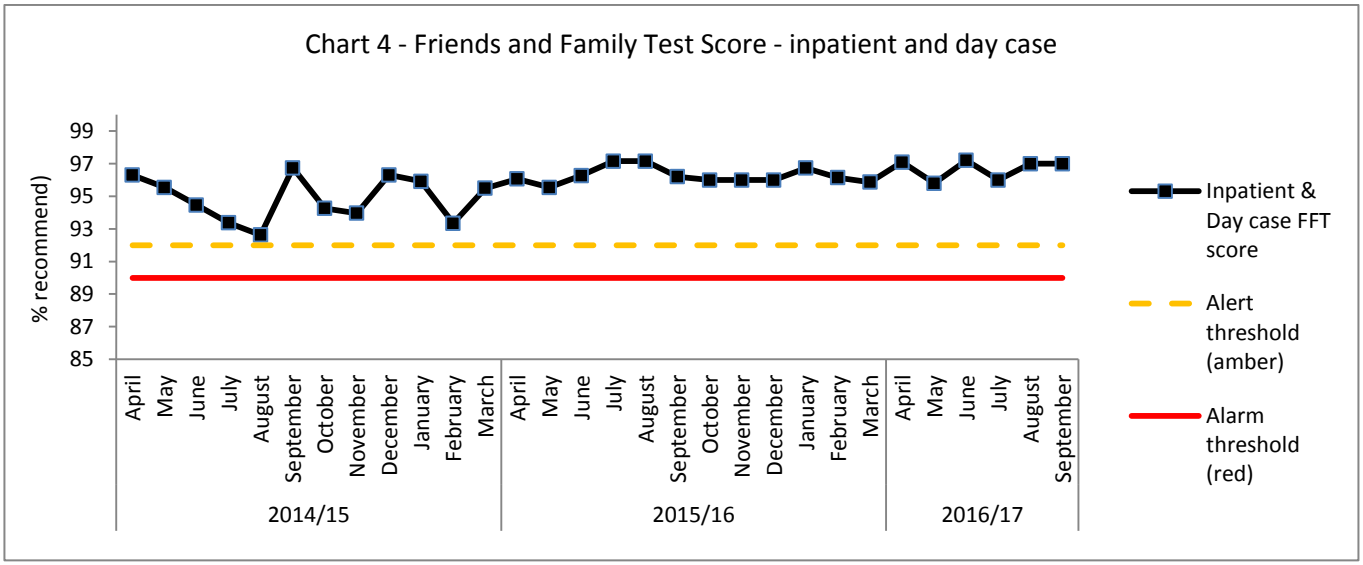


Chart 4 - Friends and Family Test Score - inpatient and day case
% recommend)
99
97
95
93
91
89
87
85
April
May
June
July
August
September
October
November
December
January
February
March
April
May
June
July
August
September
October
November
December
January
February
March
April
May
June
July
August
September
2014/15
2015/16
2016/17
Inpatient & Day case FFT score
Alert threshold (amber)
Alarm threshold (red)

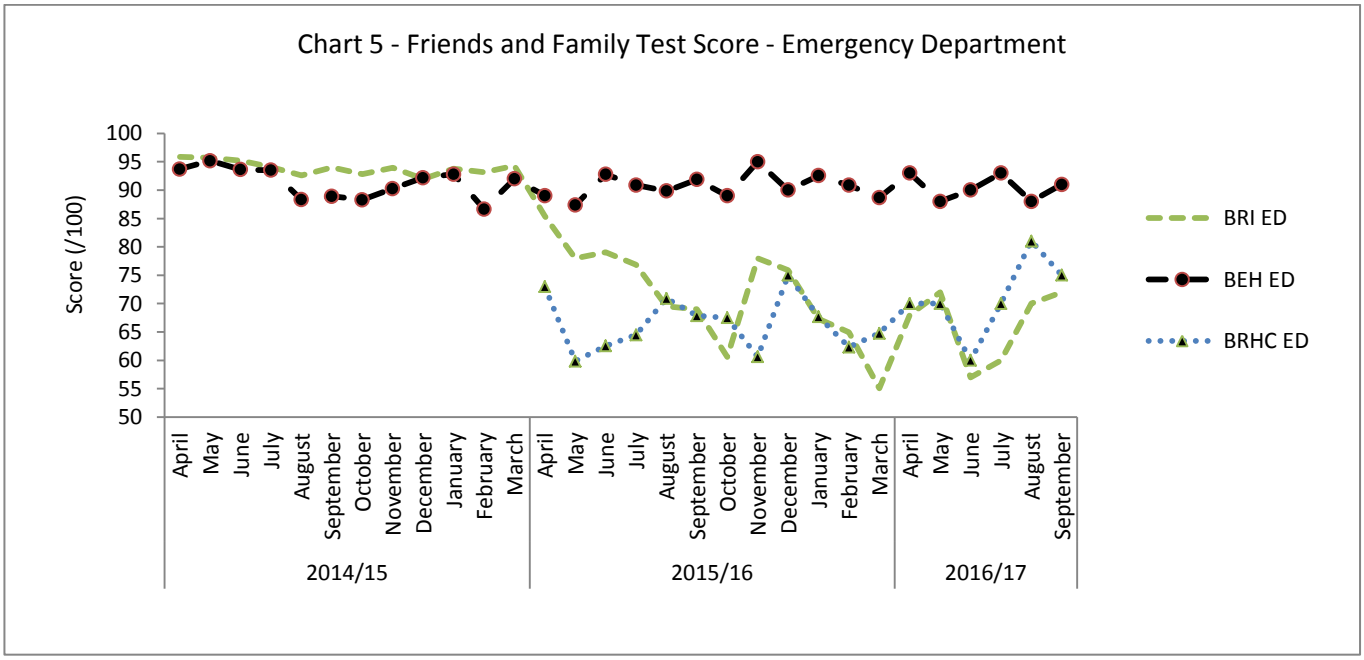


Chart 5 - Friends and Family Test Score - Emergency Department
Score (/100)
100
95
90
85
80
75
70
65
60
55
50
April
May
June
July
August
September
October
November
December
January
February
March
April
May
June
July
August
September
October
November
December
January
February
March
April
May
June
July
August
September
2014/15
2015/16
2016/17
BRI ED
BEH ED
BRHC ED

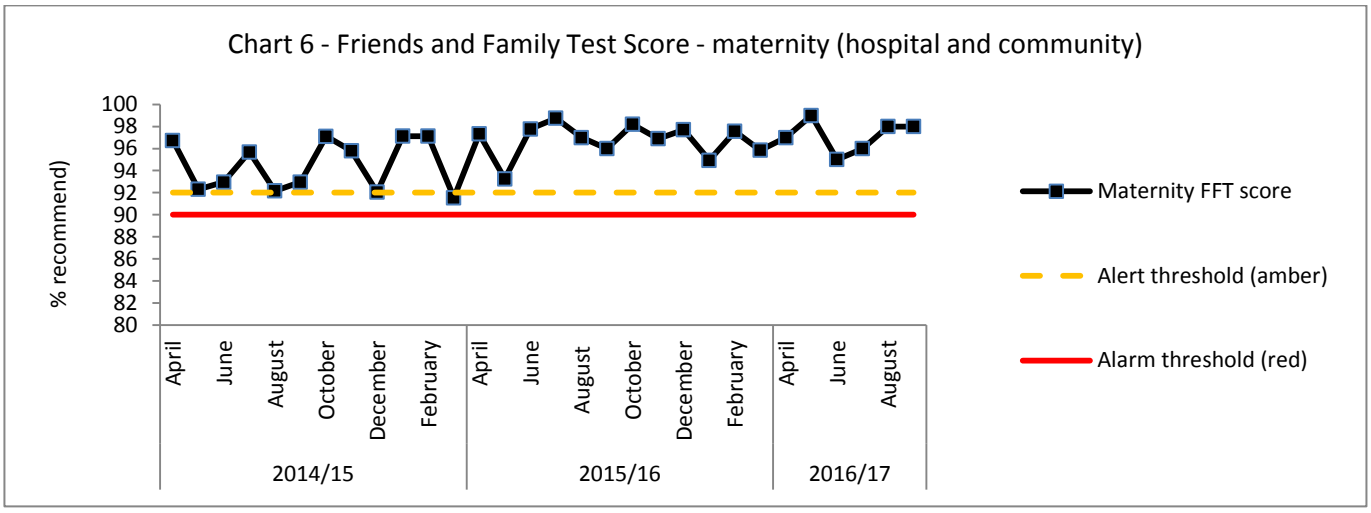


Chart 6 - Friends and Family Test Score - maternity (hospital and community)
% recommend)
100
98
96
94
92
90
88
86
84
82
80
April
June
August
October
December
February
April
June
August
October
December
February
April
June
August
2014/15
2015/16
2016/17
Maternity FFT score
Alert threshold (amber)
Alarm threshold (red)

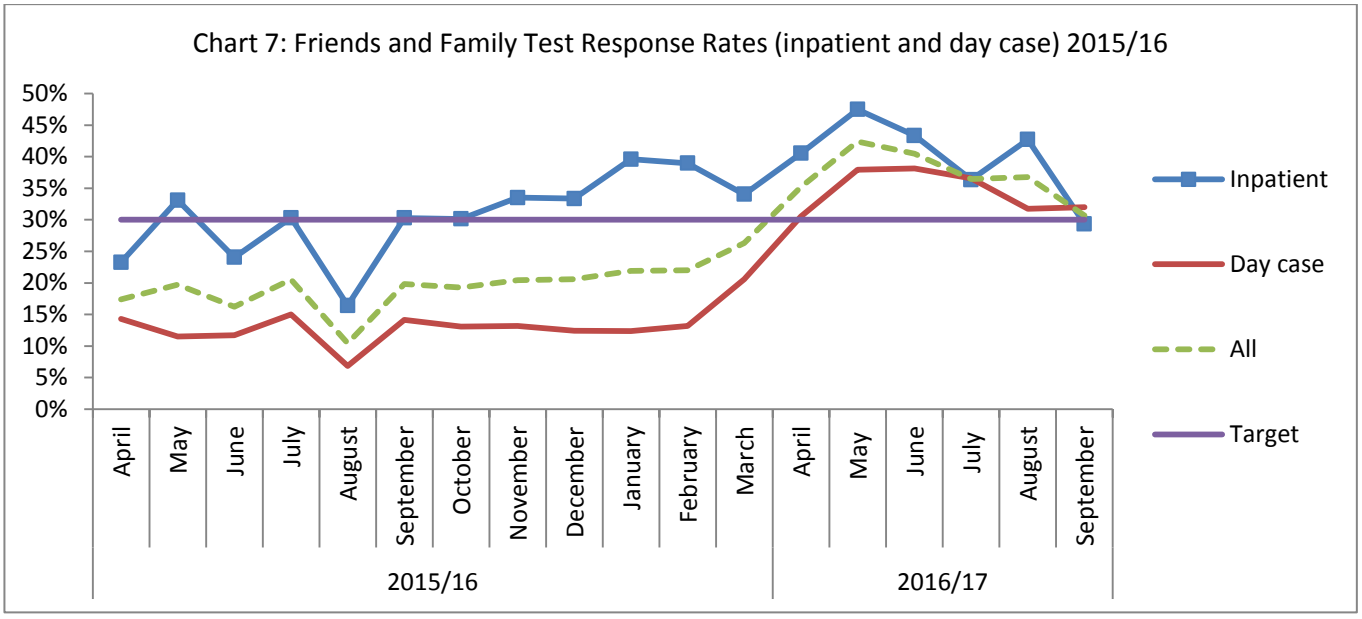


Chart 7: Friends and Family Test Response Rates (inpatient and day case) 2015/16
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
April
May
June
July
August
September
October
November
December
January
February
March
April
May
June
July
August
September
2015/16
2016/17
Inpatient
Day case
All
Target

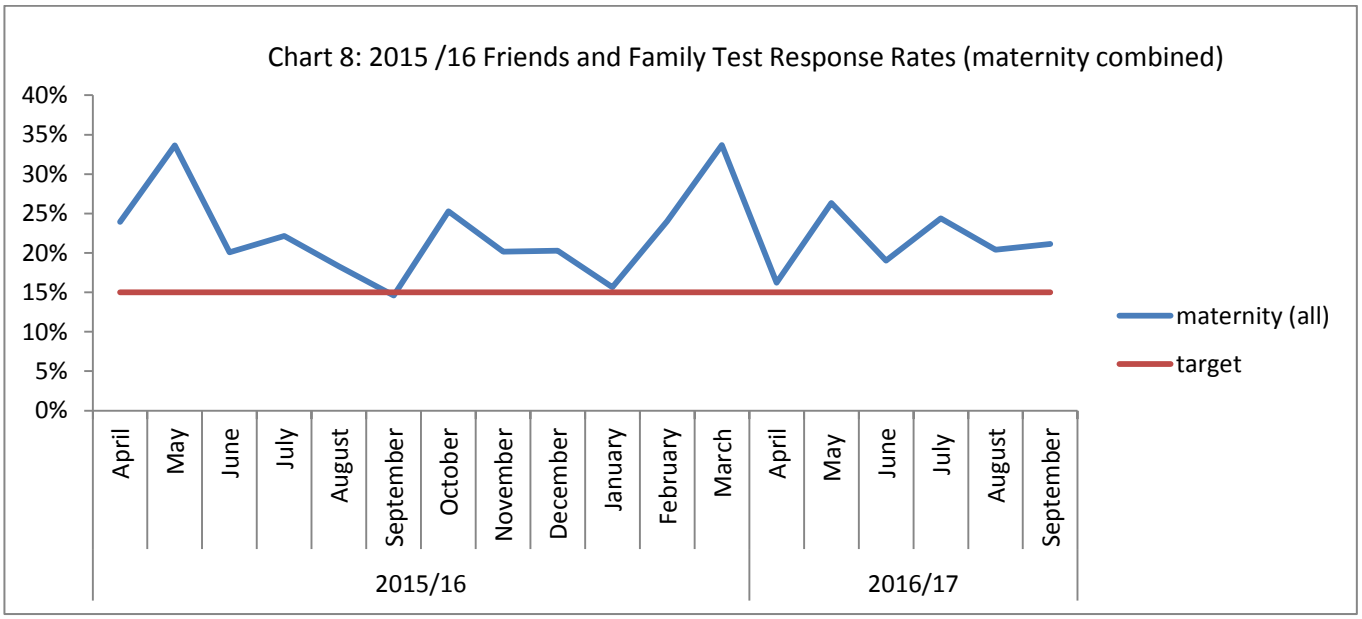
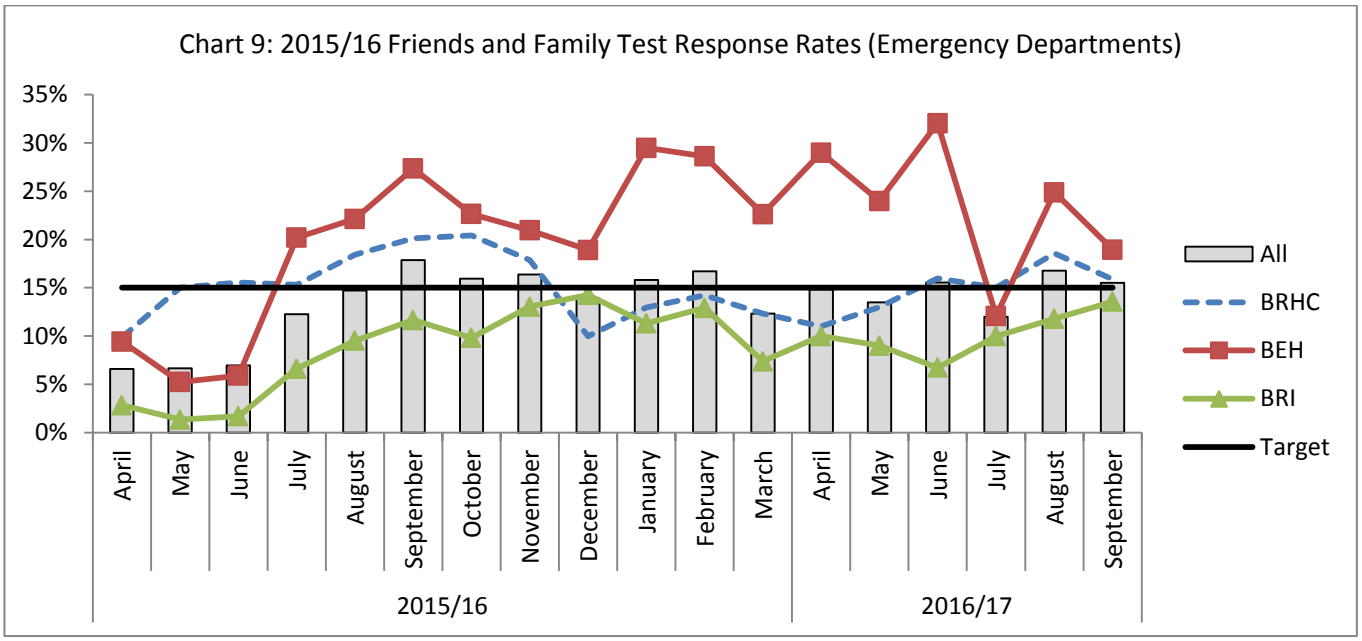


Chart 8: 2015 /16 Friends and Family Test Response Rates (maternity combined)
40%
35%
30%
25%
20%
15%
10%
5%
0%
April
May
June
July
August
September
October
November
December
January
February
March
April
May
June
July
August
September
2015/16
2016/17
maternity (all)
target



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

3.2 Divisional, hospital and ward-level patient-reported experience

Charts 10-20 provide a view of patient-reported experience at UH Bristol, from a Division to ward-level. Please note that the margin of error gets larger as the data is broken down, so it becomes important to look for consistent trends across more than one of the scores (particularly at ward-level). The full Divisional-level inpatient and outpatient survey question data is provided in Tables 1 and 2 (pages 14-17).

All of UH Bristol's Divisions and hospitals scored above the target thresholds for the headline patient survey measures in Quarter 2 (charts 10-17) – the first time that this has been the case in the Quarterly Report. Nevertheless, in looking at the full set of survey questions (Tables 1 and 2) and ward-level data (charts 18-20), some negative outliers are present:

Ward 37

Ward 37 is a renal ward at the Bristol Royal Hospital for Children and had the lowest Friends and Family Test score and second lowest "kindness and understanding" score in Quarter 2 (Charts 18 and 20). A detailed analysis of the results has been carried out by the Patient Experience and Involvement Team. In terms of the Friends and Family Test ratings, of the thirteen people who rated Ward 37 in Quarter 2, eleven said they would be extremely likely or likely to recommend the care and two said they "didn't know". Unfortunately, "don't know" responses are counted as negatives in the Friends and Family Test scoring system, which served to skew the result in this case. (It should be noted however that underlying this issue was a low response rate - 8.5% in Quarter 2 - and so the Head of Nursing has raised this with the Matron.) The "kindness and understanding" score is derived from the Trust's postal survey programme, but was again skewed by small sample sizes: one respondent stating that they were not treated with kindness and understanding during Quarter 2. This person's experience is not typical of Ward 37's feedback but provides an important learning point for the ward, with the comments from this respondent citing issues around privacy, staff responsiveness, and pain control during their child's care. These comments have been shared with the ward and the survey scores will continue to be closely monitored during Quarter 3 (no issues have been detected to date).

Ward A400

Ward A400 (Older people's assessment unit, Division of Medicine) had the lowest "kindness and understanding" score in Quarter 2. However, this was an artefact of low sample sizes for that ward, with only five respondents over the quarter: one of whom gave a negative rating to this question. This shouldn't be considered "acceptable", but in terms of assuring that the ward generally provides a positive patient experience, it is important to note that this is the only negative rating the ward has received on this measure in 2016. No comments were left by the respondent to provide insight into why a negative rating was given on this question. In light of this result, the Division has reviewed other quality data for the ward and have not found cause for concern. The result will be discussed further at the next Care of the Elderly Sisters meeting and will continue to be monitored, but at present the working hypothesis should be that it is a "statistical blip" caused by small sample sizes.

Wards C808 (lowest inpatient tracker score)

The Care of the Elderly wards (C808 and A528) have been noted in previous Quarterly Reports as achieving relatively low scores on the inpatient tracker compared to other wards (although in Q2 ward A528 was not an outlier), particularly in respect of the "communication" elements of this aggregate measure. The Division of Medicine has not been able to correlate this with other quality data that they collect, and it is also broadly reflective of trends seen nationally. This suggests that the scores reflect the real challenges of communicating effectively with patients who have complex health and social care needs (including a high proportion of patients with a cognitive impairment) – rather than an issue with the quality of caring. Nevertheless, in recognition that patient experience can be improved, the care of the elderly wards have committed to carrying out "Patient Experience and Heart" staff workshops in collaboration with the Patient Experience and Involvement Team. It had been anticipated that this would commence during Quarter 3, but clinical pressures mean that this was not possible and it will instead take place during Quarter 4. In addition, understanding and learning from experiences in the Trust's care of the elderly services will be a major theme for the Patient Experience and Involvement Team during Quarter 1 2017/18.

Individual survey questions (Tables 1 and 2)

The Division of Medicine had a relatively low score on telling patients information about operations / procedures and who to contact if they were concerned after they left hospital (Table 1). Unfortunately it has not been possible to ascertain why the operations / procedures question generates these scores, because the Division does not usually carry out formal procedures or operations. A *Face2Face* interview team will visit the Division in Quarter 4 to further explore this issue with patients and visitors. Nevertheless, it is broadly reflective of the challenges around communication with patients (see above re: care of the elderly and South Bristol Community Hospital) which the Division is seeking to understand and improve (e.g. via the Patient Experience at Heart workshops). In respect of ensuring that people know who to contact with concerns after they leave hospital, a new discharge checklist is currently being trialled and will be reviewed to ensure that it contains clear information in this respect.

A cluster of low survey scores are present in the outpatient survey data (Table 2), relating to ensuring patients are kept informed about delays in clinic, either via a member of staff or an information board (ideally both). The Bristol Royal Hospital for Children has tended to receive particularly low scores in this respect (these have been shared with the Hospital and also the Trust's Outpatient Steering Group) - although none of the Divisions perform well. The Trust recognises these issues and ensuring that patients are kept informed of delays is currently a corporate quality objective, which means that it is a key focus of improvement for the Trust during 2016/17 (a separate report about progress against these objectives is provided to the Trust Board each quarter). For

example, recently new, standardised, clinic information boards have been purchased for a number of outpatient department. Alongside this, a Standard Operating Procedure associated with keeping the information on the boards up to date has been reviewed and re-circulated to clinics. It should be noted that whilst the Diagnostics and Therapies Division doesn't generally have information boards in place (hence their particularly low survey score on this question), relatively few of their patients report delays in clinic.

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

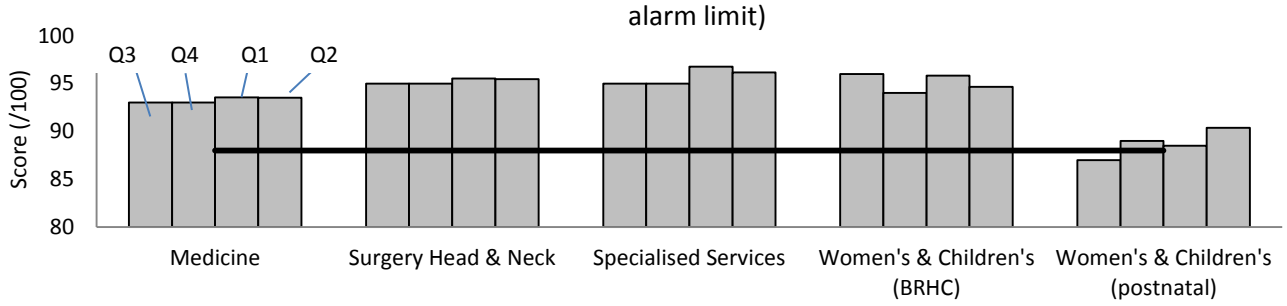


Chart 11 - Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)

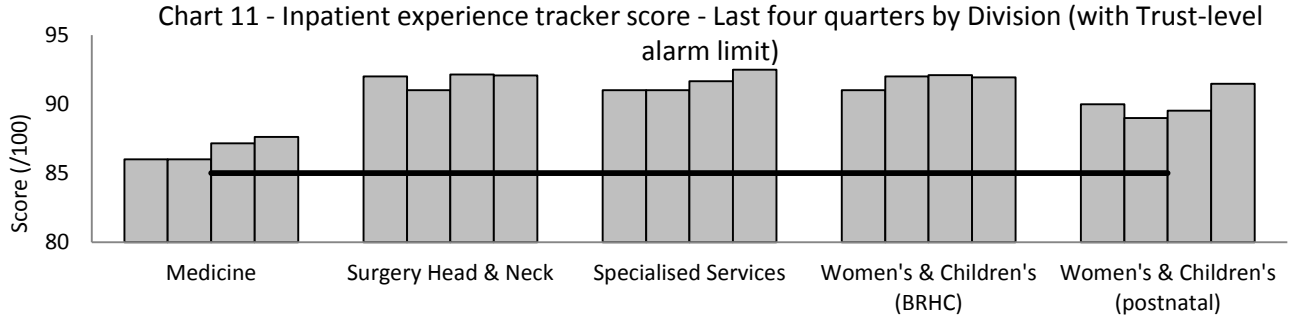


Chart 12 - Inpatient Friends and Day Case Family Test score - last four quarters by Division (with Trust-level alarm limit)

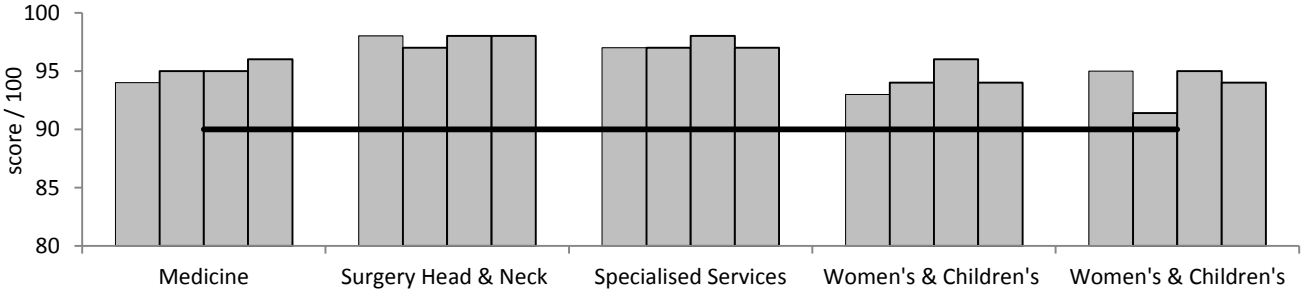


Chart 13 - Outpatient experience tracker score by Division - with Trust-level alarm limit

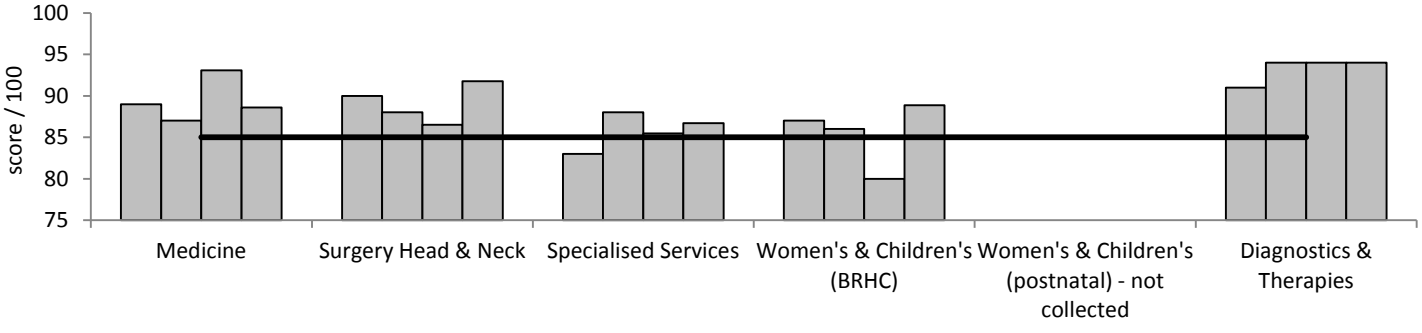


Chart 14: Kindness and understanding score by hospital (last four quarters; with Trust-level alert limit)

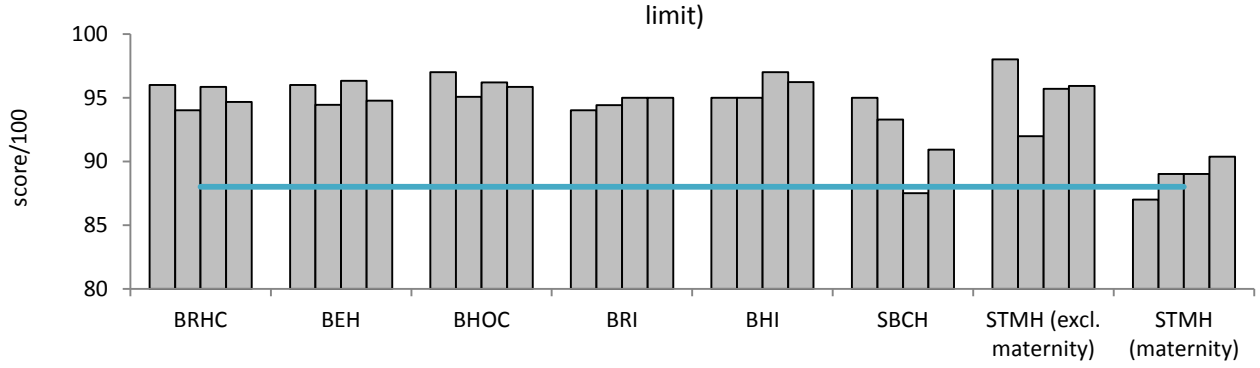


Chart 15: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)

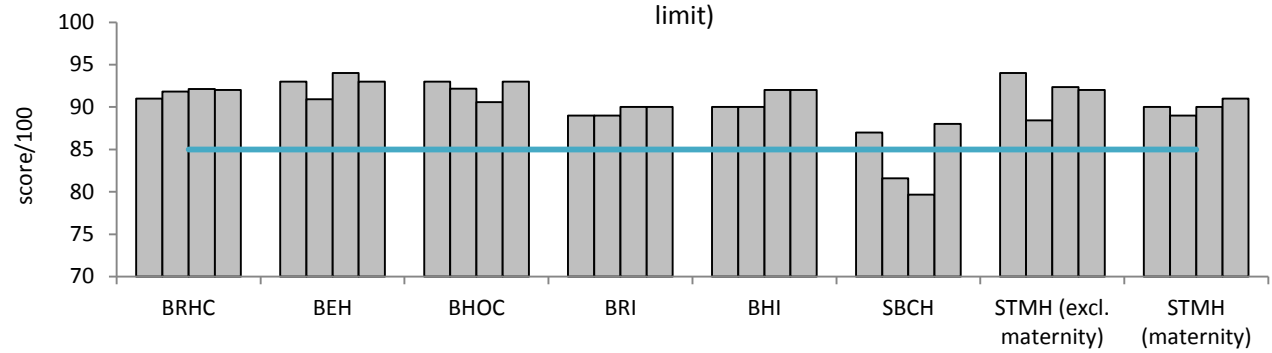


Chart 16: Inpatient and day case Friends and Family Test (last four quarters; with Trust-level alarm limit)

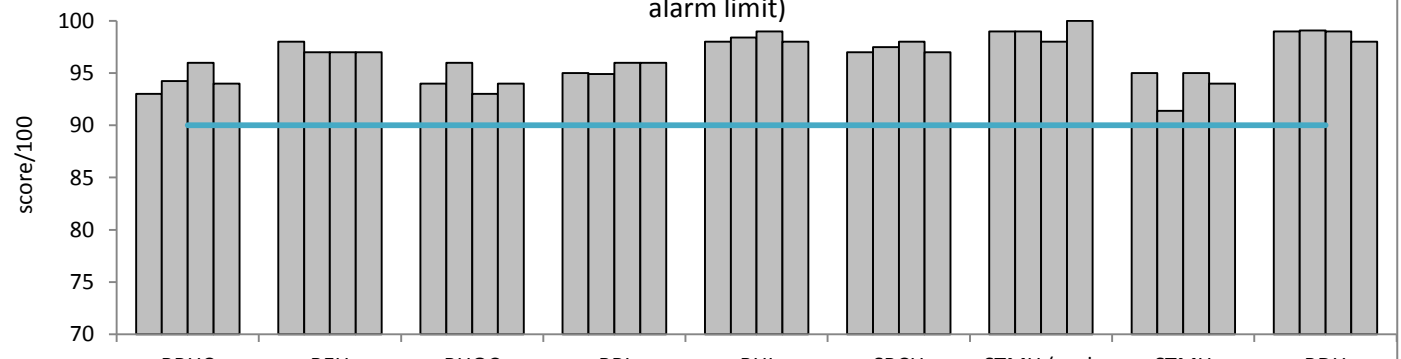
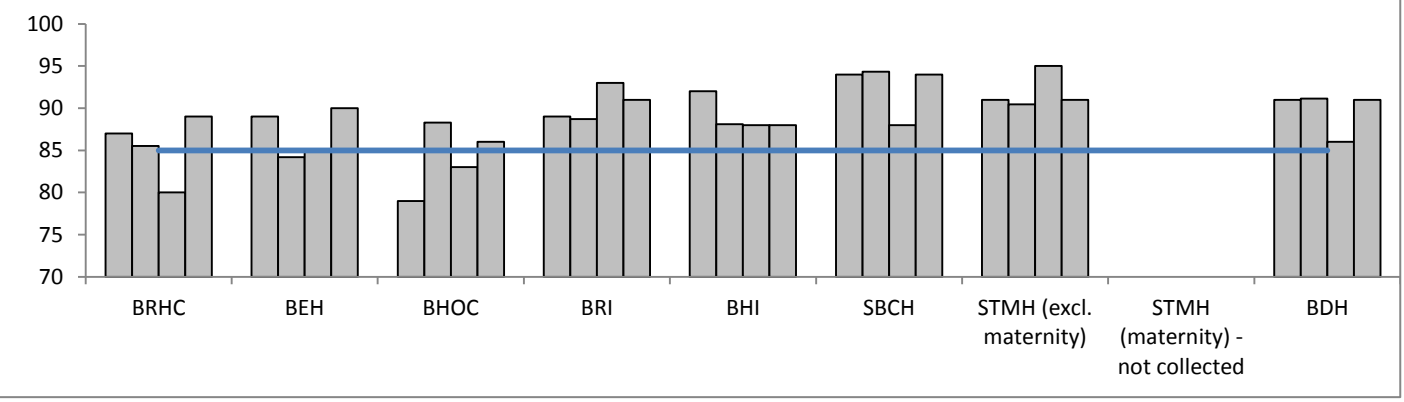
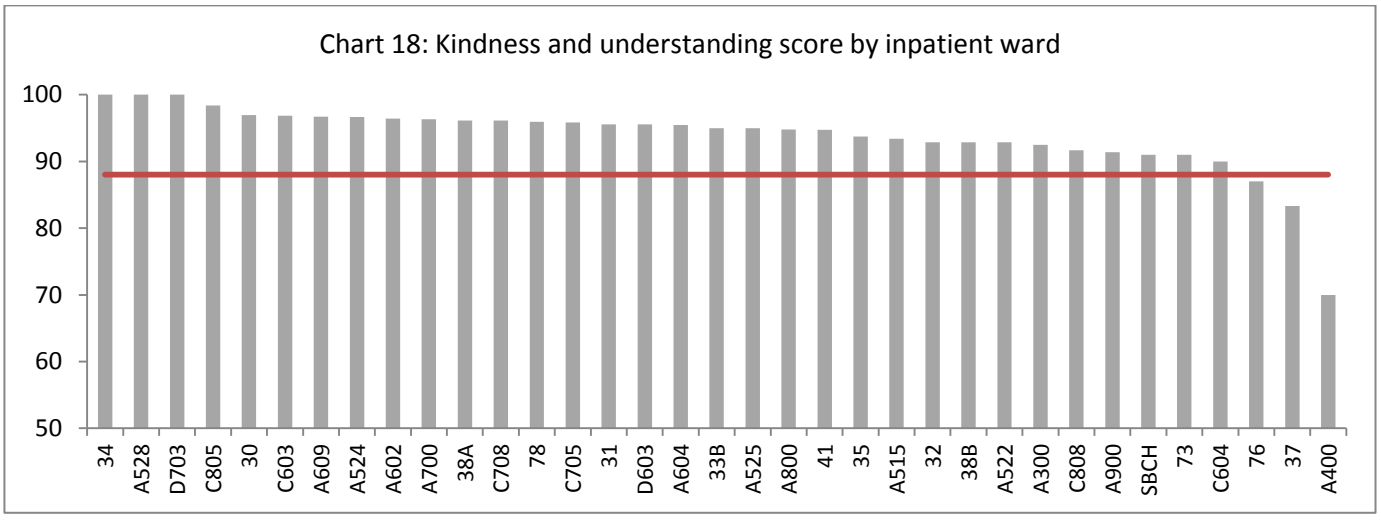
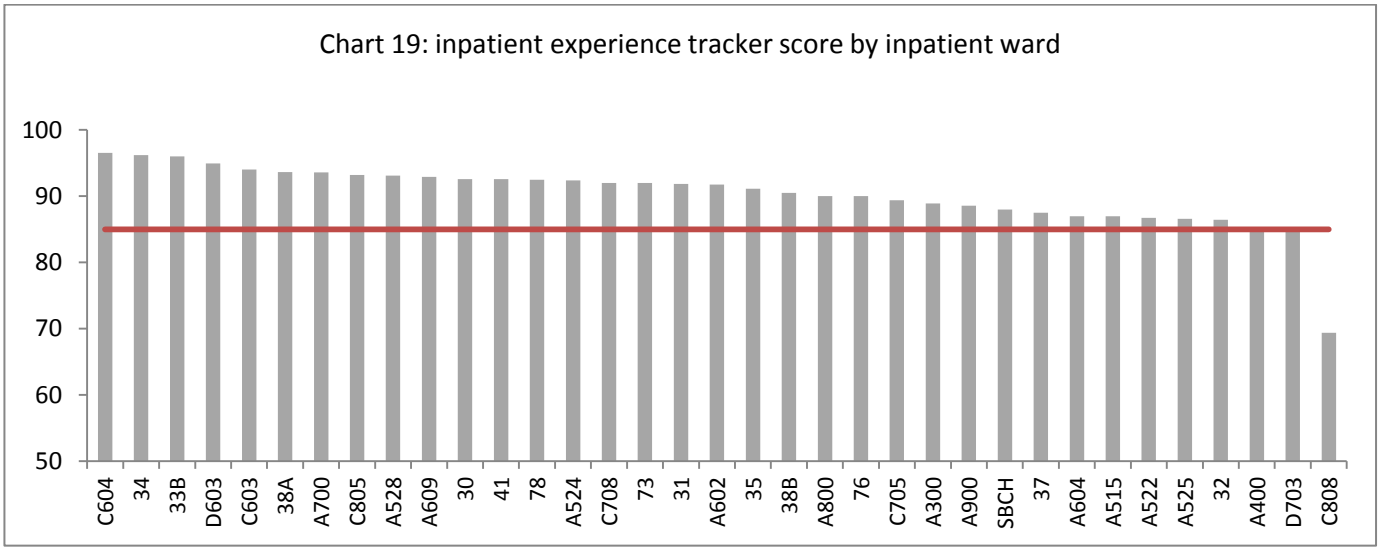
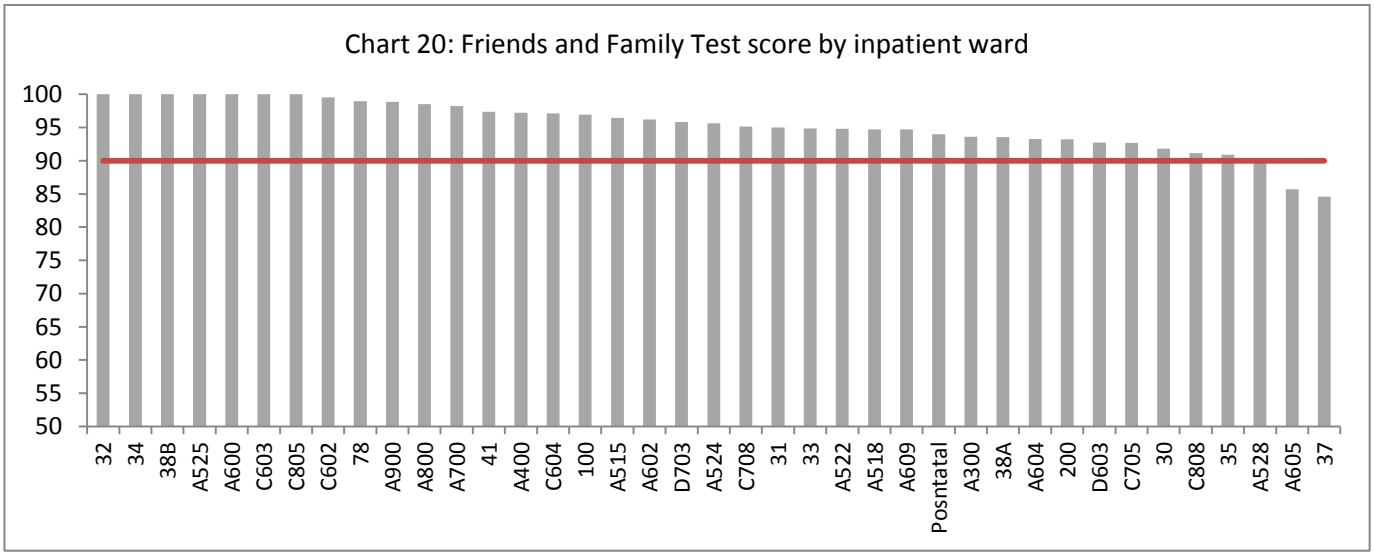


Chart 17: Outpatient experience tracker score by hospital (with Trust-level alarm limit)









(Please note that aggregated scores are provided for South Bristol Community Hospital postal survey in Chart 18 and 19, and for postnatal wards in Chart 20, due to very small sample sizes at individual ward-level)

Table 1: Full Quarter 2 Divisional scores from UH Bristol's monthly **inpatient** postal survey (cells are highlighted if they are 10 points or more below the Trust score). Scores are out of 100 unless otherwise stated – see appendices for scoring mechanism. Note: not all inpatient questions are included in the maternity survey.

	Medicine	Surgery, Head & Neck	Specialised Services	Women's & Children's	Maternity	Trust (excl. Maternity)
Were you given enough privacy when discussing your condition or treatment?	91	95	94	93		93
How would you rate the hospital food?	63	65	63	63	56	64
Did you get enough help from staff to eat your meals?	78	89	86	81		85
In your opinion, how clean was the hospital room or ward that you were in?	95	96	96	93	92	95
How clean were the toilets and bathrooms that you used on the ward?	90	93	92	92	82	92
Were you ever bothered by noise at night from hospital staff?	81	87	79	86		84
Do you feel you were treated with respect and dignity by the staff on the ward?	94	97	97	97	93	96
Were you treated with kindness and understanding on the ward?	94	95	96	95	90	95
Overall, how would you rate the care you received on the ward?	85	91	91	91	84	90
When you had important questions to ask a doctor, did you get answers that you could understand?	82	90	91	89	92	89
When you had important questions to ask a nurse, did you get answers that you could understand?	86	91	91	91	91	90
If your family, or somebody close to you wanted to talk to a doctor, did they have enough opportunity to do so?	76	77	78	78	80	77
If your family, or somebody close to you wanted to talk to a nurse, did they have enough opportunity to do so?	86	89	89	91	88	89
Were you involved as much as you wanted to be in decisions about your care and treatment?	81	87	87	90	90	87
Do you feel that the medical staff had all of the information that they needed in order to care for you?	84	90	91	90		89
Did you find someone on the hospital staff to talk to about your worries or fears?	68	80	77	81	86	77
Did a member of staff explain why you needed these test(s) in a way you could understand?	85	87	87	93		88

	Medicine	Surgery, Head & Neck	Specialised Services	Women's & Children's	Maternity	Trust (excl. Maternity)
Did hospital staff keep you informed about what would happen next in your care during your stay?	78	86	87	88		85
Were you told when this would happen?	79	82	82	81		81
Before your operation or procedure, did a member of staff explain the risks/benefits in a way you could understand?	79	93	92	96		92
Before your operation or procedure, did a member of staff explain how you could expect to feel afterwards?	74	79	78	84		79
Were staff respectful of any decisions you made about your care and treatment?	89	95	95	95		94
During your hospital stay, were you ever asked to give your views on the quality of your care?	27	28	27	32	34	29
Do you feel you were kept well informed about your expected date of discharge from hospital?	77	88	82	84		84
On the day you left hospital, was your discharge delayed for any reason?	57	64	53	70	62	61
Did a member of staff tell you about medication side effects to watch for when you went home?	54	68	60	65		63
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	73	82	85	89		83
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	84	92	93	92	90	91
Number of survey responses	210	425	351	283	220	1489

Table 2: Full six-monthly Divisional-level scores from UH Bristol's monthly **outpatient** postal survey (cells are highlighted if they are 10 points or more below the Trust score). Scores are out of 100 unless otherwise stated – please see appendices for scoring mechanism.

(Quarter 1 and 2: April-September 2016. Data combined to increase same sizes / reliability)	Diagnostic & Therapy	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's (excl. maternity)	Trust
When you first booked the appointment, were you given a choice of appointment date and time?	86	72	73	65	56	72
Was the appointment cancelled and re-arranged by the hospital?	95	95	97	95	95	95
When you arrived at the outpatient department, how would you rate the courtesy of the receptionist?	84	85	87	86	77	85
If you contacted the hospital, how easy was it to get through to a member of staff who could help you?	73	63	69	58	59	64
Were you and your child able to find a place to sit in the waiting area?	99	99	98	98	100	99
In your opinion, how clean was the outpatient department?	91	93	94	93	88	92
How long after the stated appointment time did the appointment start? (% on time or within 15 minutes)	88%	69%	62%	71%	66%	71%
Were you told how long you would have to wait?	33	38	31	43	18	33
Were you told why you had to wait?	65	57	52	59	56	56
Did you see a display board in the clinic with waiting time information on it?	32	61	52	48	49	49
In your opinion, did he / she have all of the information needed to care for you (e.g. medical records, test results, etc)?	86	92	91	95	87	91
Did he / she listen to what you had to say?	97	96	96	94	95	96
If you had important questions to ask him / her, did you get answers that you could understand?	91	94	92	91	91	92
Did you have enough time to discuss your health or medical problem with him / her?	92	93	93	90	94	92
Were you treated with respect and dignity during the outpatient appointment?	100	99	99	98	97	99

	Diagnostic & Therapy	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's (excl. maternity)	Trust
If you had any treatment, did a member of staff explain any risks and/or benefits in a way you could understand?	88	91	88	85	82	87
If you had any tests, did a member of staff explain the results in a way you could understand?	78	86	75	80	74	79
Did a member of staff tell you about medication side effects to watch for when you went home?	60	72	58	71	57	65
Overall, how would you rate the care you received during the outpatient appointment? (% excellent, very good, or good)	99%	99%	98%	98%	97%	98%
Number of survey responses	156	176	244	185	90	851

4 Specific issues raised via the Friends and Family Test in Quarter 2

The feedback received via the Trust's Friends and Family Test is generally very positive. Table 3 provides an overview of activity that has arisen from the relatively small number of negative ratings, where this rating is accompanied by a specific, actionable, comment from the respondent.

Table 3: Divisional response to specific issues raised via the Friends and Family Test in Quarter 2, where patients / parents stated that they would not recommend the care provided by UH Bristol

Division	Ward	Issue raised	Response from Division
Division of Medicine	A604	A patient lost her dentures during her stay.	Unfortunately the dentures have not been found, but a member of staff was able to contact the patient's family to advise them of the reimbursement process.
	Bristol Royal Infirmary Emergency Department	Three comments related to responsiveness to patient needs: • One patient pulled the emergency cord in the bathroom and was not attended to • A patient left in pain for four hours with head blocks and no way of alerting staff to the pain • One person commented that they had to ask several times for their son to receive oxygen for severe pain, and was then asked by a doctor why they hadn't gone to another hospital ED nearer to their home	We are sorry that the patients did not receive more responsive care from us - these poor experiences fall well below the standards we expect our staff to deliver. Staff will be reminded of their responsibilities to keep patients informed, check on them regularly (including carrying out pain scores where necessary) and to ensure that patients have access to call bells. We will review the call bell system in the department to ensure that it meets patient and staff needs.
Division of Specialised Services	Chemotherapy day unit	Waiting times and temperature of the ward (too hot)	Work has been undertaken with the Trust Transformation team to review and improve the processes in delivering chemotherapy within the specified time frames. The general manager is currently reviewing the recommendations from the review to enable some changes within the process. Air conditioning units have been fitted within the outpatient department to resolve this issue.

Division	Ward	Issue raised	Response from Division
Women's & Children's Division	Maternity Services - Amelia Nutt community midwifery	Found myself waiting in all day for appointments and one day the health visitor didn't show up. Sometimes they would speak to my partner like I wasn't in the room asking about my moods.	Unfortunately the Community midwives are unable to give specific times for post-natal visits because it is difficult to predict how long each visit will take. The community midwifery service has introduced postnatal clinics where women can have an appointment time. The feedback has been shared with Amelia Nutt Team to reflect on how they approach discussions around post-natal depression, particularly if partners are involved in the discussion.
	Bristol Royal Hospital for Children Emergency Department	A bed that the patient was on had blood from a previous patient on it	This has been fed back to the care team and cleaners in the Emergency Department as a point of learning.
Division of Surgery, Head and Neck	Ward 41 (Bristol Eye Hospital)	Window on the ward not closing properly, with resulting traffic noise making it hard to sleep	This issue was reported to the Estates Department and the window has now been fixed.
	Queen's Day Unit	A patient said that the receptionist was rude to them	This feedback has been shared with the teams to ensure that they provide a consistently good reception service. Although patients are generally positive about our receptionists, we are going to implement checks around the quality of service being provided: this will be built in to our internal inspection processes in 2017
	Bristol Eye Hospital Emergency Department	Two comments about a receptionist who was unfriendly and "sharp" with patients	
	Bristol Eye Hospital Emergency Department	Urine on the floor of the toilet had not been cleaned	We are sorry that this patient experienced a lack of cleanliness on this occasion. The department receives very positive results in its cleanliness audits and we will continue to monitor these scores
	A700	A patient said that they had not received food or treatment for three days on the ward	The ward has reviewed and updated its Standard Operating Procedure (SOP) for "nil by mouth" patients. There are a number of new staff on the ward and the importance of this SOP has been raised with them.

5 Update on key issues identified in the previous Quarterly report

The previous (Quarter 1) Quarterly Patient Experience report identified a number of survey scores that required further attention. Table 4 provides a summary and update on these issues.

Table 4: update on key issues identified in the previous Quarterly Patient Experience report

Issue / area	*Main action(s) cited*	*Outcome*
Low survey scores on Ward 38b (paediatric neurology).	A member of the LIAISE Team to visit Ward 38b and talk to parents about their levels of satisfaction with their experience, and identify improvements where necessary.	There have been a number of ward moves involving paediatric neurology. This action has therefore been deferred until January 2017, at which time the ward will be settled into their new location.
Emergency Department Friends and Family Test response rates	SMS (text message) technology introduced to carry out the survey	This has been successfully introduced and response rates are now hitting the 15% target
Relatively low survey scores in South Bristol Community Hospital and care of the elderly wards	Healthwatch South Bristol Community Hospital enter and view	An enter and view was carried out in October. The report is being reviewed and a response will be provided to Healthwatch in January 2017.
Ensure that each ward has a "Tell us about your care poster", signposting people to the main feedback and complaints opportunities	Install a framed A1 size poster on each ward.	Complete.
Ward A518 – low Friends and Family Test and headline postal survey scores	Likely explanation identified as a statistical blip – further monitoring of scores	The scores were back within the expected range in Quarter 2 for the Friends and Family Test. Low numbers for the postal survey for this ward in Quarter 2 meant that this data could not be evaluated.
Waiting times in outpatient clinics – particularly in the Bristol Haematology and Oncology Centre and Bristol Royal Hospital for Children	Reducing waiting times is a Trust corporate quality objective	The outpatient experience tracker scores were above (i.e. better than) the target in Quarter 2 for all sites, but it is likely that waiting times will continue to fluctuate in the future due to increasing demands on services
Ensuring that outpatient clinics have a functioning comments card collection and review process	• Re-issuing guidance on this process to clinics • Review of core materials (cards / comments boxes) and where necessary providing these to clinics • An audit to check that the process is now functioning in all clinics	Complete. A further audit will be carried out in early 2017/18.

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. The themes from these comments are provided in Table 5 (inpatients) and Table 6 (outpatients). (Please note that "sentiment" is a term that identifies whether a comment theme is positive (i.e. praise) or negative (improvement needed)). The themes are broad, but it can be seen that they are reasonably 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 2 complaints report). Please note that the coding of the outpatient survey comments is a relatively recent development, and therefore we do not currently have a Divisional breakdown of these themes. However, these should be available for the next Quarterly Patient Experience and Involvement report.

Table 5: inpatient survey comments by theme (Quarter 2 2016/17)

	Theme	*Sentiment*	*Percentage of comments containing this theme*
Trust (excluding maternity[2])	Staff	Positive	62%
	Communication / information	Negative	13%
	Food / catering	Negative	12%
	Staff	Negative	10%
	Waiting / delays	Negative	7%
Division of Medicine	Staff	Positive	63%
	Food / catering	Negative	16%
	Staff	Negative	15%
Division of Specialised Services	Staff	Positive	67%
	Food / catering	Negative	13%
	Communication / information	Negative	11%
Division of Surgery, Head and Neck	Staff	Positive	75%
	Communication / information	Negative	13%
	Food / catering	Negative	8%
Women's and Children's Division (excluding Maternity)	Staff	Positive	74%
	Communication / information	Negative	15%
	Food / catering	Positive	14%
Maternity	Staff	Positive	62%
	Care during labour and birth	Positive	26%
	Staff	Negative	11%

Table 6: outpatient comments themes (Trust-wide, excluding maternity)

Positive		*Negative*	
Staff	56%	Communication / information	11%
Communication / information	9%	Waiting / delays	9%
Clinic environment	5%	Staff	5%
Waiting / delays (lack of)	4%	Car parking	5%
Follow up appointments	3%	General administration issues	4%

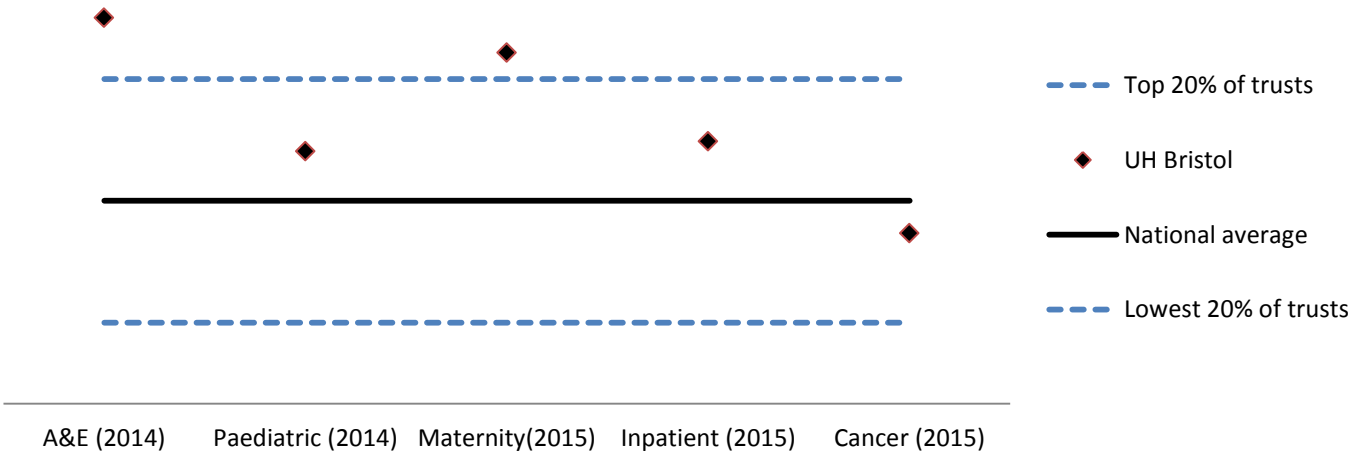
[2] The maternity inpatient comments have a slightly different coding scheme to the other areas, and maternity is not part of the outpatient survey due to the large number of highly sensitive outpatient clinics in that area of care.

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 provides a broad summary of the Trust's position[3]. The Trust Board receives a full report containing an analysis of each national survey and UH Bristol's response to these results (see Appendix A for a summary).

There have been no further national survey results since the last Quarterly Report was published and therefore Chart 21 is provided for information only.

Chart 21: Indication of UH Bristol patient-reported satisfaction relative to the national average



[3] It is difficult to directly compare the results of different surveys, and also to encapsulate performance in a single metric. Chart 21 is an attempt to do both of these things. It should be treated with caution and isn't an "official" classification, but it is broadly indicative of UH Bristol's performance relative to other trusts.

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)*
2015 National Inpatient Survey	61/63 scores were in line with the national average. One score was below (availability of hand gels) and one was (privacy when discussing the patients treatment or condition)	July 2016	Six-monthly	• Availability of hand gels • Awareness of the complaints / feedback processes • Asking patients about the quality of their care in hospital	July 2017
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
2015 National Cancer Survey	45/50 scores were in line with the national average; one score was above the national average (being assigned a nurse specialist); four were worse (related to holistic care)	September 2016	Six-monthly	• Support from partner health and social care organisations • Providing patients with a care plan • Coordination of care with the patient's GP	September 2017
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	August 2017
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	November 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.
	Involvement Network	UH Bristol has direct links with a range of patient and community groups across the city, who the Trust engages with in various activities / discussions
	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.

The methodology for the UH Bristol postal survey changed in April 2016 (inclusive), and so caution is needed in comparing data before and after this point in time. Up until April 2016, the questionnaire had one reminder letter for people who did not respond to the initial mail out. In April we changed the methodology so that the questionnaire had no reminder letters. A larger monthly sample of respondents is now taken to compensate for the lower response rate that the removal of the reminder letter caused (from around 45% to around 30%). This change allowed the data to be reported two weeks after the end of month of discharge, rather than six weeks. It appears to have had a limited effect on the reliability of the results, although at a Trust level they are perhaps marginally more positive following this change (these effects will be reviewed fully later in 2016/17, and the target thresholds adjusted if necessary). The survey remains a highly robust patient experience measure.

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.

Cover report to the Trust Board meeting to be held on Tuesday, 31st January 2017 at 11:00 am – 1:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	12
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Chairs Report Quality and Outcomes Committee		
Author	Alison Ryan, Non- Executive		
Executive Lead(s)	Carolyn Mills, Chief Nurse	Sean O'Kelly, Medical Director	
Freedom of Information Status		Open	

Reporting Committee	Quality and Outcomes Committee	
Chaired by	Alison Ryan, Non-Executive Director	
Lead Executive Director (s)	Carolyn Mills, Chief Nurse	Sean O'Kelly, Medical Director
Date of last meeting	22 December 2016	

Summary of key matters considered by the Committee and any related decisions made.

Matter Arising from October Minutes

Follow up to October report on progress in NICU following the visit of the RCPCH.

The Chair of QOC had met with the Clinical Chair of Women and Children's Division and received assurance on:

- The involvement of all parts of the team, now and in future, on the creation of an improvement programme
- Evidence that poor behaviours were now being actively challenged
- Appropriate and effective external facilitation of team learning was being used
- Where appropriate, parallel HR processes were being used to ensure improvement by individuals.

Serious Incident Report

6 Serious Incidents were reviewed. The key points raised included:

- Robustness of on call and cover arrangements in Maxiliofacial and other surgical specialties
- Importance of clear communication when reporting deterioration of patients
- Reviews needed for some pathways for dealing with some rare situations was identified Importance of checking that patients "normal" mobility aids were available to them on wards.

Quality Performance Report
Members received the performance report for assurance prior to consideration by the Trust Board.

Key points to note included:

- Achievement of the 92% national standard for the percentage of patients waiting under 18 weeks from Referral to Treatment (RTT), but warnings that pressures in the system threatened sustained achievement
- Achievement of the 99% national standard for the percentage of patients waiting under 6 weeks for a diagnostic test.
- Although performance against the 62-day referral to treatment GP cancer standard in October was below 85%, the national standard was achieved with adjustments applied for the reallocation of breaches following late referrals Zero missed doses of critical medication in the period;
- Performance against A&E 4-hour was below the in-month trajectory; pressure in BCH has been particularly high. Pressure in BRI was no higher than last year; members sought assurance that there were not "burnout" issues in the BRI A&E department.
- Continued satisfactory quality performance

Patient Safety Improvement Programme
There was satisfactory progress in all work streams except "Culture" and "Leadership" where pressure of time at a senior level had delayed actions.

Safety Culture Feedback
QOC considered its role, as a Board Committee, in furthering the development of a safety culture. It confirmed a commitment to promoting:

- Improvement – by challenging, by encouraging innovation and investment in technology
- Communication – by promoting candour and transparency
- Culture and Leadership – by prioritising the investment of time and visibility, and leading curiosity rather than blame when looking at perturbations in the system

Quarterly Complaints and Patients' Experience Reports
Most indicators moved in a positive direction although the numbers of people dissatisfied with responses to complaints is still resistant to improvement.

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Nursing and Midwifery staffing report
Members received the monthly staffing for assurance. This now included theatres staffing and emergency department data.

Other items discussed by the Committee included:

- National Quarterly Report on Never Events
- Clinical Quality Group

Key risks and issues/matters of concern and any mitigating actions

Continued focus on flow issues in the hospitals

Matters requiring Committee level consideration and/or approval

The Committee received and recommended approval of the Safety Culture Programme to the Trust Board.	
Matters referred to other Committees	
None	
Date of next meeting	27 January 2017

Cover report to the Trust Board meeting to be held on 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	13
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Transforming Care Programme Board		
Author	Paula Clarke, Director of Strategy and Transformation		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☒
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☐

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

Executive Summary

Purpose

The purpose of this report is to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme.

Key issues to note

The report sets out the highlights of progress over the last quarter and the next steps

Recommendations
Members are asked to: • Receive the report for assurance.

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

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☒	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☒
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

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

Impact Upon Corporate Risk
N/A

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

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

Transforming Care

Transforming Care Update to Trust Board

January 2017

The purpose of this report is to update the Trust Board on progress over the last quarter with the Trust wide programmes of work within the Transforming Care programme.

1. In our Operating Model programme we have continued to develop and embed our standard Ward Processes approach across inpatient areas. A key measure of success for this work is timely discharges. In the last quarter of 2016 the number of timely discharges has been consistently above 900 per month, short of our target of 1,100 but significantly ahead of the same period in 2015. The progress is led in Medicine where in each month of the last quarter over 30% of patients are discharged before 12 noon, again well ahead of the figures for 2015. Many wards in the other Divisions show similar progress but in some areas further support to embed the processes is planned.

2. The Integrated Discharge Service continues to be developed to better support patients on the Green to Go list. The leadership arrangements for the service have been changed so all of the discharge teams now come under a single leader and we have introduced new routine progress meetings to assess actions in place for patients on the Green to Go list, supported by our community partners. However this remains an area of focus and further development is planned.

3. The progress made in our Operating Model work was underlined by the “Reset Events which were held before and after the Christmas holiday period. The purpose of the events was to improve quality and safety by improving discharges and removing where possible any barriers to patient flow. During the weeks of 14th-20th December and 4th-10th January additional reviews of inpatients were held to identify and progress potential discharges, additional support was provided to escalate barriers and a daily executive led wash up meeting was put in place (with support from partner organisations) to support actions arising and to ensure learning was shared. The pre-Christmas event particularly was successful in promoting increased levels of discharges and use of the discharge lounge to help improve patient flow. The events also demonstrated how our ward processes work, including the use of reverse triage and Estimated Dates of Discharge (EDDs) was very well embedded across many areas. During the post-Christmas week we specifically investigated patients with a length of stay over seven days to ensure any unnecessary delays in progressing their care were raised. The work identified very few issues.

The findings of these events have been reviewed and are shaping the Operating Model priorities for the next quarter, including: further work to promote use of the Discharge Lounge and changes to ways of working to “pull” patients from inpatient wards; further Ward Processes work in specific areas to further embed good practices; and new guidance on the use of EDDs and tools to monitor the use and maintenance of EDDs.

4. During December we went live with two initiatives to provide real-time patient flow information to our teams. The pathway status trackers are now live in Surgery, Head & Neck areas across the BRI, indicating the status of each area of the surgical pathway. And the revised pilot electronic whiteboard went live in the Surgical and Trauma Assessment Unit (STAU). The eWhiteboard replaces the traditional dry-wipe whiteboards and is key to driving the visibility and accuracy of the patient flow data held in our information systems so that we can make flow management more timely and less based on paper updates and phone calls to wards. Feedback on the eWhiteboard from staff has been very positive to date and roll out plans are being developed.

5. Our Outpatients Transformation team has been finalising the updated operational standards and procedures for managing clinic booking and delivery. With strong involvement from operational teams and managers these will be published via our intranet from the end of January to support staff with the key standards for their job role which support patient experience and efficient clinic operation Alongside this we are developing new processes and IT tools to support the triage of referrals which will remove the paper from this process and reduce the time taken from referral to first appointment. And we have developed with operational managers further tools to give visibility of clinic utilisation performance and identify opportunities to improve clinic productivity.

6. The Theatre Transformation programme supported the implementation of the Bluespier theatre management system across our operating theatres. This system, which went live at the beginning of November, provides real time information about the status of operating theatres and again takes paper out of our processes. An electronic whiteboard for emergency and trauma patients has been introduced to improve communications around planning for our non-elective patients. The implementation went ahead without disruption and we are now planning a further phase of work to exploit the new functionality which Bluespier provides.

7. The Children’s Flow programme has mobilised further work to improve flow through the Children’s Hospital. This partly builds on previous work, further developing the flow management and reporting, and reinvigorating the use of the iPod Touch devices which support real time communication between clinical teams. We are renewing the procedures for hospital outliers enabling better planning and governance for children being transferred in from other hospitals. We are undertaking a detailed study of the flow through the Clinical Investigations Unit to

allow more day care to take place in this facility rather than in inpatient areas and reduce waiting for patients requiring ambulatory procedures. And the new procedures developed by last year's surgical flow programme are being made available via our intranet to improve the consistency of our communications with patients and support staff training.

8. Our Admin Teams Transformation programme has focussed on building the capability in teams which provide vital admin support to the clinical pathways. In 2015 we completed a series of workshops with job holder of core clinical admin roles across our hospitals, which led to the agreement of ten common job descriptions and competencies across these roles. These have supported the development of a central values based assessment centre process for recruitment to these admin roles. This removes from operational managers much of the time consuming admin in recruiting to these roles (which is a significant draw on their time) and allows us to screen candidates using a consistent set of competency tests, creating a pool of candidates from managers to recruit from. We expect to grow the number and quality recruits in this way and provide a pool of screened staff to support our admin bank. It will also drive improved staff experience and help to reduce turnover amongst this staff group.

9. In November we held a second Patient Letters Champions week to assess the impact of our new standardised design for patient appointment letters. Interviews carried out with patients in the Cardiology Outpatients area showed that the new letters were much easier for patients to understand, and that it was easier for patients to find the information they needed about their appointment. The new format will now be introduced in Surgery Head & Neck outpatient letters. This expansion has been delayed while the accompanying leaflets were redesigned but will proceed shortly. Letters sent from the Children's Hospital will be next to adopt this format. This work is a core part of addressing patient complaints related to communications.

10. The final preparations for sending Medway generated appointment letters by email are taking place. We will shortly start training staff to validate patient email addresses in line with the agreed information governance protocols for the new process to start in February.

11. Our work on staff engagement has been supported by the further roll out of the Happy App. This has now expanded to cover over 85 areas of the Trust and in December staff using the tool were leaving over 400 entries per week. The Happy App also received national recognition, being announced as the winner of the Staff Engagement category of the 2016 Health Service Journal awards at a ceremony in London in November. The Happy App has attracted interest from a number of other Trusts who are interested in adopting it.

12. Improving staff experience has also been the focus of a series of workshops to explore leadership behaviours. Over 120 line managers have been taking part in a

series of events to identify positive and negative leadership behaviours, and how we can promote more of the behaviours which improve staff engagement. The outcomes of these events will be used to renew the expectations of leaders across our organisation and to ensure our leadership training and development is focussed on promoting the behaviours which reinforce a positive staff experience.

13. A cross functional team of leaders responsible for a range of improvement programmes and functions has been meeting to redesign our approach to supporting innovation and improvement across the Trust. As a result we have agreed a set of methods, roles and responsibilities for promoting and supporting improvement ideas from our staff. We are now developing the detailed plans and communications to support the launch of this. Closely linked will be the launch of a Quality Improvement Academy which will provide structured training in improvement tools for staff who wish to develop skills in quality improvement methods. We have visited other Trusts to learn from what has worked for others and are now in the detailed design of the courses which we hope to launch in the first quarter of 2017.

14. We have started the process of renewing our Transformation priorities for 2017/18. The Transformation Board meeting in January considered a “long list” of potential projects drawn from operating plans, our quality strategy, our clinical strategy work programme, IT developments (including the proposed Global Digital Exemplar work), system wide projects within the Sustainability and Transformation programme (STP) and our existing transformation initiatives. We then developed a short list of transformation projects which the Senior Leadership Team will now consider. The aim is to ensure we have updated the portfolio of transformation projects and prioritised our resourcing ahead of the new financial year in April.

15. The latest version of the Transforming Care programme status report as prepared for the Transformation Board is attached at appendix 1.

Simon Chamberlain

Director of Transformation

20th January 2017

Transforming Care Programme report

Pillar	Details	Purpose	Key deliverables	Planned Month	Status	Forecast month	Current status	Risks	Benefits / Measures
Delivering best care	**Project:** Patient Communications **Exec lead:** Carolyn Mills **Project lead:** Alison Grooms **Transformation lead:** Stephanie Smith-Clarke **Project phase:** implementation	**Patient Letters** To improve and standardise the quality of all appointment letters that are sent by UHBristol to patients, guardians and carer (both electronically and non-electronically generated) in line with the Trust's Objective 5 - 'To improve how the Trust communicates with patients'.	• Plan agreed for roll out of letter quality standards across Trust	Nov	A	Jan	• For consideration at 9/01/2017 Patient Letters Working Group following 05/12/2016 Transformation Board presentation	• Ability to resource the rewriting of letters Trust wide against the letter quality standards. • Costs associated with sending of new Outpatient and Inpatient leaflets. Costs will be established during pilot phase. Divisions to agree to spend for further roll out. • High number of letter templates required to provide correct telephone numbers per specialty.	• To improve patient experience and reduce patient communication related complaints and DNA's
			• Elective surgery leaflet completed	Nov	G	Jan	• Final updates in progress		
			• SH&N Letter Pilot commenced	Nov	A	Jan	• Final updates in progress		
			• Financial benefits to be agreed	Jan	G				
		Medway based email correspondence To provide our patients with the option of receiving their appointment letter via email instead of post, as preferred by many of our patients, especially those with visual impairment.	• Creation of inboxes, Medway functionality for administrators and letter templates copied to email actioned by IM&T	Jan	G			• Low up-take of email option • Staff training in SOP • Recruiting of Email Validators	• To provide our patients with the choice of receiving their appointment letter via email. • To reduce printing and postage costs
			• Go-live coms in place prior to project launch	Jan	G				
			• Training session arrangements in place for Assessment Centre Staff	Feb	G		• Provisionally scheduled for 9th Feb		
			• Training of receptionists and booking coordinators in SOPs for email correspondence	Jan	A	Feb	• Recruitment of booking coordinators has taken longer than expected. 1 of the 3 positions has been filled, with the other 2 to recruit Jan 2017. Agreed with Marisa Kegg that email validation will be split amongst the team, with training in email validation occurring early Feb. Concurrent to this, Reception staff will be trained in taking email addresses and end dating them in Medway.		
			• Email collection commenced	Feb	A	Feb	• Dependent on the above		
	Project: CSIP **Exec lead:** Paul Mapson **Project lead:** Steve Gray **Project phase:** implementation	Implementation of a cohesive set of clinically-focused applications and technologies that will transform business processes and provide users with tools and opportunities to improve patient care and achieve efficiencies.	• Pilot of the Wardview interactive electronic whiteboards (to replace the magnetic whiteboard)in STAU	Nov	G	Dec	• User testing is underway and is going well.	Risk of poor performance of IT infrastructure may impact usability of new systems.	• Improved patient safety and experience through ready access to timely, accurate information • Improved efficiency for all staff involved in handling/viewing/creating patient information • Increased security of patient information (e.g. patient images)
			• EDM Project Ready to go-live in BRI, BHI and SBCH	Apr-17	G	May	• 2nd of May		
			• Submission of Clinical Utilisation Review (CUR) evaluation report	Mar-17	G		• CUR went live with the pilot wards on 1st Dec following a three day training roll out		
			• Electronic Observations Project Initiation	Jan-17	G		• Nursing Electronic Observations. The project is in early preparation stage and will need formal kick off once the Global Digital Excellence initiative is agreed		
	Project: Sign up to Safety Patient Safety Programme **Exec lead:** Carolyn Mills **Project lead:** Caroline Beale **Project phase:** implementation	To reduce avoidable harm by 50% and to reduce mortality by a further 10% by 2018.	• Developing, testing and implementing WHO checklists and LocSSIPs for other invasive procedures continued	Q3	G		• Plan for Q4 - Dissemination of the LocSSIPs to all procedural areas and raising awareness of their implementation particular focus on junior doctors	• Risk front line staff cannot release sufficient time to engage and particpate in quality and safety improvement • Risk that the Patient Safety Improvement Programme objectives, corporate quality objectives and sepsis CQUIN are not achieved if funding for patient safety audit and quality improvement nurse is not secured beyogn March 2017 • Risk of slippage of programme due to long term absence of Programme Manager • Risk of inabilty to effectively measure improvements for some workstreams due to availabilty of valid and reliable data sources or need for signifcant manual audit	• Reduction in mortality and avoidable harm • Earlier recognition and management of deteriorating patients • Prevention of peri-procedure never events Reduction in insulin medication errors and readmissions due to poor medicines compliance • Increased sustained compliance with patient safety risk assessments and controls
			• Medicines safety work stream milestone: the 'PharmOutcomes' referral pilot completed and U500 insulin prescription chart and guidelines produced	Q2	G		Plan for Q4 - Guidance for compatabilty of insulin pens and needles for insulin pens produced		
			• OPP funding bid for IT link to improve speed of PharmOutcomes referrals made (currently 20 mins per patient to complete for all, but those with simple dosette box, referrals).	Q3	A		Milestone has changed and rather than purchasing the IT link, the system is being developed locally and this is in D & T's OPP		
			• Deteriorating patient work stream: Sepsis screening tool and pathway implemented and audits recommenced. Automated sepsis screening in CED in place. Joint education in place for deteriorating patient, sepsis and AKI.	Q3	G		Plan for Q4 - Test sepsis screening tools in paediatrics and maternity. Issues with automated sepsis screening in CED rectified. Communication of escalation and map cover of responders revisited.		
			• AKI workstream refresh. Deliver Q3 sepsis CQUIN targets. NEWS credit cards produced. Focus doctor education on resetting triggers. Human factors thematic assessment of NEWS related incidents completed.	Q3	R		All have slipped in Q2 and Q3		
			• Safety culture feedback to clinical teams completed end November 2016 (risks slippage)	Nov-16	A		Plan for Q4 - Safety culture feedback to clincal teams continued and safety culture toolkit completed		
			• 2017 walk rounds by all Executive Directors planned (Green). Tests of change for ward round checklist in Oncology and Haemtology completed (Red).	Q3	A		Plan for Q4 - Tests of change for ward round checklist in Oncology and Haemtology completed		
	Project: Outpatients **Exec lead:** Owen Ainsley **Project lead:** Alison Grooms **Transformation lead:** Marjolein Vries **Project phase:** implementation	To deliver a high quality service through a friendly, accessible, consistent and timely service.	• Outpatient Standards updated version available	Nov	A	Jan-17	• This will be the full electronic outpatient pages, besides the standards it will have links to key documents, training and performance reports, displayed by relevance by job role	• Delays in Outpatients Programme due to gap in Outpatient Manager post and Appointment Centre Manager post.	• Improved patient experience due to services working according to the standards, improved training of outpatients staff and one single place to call for appointments • Income generation via 1% DNA reduction/activity increase in 6 specialties who pilot reworded text reminder • Utilisation targets to be agreed
			• Outcome of Patient Association pilot for telephone follow ups in Dermatology reviewed	Nov	A	Dec	Last interviews carried out by the Patient Association on 23rd November. Outcomes not yet received.		
			• Remaining specialties and volumes to transfer to Appointment Centre identified	Dec	G		• Work with informatics underway to produce report on specialties and volumes		
			• Appointment Centre moved to new location	Jan-17	A	Feb-17	• W.C. 6th February		
			• Method for embedding standards and frequency of monitoring compliance agreed	Jan-17	G		• Operational Managers group is drafting a plan for this		
			• Implementation plan for piloting and roll out of EVOLVE electronic triaging module developed	TBC					
Improving patient flow	**Project:** Operating Model **Exec lead:** Owen Ainsley **Project leads:** IDS lead: Andy Burgess Phase 1 Ward processes: Dr Rachel Bradley and Sarah Chalkley Phase 2 EDD and ?Home within 24 hours: Miss Meg Finch-Jones and Alice Woolstenholmes Phase 2 Discharge Lounge: Trevor Brooks Phase 3 Operational Reporting and Bed Management: Dr Rachel Bradley and Jan Sutton Phase 3 e-Whiteboards and effective board rounds: TBC Phase 4 Flow trackers and e-dashboards: Mr Andrew Hollowood ORLA: Dr Peter Collins >7 day LOS senior review: Julia Wynn Joint Front Door: Dr Peter Collins **Transformation Lead:** Kirstie Corns **Project phase:** planning	**Integrated Discharge Service** To establish a fully Integrated Discharge Service which reduces occupied bed days whilst improving patient outcomes and experience	• Workshop to agree IDS measures held (rescheduled for 9th Nov)	Oct	A	Dec	• Meeting 9th Nov cancelled, will be rescheduled for Dec.	• Insufficient capacity in the community • Insufficient resilience in community • Risk that without appointment of an IDS lead, the IDS project won't deliver	• Achievement of AS18 (17 beds) closure • Achievement of occupancy at 92% in Medicine Division • Reduction in Medicine Green to Go to 38, to support reduction in bed base by 17 beds • Increase in before 12 noon discharges to 1100 pts per month • Increase nos. to the discharge lounge • Reduction in last minute cancellations to 0.8% **Snapshot update: A800 has increased their use of the Discharge Lounge from 25% in October to 29.8% in November.**
			• Integrated Discharge Service lead appointed	Nov	A		• Andy Burgess in discussion with partners to appoint lead. Agreement in principle reached, yet to be formalised. • Aiming to have lead in place by end of Nov 2016		
			• Pilot of Homelessness Support team project	Sep	A	Jan-17	• Appointed band 7 Clinical Coordinator with start date 16th Jan 2017.		
			• Discharge to assess pathways 2 & 3 relaunched	Q2	R	TBC	• Julia Wynn to contact Kerry Joyce (BCH) for update on pathway 2. • Pathway 3 - project group has met twice. C808 identified, but no start date confirmed.		
			• Project rescoped in light of Reset Week findings	TBC					
		Ward Processes and Real Time Roll out an integrated Ward Processes and Real Time programme	**Phase 1 Ward Processes workstream**					• Capacity within Divisions to lead and support programmes cross divisionally given operational demands and winter pressures • Short term capacity constraints within the Transformation Team • Divisions do not enact commitment to prioritise governance of ward processes at Divisional level	
			• Ward Processes roll out in SHN completed	Mar-17	G		• Transformation lead confirmed • Regular meetings with A602, A604, A609, A600 and A800 to monitor performance and trouble shoot problems • Meeting with A700 held, workshop to be rescheduled		
			• Ward processes roll out in W&C completed	Mar-17	G		• Transformation lead confirmed • 6 out of 8 wards have completed workshops • Remaining wards being scheduled for Jan-17		
			• Ward processes roll out in SPS completed	Mar-17	A		• Transformation lead to be confirmed • Awaiting confirmation of Transformation resource to complete roll out • Sarah Chalkley and Charlotte Nichol undertaking formal gap analysis of BHI and BHOC respectively		
			Phase 2 EDD and ?Home within 24 hours						
			• EDD and ?Home within 24 hours workstream project scope signed off	Nov	A	Dec	• Clinical and operational leads appointed • Draft project on a page complete and kick off meeting held		
			• EDD and ?Home within 24 hours project plan complete	Nov	A	Dec	• Meeting rescheduled due to sickness, forecasting January completion		
			• Updated definition launched and communicated	Dec	A	Jan	• Aim for January launch following feedback from pre and post Christmas reset events		
			Phase 2 Discharge Lounge						
			• Discharge Lounge project scoped and project on a page completed	Sep	G				
			• Project plan completed	Nov	A	Jan	• Project plan and project on a page to be re-drafted and shared with steering group for feedback following recent review.		
			• Work stream communications plan developed	Nov	G				
			• Transport and pharmacy process review	TBC			• 3 weekly meetings taking place to work through reasons for delays and solutions to remove barriers to discharge.		
			• Discharge Lounge article in Voices magazine	Jan	G				
			Phase 3 Operational Reporting and Bed Management						
			• New operational report developed and ready to pilot	Dec	A	TBC	• Operational report developed and being piloted as part of post Christmas reset event. • Post reset pilot date, scope and design to be agreed • Dr Rachel Bradley, Jan Sutton, Sarah Jenkins and Ben Osguthorpe continue to develop the report before sharing with a wider audience		
			Phase 3 e-Whiteboards and effective board rounds						
			• Electronic ward whiteboard roll out plan developed	Aug	R	TBC			
			• First electronic ward whiteboard (STAU) ready for user acceptance testing	Sep	G	Dec	• Currently being piloted in STAU		
			Phase 4 Flow trackers and e-dashboards						
			• Surgical flow tracker implemented and roll out across SHN (including escalation SOP)	Q3	G	Dec	• Screens installed in SHN. Awaiting IT and Estates work for screen in Heygroves theatre 4 and Recovery. • Patient flow procedure updated, reviewed and awaiting sign off		
			• BHI flow tracker implemented and roll out across BHI (including escalation SOP)				• Screens installed in BHI. • Approach to define data set and RAG parameters to be agreed by the Division. Agreement on procedure document/SOP required from key stakeholders.		
		>7 day LOS senior review All patients with a >LoS of 7 days with have a senior review – business as usual.	• Review of meetings	Oct	G	Dec	• Meetings underway	• Operational pressures with external partners leads to inconsistent meeting attendance	
			• KPIs developed	Oct	A	Dec	• Work started but not complete		
		Joint front door Establish a "joint front door" with primary care (CCG led)	• Trial of primary care streaming in adult and children's ED launched		R		• Project on hold - pending review of clinical incident		
			• Pilot commenced						
			• Joint front door project closed and post evaluation completed	Mar-18					
	Project: Theatre Transformation Programme **Exec Lead:** Paul Mapson **Project Lead:** **Project phase:** implementation	To provide individualised safe quality patient care with maximum efficiency in responsive operating theatres Trust wide. Which in turn will support the capacity demands for surgical intervention.	• Bluespier phase 1 hardware roll out completed	Dec	A	Jan		• Theatre Management team recruitment and retention will impact capacity	• Start on time 90% achievement • Turnaround Time 85% achievement • Theatre utilisation 85% achievement
			• Bluespier phase 2 programme agreed	Dec	R	TBC	• Detailed plan and resources to be agreed		
	Project: BRHC Flow **Exec Lead:** TBC **Project Lead:** Lisa Davies **Project phase:** planning	To improve patient flow at Bristol Children's Hospital so that children and young people receive quality healthcare at the right time, in the right place with no delays.	• Focused week on understanding delays across BRHC	Dec	G		• Information gathered being used to inform plan for 'Making each bed day count' workstream	• Increase in winter demand and acuity of patients requiring more admissions impacting flow and capacity to deliver programme	• Improvement in 4 hour target in • Reduction in last minute cancellations Trajectories and timescales to be agreed.
			• External outlier referral form go live	Jan-17	G				
			• Relaunch use of ipods as communication tool across BRHC	Jan-17	G				
			• 'Regional hospital and network' workstream project on a page written	Feb-17	G				
	Project: Real Time Staff Engagement (The Happy App) **Exec Lead:** Alex Nestor **Project Lead:** Anne Frampton, Andrew Hollowood **Transformation Lead:** Stephanie Smith-Clarke **Project phase:** implementation	To provide a method for staff to leave real-time feedback regarding how they are feeling and the related causes. By doing so we will improve engagement with staff, and in turn we believe this will help us to provide a better quality of care to our patients.	• Roll out of website to a further 10 new areas across the Trust	Nov	G		• Awaiting ipads and wall mounts ordered December 2016 and previous order amounts to be reviewed	• Availability of IT support/resource • Willingness of staff to engage • Administrator resource to respond to comments	• Use of app (number of hits a day per area) • No of areas using website • No of resolved & closed actions per area • Improved staff Friends and Family
			• Trial of app for Junior Doctor feedback in BCH following GMC survey	Jan	G		• Roll out of desk top icon to whole trust plus ongoing training of administrators		
			• Video training uploaded to connect for administrators to access for reference	Jan	G				
Building capability	**Project:** Appraisal improvement project **Exec Lead:** Alex Nestor **Project Lead:** Sam Chapman **Project phase:** Implementation	• Staff appraisals are considered valuable and worthwhile • Staff receive an annual appraisal and regular reviews which integrate objectives, development, performance and career discussions • Staff appraisals link to the overall strategic direction of the organisation	• Pilot with stakeholder group held	Oct	A	Jan	New system update came in December, will pilot in January target managers who will do appraisals in March completed	• Challenges IT could delay project roll out - mitigated through the HRIS subgroup and weekly AIP meeting	• Improved Staff Experience • Reduction in staff turn over • Able to monitor the quality of appraisals • Support a culture of Collective Leadership
			• Development of training materials completed	Nov	G				
			• Trust wide comms plan in place (Meeting with Fiona Reid on Nov)	Jan-Feb	G		• Meeting taken place. Meeting to finalise comms plan on 15th Dec. Visiting Divisional Boards in Jan and Feb		
			• Electronic appraisal system implementation trust wide	Q4	G		• Go live date 6th March 2017. Training, eLearning and user guides available at go live		
	Project: Leadership behaviours **Exec Lead:** Alex Nestor **Project Lead:** Sam Chapman **Project phase:** Implementation	To improve staff experience and consistency of leadership behaviours across the Trust this programme is designed to introduce UHBristol Leadership Behaviours in 2017.	• Survey monkey circulated to all line managers	Dec	G			• Not realising the benefits of the leadership behaviour work in the 2017 staff survey due to timing of roll-out and staff survey • Not measuring the behaviour work through 360 feedback in 2017 due to system implementation post the roll-out of phase one of the appraisal improvement programme	Staff survey & implement leadership behaviours from appraisal process Specific targets to be agreed.
			• Workshops with line managers held	Jan	G		• Six workshops in total, with over 100 line managers, starting in December, finishing in January		
			• Findings reviewed by subgroup	Jan	G				
			• Findings shared with line managers	Feb	G				
			• Findings shared and leadership behaviours agreed at SLT	Mar	G				
			• UHBristol leadership behaviours training go live	Apr	G				
	Project: Admin Teams Transformation Trust Wide **Exec Lead:** Alex Nestor **Project Lead:** **Transformation Lead:** Stephanie Smith-Clarke **Project phase:** implementation	To join up the work going on across the Trust in relation to our admin teams and realise the benefits that we could be recognising in our savings programme.	• Design of training programmes per role	Jan	G		• TNA reviewed and GAP analysis performed. Business case in draft	• Divisional ability to resource project • Possibility for consultation required for changes to job descriptions	• Reduction in bank and agency spend • Reduction in manager time spent recruiting admin roles • Reduction in staff turnover • Improved staff retention • Improved friends and family score/trust survey from A&C staff • Reduction in stress related sick days
			• Approved (and matched) standardised job descriptions held centrally by HR	Dec/Jan	G		• 10 JD's drafted, reviewed, matched and 6 in process of consistency checking. To be used for January assessment centre adverts.		
			• Recruitment pilot commenced	Jan	G				

Updated: 19.01.2017

Milestone complete / Activities on track to achieve milestone
Milestone behind plan, with action to remedy
Milestone behind plan, project/programme risk

Cover report to the Trust Board meeting to be held on Tuesday, 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	14
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Finance Report		
Author			
Executive Lead	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☒

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

Executive Summary

Purpose

To report to the Board on the Trust's financial position and related financial matters which require the Board's review.

Key issues to note

The Trust is reporting a surplus of £10.929m (before technical items) at the end of December. The Operational Plan to date requires a surplus of £12.088m and therefore the Trust is £1.159m behind plan. The adverse position is due to the loss of Sustainability and Transformation (S&T) funding reflecting the Trust's failure to achieve the access performance standard trajectories and the rejection of the Trust's appeal by NHS Improvement relating to quarter two access performance.

Recommendations
Members are asked to: • **Note**

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

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

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

Impact Upon Corporate Risk
N/A

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
	27 January 2017			

University Hospitals Bristol NHS Foundation Trust

REPORT OF THE FINANCE DIRECTOR

1. Overview

The Trust is reporting a surplus of £10.929m (before technical items) at the end of December. The Operational Plan to date requires a surplus of £12.088m and therefore the Trust is £1.159m behind plan. The adverse position is due to the loss of Sustainability and Transformation (S&T) funding reflecting the Trust's failure to achieve the access performance standard trajectories and the rejection of the Trust's appeal by NHS Improvement relating to quarter two access performance.

The Trust receives S&T funding as follows:

- S&T core funding – this represents £10.075m of the total of £13.000m and is dependent on meeting the plan excluding S&T funding. The surplus excluding S&T funding has been achieved in December, the surplus being £0.006m above plan excluding S&T funding.
- S&T performance funding – this represents £2.925m of the total £13.000m and is dependent on meeting the control total and then delivery of cumulative performance trajectories for RTT, Cancer and A&E targets.

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Excluding technical items: Surplus/(deficit)	Operational Plan £m	Plan to date £m	Actual to date £m	Variance Fav/(adv) £m	Forecast outturn £m
Net surplus including S&T core funding	12.975	10.138	10.144	0.006	12.975
S&T performance funding	2.925	1.950	0.785	(1.165)	1.190
Net surplus including S&T funding	15.900	12.088	10.929	(1.159)	14.165

Therefore the plan to date, excluding S&T performance funding has been achieved and is forecast to be achieved at year end. The S&T performance funding is however £1.165m behind plan year to date and is forecast to be £1.735m behind plan at year end.

The key metric therefore is the net surplus including S&T core funding which is ahead of plan by £0.006m and on plan at year end.

The overspend in Clinical Divisions and Corporate Services for December increased significantly this month by £1.544m. The year to date overspend is now £10.035m compared with the operating plan trajectory to date of £2.406m. The table overleaf summarises the financial performance in December for each of the Trust's management divisions against their budget, Operating Plan trajectory and control total.

	Budget Variance favourable/(adverse)			Operating Plan Trajectory favourable/(adverse)		Control Total
	To 30 Nov £m	December £m	To 31 Dec £m	Trajectory To Nov £m	Variance £m	£m
Diagnostic & Therapies	0.292	0.087	0.379	(0.029)	0.408	-
Medicine	(2.715)	(0.422)	(3.137)	(0.739)	(2.398)	(2.480)
Specialised Services	(1.220)	(0.148)	(1.368)	(0.088)	(1.280)	(1.060)
Surgery, Head & Neck	(2.697)	(0.348)	(3.045)	(0.772)	(2.273)	(3.700)
Women's & Children's	(2.418)	(0.810)	(3.228)	(0.764)	(2.464)	(2.500)
Estates & Facilities	0.005	0.017	0.022	(0.028)	0.050	-
Trust Services	(0.002)	(0.024)	(0.026)	0.014	(0.040)	-
Other corporate services	0.264	0.104	0.368	-	0.368	-
Totals	**(8.491)**	**(1.544)**	**(10.035)**	**(2.406)**	**(7.629)**	**(9.740)**

The adverse variance of £1.544m in December compares with £1.234m in November and £0.530m in October. Analysis of the variances by subjective is shown below:

(Adverse)/Favourable	Dec £m	Nov £m	Oct £m	Quarter 2 £m	Quarter 1 £m	2016/17 to date £m
Nursing & midwifery pay	(0.172)	(0.367)	(0.612)	(0.963)	(1.154)	(3.268)
Medical & dental staff pay	(0.112)	(0.162)	(0.073)	(0.453)	(0.419)	(0.995)
Other pay	0.283	0.066	0.280	0.506	0.630	1.541
Non-pay	(1.091)	(1.539)	(0.592)	(0.938)	(0.926)	(5.086)
Income	(0.452)	0.768	0.467	(2.179)	(0.832)	(2.228)
Totals	**(1.544)**	**(1.234)**	**(0.530)**	**(4.027)**	**(2.701)**	**(10.035)**

The continuing non pay overspend represents a significant concern. Divisions continue to investigate this sustained increase in overspend. The initial analysis is summarised in section 3 with further details given in the Divisional reports at agenda item 2.3.

The nursing pay overspend reduced again this month which is promising, although the year to date overspend of £3.268m compares with the 2015/16 outturn overspend of £2.8m (after £1.4m of 1:1 costs were funded).

The income variance in month is £0.452m adverse. £0.240m of this relates to clinical income, the remainder primarily relates to lower than planned income for research and development which is reflected in lower than planned expenditure.

The cumulative income under-performance on activity based SLA lines is £2.496m, of which £1.674m relates to elective activity, a deterioration of £0.017m in the month which is encouraging given the operation pressures present.

2. Forecast outturn assessment

NHS Improvement introduced a protocol for revising financial forecasts on 7th October 2016. In line with the protocol, the forecast outturn has been assessed accordingly. Item 7.2 describes the requirements of the protocol and the Trust's response in more detail.

Last month, the loss of S&T performance funding was reported as a significant risk to the non-delivery of the Trust's Control Total of £15.9m surplus requiring the loss of S&T performance funding to be made good by equivalent surpluses on Trust clinical services. It is now clear that clinical services cannot mitigate the loss of S&T performance funding given the current operational and financial challenges faced by Divisions. Therefore, any loss of S&T funding due to the Trust's failure to achieve the access performance trajectories, goes straight to the Trust's bottom line.

The Trust is currently forecasting delivery of the RTT performance trajectory and failure of the A&E and Cancer performance trajectories in quarter four. Based on this forecast, the total S&T performance funding loss for the year would increase to £1.735m. Therefore the Trust is currently forecasting a year end net surplus of £14.2m, a reduction of £1.7m against the Control Total surplus of £15.9m.

It is important to note, that the Trust is forecasting delivery of a £12.975m surplus before the receipt of S&T performance funding in line with the Operational Plan as summarised in the table below.

3. Key Financial Drivers

The key financial drivers to controlling the Trust's financial position to achieve the 2016/17 financial plan requiring further consideration are:

a) Sustainability funding;
b) Nursing and midwifery pay;
c) Medical and dental pay;
d) Clinical activity; and
e) Savings programme.

These are described in the following sections.

a) Sustainability Funding

The Trust's financial position to date includes £8.585m of sustainability funding, £1.165m behind the plan to date of £9.750m.

The Trust failed to achieve A&E, Cancer and RTT access performance standards in December losing S&T funding of £0.325m available in December. The Trust's delivery of the RTT access trajectory for August and September and Cancer access trajectory in July and September was subject to appeal. The appeal has been rejected by NHS Improvement. The position is summarised in the table below. Further detail is provided in Appendix 9.

	Q1	July	August	Sept	October	Nov	Dec	Total YTD
Control Total agreed/achieved	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
STF earned	£3.250m	£0.758m	£0.758m	£0.759m	£0.758m	£0.758m	£0.759m	£7.800m
A&E trajectory achieved		Yes	Yes	Yes	No	No	No	
STF earned		£0.135m	£0.135m	£0.135m	£0.000m	£0.000m	£0.000m	£0.405m
Cancer trajectory achieved		No**	Yes	No**	No	No	No	
STF earned		£0.000m	£0.055m	£0.000m	£0.000m	£0.055m	£0.000m	£0.110m
RTT National target achieved		Yes	No**	No**	No	Yes	No	
STF earned		£0.135m	£0.000m	£0.000m	£0.000m	£0.135m	£0.000m	£0.270m
Total	£3.250m	£1.028m	£0.948m	£0.894m	£0.758m	£0.948m	£0.759m	£8.585m

** appeal rejected by NHS Improvement

Of the £13.0m S&T funding, £2.925m is available for the delivery of the Trust's access performance trajectories. The current forecast performance assumes that only RTT will be achieved in quarter four resulting in a potential loss of S&T performance funding of £1.735m for the year. If RTT is not achieved in quarter four, the loss of S&T funding for the year could be as high as £2.140m.

b) Nursing & Midwifery Pay

The nursing and midwifery pay variance for the month is £0.172m adverse. The table below shows the analysis between substantive, bank and agency for the last three months, previous quarters and year to date. The 2015/16 position is shown for comparison.

	Dec £m	Nov £m	Oct £m	Qtr 2 £m	Qtr 1 £m	2016/17 to date £m	2015/16 Outturn exc. 1:1 funding £m
Substantive	0.759	0.862	0.615	2.466	2.230	6.932	10.099
Bank	(0.475)	(0.565)	(0.511)	(1.599)	(1.440)	(4.590)	(5.684)
Agency	(0.456)	(0.664)	(0.716)	(1.830)	(1.945)	(5.611)	(7.268)
Total	**(0.172)**	**(0.367)**	**(0.612)**	**(0.963)**	**(1.155)**	**(3.269)**	**(2.853)**
Restated for agency				**(0.387)**		(0.387)	
Reversal of 15/16 accrual				0.387		0.387	
	(0.172)	**(0.367)**	**(0.612)**	**(0.963)**	**(1.155)**	**(3.269)**	**(2.853)**

The adverse variance on nursing continues to be driven by high bank and agency usage, offset by a favourable variance on substantive posts due to vacancies. December shows an improving trend compared with October and November. The reduction in overspend this month on agency reflects reduced usage across all Divisions which is linked to a reduction in activity and control of annual leave during the Christmas period.

The Nursing and ODP price and volume variance for December is shown at appendix 3. Nursing and ODPs were £0.211m adverse with a £0.267m adverse variance due to volume above the funded establishment (wte) and a £0.056m favourable variance due to

price. The individual authorisation for non-framework agency continues to have some impact.

The nursing control dashboard is attached at appendix 4. Surgery, Head and Neck and Women's and Children's Divisions continue to be above their sickness trajectory and their performance deteriorated in December. After last month's improvement Medicine saw a further reduction and improved from 4.2% last month to 3.5% this month.

Every Division is above their Operating Plan position for nursing agency wte and expenditure, although all showed a decrease from November to December. Surgery Head and Neck remains the most concerning, with a usage of 17.60wte against a plan of 2.00wte leading to expenditure £0.097m higher than planned. Women's and Children's plan reduced from 25.80wte to 5.80wte between October and November, and in December usage fell by 7.2wte to 11.70wte. Agency usage by Medicine and Specialised Services decreased by 3.30wte and 4.70wte respectively.

The Divisions of Medicine, Women's and Children's, and Specialised Services were above the funded level for NA 1:1's and RMN's in December. The amount spent reduced or remained the same in all Divisions except Medicine, where spending was £0.063m more than planned compared to £0.056m more in November.

Vacancy rates increased across all Divisions by varying amounts, although only Medicine and Specialised Services were above the target of 5%.

c) Medical and Dental Pay

The medical and dental pay variance for the month is £0.112m adverse, an improvement compared with November. The table below shows the analysis between substantive, locum and agency staff types for the last three months, previous quarters and year to date. The 2015/16 position is shown for comparison.

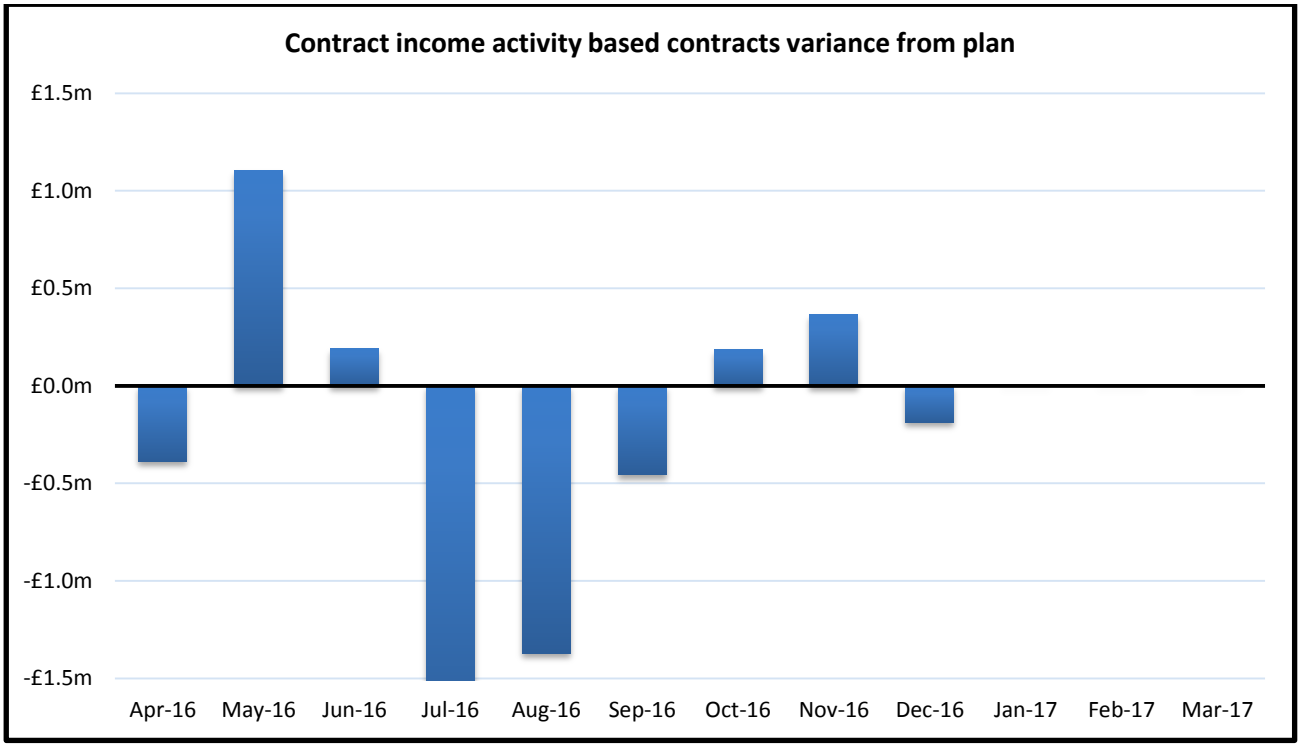
	Dec £m	Nov £m	Oct £m	Quarter 2 £m	Quarter 1 £m	2016/17 to date £m	2015/16 Outturn £m
Substantive	0.114	0.086	0.057	0.215	0.645	1.117	2.387
Locum	(0.204)	(0.222)	(0.146)	(0.469)	(0.630)	(1.671)	(1.803)
Agency	(0.022)	(0.026)	0.016	(0.199)	(0.434)	(0.665)	(2.389)
Totals	**(0.112)**	**(0.162)**	**(0.073)**	**(0.453)**	**(0.419)**	**(1.219)**	**(1.805)**

The improved favourable variance for substantive staff in December reflects a further reduction in wte in month.

The variances on agency and locum expenditure improved by £0.004m and £0.018m in the month. The locum variance is due to additional sessions paid as part of the Trust's initiative for additional weekend activity. The agency variance has returned to its usual level following the reassessment of aged accruals in October.

d) Clinical Activity

Activity based contract performance decreased by £0.186m in December to give a cumulative under performance of £2.496m. The position improved for Medicine this month (£0.055m) but deteriorated for Women's and Children's (£0.105m) and Specialised Services (£0.087m). Performance at Clinical Divisional level is shown at appendix 5a. The graph below shows the monthly performance for all activity based contracts.



The table below summarises the overall clinical income by work type, which is described in more detail under agenda item 2.2.

	In Month Variance Fav/(Adv) £m	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance Fav/(Adv) £m
Activity Based				
Accident & Emergency	(0.032)	11.800	12.103	0.303
Bone Marrow Transplants	(0.014)	6.188	5.671	(0.517)
Critical Care Bed days	0.047	33.090	33.002	(0.088)
Day Cases	0.113	29.060	28.923	(0.137)
Elective Inpatients	(0.178)	38.180	37.230	(0.950)
Emergency Inpatients	0.624	58.573	61.131	2.558
Excess Bed days	0.054	5.224	5.255	0.031
Non – Elective Inpatients	(0.625)	20.571	17.856	(2.715)
Other	(0.223)	60.816	60.422	(0.394)
Outpatients	0.048	61.914	61.327	(0.587)
Sub Totals	**(0.186)**	**325.416**	**322.920**	**(2.496)**
Contract Penalties	(0.403)	(0.719)	(1.178)	(0.459)
Contract Rewards	0.074	6.094	6.674	0.580
Pass through payments	(0.203)	65.232	63.235	(1.997)
Sustainability and Transformation Funding	(0.271)	9.750	8.585	(1.165)
2016/17 Totals	**(0.989)**	**405.773**	**400.236**	**(5.537)**
Prior year income	0.335	-	3.016	3.016
Overall Totals	**(0.654)**	**405.773**	**403.252**	**(2.521)**

Outpatient activity improved in the month by £0.048m and reflects ongoing increased activity particularly within Ophthalmology and Dental as well as additional capacity offered at weekends throughout the Trust. The cumulative underperformance has reduced to £0.587m.

Elective inpatients were £0.178m below plan. Activity in the Children's Hospital was £0.21m below plan, particularly paediatric cardiac surgery (£0.11m) and paediatric trauma

& orthopaedics (£0.06m). Adult cardiac surgery and cardiology was £0.07m below plan largely as a result of cancelled operations due to medical outliers reducing bed availability.

Performance against CQUIN continues higher than plan. The year to date assessment shows an overachievement against plan of £0.580m. The planning assumption was to achieve 75% however assessment of delivery is at 83.4% for year end.

Performance against penalties was £0.403m below plan this month, increasing the cumulative performance to £0.459m below plan.

Pass through payments were £0.203m lower than plan in December, increasing the adverse cumulative position to £1.997m. The year to date adverse variance relates to excluded drugs (£0.980m), excluded devices (£0.850m) and blood products (£0.410m).

e) Savings Programme

The savings requirement for 2016/17 is £17.420m. Savings of £9.640m have been realised to date, a shortfall of £3.451m against divisional plan. The shortfall is a combination of unidentified schemes of £2.382m and a further £1.069m for scheme slippage. The 1/12th phasing adjustment reduces the shortfall to date by £0.026m.

The year-end forecast outturn has decreased this month by £0.120m. Diagnostics & Therapies decreased by £0.042m, Specialised Services by £0.034m, Surgery Head & Neck by £0.027m, Medicine by £0.020m and Women's & Children's increased by £0.003m.The revised outturn is now £13.494m, a shortfall of £3.926m against plan, which represents delivery of 77%.

A summary of progress against the Savings Programme for 2016/17 is summarised in the following table. A more detailed report is given under item 2.4 on this month's agenda.

	Savings Programme to 31st December 2016				
	Plan £m	Actual £m	Variance fav / (adv) £m	Phasing adjustment fav/(adv) £m	Total variance Fav/(adv) £m
Diagnostics & Therapies	1.202	1.206	0.004	(0.030)	(0.026)
Medicine	1.254	0.984	(0.270)	(0.009)	(0.279)
Specialised Services	1.129	0.859	(0.270)	(0.003)	(0.273)
Surgery, Head and Neck	3.665	2.091	(1.574)	(0.052)	(1.626)
Women's and Children's	3.540	2.010	(1.530)	0.062	(1.468)
Estates and Facilities	0.561	0.608	0.047	(0.027)	0.020
Trust Services	0.623	0.574	(0.049)	0.085	0.036
Corporate Services	1.117	1.308	0.191	-	0.191
Totals	**13.091**	**9.640**	**(3.451)**	**0.026**	**(3.425)**

The performance for the year by category is also shown in the following table.

	Year to Date			Variance Against Adjusted Plan £m	Forecast Outturn		
	Plan £m	Actual £m	Variance £m		Plan £m	Actual £m	Variance £m
Pay	1.939	1.630	(0.309)	(0.317)	2.597	2.249	(0.348)
Drugs	0.833	0.888	0.055	0.105	1.044	1.182	0.138
Clinical Supplies	2.316	2.507	0.191	0.202	3.073	3.456	0.383
Non Clinical Supplies	3.141	2.755	(0.386)	(0.426)	4.241	3.793	(0.448)
Other Non Pay	0.043	0.043	-	-	0.057	0.057	-
Income	1.919	1.299	(0.620)	(0.608)	2.543	2.067	(0.476)
Capital Charges	0.518	0.518	-	-	0.690	0.690	-
Unidentified	2.382	-	(2.382)	(2.381)	3.175	-	(3.175)
Totals	**13.091**	**9.640**	**(3.451)**	**(3.425)**	**17.420**	**13.494**	**(3.926)**

4. Divisional Financial Position

Clinical Divisions and Corporate Services overspend against budget increased by £1.544m in December to a cumulative position of £10.035m adverse to plan. The following table shows the Clinical Divisions and Corporate Services budget variances against the four main income and expenditure headings.

	Budget Variance favourable/(adverse)		
	To 30 Nov £m	December £m	To 31 Dec £m
Pay	(2.418)	0.015	(2.403)
Non Pay	(1.768)	(0.826)	(2.594)
Operating Income	0.075	(0.227)	(0.152)
Income from Activities	(1.327)	(0.134)	(1.461)
Sub Total	(5.438)	(1.172)	(6.610)
Savings programme	(3.053)	(0.372)	(3.425)
Totals	**(8.491)**	**(1.544)**	**(10.035)**

Analysis of the subjective movements by Division is summarised in the following table, with further detail given under agenda item 2.3 in the Finance Committee papers.

Variance in month favourable/(adverse)	Pay £m	Non Pay £m	Operating Income £m	Income from activities £m	Savings £m	Total £m
Diagnostic & Therapies						
– To 30 November	1.006	(0.780)	0.012	0.066	(0.012)	0.292
– Dec	0.159	(0.160)	0.040	0.062	(0.014)	0.087
– To 31 December	1.165	(0.940)	0.052	0.128	(0.026)	0.379
Medicine						
– To 30 November	(1.253)	(0.391)	0.028	(0.840)	(0.259)	(2.715)
– Dec	(0.221)	(0.193)	0.002	0.010	(0.020)	(0.422)
– To 31 December	(1.474)	(0.584)	0.030	(0.830)	(0.279)	(3.137)
Specialised Services						
– To 30 November	(0.633)	(0.581)	0.131	0.111	(0.248)	(1.220)
– Dec	(0.030)	(0.009)	(0.006)	(0.078)	(0.025)	(0.148)
– To 31 December	(0.663)	(0.590)	0.125	0.033	(0.273)	(1.368)
Surgery, Head & Neck						
– To 30 November	(0.252)	(1.056)	0.007	0.075	(1.471)	(2.697)
– Dec	0.134	(0.390)	0.002	0.061	(0.155)	(0.348)
– To 31 December	(0.118)	(1.446)	0.009	0.136	(1.626)	(3.045)
Women's & Children's						
– To 30 November	(1.832)	1.403	0.056	(0.749)	(1.296)	(2.418)
– Dec	(0.161)	(0.249)	0.004	(0.232)	(0.172)	(0.810)
– To 31 December	(1.993)	1.154	0.060	(0.981)	(1.468)	(3.228)
Corporate Services						
– To 30 November	0.546	(0.363)	(0.159)	0.010	0.233	0.267
– Dec	0.134	0.175	(0.269)	0.043	0.014	0.097
– To 31 December	0.680	(0.188)	(0.428)	0.053	0.247	0.364

The significant adverse pay variances in month were again within Medicine and Women's and Children's. Medicine continued to incur additional costs associated with 1:1 nursing and staffing the ED queue and Therapy Gym. Women's and Children's nursing pay continued to overspend but was lower than previous months. Additional capacity was required in December but agency usage reduced as the newly qualified nurses came into post. Medical pay in the Division continues to overspend primarily due to high levels of maternity leave.

The £0.826m adverse variance in month on non pay expenditure represents a further significant deterioration. Surgery Head and Neck relates to increased outsourcing costs as well as clinical supplies in theatres. Women's and Children's overspend was within clinical supplies.

The £0.224m adverse variance on income from operations relates to lower than planned research and development income offset by a reduction in expenditure.

The £0.134m adverse variance on income from activities was predominantly within Women's and Children's as described in section 3d.

The £0.372m adverse savings variance in month was across all Divisions but predominantly Surgery, Head and Neck and Women's and Children's as described in section 3e.

5. Use of Resources Rating

The Use of Resources Rating (URR) for the Trust to date is 2, compared with a plan to date of 1, the highest rating. The Trust's capital servicing capacity metric is 0.12 times behind plan as per last month due to the loss of S&T performance funding. The planned and actual reduction of 0.51 times from November is due to the Trust's long term loan principle repayment in December of £2.787m. However, the under-performance of 0.12 times in December means the capital servicing capacity score now falls below the threshold of 2.5 times giving a metric result of 2. This pushes the Trust's overall URR to 1.6 from 1.4 last month and a rounded URR of 2. The table below summarises the position.

		31 December 2016		31 March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		11.87	13.44	11.96	11.87
Metric Rating	20%	1	1	1	1
Capital Servicing Capacity					
Metric Result – times		2.56	2.44	2.77	2.64
Metric Rating	20%	1	2	1	1
Income & expenditure margin					
Metric Result		2.56%	2.31%	2.53%	2.25%
Metric Rating	20%	1	1	1	1
Variance in I&E margin					
Metric Result		0.00%	(0.25)%	0.00%	(0.28)%
Metric Rating	20%	1	2	1	2
Variance from agency ceiling					
Metric Result		0.00%	15.1%	0.00%	21.8%
Metric Rating	20%	1	2	1	2
Overall URR		**1.0**	**1.6**	**1.0**	**1.4**
Overall URR (rounded)		**1**	**2**	**1**	**1**

The agency ceiling set by NHSI of £12.793m is based on data submitted in 2015/16 which included medical locums. Following the change in NHSI definition the Trust has split out the locum costs and whilst NHSI support this approach they have yet to confirm whether this requires an adjustment to the ceiling. The recently communicated target for 2017/18 remains unchanged.

At the end of December the Trust is £1.535m adverse against the NHSI ceiling, deterioration in the month of £0.155m. The following table summarises this position:

	Current month position (December)			Year to date position		
Staff category	NHS I Ceiling £m	Actual £m	Variance fav/(adv) £m	NHS I Ceiling £m	Actual £m	Variance fav/(adv) £m
Medical Agency	-	0.003	-	-	1.052	-
Medical Locum – Zero Hours		0.141			0.829	
Medical Locum – Fixed Term		0.253			2.129	
Nursing Agency (RNs and NAs)	-	0.504	-	-	6.275	-
Other Agency	-	0.150	-	-	1.402	-
Totals	**0.896**	**1.051**	**(0.155)**	**10.152**	**11.687**	**(1.535)**

6. Capital Programme

A summary of income and expenditure for the nine months ending 31 December 2016 is provided in the following table. The Operational Plan of £35.0m shows a profiled planned spend to date of £25.584m. The internal plan reflects the Trust's re-profiled plan.

Operational Plan £m	Subjective Heading	Period ended 31 December 2016				
		Operational Plan to Date £m	Internal Plan £m	Actual £m	Variance £m	Forecast Out-turn £m
	Sources of Funding					
0.273	PDC	0.273	0.273	0.272	(0.001)	2.068
2.732	Donations	2.270	2.270	2.202	(0.068)	2.732
	Cash:					
22.054	Depreciation	16.277	15.894	15.946	0.052	21.273
9.941	Cash balances	6.764	2.901	2.663	0.238	8.927
35.000	**Total Funding**	**25.584**	**21.338**	**21.083**	**0.255**	**35.000**
	Expenditure					
(14.244)	Strategic Schemes	(9.764)	(10.888)	(11.255)	(0.367)	(11.258)
(11.142)	Medical Equipment	(5.244)	(2.679)	(2.157)	0.522	(10.449)
(4.659)	Information Technology	(3.153)	(2.557)	(2.393)	0.164	(4.146)
(2.815)	Estates Replacement	(2.138)	(1.747)	(1.515)	0.232	(2.550)
(13.191)	Operational Capital	(6.192)	(5.253)	(3.763)	1.490	(8.264)
(46.051)	**Gross Expenditure**	**(27.584)**	**(23.124)**	**(21.083)**	**2.041**	**(36.667)**
2.706	Planned Slippage: Lin Acc	2.000	1.786	-	(1.786)	1.667
8.345	I&E Variation from Plan		-	-	-	-
(35.000)	**Net Expenditure**	**(25.584)**	**(21.338)**	**(21.083)**	**(0.255)**	**(35.000)**

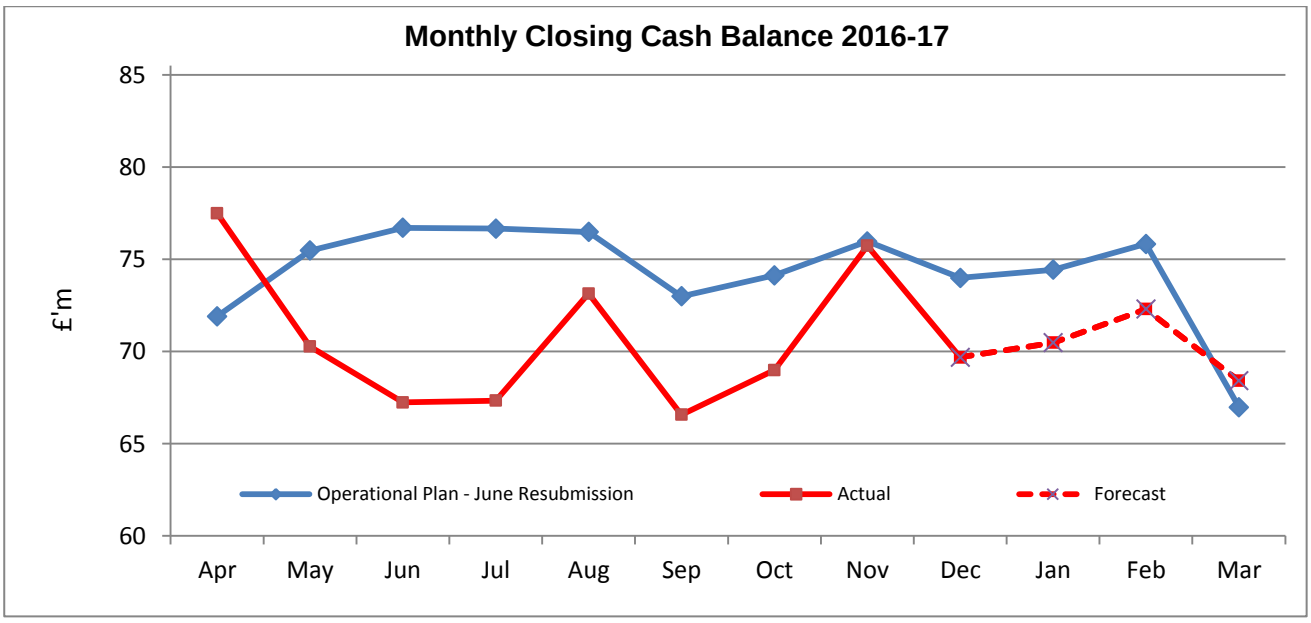
Capital expenditure for the period is £21.083m against an internal plan of £21.338m, £0.255m behind plan. The forecast out-turn remains in line with the Operational Plan of £35.0m following a review of significant items by the Trust's Capital Group. Further information is provided under agenda item 3.1.

7. Statement of Financial Position and Cashflow

Overall, the Trust had a strong statement of financial position as at 30 December 2016 with net current assets of £32.811m, £2.893m higher than the Operational Plan.

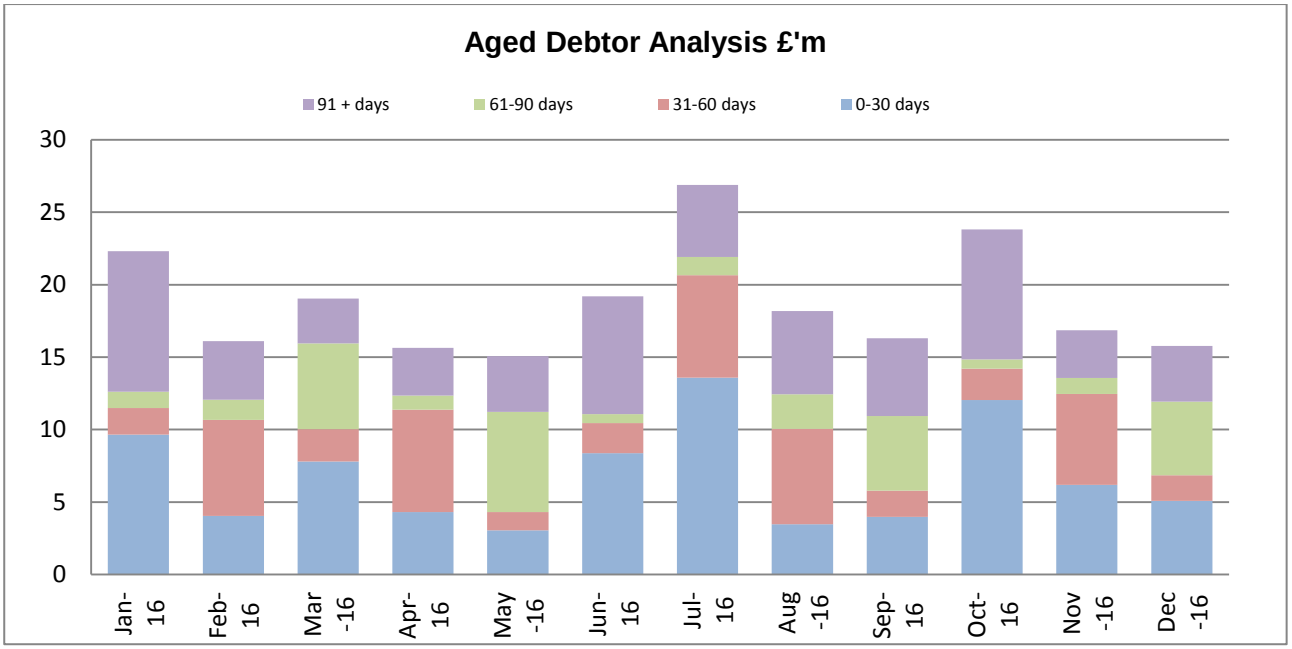
The Trust held cash and cash equivalents of £69.900m at the end of December, £4.094m lower than plan mainly reflecting delayed receipt of Sustainability and Transformation Funding for the third quarter of £2.248m.

The forecast year end cash balance is £68.415m. The following graph shows the month end cash balance trajectory for the financial year.

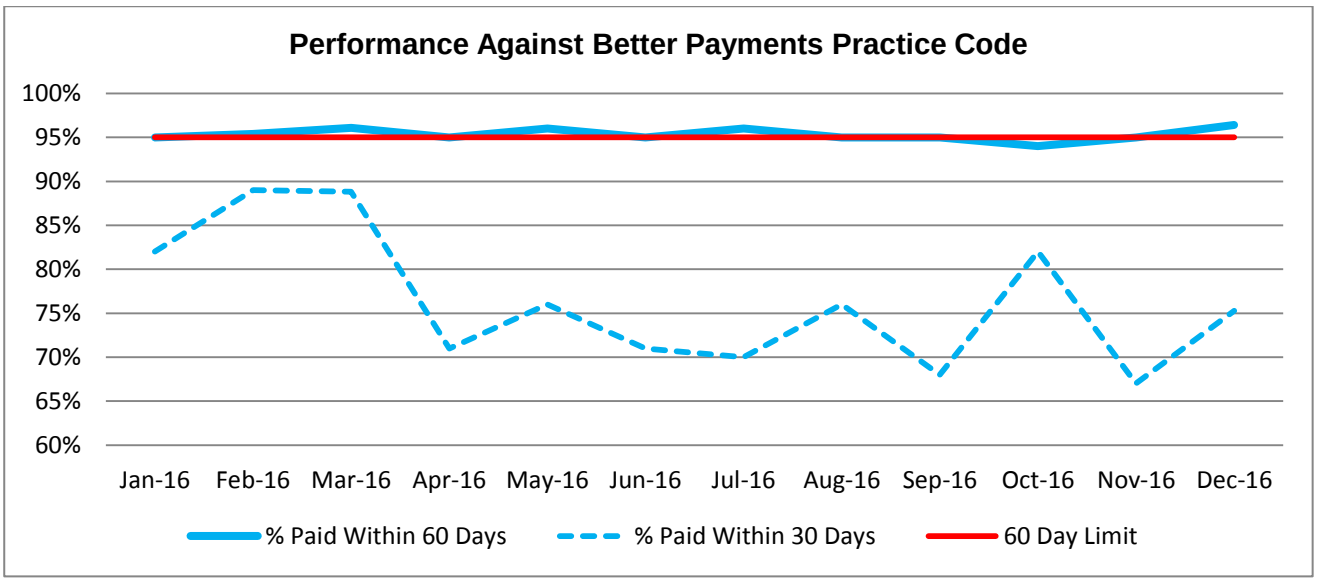


The total value of debtors was £15.763m (£7.187m SLA and £8.576m non-SLA). This represents a decrease in the month of £1.102m (£1.574m SLA decrease and £0.472m non-SLA increase).

Debts over 60 days old have increased by £4.511m (£4.572m SLA increase and £0.061m non-SLA decrease) to £8.912m (£6.155m SLA and £2.757m non-SLA). The SLA increase is primarily due to invoices to NHS England South West Commissioners for supplementary charges. The Commissioners have now agreed to settle the majority of the debt with payment expected in January. The position is summarised in the following chart. Further details are provided in agenda item 4.1.



In December the Trust's performance against the 60 day target was 96%. The Accounts Payable team continues to focus on clearing older invoices and resolving supplier queries.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Nursing & ODP variances
Appendix 4 – Nursing KPIs
Appendix 5 – Key Financial Metrics
Appendix 6 – Financial Risk Matrix
Appendix 7 – Monthly Analysis of Pay Expenditure
Appendix 8 - Release of Reserves
Appendix 9 – Sustainability funding and access performance trajectories

Appendix 1

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report December 2016- Summary Income & Expenditure Statement

Approved Budget / Plan 2016/17	Heading	Position as at 31st December			Actual to 30th November	Forecast Outturn
		Plan	Actual	Variance Fav / (Adv)		
£'000		£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)					
540,440	From Activities	404,947	404,018	(929)	360,768	538,691
92,092	Other Operating Income	69,126	68,767	(359)	61,260	91,951
632,532	**Sub totals income**	**474,073**	**472,785**	**(1,288)**	**422,028**	**630,642**
	Expenditure					
(364,579)	Staffing	(273,096)	(275,817)	(2,721)	(245,209)	(367,813)
(209,759)	Supplies and Services	(156,445)	(161,455)	(5,010)	(144,893)	(215,903)
(574,338)	**Sub totals expenditure**	**(429,541)**	**(437,272)**	**(7,731)**	**(390,102)**	**(583,716)**
(8,143)	Reserves	(6,000)	-	6,000	-	-
	NHS Improvement Plan Profile	(892)		892		
50,051	**EBITDA**	**37,640**	**35,513**	**(2,127)**	**31,926**	**46,926**
7.91	**EBITDA Margin - %**		**7.51**		**7.56**	**7.44**
	Financing					
(22,472)	Depreciation & Amortisation - Owned	(16,793)	(15,946)	847	(14,189)	(21,273)
244	Interest Receivable	183	155	(28)	144	197
(290)	Interest Payable on Leases	(218)	(220)	(2)	(196)	(300)
(3,124)	Interest Payable on Loans	(2,343)	(2,195)	148	(1,954)	(2,884)
(8,509)	PDC Dividend	(6,381)	(6,378)	3	(5,669)	(8,501)
(34,151)	**Sub totals financing**	**(25,552)**	**(24,584)**	**968**	**(21,864)**	**(32,761)**
15,900	**NET SURPLUS / (DEFICIT) before Technical Items**	**12,088**	**10,929**	**(1,159)**	**10,062**	**14,165**
	Technical Items					
-	Profit/(Loss) on Sale of Asset	-	(30)	(30)	(28)	(30)
2,732	Donations & Grants (PPE/Intangible Assets)	2,270	2,202	(68)	2,187	2,732
(6,436)	Impairments	(6,436)	(1,362)	5,074	(1,362)	(6,436)
385	Reversal of Impairments	-	-	-	-	385
(1,610)	Depreciation & Amortisation - Donated	(1,212)	(1,192)	20	(1,060)	(1,612)
10,971	**SURPLUS / (DEFICIT) after Technical Items**	**6,710**	**10,547**	**3,837**	**9,799**	**9,204**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report December 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 November	Operating Plan Trajectory Year to Date	Variance from Operating Plan Year to Date
				Pay	Non Pay	Operating Income	Income from Activities	CIP				
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income											
540,682	Contract Income	405,773	405,773	-	-	(36)	36	-	0	0		
-	Sustainability and Transformation Funding Variance	-		-	-	-	(1,165)	-	(1,165)	(894)		
-	Fines & Rewards	-			-	-	(242)	-	(242)	159		
1,071	Overheads	1,071	2,087	-	81	-	2,342	-	2,423	2,167		
36,766	NHSE Income	27,551	27,551	-	-	-	-	-	-	-		
578,519	**Sub Total Corporate Income**	**434,395**	**435,411**	**-**	**81**	**(36)**	**971**	**-**	**1,016**	**1,432**		
	Clinical Divisions											
(51,766)	Diagnostic & Therapies	(38,704)	(38,325)	1,165	(940)	52	128	(26)	379	292	(29)	408
(76,659)	Medicine	(57,728)	(60,865)	(1,474)	(584)	30	(830)	(279)	(3,137)	(2,715)	(739)	(2,398)
(102,877)	Specialised Services	(77,110)	(78,478)	(663)	(590)	125	33	(273)	(1,368)	(1,220)	(88)	(1,280)
(105,718)	Surgery Head & Neck	(79,265)	(82,310)	(118)	(1,446)	9	136	(1,626)	(3,045)	(2,697)	(772)	(2,273)
(120,492)	Women's & Children's	(90,008)	(93,236)	(1,993)	1,154	60	(981)	(1,468)	(3,228)	(2,418)	(764)	(2,464)
(457,512)	**Sub Total - Clinical Divisions**	**(342,815)**	**(353,214)**	**(3,083)**	**(2,406)**	**276**	**(1,514)**	**(3,672)**	**(10,399)**	**(8,758)**	**(2,392)**	**(8,007)**
	Corporate Services											
(36,425)	Facilities And Estates	(27,289)	(27,267)	56	(33)	(34)	13	20	22	5	(28)	50
(26,154)	Trust Services	(19,916)	(19,942)	529	(425)	(196)	31	35	(26)	(2)	14	(40)
(234)	Other	157	525	95	270	(198)	9	192	368	264	-	368
(62,813)	**Sub Totals - Corporate Services**	**(47,048)**	**(46,684)**	**680**	**(188)**	**(428)**	**53**	**247**	**364**	**267**	**(14)**	**378**
(520,325)	**Sub Total (Clinical Divisions & Corporate Services)**	**(389,863)**	**(399,898)**	**(2,403)**	**(2,594)**	**(152)**	**(1,461)**	**(3,425)**	**(10,035)**	**(8,491)**	**(2,406)**	**(7,629)**
(8,143)	Reserves	(6,000)	-	-	6,000	-	-	-	6,000	4,667		
-	Reserves profiling	(892)	-	-	892	-	-	-	892	692	-	-
(8,143)	**Sub Total Reserves**	**(6,892)**	**-**	**-**	**6,892**	**-**	**-**	**-**	**6,892**	**5,359**		
50,051	**Trust Totals Unprofiled**	**37,640**	**35,513**	**(2,403)**	**4,379**	**(188)**	**(490)**	**(3,425)**	**(2,127)**	**(1,700)**		
	Financing											
(22,472)	Depreciation & Amortisation - Owned	(16,793)	(15,946)	-	847	-	-	-	847	799		
244	Interest Receivable	183	155	-	(28)	-	-	-	(28)	(19)		
(290)	Interest Payable on Leases	(218)	(220)	-	(2)	-	-	-	(2)	(3)		
(3,124)	Interest Payable on Loans	(2,343)	(2,195)	-	148	-	-	-	148	129		
(8,509)	PDC Dividend	(6,381)	(6,378)	-	3	-	-	-	3	3		
(34,151)	**Sub Total Financing**	**(25,552)**	**(24,584)**	**-**	**968**	**-**	**-**	**-**	**968**	**909**		
15,900	**NET SURPLUS / (DEFICIT) before Technical Items**	**12,088**	**10,929**	**(2,403)**	**5,347**	**(188)**	**(490)**	**(3,425)**	**(1,159)**	**(791)**		
	Technical Items											
-	Profit/(Loss) on Sale of Asset	-	(30)	-	(30)	-	-	-	(30)	(28)		
2,732	Donations & Grants (PPE/Intangible Assets)	2,270	2,202	-	-	(68)	-	-	(68)	(83)		
(6,436)	Impairments	(6,436)	(1,362)	-	5,074	-	-	-	5,074	(89)		
385	Reversal of Impairments	-	-	-	-	-	-	-	-	-		
(1,610)	Depreciation & Amortisation - Donated	(1,212)	(1,192)	-	20	-	-	-	20	18		
(4,929)	**Sub Total Technical Items**	**(5,378)**	**(382)**	**-**	**5,064**	**(68)**	**-**	**-**	**4,996**	**(182)**		
10,971	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**6,710**	**10,547**	**(2,403)**	**10,411**	**(256)**	**(490)**	**(3,425)**	**3,837**	**(973)**		

Nursing & ODP Variance – December 2016

Division	Nursing Category	Price Variance fav/ (adv) £'000	Volume Variance fav/ (adv) £'000	Total Variance fav/ (adv) £'000	Lost Time % (Wards/ED/Theatres)
Medicine	Ward	61	(94)	(34)	
	Other	(20)	(95)	(115)	
	ED	3	(5)	(2)	
Medicine Total		**43**	**(194)**	**(150)**	**124%**
Surgery, Head & Neck	Ward	101	(87)	13	
	Theatres	(51)	32	(19)	
	Other	(90)	33	(57)	
	ED	2	2	4	
Surgery, Head & Neck Total		**(39)**	**(20)**	**(59)**	**121%**
Specialised Services	Ward	40	(4)	36	
	Other	(10)	6	(4)	
Specialised Services Total		**30**	**2**	**32**	**117%**
Women's & Children's Services	Ward	8	(73)	(65)	
	Theatres	(53)	31	(22)	
	Other	32	(6)	26	
	ED	12	4	16	
Women's & Children's Services Total		**(2)**	**(44)**	**(46)**	**124%**
Clinical Division Total	Ward	211	(261)	(50)	
	Theatres	(103)	61	(41)	
	Other	(103)	(47)	(150)	
	ED	16	2	18	
CLINICAL DIVISIONS TOTAL		**21**	**(244)**	**(223)**	**122%**
NON CLINICAL DIVISIONS	Other	35	(23)	12	
NON CLINICAL DIVISIONS TOTAL		**35**	**(23)**	**12**	
TRUST TOTAL		**56**	**(267)**	**(211)**	**122%**

REGISTERED NURSING - NURSING CONTROL GROUP AND HR KPIs

Graph 1 **Sickness**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*3.9%*	*3.9%*	*3.9%*	*4.3%*	*4.3%*	*4.3%*	*4.2%*	*4.2%*	*4.2%*	*4.1%*	*4.1%*	*4.1%*
Medicine	Actual	3.1%	1.9%	2.2%	3.1%	4.5%	4.2%	5.4%	4.0%	3.5%			
Specialised Services	*Target*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.2%*	*4.2%*	*4.2%*	*4.0%*	*4.0%*	*4.0%*
Specialised Services	Actual	3.2%	3.5%	3.0%	2.7%	3.2%	2.5%	4.1%	3.7%	3.7%			
Surgery, Head & Neck	*Target*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*
Surgery, Head & Neck	Actual	3.8%	3.9%	5.1%	4.9%	4.1%	4.4%	4.9%	4.8%	5.4%			
Women's & Children's	*Target*	*3.4%*	*3.4%*	*3.4%*	*3.7%*	*3.7%*	*3.7%*	*4.5%*	*4.5%*	*4.5%*	*4.5%*	*4.5%*	*4.5%*
Women's & Children's	Actual	3.8%	3.9%	3.4%	3.7%	4.0%	4.0%	4.9%	5.7%	5.9%			

Source: HR info available after a weekend

Graph 2 **Vacancies**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Medicine	Actual	7.5%	8.7%	8.3%	9.4%	10.6%	7.3%	6.1%	5.3%	5.8%			
Specialised Services	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Specialised Services	Actual	6.5%	7.7%	7.0%	7.0%	6.8%	5.4%	5.6%	5.2%	5.9%			
Surgery, Head & Neck	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Surgery, Head & Neck	Actual	3.9%	5.9%	8.1%	8.2%	8.1%	6.6%	5.4%	4.8%	4.9%			
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%	3.0%	4.8%	2.5%	2.0%	0.5%	0.3%	1.4%			

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	16.9%	16.7%	16.0%	17.4%	15.8%	15.2%	15.2%	15.6%	16.4%			
Specialised Services	*Target*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*
Specialised Services	Actual	15.6%	14.2%	13.2%	13.2%	12.9%	13.2%	12.5%	12.6%	13.0%			
Surgery, Head & Neck	*Target*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*
Surgery, Head & Neck	Actual	14.6%	13.6%	13.3%	13.9%	11.9%	11.8%	11.0%	10.2%	10.2%			
Women's & Children's	*Target*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*
Women's & Children's	Actual	9.3%	10.0%	10.5%	10.9%	11.6%	11.2%	10.9%	10.5%	10.8%			

Source: HR - Registered
Note: M4 figs restated

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*145.0*	*115.0*	*131.0*	*140.0*	*150.0*	*150.0*	*80.0*	*90.0*	*90.0*	*75.0*	*80.0*	*75.0*
Medicine	Actual	244.6	132.0	169.6	203.8	265.4	179.6	245.8	197.9	166.2			
Specialised Services	*Target*	*54.7*	*54.7*	*54.7*	*36.7*	*36.7*	*32.1*	*32.1*	*27.5*	*18.3*	*18.3*	*18.3*	*18.3*
Specialised Services	Actual	95.0	108.4	107.8	85.2	135.7	129.2	119.5	99.5	52.3			
Surgery, Head & Neck	*Target*	*38.6*	*38.3*	*54.6*	*56.9*	*53.6*	*25.8*	*12.5*	*12.5*	*12.5*	*12.5*	*12.5*	*12.5*
Surgery, Head & Neck	Actual	215.0	201.7	183.4	182.8	245.2	247.3	187.9	179.3	109.2			
Women's & Children's	*Target*	*36.9*	*50.8*	*71.8*	*37.7*	*50.7*	*79.5*	*122.1*	*29.1*	*29.1*	*25.3*	*25.3*	*25.3*
Women's & Children's	Actual	158.8	134.0	109.2	219.1	179.2	173.3	176.3	186.7	141.0			

Source: Finance GL (excludes NA 1:1)

Graph 5 **Operating plan for nursing agency wte**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*28.5*	*18.5*	*20.5*	*21.3*	*26.3*	*15.7*	*10.5*	*11.3*	*18.5*	*8.4*	*9.4*	*8.4*
Medicine	Actual	31.3	18.8	24.9	27.9	32.4	27.2	31.1	27.9	24.6			
Specialised Services	*Target*	*8.0*	*8.0*	*8.0*	*8.0*	*8.0*	*7.0*	*7.0*	*6.0*	*4.0*	*4.0*	*4.0*	*4.0*
Specialised Services	Actual	10.6	13.2	13.6	11.7	14.7	14.4	14.1	12.7	8.0			
Surgery, Head & Neck	*Target*	*6.0*	*6.1*	*8.6*	*9.1*	*8.6*	*4.1*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*
Surgery, Head & Neck	Actual	27.5	29.6	25.9	27.1	30.2	28.8	26.0	23.8	17.6			
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	10.7	19.7	15.4	19.1	16.8	18.9	11.7			

Source: Finance GL (excludes NA 1:1)

Graph 6 **Operating plan for nursing agency as a % of total staffing**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*7.9%*	*6.4%*	*7.2%*	*7.7%*	*8.3%*	*8.1%*	*4.6%*	*5.1%*	*5.2%*	*4.4%*	*4.6%*	*4.4%*
Medicine	Actual	13.4%	7.1%	9.5%	11.4%	14.6%	9.3%	13.0%	10.7%	9.3%			
Specialised Services	*Target*	*4.3%*	*4.3%*	*4.3%*	*2.9%*	*2.9%*	*2.5%*	*2.5%*	*2.1%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*
Specialised Services	Actual	7.3%	7.7%	7.9%	6.4%	9.8%	8.9%	8.2%	7.2%	3.9%			
Surgery, Head & Neck	*Target*	*1.8%*	*1.8%*	*2.6%*	*2.7%*	*2.5%*	*1.2%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*
Surgery, Head & Neck	Actual	11.5%	10.5%	10.0%	10.2%	13.2%	12.3%	9.9%	9.9%	6.3%			
Women's & Children's	*Target*	*1.2%*	*1.6%*	*2.3%*	*1.2%*	*1.6%*	*2.5%*	*3.7%*	*0.9%*	*0.9%*	*0.8%*	*0.8%*	*0.8%*
Women's & Children's	Actual	4.7%	3.8%	3.2%	6.4%	5.1%	4.9%	4.9%	5.2%	4.0%			

Source: Finance GL (RNs only)

Graph 7 **Funded bed days vs occupied bed days**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*9,270*	*9,579*	*9,270*	*9,579*	*9,579*	*9,270*	*9,579*	*9,270*	*9,579*	*9,579*	*8,652*	*9,579*
Medicine	Actual	9,235	9,359	9,250	9,543	9,238	8,621	9,394	8,944	8,983			
Specialised Services	*Target*	*4,800*	*4,960*	*4,800*	*4,960*	*4,960*	*4,800*	*4,960*	*4,800*	*4,960*	*4,960*	*4,480*	*4,960*
Specialised Services	Actual	4,507	4,639	4,523	4,729	4,829	4,499	4,665	4,556	4,476			
Surgery, Head & Neck	*Target*	*4,740*	*4,898*	*4,740*	*4,898*	*4,898*	*4,740*	*4,898*	*4,740*	*4,898*	*4,898*	*4,424*	*4,898*
Surgery, Head & Neck	Actual	4,657	4,556	4,452	4,431	4,537	4,392	4,643	4,442	4,394			
Women's & Children's	*Target*	*8,790*	*9,083*	*8,790*	*9,083*	*9,083*	*8,790*	*9,083*	*8,790*	*9,083*	*9,083*	*8,204*	*9,083*
Women's & Children's	Actual	7,087	7,399	6,957	6,548	6,070	6,470	7,243	6,891	6,435			

Source: Info web: KPI Bed occupancy

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*
Medicine	Actual	70	66	78	82	83	113	91	90	97			
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	23	27	14	24	30	15	24	32	25			
Surgery, Head & Neck	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery, Head & Neck	Actual	25	20	31	34	30	26	21	33	25			
Women's & Children's	*Target*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
Women's & Children's	Actual	87	31	10	28	10	20	19	18	19			

Source: Finance temp staffing graphs (history changes)

Key Financial Metrics - December 2016

Appendix 5

	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	3,143	4,268	4,702	6,530	8,553	298		7,281	34,775
Actual	3,178	4,323	4,615	6,524	8,448	297		7,204	34,589
Variance Fav / (Adv)	35	55	(87)	(6)	(105)	(1)	-	(77)	(186)
Year to date									
Budget	29,868	39,261	45,083	62,071	78,366	2,782		67,985	325,416
Actual	29,993	38,701	45,039	61,824	77,229	2,743		67,392	322,921
Variance Fav / (Adv)	125	(560)	(44)	(247)	(1,137)	(39)	-	(593)	(2,495)
Contract Income - Penalties									
Current Month									
Plan	-	(17)	(2)	(8)	(4)			(48)	(79)
Actual	-	(22)	(2)	(9)	0			(450)	(483)
Variance Fav / (Adv)	-	(5)	0	(1)	4	-	-	(402)	(404)
Year to date									
Plan	-	(147)	(21)	(65)	(28)			(457)	(718)
Actual	(1)	(149)	(18)	(174)	(138)			(699)	(1,179)
Variance Fav / (Adv)	0	(2)	3	(109)	(110)	-	-	(242)	(460)
Information shows the financial performance against the planned penalties as per agenda item 5.2									
Contract Income - Rewards									
Current Month									
Plan	69	101	137	140	159	10	-	72	688
Actual	76	112	151	156	176	11	-	80	762
Variance Fav / (Adv)	7	11	14	16	17	1	-	8	74
Year to date									
Plan	607	898	1,209	1,243	1,408	91	-	639	6,095
Actual	665	983	1,324	1,361	1,542	100	-	699	6,674
Variance Fav / (Adv)	58	85	115	118	134	9	-	60	579
Information shows the financial performance against the planned rewards as per agenda item 5.2									
Cost Improvement Programme									
Current Month									
Plan	149	141	134	415	372	74	35	124	1,444
Actual	123	120	102	258	214	81	30	152	1,080
Variance Fav / (Adv)	(26)	(21)	(32)	(157)	(158)	7	(5)	28	(364)
Year to date									
Plan	1,202	1,254	1,129	3,666	3,540	562	622	1,116	13,091
Actual	1,206	984	860	2,091	2,010	609	573	1,307	9,640
Variance Fav / (Adv)	4	(270)	(269)	(1,575)	(1,530)	47	(49)	191	(3,451)

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report December 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
1843	Failure to deliver the Trust's Operating Plan Control Total surplus of £15.9m based on the Divisions run rate of overspend to the end of September (month 6).	16 - Very High	£5.0m	Divisions have been given a control total deficit which cannot be exceeded. Recovery plans to deliver the control totals have been agreed.	PM	12 - High	£2.0m	4 - Moderate	£0.0m
959	Risk that Trust does not deliver future years financial plan due to under delivery of recurrent savings in year. Only 77% of the required savings have been identified at 31st December 2016, leaving a savings gap of £3.9m.	16 - Very High	£3.9m	Trust is working to develop savings plans to meet 2016/17 target of £17.4m and close the current savings gap of £3.9m. Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes.	OA	12 - High	£3.9m	4 - Moderate	£0.0m
416	Risk that the Trust's Financial Strategy may not be deliverable in changing national economic climate.	9 - High	-	Maintenance of long term financial model and in year monitoring on financial performance through monthly divisional operating reviews and Finance Committee and Trust Board.	PM	9 - High	-	9 - High	-
951	Risk of national contract mandates financial penalties and loss of Sustainability & Transformation Funding due to under-performance against key indicators.	9 - High	£3.0m	30% of the agreed Sustainability & Transformation Funding is subject to forfeit if core targets are not delivered. The current risk of loss is high.	PM	15 - Very High	£2.1m	3 - Low	£0.0m
50	Risk of Commissioner Income challenges	6 - Moderate	£3.0m	The Trust has strong controls of the SLA management arrangements.	PM	6 - Moderate	£2.0m	3 - Low	£0.0m
408	Risk to UH Bristol of fraudulent activity.	3 - Low	-	Local Counter Fraud Service in place. Pro active counter fraud work. Reports to Audit Committee.	PM	3 - Low	-	3 - Low	-

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17														
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Sep £'000	Q2 £'000	Oct £'000	Nov £'000	Dec £'000	Q3 £'000	Total £'000	Mthly Average £'000	Mthly Average %
Diagnostic & Therapies	Pay budget	10,357	10,483	10,432	10,413	41,686	3,474		3,580	3,350	3,370	10,299	3,365	3,491	3,449	10,305	3,476	3,473	3,497	10,446	31,050	3,450	
	Bank	82	109	93	88	371	31	0.9%	20	21	25	66	29	32	31	92	23	21	27	72	230	26	0.8%
	Agency	377	242	186	168	972	81	2.4%	36	(11)	18	42	39	32	35	106	24	24	40	88	236	26	0.8%
	Waiting List initiative	98	54	95	95	342	29	0.8%	62	35	53	150	72	35	27	134	30	27	6	63	347	39	1.2%
	Overtime	147	94	100	110	450	38	1.1%	47	37	36	120	30	33	41	104	40	46	31	117	342	38	1.1%
	Other pay	9,572	9,648	9,788	9,920	38,927	3,244	94.8%	3,310	3,119	3,049	9,478	3,082	3,244	3,200	9,526	3,247	3,202	3,236	9,685	28,689	3,188	96.1%
	Total Pay expenditure	10,276	10,146	10,261	10,382	41,063	3,422	100.0%	3,475	3,201	3,181	9,857	3,253	3,376	3,334	9,963	3,364	3,320	3,341	10,025	29,845	3,316	100.0%
	Variance Fav / (Adverse)	82	337	172	31	623	52		105	149	189	443	112	115	115	342	112	152	156	421	1,205	134	
Medicine	Pay budget	12,841	12,458	12,400	12,606	50,305	4,192		4,306	4,290	4,258	12,853	4,244	4,388	4,191	12,824	4,185	4,176	4,198	12,559	38,235	4,248	
	Bank	897	935	905	1,039	3,775	315	7.2%	243	319	318	880	338	358	290	986	277	293	292	861	2,727	303	6.8%
	Agency	826	875	814	1,119	3,634	303	7.0%	333	239	290	861	274	320	265	858	250	291	212	752	2,472	275	6.2%
	Waiting List initiative	51	45	56	42	194	16	0.4%	30	30	17	77	3	16	13	32	4	6	6	16	125	14	0.3%
	Overtime	16	21	35	32	105	9	0.2%	8	9	7	23	8	5	5	18	6	5	3	15	56	6	0.1%
	Other pay	11,212	10,941	10,982	11,308	44,443	3,704	85.2%	3,789	3,850	3,796	11,435	3,701	3,784	4,001	11,486	3,919	3,895	3,926	11,741	34,662	3,851	86.6%
	Total Pay expenditure	13,002	12,817	12,792	13,539	52,151	4,346	100.0%	4,403	4,447	4,428	13,278	4,324	4,483	4,574	13,380	4,456	4,490	4,439	13,385	40,042	4,449	100.0%
	Variance Fav / (Adverse)	(161)	(359)	(391)	(933)	(1,846)	(154)		(97)	(157)	(170)	(424)	(80)	(95)	(383)	(557)	(272)	(314)	(240)	(827)	(1,807)	(201)	
Specialised Services	Pay budget	10,135	10,245	10,342	10,557	41,279	3,440		3,657	3,968	3,834	11,459	3,829	3,886	3,812	11,526	3,901	3,885	3,886	11,672	34,657	3,851	
	Bank	402	404	352	423	1,581	132	3.7%	94	159	172	425	151	176	122	449	139	155	131	425	1,299	144	3.7%
	Agency	671	710	582	689	2,651	221	6.3%	182	196	177	555	166	206	219	591	173	125	95	393	1,539	171	4.4%
	Waiting List initiative	125	144	156	103	528	44	1.2%	42	58	36	136	21	45	20	86	42	40	71	153	375	42	1.1%
	Overtime	29	29	30	25	114	9	0.3%	8	11	13	32	16	11	9	36	10	12	13	36	103	11	0.3%
	Other pay	9,189	9,222	9,395	9,674	37,480	3,123	88.5%	3,329	3,644	3,515	10,487	3,522	3,587	3,619	10,728	3,593	3,642	3,596	10,831	32,046	3,561	90.6%
	Total Pay expenditure	10,415	10,510	10,516	10,913	42,354	3,529	100.0%	3,654	4,068	3,913	11,635	3,876	4,025	3,989	11,889	3,958	3,974	3,906	11,838	35,363	3,929	100.0%
	Variance Fav / (Adverse)	(280)	(265)	(174)	(356)	(1,075)	(90)		3	(100)	(79)	(176)	(47)	(139)	(177)	(363)	(57)	(89)	(20)	(167)	(706)	(78)	
Surgery Head and Neck	Pay budget	19,366	19,669	19,708	19,855	78,598	6,550		6,588	6,629	6,673	19,890	6,739	6,846	6,785	20,371	6,804	6,743	6,817	20,364	60,625	6,736	
	Bank	559	683	488	624	2,355	196	3.0%	172	176	194	542	229	261	216	706	209	214	184	607	1,854	206	3.1%
	Agency	603	908	738	752	3,000	250	3.8%	262	251	193	707	238	242	256	736	217	205	123	545	1,988	221	3.3%
	Waiting List initiative	407	387	371	249	1,414	118	1.8%	98	154	130	382	90	71	45	206	12	58	97	167	755	84	1.2%
	Overtime	38	47	45	41	171	14	0.2%	11	12	9	33	8	11	7	26	10	10	7	27	86	10	0.1%
	Other pay	17,853	17,860	18,200	18,209	72,122	6,010	91.2%	6,144	6,165	6,159	18,467	6,040	6,202	6,389	18,631	6,381	6,271	6,283	18,935	56,032	6,226	92.3%
	Total Pay expenditure	19,461	19,885	19,844	19,875	79,062	6,589	100.0%	6,687	6,758	6,685	20,130	6,605	6,786	6,913	20,304	6,829	6,758	6,693	20,280	60,716	6,746	100.0%
	Variance Fav / (Adverse)	(95)	(215)	(136)	(20)	(466)	(39)		(99)	(129)	(12)	(240)	134	60	(128)	66	(25)	(15)	124	84	(90)	(10)	

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17														
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Sep £'000	Q2 £'000	Oct £'000	Nov £'000	Dec £'000	Q3 £'000	Total £'000	Mthly Average £'000	Mthly Average %
Women's and Children's	Pay budget	22,562	22,828	23,290	23,780	92,460	7,705		7,944	7,602	7,919	23,465	7,899	7,950	7,870	23,718	7,954	7,981	7,958	23,892	71,076	7,897	
	Bank	533	582	487	611	2,213	184	2.3%	141	185	172	498	181	194	173	549	119	176	131	426	1,473	164	2.0%
	Agency	703	840	866	719	3,128	261	3.3%	255	162	131	548	269	204	238	711	194	191	120	505	1,765	196	2.4%
	Waiting List initiative	205	169	203	206	783	65	0.8%	33	73	40	146	48	30	62	140	29	38	49	116	402	45	0.6%
	Overtime	23	19	26	35	102	9	0.1%	9	15	17	42	13	11	11	35	17	14	9	40	116	13	0.2%
	Other pay	21,492	21,695	22,409	22,958	88,554	7,379	93.4%	7,749	7,623	7,575	22,947	7,530	7,698	7,735	22,963	7,776	7,808	7,812	23,395	69,306	7,701	94.9%
	Total Pay expenditure	22,956	23,305	23,991	24,530	94,780	7,898	100.0%	8,188	8,058	7,935	24,181	8,041	8,137	8,219	24,398	8,135	8,227	8,121	24,483	73,062	8,118	100.0%
	Variance Fav / (Adverse)	(393)	(477)	(701)	(750)	(2,320)	(193)		(244)	(456)	(16)	(716)	(142)	(187)	(349)	(679)	(181)	(246)	(163)	(591)	(1,986)	(221)	
Facilities & Estates	Pay budget	5,057	5,113	5,142	5,070	20,382	1,699		1,708	1,788	1,744	5,239	1,740	1,770	1,780	5,291	1,739	1,705	1,732	5,175	15,705	1,745	
	Bank	296	320	278	246	1,140	95	5.6%	45	78	72	195	82	107	80	269	80	80	99	260	723	80	4.6%
	Agency	145	189	249	154	738	62	3.6%	32	27	37	96	26	29	28	84	33	27	33	93	273	30	1.7%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
	Overtime	225	244	207	200	876	73	4.3%	68	68	65	201	66	82	66	213	80	64	62	206	620	69	4.0%
	Other pay	4,406	4,373	4,371	4,499	17,649	1,471	86.5%	1,572	1,609	1,592	4,773	1,546	1,567	1,580	4,693	1,532	1,537	1,527	4,596	14,062	1,562	89.7%
	Total Pay expenditure	5,072	5,126	5,106	5,100	20,403	1,700	100.0%	1,717	1,782	1,766	5,265	1,720	1,785	1,754	5,259	1,726	1,708	1,721	5,155	15,679	1,742	100.0%
	Variance Fav / (Adverse)	(16)	(12)	36	(30)	(21)	(2)		(9)	6	(22)	(26)	20	(16)	26	31	13	(3)	10	20	26	3	
(Including R&I and (Incl R&I and Support Services)	Pay budget	6,487	6,496	6,977	7,438	27,398	2,283		2,327	2,532	2,398	7,257	2,382	2,218	2,431	7,030	2,420	2,523	2,519	7,462	21,749	2,417	
	Bank	179	211	232	223	846	70	3.2%	60	61	92	213	70	71	43	184	84	63	39	185	583	65	2.8%
	Agency	69	177	390	367	1,002	83	3.7%	26	98	116	239	35	44	23	102	37	43	34	114	455	51	2.2%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
	Overtime	22	23	20	16	81	7	0.3%	4	5	3	13	5	9	7	21	5	5	9	19	53	6	0.3%
	Other pay	6,029	5,967	6,201	6,662	24,859	2,072	92.8%	2,190	2,213	2,191	6,594	2,194	1,997	2,283	6,474	2,288	2,360	2,305	6,953	20,020	2,224	94.8%
	Total Pay expenditure	6,299	6,378	6,843	7,268	26,788	2,232	100.0%	2,280	2,377	2,403	7,059	2,305	2,120	2,356	6,781	2,414	2,470	2,387	7,271	21,112	2,346	100.0%
	Variance Fav / (Adverse)	188	118	134	169	610	51		47	155	(5)	197	77	97	75	249	6	53	132	190	637	71	
Trust Total	Pay budget	86,805	87,293	88,292	89,718	352,109	29,342		30,109	30,158	30,194	90,462	30,198	30,548	30,319	91,065	30,478	30,485	30,607	91,570	273,096	30,344	
	Bank	2,949	3,244	2,834	3,254	12,281	1,023	3.4%	774	998	1,046	2,818	1,080	1,199	955	3,235	931	1,002	903	2,836	8,889	988	3.2%
	Agency	3,393	3,941	3,824	3,967	15,126	1,260	4.2%	1,127	961	961	3,049	1,047	1,078	1,064	3,188	929	904	657	2,491	8,729	970	3.2%
	Waiting List initiative	886	799	881	695	3,261	272	0.9%	265	350	276	891	234	197	167	598	117	169	229	515	2,004	223	0.7%
	Overtime	499	478	463	460	1,899	158	0.5%	156	157	150	463	146	160	148	454	168	157	134	459	1,376	153	0.5%
	Other pay	79,752	79,705	81,348	83,230	324,035	27,003	90.9%	28,083	28,223	27,876	84,183	27,616	28,078	28,805	84,500	28,737	28,715	28,685	86,136	254,819	28,313	92.4%
	Total Pay expenditure	87,480	88,166	89,352	91,607	356,602	29,717	100.0%	30,405	30,690	30,310	91,404	30,123	30,712	31,139	91,975	30,882	30,947	30,608	92,438	275,817	30,646	100.0%
	Variance Fav / (Adverse)	(674)	(873)	(1,058)	(1,889)	(4,493)	(374)		(296)	(532)	(115)	(942)	74	(164)	(821)	(911)	(404)	(463)	(1)	(868)	(2,720)	(302)	

NOTE: Other Pay includes all employer's oncosts.

	Significant Reserve Movements							Divisional Analysis								
	Contingency Reserve	Inflation Reserve	Operating Plan	Savings Programme	Other Reserves	Non Recurring	Totals	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Estates & Facilities	Trust Services	Other including income	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Resources Book	700	11,709	38,455	(690)	2,426	3,194	55,794									
April movements	(120)	(8,993)	(31,315)	-	166	(208)	(40,470)	3,694	9,102	8,756	7,388	9,590	1,238	1,749	(1,047)	40,470
May movements	(28)	(6)	(3,529)	7	(588)	(217)	(4,361)	(119)	(22)	1	1,914	47	26	194	2,320	4,361
June movements	97	(9)	87	-	(160)	(366)	(351)	10	165	28	40	83	99	141	(215)	351
July movements	(20)	(45)	447		(119)	(207)	56	9	91	45	27	103	98	218	(647)	(56)
August Movements		(6)	234		(80)	(118)	30	58	31	42	42	59	37	122	(421)	(30)
September movements	(17)	(9)	(120)		(165)	(105)	(416)	8	24	57	43	131	24	160	(31)	416
October movements	(53)	(529)	(1,532)		(143)	(98)	(2,355)	46	79	110	192	477	40	139	1,272	2,355
November movements	(34)	(22)	(294)		(122)	(171)	(643)	55	219	43	80	81	57	207	(99)	643
December																
Strategic Scheme Costs						(29)	(29)						29			29
Junior Doctor Contract		(19)					(19)							19		19
Spend to Save						(33)	(33)			10				23		33
CQUINs			(7)				(7)							7		7
STP	(90)					25	(65)							65		65
Developments	51		(95)			(58)	(102)		72					30		102
CSIP						(39)	(39)							39		39
EWTD					(122)		(122)	9	25	17	21	46	2	2		122
Other	8	(12)	(2)			(11)	(17)		1				6	10		17
Month 9 balances	494	2,059	2,329	(683)	1,093	1,559	6,851	3,770	9,787	9,109	9,747	10,617	1,656	3,125	1,132	48,943

2016/17 Sustainability & Transformation Funding – December trajectory performance

In order for the Trust to be eligible for Sustainability & Transformation Funding (STF), first it must deliver the monthly net surplus Control Total excluding STF. Delivery of the Control Total entitles the Trust to 70% of the STF from July onwards.

Net surplus Control Total

The cumulative net surplus Control Total (excluding STF) was achieved for the period to November with an actual cumulative net surplus excluding STF of £2.344m against a plan of £2.335m. Please see table one below.

Table one: Net surplus Control Total and performance to date

Control Total	Q1 £m	July £m	August £m	Sept £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m
Planned net surplus	3.858	5.258	6.719	8.135	9.486	10.853	12.088	13.383	14.475	15.900
Less planned STF	(3.250)	(4.333)	(5.416)	(6.500)	(7.583)	(8.667)	(9.750)	(10.833)	(11.916)	(13.000)
Planned net surplus exc STF	**0.608**	**0.925**	**1.303**	**1.635**	**1.903**	**2.186**	**2.338**	**2.550**	**2.559**	**2.900**
Actual reported net surplus	3.871	5.275	6.722	8.170	9.086	10.062	10.929			
Less STF	(3.250)	(4.279)	(5.308)	(6.337)	(7.014)	(7.773)	(8.585)			
Actual net surplus exc STF	**0.621**	**0.996**	**1.414**	**1.833**	**2.072**	**2.289**	**2.344**			
Control Total delivered / Eligible for STF?	Yes	Yes	Yes	Yes	Yes	Yes	Yes			

A&E waiting times

The Trust did not achieve the A&E waiting times standard trajectory in December with performance of 79.6% against the in-month trajectory of 89.3%. The cumulative performance was 86.1% behind the agreed trajectory of 87.7%. Therefore, the Trust was not eligible for A&E STF of £0.135m for December.

The Trust is currently forecasting failure of the in-month and cumulative trajectory for quarter four. Failure to achieve the A&E trajectory for the last quarter of the financial year would mean a further loss of A&E STF of £0.405m in addition to quarter three, giving a likely total loss of £0.810m for the year. Table two summarises the position to date below.

Table two: A&E waiting times trajectories and performance to date

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
National standard	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Agreed in month trajectory	81.9%	84.4%	85.9%	86.6%	88.4%	92.2%	93.3%	90.0%	89.3%	88.5%	87.4%	91.0%
Actual performance	87.2%	91.7%	89.0%	89.3%	90.0%	87.3%	82.9%	78.5%	79.6%			
Agreed cumulative trajectory	81.9%	83.2%	84.1%	84.7%	85.2%	86.2%	87.2%	87.5%	87.7%	87.8%	87.7%	88.1%
Actual - cumulative performance	87.2%	89.5%	89.3%	89.3%	89.5%	89.1%	88.2%	86.9%	86.1%			
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory agreed/delivered	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No			
STF due	*£135k*	*£135k*	*£135k*	£135k	£135k	£135k	£0k	£0k	£0k			

Italics represent notional values relating to the agreement of trajectories only for quarter 1.

Cancer waiting times

November's performance against the 62-day GP standard has been subsequently confirmed as achieved at 85.2% compared with a trajectory of 85.1%, therefore securing STF funds for the month.

A formal appeal was submitted for securing funds for the second quarter due to the number of breaches outside of the control of the Trust. The appeal has been rejected by NHS Improvement. The issue has been raised with the Finance Director of NHS Improvement.

Despite achievement of the national standard in November, current performance in quarter three remains below the cumulative trajectory, with draft performance for December at 82.1% (i.e. below the national standard of 85%). With adjustments to performance taking into account breach reallocations that apply under the new national and local CQUIN rules which came into effect on the 1 October 2016, performance for October and December will be above 85%. However, the Trust will need to make a formal appeal in order to attempt secure funds based on adjusted performance, and confidence of success in securing funds via this route is low.

Quarter four is considered a high risk quarter with the achievement of the Cancer standard being unlikely due to higher levels of patient choice and also emergency pressures which often impact to a greater extent in the last quarter of the year than in other quarters. The likely failure to achieve the Cancer access trajectory for the last quarter would mean a loss of Cancer STF of £0.165m in addition to the £0.220m forfeited to date in July, September, October and December. The total forecast loss of Cancer STF for the year increases to £0.385m out of the £0.495m available. Table three summarises the position to date below.

Table three: Cancer waiting times trajectories and performance to date

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
National standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Agreed in month trajectory	72.7%	73.2%	81.8%	84.7%	81.7%	85.0%	85.2%	85.1%	86.9%	83.6%	85.7%	85.9%
Actual performance	77.2%	70.5%	70.8%	73.3%	84.8%	80.5%	79.5%	85.2%	82.1%			
Agreed cumulative trajectory	72.7%	73.0%	76.0%	83.7%	82.3%	82.8%	84.7%	84.6%	85.0%	83.6%	84.7%	85.0%
Actual - cumulative performance	77.2%	73.7%	72.7%	73.3%	80.0%	80.1%	79.5%	85.1%	82.5%			
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory agreed/ delivered	Yes	Yes	Yes	No*	Yes	No*	No	Yes	No			
STF due	*£55k*	*£55k*	*£55k*	£0k	£55k	£0k	£0k	£55k	£0k			

Italics represent notional values relating to the agreement of trajectories only for quarter 1.
** Subject to appeal*
Please note: December figures are still subject to final reporting

Referral to Treatment Time (RTT)

At the time of closing the financial position, achievement of the RTT performance trajectory in December was not assumed. However, achievement of the RTT trajectory in December was confirmed. Recovery plans are expected to continue to support achievement in each month in quarter four. But, this will not be sufficient to earn back the full quarter three's STF (i.e. to make-up for non-achievement in October), due to the scale of performance already lost in quarter two and three, and hence the scale of recovery required to meet the cumulative trajectory.

An appeal has been made to attempt to secure the RTT funding for quarter two. The appeal has been rejected by NHS Improvement. On this basis, the Trust has forfeited RTT STF of £0.270m for August and September. The forecast for the remainder of the year suggests the Trust will achieve the trajectory for quarter four, earning RTT STF of £0.405m bringing the total RTT STF loss for the year of £0.540m. The worst case scenario would be failure to achieve the RTT requirement in quarter four meaning a further loss of £0.405m taking the total worst case RTT STF loss for the year to £0.945m of the £1.215m available. Table four summarises the position to date below.

Table four: RTT waiting times trajectories and performance to date

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
National standard	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Agreed in month trajectory	92.6%	92.6%	92.8%	93.2%	93.2%	93.4%	93.4%	93.4%	92.8%	92.8%	92.8%	93.0%
Actual performance	92.3%	92.6%	92.1%	92.0%	90.5%	90.4%	91.2%	92.0%	92.0%			
Agreed cumulative trajectory	92.6%	92.6%	92.7%	92.8%	92.9%	93.0%	93.0%	93.1%	93.0%	93.0%	93.0%	93.0%
Actual - cumulative performance	92.3%	92.5%	92.3%	92.3%	91.9%	91.6%	91.6%	91.6%	91.7%			
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory / national standard agreed/ delivered	Yes	Yes	Yes	Yes	No*	No*	No*	Yes	Yes**			
STF due	*£135k*	*£135k*	*£135k*	£135k	£0k	£0k	£0k	£135k	£135k **			

Italics represent notional values relating to the agreement of trajectories only for quarter 1.
**Subject to appeal*
*** At financial close, achievement was not assumed.*

Diagnostics

The Diagnostics access trajectory does not attract STF and is not therefore considered here.

Summary

The Trust's Operational Plan Control Total surplus of £15.9m assumed full receipt of the STF at £13.0m of which £2.925m relates to the delivery of the Trust's access performance trajectories. The current assessment of performance against the access standard trajectories indicate a potential loss of funding of £1.735m, the most likely scenario, assuming RTT is achieved in quarter four. If RTT is not achieved in the last quarter, the potential loss of sustainability funding could be as high has £2.140m of the £2.925m available.

University Hospitals Bristol
NHS Foundation Trust

NHS Improvements protocol for revising financial forecasts

Introduction

The Trust's regulator, NHS Improvement, wrote to all Trust Chief Executives and Finance Directors on 7th October 216 and outlined the revised reporting arrangements aimed at strengthening financial performance and accountability in the NHS.

NHS Improvement recognises that, in exceptional circumstances, it may be necessary for a Trust to consider revising its year end financial forecast during the year. In order that Trust Boards are able to demonstrate the highest standards of governance, and for the purposes of consistency and transparency, NHS Improvement has introduced a protocol for any adverse change to a financial forecast compared with the Operational Plan that it expects all Trust Boards to adhere to.

The protocol

In the event of an adverse forecast outturn, the protocol describes "…the Trust Board's primary focus must be the identification and delivery of a recovery plan that demonstrates the mitigating actions being implemented that ensure any proposed revision to forecast outturn is minimised, managed and fully recovered at the earliest possible time." Further, the protocol details the following requirements:

- Revisions to forecast outturn can only be made at Quarter 2 and Quarter 3;
- Trusts are required to have discussed the financial deterioration with NHS Improvement in advance of formally reporting a forecast outturn variance from plan;
- A recovery plan describing the key financial drivers for the deterioration, an analysis of the underlying cause and the actions being taken to return to plan;
- A completed Assurance Statement signed by the Trust Director of Finance, Chief Executive and Chair. This statement will be addressed to the Chair and Chief Executive of NHS Improvement and will be formally reported to NHS Improvement's Board; and

The Trust's financial position

The Trust's revised forecast outturn is a net surplus of £14.2m compared with NHS Improvement's Control Total net surplus of £15.9m agreed by the Trust in June 2016. The deterioration of £1.7m is due to the forecast loss of the performance element of the Sustainability & Transformation Funding (STF) of £1.735m as follows:

- NHS Improvement's rejection of the Trust's appeals in respect Cancer and RTT performance in quarter two worth £0.650m;
- The failure to achieve the A&E and Cancer trajectories in quarter three losing £0.515m; and
- The forecast failure of A&E and Cancer performance trajectories in quarter four losing £0.570m.

There are two levels of Control Total delivery:

- The delivery of a £13.0m surplus before the receipt of STF performance funding. This is still forecast to be achieved.
- The delivery of a £15.9m surplus after the receipt of STF performance funding of £2.9m.

Therefore the Trust will still deliver the first level but not the second.

The Trust's response to the protocol

The Trust has undertaken the following steps in response to the protocol:

- The impact of the performance trajectory and specifically the impact of the strong appeals recently lodged with NHS England and NHS Improvement, but now rejected, has been discussed with the NHS Improvement Director of Finance.
- The ability to mitigate these losses of STF performance funding has been reviewed in the light of recent months financial performances which have been disappointing. It is now the view of the Director of Finance that all flexibility will now be required to deliver the level one measure of Control Total achievement. It is no longer possible to create additional surpluses to cover off the loss of STF performance funding.
- A recovery plan has already been implemented with Divisions and this position is with that already in place.

Conclusion

The Finance Committee is ask to note the Trust's revised forecast outturn assessment, the steps the Trust has taken in response to NHS Improvement's protocol and considers the Assurance Statement for onward approval by the Trust Board.

Paul Mapson
Director of Finance
16th January 2017

Adverse Changes to Forecast Protocol - Board Assurance Statement

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (notes below)

Board Response

Where a provider plans to make an adverse change to an in-year forecast it must be reported through the national reporting process and accompanied with this Board Assurance Statement which has been signed by the Trust Chair, Chief Executive and Director of Finance

For finance:

The Board has been fully briefed on the planned adverse change to forecast and has adhered to the NHS Improvement protocol for ***'Adverse Changes to the In-Year Forecasts'*** prior to requesting the change	Confirmed
All reporting revisions are accompanied with detailed actions to confirm how the position will be recovered and the original financial plan will be delivered	Not Confirmed
The Board is full committed to the delivery of the Trust recovery plan and will actively monitor the recovery plan milestones	Not Confirmed
In advance of formally reporting a forecast outturn variance from plan the Trust has discussed the financial deterioration and remedial actions with the NHS Improvement Regional Managing Director and Regional Director of Finance	Not Confirmed

For governance:

Relevant commissioners have been informed of the position and all opportunities for support have been explored and the recovery actions agreed	Not Confirmed
The senior clinical decision making body within the Trust has been engaged with and are party to the identification and delivery of the recovery actions	Not Confirmed
The Trust Executive Committee, Finance Committee and Board have considered and agree the proposed financial forecast revision and recovery actions	Not Confirmed

Board Declaration

I can confirm that in my capacity as a member of the Trust Board, I understand the financial forecast, its key drivers and where there has been a variance signalled, I can confirm that additional actions to deliver the original plan that was signed off by this Trust Board have been considered in full by Clinical Decision Making Groups the Finance Committee and the Board as a minimum

Signed on behalf of the board of directors

Signature		Signature	
Name	Robert Woolley	Name	John Savage
Capacity	Chief Executive	Capacity	Chair
Date	31/01/2017	Date	31/01/2017
Signature		Signature	
Name	Paul Mapson	Name	John Moore
Capacity	Finance Director	Capacity	Audit Committee Chair
Date	31/01/2017	Date	31/01/2017

Cover report to the Trust Board meeting to be held on Tuesday, 31st January 2017 at 11:00 am – 1:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	15
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31st January 2017
Report Title	Chairs Report Finance Committee		
Author	Pam Wenger, Trust Secretary		
Executive Lead(s)	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Reporting Committee	Finance Committee
Chaired by	Lisa Gardner, Non Executive Director
Lead Executive Director (s)	Paul Mapson, Director of Finance and Information
Date of last meeting	22 December 2016

Summary of key matters considered by the Committee and any related decisions made.

This report provides a summary of the key issues considered at the Finance Committee on 22 December 2016.

Finance Directors Report

Paul Mapson, Finance Director presented the Finance Report at month 8 and outlined the summary income and expenditure statement showing a surplus of £10.062m (before technical items) for the first eight months of the year. This position includes £7.773m sustainability and transformation funding but is £0.894m behind the planned receipt of £8.667m.

It was noted that to date the plan excluding Sustainability and Transformation funding has been achieved, however, concern was raised due to the performance trajectories not being achieved, resulting in the cumulative loss of Sustainability and Transformation funding of £0.894m to date.

Members noted that the non- pay spend was of concern this month and that this was currently under review. It was recognised that whilst the Sustainability and Transformation funding was important the main focus must be on the divisional control of spend. Members noted that there were risks in relation to agency spend and assurance was provided that in order to reduce the risks a number of actions were being progressed in relation to rostering, and decision making regarding agency cover. Members noted that improvements were being made and that the changes were taking some time to fully embed.

Divisional Financial Reports

The Divisional Financial Reports were received and it was noted that the Clinical Divisions and Corporate Services that the overspend against budget increased by £1.234m in November to a cumulative position of £8.491m adverse to plan.

Savings Programme
Members received an update against the Savings Programme and it was noted that the year to date achievement was £8.560m against a plan of £11.647m, leaving a shortfall of £3.087m.

Members noted that a review of the current position is underway and that areas from the Carter Review which were being considered including catering services and procurement.

Contract and Activity Income
Members received an update in relation to the Trust's contract and activity income and noted that contract income was £0.79m higher than plan in November and is £1.87m lower than plan for the year to date. Contract Penalties and Sustainability Fund income were lower than plan, whilst Activity based, pass through payments, contract rewards and prior year income were all higher than plan

Capital Programme
Members received an update against the Capital Programme and noted the position at the end of November is £4.053m lower than the Operational Plan, however it is expected that the out-turn for the year will be in line with plan.

Members received the minutes of the Capital Steering Group held on 13 December 2016 and noted that the final submission of the Trust's 2017/18 – 2018/19 Operational Plan to NHS Improvement on 23 December 2016 will include forecast capital expenditure of £30m in 2016/17 and £36m in 2017/18. This is unchanged from the draft submission made in November.

Statement of Financial Position & Treasury Management
Members noted that the financial position remains strong with net current assets of £34.714m, an increase of £0.215m since last month. Current assets have decreased by £0.059m and current liabilities increased by £0.274m.

NHS Improvement Monthly Return
Members received and noted the financial monthly return to NHS Improvement.

Key risks and issues/matters of concern and any mitigating actions
Members of the Committee discussed in detail the financial position and the plans in place to address achievement of the national targets.
Matters requiring Committee level consideration and/or approval
None.
Matters referred to other Committees
None

Date of next meeting	27 January 2017

Cover report to the Trust Board meeting to be held on Tuesday, 31st January 2017 at 11:00 am – 1:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	15
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31st January 2017
Report Title	Chairs Report Finance Committee		
Author	Pam Wenger, Trust Secretary		
Executive Lead(s)	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Reporting Committee	Finance Committee
Chaired by	Lisa Gardner, Non Executive Director
Lead Executive Director (s)	Paul Mapson, Director of Finance and Information
Date of last meeting	27 January 2017

Summary of key matters considered by the Committee and any related decisions made.

This report provides a summary of the key issues considered at the Finance Committee on 27 January 2017.

Finance Directors Report
Paul Mapson, Finance Director presented the Finance Report at month 9 and outlined the summary income and expenditure statement showing a surplus of £10.929m (before technical items) for the first nine months of the year. This position includes £8.585m sustainability and transformation funding but is £1.165m behind the planned receipt of £9.750m.

Members noted that the nursing pay overspend reduced again this month and that the activity delivery position was encouraging despite the acute emergency pressures.

Members noted that the non- pay spend was of concern this month and that this was currently under review. Members discussed in some detail the reasons for the non pay significant increases over the last two months, it was noted that this covered a whole range of areas and this is currently being investigated. Assurance was provided that the issues have been picked up as part of the Controls Assurance Programme and that an update would be received at the next meeting,

Divisional Financial Reports
The Divisional Financial Reports were received and it was noted that the Clinical Divisions and Corporate Services that the overspend against budget increased by £1.544m in November to a cumulative position of £10.035m adverse to plan. In respect of the Women and Childrens Division, assurance was provided and in relation to the actions taken to address the position.

Savings Programme
Members received an update against the Savings Programme and it was noted that the year to date achievement was £9.400m against a plan of £13.091m, leaving a shortfall of £3.451m. Members noted that work was in progress to refresh the Savings Programme in discussion with the Senior Leadership Team.

Contract and Activity Income
Members received an update in relation to the Trust's contract and activity income and noted that contract income was £0.65m higher than plan in November and is £2.52m December lower than plan for the year to date. Assurance was provided that contracts had been signed with Commissioners for 2016/17 and 2017/18.

Capital Programme
Members received an update and noted that capital expenditure at the end of December totals £21.083m against an internal plan of £21.338m, £0.255m behind plan. An update was provided against the schemes including the King Edward Building (KEB) and the BRI Old Building.

Members received the minutes of the Capital Steering Group held on 11 January 2017.

Statement of Financial Position & Treasury Management
Members noted that the financial position remains strong with net current assets of £32.811m, £2.893m higher than the Operational Plan. It was noted that the variance is primarily due to accrued income which is £6.226m higher than plan and cash which is £4.094m below plan. Members noted that debts over 60 days old have increased by £4.511m to £8.912m and assurance was provided that the Commissioners have now agreed to settle the majority of the debt with payment expected in January.

Quarterly Treasury Management Report
Members received the quarterly report for assurance and it was agreed to receive this report each quarter with the monthly Finance Committee reporting requirements delivered through the Finance Directors report and the Statement of Financial Position agenda items.

NHS Improvement Monthly Return
Members received and noted the financial monthly return to NHS Improvement.

NHS Improvement protocol for revising forecast financial forecasts
Members noted that NHS Improvement introduced a protocol for revising financial forecasts. It was noted that the forecast outturn has been re-assessed and the forecast year end net surplus at £14.2m, a reduction of £1.7m compared with the agreed Operational Plan and Control Total of £15.9m surplus.

Key risks and issues/matters of concern and any mitigating actions	
Members of the Committee discussed in detail the financial position and the plans in place to address achievement of the national targets.	
Matters requiring Committee level consideration and/or approval	
The Finance Committee supported the Trust's revised forecast outturn assessment, the steps the Trust has taken in response to NHS Improvement's protocol and recommend approval.	
Matters referred to other Committees	
None	
Date of next meeting	24 February 2017

Cover report to the Trust Board meeting to be held on Tuesday, 31 January 2017 at 11.00 am – 1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	16
Meeting Title	Audit Committee	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Chairs Report		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Reporting Committee	Audit Committee
Chaired by	John Moore, Non Executive Director
Lead Executive Director	Pam Wenger, Trust Secretary
Date of last meeting	16 January 2017

Summary of key matters considered by the Committee and any related decisions made.

DATIX Presentation
Members received a presentation on the implementation of DATIX. It was noted that the DATIX system provides an integrated approach to storing, tracking and correlation incidents, complaints, claims, Freedom of Information and Data Subject Access request. The committee learnt that over 2300 staff now use the system, and further roll out can be expected during 2017 whilst breadth of functionality will also increase.

Counter Fraud
Members received a report in respect of counter fraud activity and received an update on national developments and areas of interest in relation to counter fraud. It was noted that cases of timesheet fraud and overpayments had been investigated recently and police are involved in certain cases.

Internal Audit
Members received an update on the progress against the Internal Audit Plan and noted that there had been a significant reduction on the outstanding internal audit recommendations covering the period April 2014 to September 2016.

Members received an update in relation to the audit work completed/currently being undertaken. It was noted that 3 reports have been issued and 2 of those were graded as amber and 1 was graded as green. The amber reports were DATIX implementation (due to breadth of roll out, which has been addressed) and Financial Sustainability and Cost Improvement Plans. It was noted that Amber reports studied at previous Audit Committee meetings, were being addressed by the executives.

Members received the draft Internal Audit Plan for 2017/18 – 2019/20 and were invited to comment on the content. It was agreed to receive the final Audit Plan at the next meeting of the Audit Committee.
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The Audit Committee received the revised Internal Audit Charter for the Audit South West

Consortium which sets out the purpose, authority and responsibilities of Internal Audit in accordance with Public Sector Internal Audit Standards.

External Audit Report
Members received the External Audit Report which included the external auditors plan for the audit of the 2016/17 annual accounts.

Sickness Management Report
Members received an update on progress against the Sickness Management Internal Audit Report. Members were assured by the progress to date and agreed to receive a further update in October 2017.

Policy Management Report
Members received an update against the Policy Management Report that was finalised in October 2016. Good progress was noted however, the issue in terms of storing policy outside of the Document Management System was not yet resolved and it was noted and that this was being progressed.

Board Assurance Framework (BAF) – Quarter 3
Members received and the BAF and were pleased with the development of the report and the clear alignment with the Corporate Risk Register. Members noted that there would be some minor amendments following the Risk Management Group. The quarter 3 BAF would be reported to the Board.

Corporate Risk Register
Members received the Corporate Risk Register as at the end of December 2016 and noted the scrutiny that had taken place at Risk Management Group. It was noted that the year end financial out turn had been raised to a high risk.

Gifts and Hospitality Register and Register of Interests
Members received the further report following consideration at the October 2016 meeting. There was a detailed discussion in terms of the improvements made including the online system and the formatting of the Registers. As part of the assurance processes the Audit Committee have requested a further report in April in relation to the processes to be followed.

Risk Management Group
Members received the minutes from the meeting held in October 2016 and an overview of the latest meeting that had taken place in January 2017. Members welcomed receiving the minutes of the Risk Management Group as it demonstrated the comprehensiveness of the agenda and the Group's ability to review and discuss risk issues and to scrutinise the Divisional Risk Registers.

Clinical Audit
Members received the Clinical Audit Quarterly Report and noted that 40/48 (83%) of Priority 1 projects were started or been completed according to timescale. Assurance was provided that overall 143/203 (70%) of projects commenced according to planned timescale.

Members invited the Clinical Audit Team to consider the frequency of reporting to the Audit Committee.

Committee Self Assessment
Members agreed that the self-assessment would be undertaken in March and reported to the next Audit Committee.

Appointment of External Auditors Members received an update on the process and timescales for the appointment of the External Auditors. Members noted routine assurance reports including: • Single Tender Action • Losses and Special Payments • Chair Reports from Finance Committee and Quality and Outcomes Committee. In particular the triangulation between the Audit Committee and the Quality and Outcomes Committee was noted.	
Key risks and issues/matters of concern and any mitigating actions	
None identified.	
Matters requiring Committee level consideration and/or approval	
None identified.	
Matters referred to other Committees	
None identified.	
Date of next meeting	11 April 2017

Cover report to the Trust Board meeting to be held on 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	17
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Register of Seals		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		

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

Executive Summary

Purpose

To report 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 since the previous report on October 2016.
Recommendations
Members are asked to: • **Note** the report.
Intended Audience (please select any which are relevant to this paper)

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

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

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

Impact Upon Corporate Risk
N/A

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

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

Register of Seals – October 2016- January 2017

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
791	02/11/16	First Floor Kitchen and storeroom. Chapter House, Lower Mauldin St. Bristol BS1 2LY	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
792	14/12/16	Contract document x2. Demolition and refurb works- level 8 and 9, queens building, BRI. UHB and J.P Projects	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary

Cover report to the Trust Board meeting to be held on 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	18
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Fit and Proper Persons Policy		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Alex Nestor, Acting Director of Workfrice and Organisational Development		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1:We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		

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

Executive Summary

Purpose

The purpose of this report is to seek approval of the Fit and Proper Persons Policy following consideration and recommendation by the Remuneration, Nominations and Appointments Committee in December 2016.

Key issues to note

University Hospitals Bristol NHS Trust's Fit and Proper Directors Policy establishes its commitment to ensuring that all persons appointed as directors, or performing the functions of, or functions equivalent or similar to those of a director satisfy the Fit and Proper Person

Requirements as directed by the Care Quality Commission (CQC) Regulation 5.

The Fit and Proper Person Test is outlined in full in Regulation 5 of the 2014 Regulations and states that providers must not appoint a person to a director level post (including permanent and interim posts) or to a non-executive director post unless he or she:

- Is of good character;
- has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed; and
- is able by reason of his or her health and after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed.

This policy will apply to all Executive Director, Non Executive Director and Associate Director posts.

Recommendations

Members are asked to:

- **Note** the report; and
- **Approve** the Fit and Proper Persons Policy.

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

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

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

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

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

Quality	☐	Equality	☐	Legal	☐	Workforce	☒

Impact Upon Corporate Risk

None.

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

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

FIT AND PROPER PERSON TEST

1. SITUATION

With effect from 27th November 2014, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the "2014 Regulations") place requirements on NHS provider organisations to ensure that director-level appointments meet the "fit and proper person test" (FPPT) also known as the "fit and proper person requirement" (FPPR). The Trust"s ability to demonstrate that it can meet the requirements of the regulations are required as part of the Care Quality Commission"s (CQC"s) registration requirements and now form part of the CQC""s regulatory and inspection approach.

2. FIT AND PROPER PERSON TEST (FPPT)

The Fit and Proper Person Test is outlined in full in Regulation 5 of the 2014 Regulations and states that providers must not appoint a person to a director level post (including permanent and interim posts) or to a non-executive director post unless he or she:

- Is of good character;
- has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed; and
- is able by reason of his or her health and after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed.

Furthermore, the regulation prohibits certain individuals from holding the office because they are unfit for a reason specified in Schedule 4 of the Regulations (for example, under a director"s disqualification order) and, significantly, also excludes people who:

"have been responsible for been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or providing a service elsewhere which, if provided in England, would be a regulated activity".

3. FIT AND PROPER PERSON TEST POLICY

University Hospitals Bristol NHS Trust's Fit and Proper Directors Policy establishes its commitment to ensuring that all persons appointed as directors, or performing the functions of, or functions equivalent or similar to those of a director satisfy the Fit and Proper Person Requirements as directed by the Care Quality Commission (CQC) Regulation 5.

The Trust Board receives an assurance report annually that all Board continue to meet the requirements of the Fit and Proper Persons Test. As part of strengthening the governance arrangements a policy has been developed which sets out the

requirements including all the relevant checks that are required to be undertaken on appointment. The Board of Directors have been consulted upon the draft policy.

4. RECOMMENDATIONS

Members are asked to:

- **Note** the report; and
- **Approve** the Fit and Proper Persons Policy.

Fit and Proper Directors Policy

Document Data			
Subject:	Fit and Proper Persons		
Document Type:	Policy		
Document Reference			
Document Status:	Draft		
Document Owner:	Trust Secretary		
Executive Lead:	Chief Executive		
Approval Authority:	Trust Board		
Review Cycle:	36 Months		
Date Version Effective From:	**31 January 2017**	**Date Version Effective To:**	**31 January 2019**

Introduction
University Hospitals Bristol NHS Trust's Fit and Proper Directors Policy establishes its commitment to ensuring that all persons appointed as directors, or performing the functions of, or functions equivalent or similar to those of a director satisfy the Fit and Proper Person Requirements as directed by the Care Quality Commission (CQC) Regulation 5. (Reproduced from the North Bristol NHS Trust Policy)

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
September 2016	0.1	Pam Wenger, Trust Secretary		Creation of document

Table of Contents

1. Introduction

1.1 New regulations came into effect for NHS bodies on 27 November 2014 (Reference A) requiring directors to be fit and proper persons (Regulation 5), and trusts to implement a duty of candour when dealing with complaints (Regulation 20). These Regulations, and the fundamental standards of care, were revised and brought into force more widely for all care providers, less partnerships, from 1 April 2015 (Reference B).

1.2 Regulation 5 establishes a statutory requirement governing the appointing of or having in place individuals as directors, or performing the functions of, or functions equivalent or similar to, the functions of a director (Regulation 5(2)).

1.3 Directors must satisfy all the requirements set out in Regulation 5(3) and be declared fit and proper persons. Individuals must be: of good character, have the necessary qualifications, competence, skills and experience for their role, have the appropriate level of physical and mental fitness, have not been party to any serious misconduct or mismanagement in the course of carrying on a regulated activity, and not be deemed unfit under the Regulation provisions. Providers must also ensure that certain information regarding the individuals is available to the CQC.

2. Purpose

2.1 The purpose of the Regulation is to ensure that all board level appointments at NHS bodies carrying on a regulated activity are held responsible for the overall quality and safety of the care provided, for making sure the care meets the existing regulations and effective requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and that providers and directors can be held to account. Services must be safe, effective, caring, responsive, and well-led.

2.2 The aim of this document is to provide the policy and procedures by which University Hospitals Bristol NHS Foundation Trust (UHB) will support its commitment to the fit and proper person requirements, and to ensuring it is not managed or controlled by individuals who present an unacceptable risk either to the Trust or to the people receiving a service: that UHB's directors are fit and proper to assume responsibility for the overall quality and safety of care delivered.

3. Scope

3.1 The Care Quality Commission (CQC) has fully integrated the fit and proper person requirements (FPPR) into their regulatory registration and inspection framework. UHB must demonstrate that it is meeting these requirements in order to continue to deliver regulated services, or to vary its registration with the CQC should it wish to do so.

3.2 The FPPR applies to all directors whether executive, non-executive, permanent, interim, or associate directors, and irrespective of directors' voting rights. The requirement does not apply to the board of governors.

Although it is for UH Bristol to determine which individuals fall within its scope, the CQC will take a view on how effectively UHB has discharged its responsibility. However, the CQC will not undertake the fit and proper persons' test of a director per se, or determine what is serious mismanagement or misconduct.

3.3 The CQC will check and monitor the extent to which UHB meets the requirements:

a) At the point of registration.

b) During an inspection. Under the 'well-led' question, CQC will confirm that UHB has undertaken appropriate checks and satisfied itself that on appointment, and subsequently, all new and existing directors meet the requirements.

c) On receipt of concerning information regarding directors, where that information may need fit and proper person checks to be performed. This will need to be addressed in line with safeguarding and whistleblowing protocols. The CQC will adopt the following process:

d) Convene a management review meeting led by the Chief Inspector of Hospitals or other person to determine whether the information is significant and should be passed to UHB.

e) Request consent from the director to pass the information to UHB. If not received the information may still be passed but governed by the Data Protection Act 1998.

f) UHB response will either convince CQC that the due process was followed, or lead to further dialogue, an inspection, or regulatory action.

g) Immediate action will not be taken if it is reasonable to wait for a tribunal decision. Thereafter CQC will assess whether UHB's judgement is reasonable.

4. Requirement

4.1 The CQC assesses the fitness of health service providers by focusing on the fitness of the nominated individuals. It will consider whether UHB has taken the appropriate steps to ensure that individuals are:

a) of good character;

b) have the necessary qualifications, competence, skills and experience for their role;

c) have the appropriate level of physical and mental fitness; and

d) have not been party to any serious misconduct or mismanagement in the course of carrying on a regulated activity, and are not deemed unfit under the Regulation provisions.

4.2 Providers must also ensure that certain information regarding the individuals is available to the CQC.

5. Policy Commitment

5.1 UHB fully endorses the importance of ensuring that all directors meet the fit and proper person's requirements under Regulation 5.

5.2 UHB will not permit any individual to hold the post of director who does not meet the standards required to be approved as a fit and proper person, either on appointment or through changing circumstances.

5.3 This policy should be read in conjunction with the following related policies.

a) Recruitment Policy

h) Equality, Diversity & Human Rights Policy

6. Process and Responsibilities

6.1 The process framework for approving individuals as fit and proper persons is attached at **Appendix 1**.

6.2 UHB is responsible for the appointment, management and dismissal of its directors, and for ensuring that the FPPR is met.

6.3 It is the overall responsibility of the Chair of the Trust to discharge the FPPR, to ensure all directors meet the fitness test and not the unfit criteria, and to declare to the CQC that the Trust complies with the requirements of Regulation 5.

6.4 UHB has a responsibility to implement the following on a continuing basis:

a) Provide the evidence that appropriate systems and processes are in place to ensure that all new and existing directors are and continue to be fit and proper persons, and do not meet any of the unfitness criteria set out in Schedule 4 part 2 of the regulations.

b) Make every reasonable effort to assure itself about the suitability of an individual by all means available.

c) Make specified information about board directors available to the CQC.

d) Be aware of the various guidelines available, and to have implemented procedures in line with this best practice.

e) Inform the regulator where a board member no longer meets the requirement and is registered with a health or social care professional regulator, and take action to ensure the position is held by someone meeting the requirement.

6.5 Specific responsibilities are held by the following posts:

a) The **Director of Workforce and Organisational Development** will keep this policy and its procedural requirements updated in accordance with regulatory guidance and best practice.

b) The **Head of the HR Service Centre** will ensure the relevant pre-employment and continuing employment checks are carried out satisfactorily in accordance with **Appendix 2**, and including the NHS Employment Check Standards as required.

c) The **Trust Secretary** will arrange for existing and prospective directors to make the necessary annual declarations, for notifying all directors that they are responsible for informing the Trust if they have reason to believe that they no longer meet the fit and proper person standard.

d) The **Head of the HR Service Centre** is responsible for updating the contracts of employment and related relevant employment and recruitment policies to reflect the requirements of this policy.

e) The **Head of the HR Service Centre** will ensure the relevant information is retained for each director in accordance with the Regulation 5 requirements and **Appendix 2**.

f) The **Trust Board** has overall responsibility for approving this policy and subsequent amendments.

7. Checks and Procedures

7.1 UHB's checks and procedures to implement the regulatory requirements are set out at **Appendix 2**. Overall responsibility lies with the Head of the HR Service Centre.

7.2 UHB will assess and review the fitness of directors every 3 years based on the risk to UHB business and people using its service.

8. Responses and Concerns

8.1 If concerns are raised about a person's fitness after they have been appointed, these will be investigated in line with the Trust's policies and action proportionate to the findings will be taken.

9. Documentation

9.1 **Retention.** Documentation verifying the checks conducted for each individual will be retained in accordance with Trust policy throughout their employment with the Trust, and subsequently to be available through archiving. Organisations registered with the Disclosure and Barring Service (DBS) must observe the Code of Practice for Registered Persons and Other Recipients of Disclosure Information, to ensure the information is stored correctly.

9.2 **Provision of Information to CQC**. The Trust Secretary is responsible for making the information required by Regulation 5 or other enactments

available for CQC inspection (see **Appendix 2)**. Any such request is to be notified to the Chairman.

10. Compliance

10.1 If an individual who holds an office or position no longer meets the requirements, UHB will take such action as is necessary and proportionate to ensure that the office or position is held by someone who does meet the requirements. The Trust may suspend individuals on full pay during investigations into whether the requirements are met, or if at any stage the Trust becomes aware of information which may mean an individual is not a fit and proper person. The issues will be addressed on a case by case basis. Where the individual is a health care professional, social worker or professional registered with a health care or social care regulator, UHB will inform the regulator in question. Interim measures may be required to minimise the risk to people who use the services.

10.2 Where UHB is unable to demonstrate it has taken the appropriate steps to achieve compliance, CQC will decide whether to take regulatory action.

11. Review

11.1 This policy will be reviewed in 3 years as set out in the Policy for the Development of Procedural Documents. It may need to be revised earlier in accordance with further regulation, or if national guidance or local arrangements change.

12. Further Information

12.1 The CQC will identify a number of core public information sources about providers that are relevant for the Trust to use as part of the FPPR due diligence. Where known these have been included within the checks set out at Appendix B, but the list requires monitoring and updating as appropriate.

13. References

13.1 Regulation 5 Fit and Proper Persons: Directors and Regulation 20 Duty of Candour, Guidance for NHS Bodies, Care Quality Commission November 2014.

(i) Guidance for Providers on Meeting the Regulations, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended), Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended), Care Quality Commission February 2015.

(ii) Regulation 5 Fit and Proper Persons: Directors, Information for NHS Bodies, Care Quality Commission March 2015.

(iii) Regulation 5 Fit and Proper Persons: Directors, Information for providers of Adult Social Care, Primary Medical and Dental

Care, and independent Healthcare, Care Quality Commission March 2015.

(iv) NHS Employment Check Standards revised July 2013.

(v) NHS Employers 'Employment History and Reference Checks' dated July 2013.

(vi) NHS Employers 'Criminal Record and Barring Checks' dated July 2013.

(vii) NHS Employers 'Professional Registration and Qualification Checks' dated July 2013.

(viii) NHS Employers 'Employment History and Reference Checks' dated July 2013.

(ix)

(x) NHS Employers ‘Work Health Assessments’ dated 2013.

(xi) National Clinical Assessment Service 'Protocol for Reviewing Health Professional Alert Notices' dated April 2013.

(xii) National Clinical Assessment Service 'NCAS Operational Protocol: Issue of Health Professional Alert Notices' dated April 2013.

(xiii) NHS Employers 'Identity Checks' dated July 2013.

(xiv) NHS Employers 'Right to Work Checks' dated June 2014.

14. Appendix A – Fit & Proper Directors Process Overview

15. Appendix B – FPPR Checks

15.1 Procedural Check 1: Good Character (see also Checks 4 & 5)

Key Document References:

NHS Employers 'Employment History and Reference Checks' dated July 2013.

NHS Employers 'Criminal Record and Barring Checks' dated July 2013.

NHS Employers 'Professional Registration and Qualification Checks' dated July 2013.

15.2 Regulatory Requirement.

Individuals are to be of good character (Regulation 5(3)(a)) with regard to (Schedule 4 Part 2):

a) Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.

b) Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

15.3 Compliance with CQC Guidance: Policy

UHB policy is that it will maintain robust processes and continuous assessment to:

a) Make sure that all available information is gathered to confirm the directors' good character, on appointment and thereafter annually through declarations.

b) Take account of the individuals' honesty, trustworthiness, reliability and respectfulness as part of their temperament, character and empathies.

c) Confirm that Individuals have not been complicit with significant care failures and none of the definitions of unfitness should apply.

d) Take appropriate and timely action to investigate and rectify instances

e) Where information is discovered that an individual is not of good character after a person has taken up their role. This will include:

   (i) Taking action as soon as possible to minimise harm or potential harm to people receiving services.

   (ii) Taking immediate action to protect people from harm, and to complete investigations quickly.

(iii) Evidencing any reasons for any delays that any reasonable trust would avoid.

i) Regard may be had to when convictions and bankruptcies are considered 'spent'

15.4 Employment of Individuals with Previous Character Issues.

Where UHB deems an individual to be suitable for employment, after checks have identified that individual as being convicted of an offence, and / or removed from the register of professional health or social care regulators, the following action will be taken:

a) The reasons are to be recorded.

b) The information regarding the decisions is to be made available to those that require to know.

15.5 Responsibilities

The Head of the HR Service Centre and Trust Secretary will jointly ensure that the data sources, to comply with the regulatory requirement as listed in section 13.5, are collected as part of the recruitment process.

15.6 Procedure for Conducting the Checks

a) All applicants will be required to provide a self-disclosure on their criminal history.

b) Once the individual has been offered the role, a Disclosure Baring Service check will be undertaken. If the individual has indicated on their application that they have worked outside of England, one of the region specific service checks will be completed.

c) A check of the registers of relevant professional bodies will be completed to confirm registration and any conditions/restrictions which may have been applied. Where this is not publicly accessible, the individual will be asked to provide proof of registration.

d) A review will be undertaken of publicly available information on the other listed organisation's websites will be undertaken, which will include searching for the individual's name within the websites.

15.7 Procedure for Recording and Retaining the Check Information

a) Copies of all documents and, where possible, searches will be included in the individual's recruitment and, if successful, their employment file. Where a search returns a nil value, then a copy of the search and result will be included within the file.

15.8 Checks and Sources.

UHB will address individuals' good character through conducting the following checks. These should be conducted in conjunction with Check 4 and 5 requirements regarding Misconduct and Mismanagement, and Grounds of Unfitness:

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
Criminal Record and Barring Checks: • To prevent unsuitable people from entering the NHS workforce and gaining access to vulnerable groups. • It is an offence for any organisation to knowingly appoint or continue to allow an individual who is barred from working with children or adults to engage in regulated activity with that group.			
1.	To review the data held about an individual's criminal history	**Self-disclosure**: • to provide the opportunity for individuals to declare their criminal history if they have one • to argue why it should not be considered relevant to the post	Where deemed justifiable in terms of the position offered, it is recommended that applicants complete a self-declaration form. This relies on the honesty of the individual to complete the information accurately. It should be made clear to applicants or post holders that in completing and signing the self-declaration form, they are giving consent for the information provided to be verified by obtaining an appropriate DBS check, where relevant.
2.	To conduct a Standard Check to verify the details of current unspent and spent convictions, cautions, reprimands and final warnings To conduct an Enhanced Check to verify additional details regarding any non-conviction information held by local police where it is relevant to the post To conduct an Enhanced Check Without and With Barred List Information, regarding those due to work with adults and children in a regulated activity	**Disclosure and Barring Service** • To provide criminal record and barring functions to help employers make safe recruitment decisions • Disclosure and Barring Service (England and Wales) www.gov.uk/disclosure-and-barring-service • Where multiple applications are to be submitted, it is recommended that the E-bulk service is used to apply for disclosures on line. www.gov.uk/e-bulk-submitting-multiple-applications-for-dbs	Not all individuals being appointed into or holding positions within the NHS are eligible for criminal record or barring checks. Employers must be clear when they may legally obtain a check as defined by the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 and, in certain circumstances, the Police Act 1997 (Criminal Records) Regulations 2002. The need for and level of check is determined by the activities and type of access to patients the individual will have as part of the role. Obtaining checks on individuals who are not being appointed to eligible positions is unlawful Employers must take care not to ask questions which could potentially lead to an applicant disclosing protected convictions or cautions, and cannot take such information into the recruitment process. These requests are usually conducted once a provisional offer has been made. However it will be a criminal offence to engage in a regulated activity for which the individual is barred. It is recommended therefore that individuals are not permitted to undertake such activity until the barred list check is competed.

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
3.		**Disclosure Scotland (Scotland)** www.disclosurescotland.co.uk	Disclosure Scotland undertake the Basic Level check
4.		**Access NI (Northern Ireland)** www.nidirect.gov.uk/access-ni	To conduct DBS checks for applicants or post holders with a Northern Irish background
5.	To review criminal records held overseas	**Overseas DBS and FCO** • Some overseas criminal records are held on the Police National Computer and will be revealed as part of the DBS check. • The DBS website explains how to access information from a list of countries at: www.gov.uk/dbs-check-requests-guidance-for-employers-overseas-applicants • If necessary embassies or high commissions may also be able to assist through the FCO.	Where appropriate it may be necessary to request a police check or to obtain a certificate of good character from an overseas country. This is recommended for all applicants who live overseas or have disclosed that they have spent a continuous period of six months or more outside the UK in the last five years prior to their application. Translation of information should be carried out by translators professionally accredited by the Chartered Institute of Linguists, or the Association of Translation Companies
Professional Registration and Qualification Checks: • To ensure that a prospective employee or post holder is recognised by the appropriate regulatory body • To confirm that individuals have the right qualifications to perform their job.			
6.	To confirm the registration of health professionals with the relevant statutory body	**Professional Registers** • To make sure that those who practice a health profession are doing so safely • That the individual is registered to carry out the proposed role, whether the individual is subject to any limitation on their registration that might affect the duties proposed, and if the individual's fitness to practice is or has been investigated. Sources include: National Clinical Assessment Service Alert Notices General Medical Council www.gmc-uk.org Nursing and Midwifery Council www.nmc-uk.org Health and Care Professions Council www.hcpc-uk.org/ General Pharmaceutical Council www.pharmacyregulation.org General Dental Council www.gdc-uk.org General Optical Council www.optical.org General Osteopathic Council www.osteopathy.org.uk General Chiropractic Council	Consent must be obtained from the health professional, with their registration number, in order to check the registration. It should be a contractual condition that registration is maintained throughout the employment, and if it is not it should be treated as a reason for exclusion from work.

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
		www.gcc-uk.org	
Further Character Checks: • Additional sources are also available to be drawn upon to validate an individual's character as necessary. • These may also address elements of **Check 4** regarding Misconduct or Mismanagement, and **Check 5** regarding Grounds for Unfitness.			
7.	See **Checks 4 and 5**		
Core Public Information Sources About Providers (Recommended by the CQC to be used as part of FPPR due diligence checks and subject to updating.)			
8.	To identify any provider (for whom the Director or NED has worked) whose registration has been suspended or cancelled due to failings in care in the last five years, or longer if the information is available because of previous registration with the CQC and CQC Predecessor Bodies To consider whether this reveals any further lines of enquiry relevant to the individual concerned	**CQC**	
9.	To review the involvement of individuals or providers in previous investigations	**Serious Case Issues** Public Inquiry Reports: National Archives Serious Case Reviews Homicide investigations for mental health trusts Criminal investigations against providers	
10.	To review the involvement of individuals or providers in previous inspections: Hospitals, care homes, dentists, community based services, clinics, GPs and doctors, services in your home, and mental health	**CQC**	Inspections cover four ratings: Outstanding, Good, Requires Improvement, and Inadequate. Inspection checks cover three levels: Met All Standards, Improvements Required, and Enforcement.
11.	To review Ombudsmen reports relating to providers To identify whether these give rise to further lines of enquiry regarding the individual concerned	**Parliamentary and Health Service Ombudsman** http://www.ombudsman.org.uk/	These address complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

Procedural Check 2: Qualifications, Competence, Skills & Experience

Key Document References:

NHS Employers 'Employment History and Reference Checks' dated July 2013.

NHS Employers 'Professional Registration and Qualification Checks' dated July 2013.

15.9 Regulatory Requirement.

Individuals are to have the necessary qualifications, competence, skills and experience required for their office or position (Regulation 5(3)(b)).

15.10 Compliance with CQC Guidance: Policy. UHB policy is that:

a) All specific qualifications deemed necessary for a role will be made clear as part of job specifications and contracts. Only individuals who meet the requirements will be employed.

b) UHB will assess and check all individuals hold the required qualifications competence, skills and experience, including the requirement to be registered with a professional regulator, the appropriate communication and leadership skills, and evidence of a caring and compassionate nature as required.

c) UHB will apply best practice guidelines addressing value-based recruitment, and in conducting regular appraisal and development of individuals.

d) UHB will take the appropriate disciplinary action including dismissal of directors if required.

15.11 Developing Competence

Where UHB consider that an individual can be appointed to a role based on their qualifications, skill and experience, with the expectation that they will develop specific competence to undertake the role within a specified timeframe, the Trust will record that fact and monitor the progress and development of the individual.

15.12 Best Practice

UHB will ensure that it applies best practice in accordance with the CQC expectation that providers be aware of the various guidelines, and to have implemented procedures in line with best practice, and the seven principles of public life (the Nolan Principles).

15.13 Responsibilities

a) The Head of the HR Service Centre will ensure that the data sources, to comply with the regulatory requirement as listed in section 14.6, are collected as part of the recruitment process.

15.14 Procedure for conducting checks:

a) All applicants will be required to submit an application which includes details of the applicants work and training history, details of at least two referees, one of whom should the individual's current or last line manager.

b) Where gaps are listed in the individual's employment history these should be challenged by the appointing manager and an explanation sought.

c) Copies of any academic and/or professional qualifications, which are used as the basis for selecting the candidate, should be requested. Only originals should be accepted as evidence of award.

d) The Trust will also undertake a check through a third party background checking service to ensure that the academic and/or professional qualifications presented are genuine.

15.15 Procedure for Recording and Retaining the Check Information

a) Copies of all documents and, where possible, searches will be included in the individual's recruitment and, if successful, their employment file. Where a search returns a nil value, then a copy of the search and result will be included within the file.

15.16 Data Sources. UHB will address the requirements through conducting the following checks:

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
1.	To obtain information about an applicant's employment and training history in order to ascertain whether or not they are suitable for a particular position	**Self-declaration, employment history, CV and reference checks** • To address employers' duty of care to patients and staff to ensure that all reasonable checks are undertaken to identify any reason that, if known, would result in an individual not being employed or appointed to undertake any activity on its behalf • To cross-reference information gained through the references with that provided by the applicant as part of their application.	As a minimum the following information should be obtained and verified: where the individual has been employed or studied; dates; position held and courses undertaken; recent or ongoing disciplinary action or referrals. Any conditional offer of appointment is subject to satisfactory employment checks being obtained and information verified. It is acceptable to obtain references prior to interview for senior appointments. For new appointees coming to the NHS for the first-time validate a minimum of three years continuous employment and training.
2.	To secure an explanation of any gaps in employment	The following sources may address these areas: • Applicant's explanation	

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
	history	• HR Departments • Referees	
3.	To verify academic and professional qualifications	The following sources may address these areas: • Academic Institutions • Professional Bodies **– see Check 1**	

15.17 Procedural Check 3: Health

Key Document References:

NHS Employers 'Work Health Assessments' dated July 2013.

15.18 Regulatory Requirement.

Individuals are to be able by reason of their health, after reasonable adjustments have been made, of properly performing those tasks which are intrinsic to the office or position for which they are appointed, or to the work for which they are employed (Regulation 5(3)(c)).

15.19 Compliance with CQC Guidance: Policy.

UHB policy is that those people in positions of control must be appropriately physically and mentally fit in accordance with their role, and after making reasonable adjustments, to enable individuals to carry out their responsibilities with regard to sustaining the management function. This must be in line with the provisions of the Equality Act 2010.

15.20 Responsibilities

a) The Head of the HR Service Centre will ensure that the data sources, to comply with the regulatory requirement as listed in section 15.4, are collected as part of the recruitment process.

15.21 Procedure for Conducting the Checks

a) Once the individual has been offered the role, they will be asked to submit an occupational health assessment to identify whether they have a health condition or disability which may require an adjustment to the workplace.

b) If the occupational health assessment indicates that further assessment is required, then this will be commissioned by the Head of the HR Service Centre.

15.22 Procedure for Recording and Retaining the Check Information

a) Copies of all documents and, where possible, searches will be included in the individual's recruitment and, if successful, their employment file. Where a search returns a nil value, then a copy of the search and result will be included within the file.

b) Copies of all documents and, where possible, searches will be included in the individual's recruitment and, if successful, their employment file. Where a search returns a nil value, then a copy of the search and result will be included within the file.

15.23 Data Sources, UHB will address the requirements through conducting the following checks:

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
1.	To assess whether a post holder has a health condition or disability that requires adjustments in the work place to enable them to undertake the post offered or undertaken, or has a health condition or disability that requires restrictions to their role	• Self-declaration • Occupational Health Assessments • Medical reports as appropriate	All work health assessments must comply with the Equality Act 2010. Reasonable adjustments must be made to ensure that people can work in the NHS regardless of physical impairment or learning disabilities Health assessments must only be made once a job offer has been made. Offers of appointment can be conditional pending successful completion of health assessments

15.24 Procedural Check 4: Misconduct or Mismanagement

Key Document References:

National Clinical Assessment Service 'Protocol for Reviewing Health Professional Alert Notices' dated April 2013.

National Clinical Assessment Service 'NCAS Operational Protocol: Issue of Health Professional Alert Notices' dated April 2013.

15.25 Regulatory Requirement:

Individuals must not at any time in their career have been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or

providing a service elsewhere which, if provided in England, would be a regulated activity. Individuals should not have been complicit with significant care failures.

15.26 Serious Misconduct or Mismanagement:

Misconduct or mismanagement means behaviour that would constitute a breach of any legislation or enactment that the CQC deems relevant to meeting these regulations or their component parts.

a) 'Serious misconduct' might be expected to include assault, fraud and theft, breaches of health and safety regulations, intoxication while on duty, any breach of confidentiality, disobedience of lawful and reasonable instruction, and disrespect in the workplace.

b) Where these actions take place, the individual concerned is to be subject to UHB disciplinary procedure under the Disciplinary Policy and the details retained on the personnel files.

c) Mismanagement might be expected to indicate that a director has dealt with responsibilities badly or carelessly, by mismanaging funds and / or not adhering to recognised practice, of following guidance, or processes within which an individual is meant to work.

d) Where these actions take place, the individual concerned is to be subject to UHB disciplinary procedure under the Disciplinary Policy and the details retained on the personnel files.

e) 'Responsible for, contributed to, or facilitated' means there is evidence that a person has intentionally, or though neglect behaved in a manner that would be considered to be, or would have led to serious misconduct or mismanagement.

f) 'Privy to' means that there is evidence that could lead the provider to reasonably conclude that a person was aware of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed.

g) **Collective Responsibility**. Where individuals are implicated in a breach of health and safety requirements, or other statutory duty or contractual responsibility due to how the management team organised and managed activities, UHB will seek to establish what role the individual played in the breach. If the breach is attributable to the individuals conduct, CQC will expect that UHB will find them unfit.

15.27 Policy.

UHB policy is to investigate any allegations that individuals may have been party to misconduct or mismanagement as defined within Regulation 5. The appropriate action will be taken to ensure that no harm comes to staff or patients, and where appropriate the individual concerned, if in post, will be suspended in accordance with the Trust's disciplinary policy whilst the investigation takes place.

15.28 Responsibilities

a) The Head of the HR Service Centre and Trust Secretary will jointly ensure that the data sources, to comply with the regulatory requirement as listed in section 16.5, are collected as part of the recruitment process.

15.29 Procedure for Conducting the Checks

a) All applicants will be required to submit an application which includes details of the applicants work and training history, details of at least two referees, one of whom should the individual's current or last line manager.

b) The references will be requested and considered by the recruiting manager to consider if there are any issues which may require any further investigation.

c) Inspection reports and other publicly available information from the CQC and Ombudsman will be searched to identify if the individual is named, and if so the context and implications will be assessed.

d) The Trust will also undertake a check through a third party background checking service to ensure that the work history for the previous five years is an accurate reflection of the history presented in the applicants CV.

15.30 Procedure for Recording and Retaining the Check Information

a) Copies of all documents and, where possible, searches will be included in the individual's recruitment and, if successful, their employment file. Where a search returns a nil value, then a copy of the search and result will be included within the file.

15.31 Data Sources.

a) UHB will investigate any allegation and make such independent enquiries as required. UHB will review any appropriate data sources, including those set out below and information arising during the other Checks.

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
1.	To review existing or newly recruited directors background	• Self-declaration • References from previous employers	
2.	To review inspection details: hospitals, care homes, dentists, community based services, clinics, GPs and doctors, services in your home, and mental health	• Reports on healthcare providers • Care Quality Commission http://www.cqc.org.uk/	As appropriate in accordance with the director's profile

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
3.	To research complaints	• To investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England. Parliamentary and Health Service Ombudsman http://www.ombudsman.org.uk/	As appropriate in accordance with the director's profile

15.32 Procedural Check 5: Grounds of Unfitness

15.33 Regulatory Requirement:

UHB must seek all available information to assure itself that directors do not meet any elements of the unfit person test (Schedule 4 Part 1). This includes whether the person is:

a) An undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.

b) Subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.

c) A person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.

d) A person who has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.

e) Included in the children's barred list or the adults barred list maintained under Section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

f) Prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment such as the Companies Act and Charities Act.

g) CQC Guidance. Only individuals acting in a role that falls within the definition of a regulated activity as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the Disclosure and Barring Service (DBS). Where providers deem the individual is suitable despite not meeting the characteristics required, the reasons must be recorded and information about the decision made available to those that need to be aware. It is for the

provider to regularly review the fitness of directors to ensure they remain fit for their role and to investigate concerns in a timely manner.

15.34 Responsibilities

a) The Trust Secretary will ensure that the data sources, to comply with the regulatory requirement as listed in section 17.10, are collected as part of the recruitment process.

15.35 Procedure for Conducting Checks

a) The various registers and sources of information will be reviewed for the details of the individuals.

b) The Trust will also undertake a check through a third party background checking service to ensure that any publicly available information such as County Court Judgments, or bankruptcy orders, have been highlighted by the individual.

15.36 Procedure for Recording and Retaining the Check Information

a) Copies of all documents and, where possible, searches will be included in the individual's recruitment and, if successful, their employment file. Where a search returns a nil value, then a copy of the search and result will be included within the file.

15.37 Data Sources.

UHB will check a number of data sources, including those below and those conducted under Check 1 and 4 regarding Good Character, and Misconduct and Mismanagement

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
1.	To review companies, for who the individual had a previous or current director role, that have become insolvent	**Register of Insolvent Companies**: held by Companies House http://wck2.companieshouse.gov.uk//wcframe?name=accessCompanyInfo	
2.	To review the register of persons who have either been disqualified through a court order or by an undertaking of the Insolvency Service from being directors of companies or members of LLPs	**Disqualified Directors Register**: held by Companies House http://wck2.companieshouse.gov.uk//wcframe?name=accessCompanyInfo	The register shows the length of time the director or member has been disqualified. It also shows the section of the Company Directors Disqualification Act 1986 under which the director has been disqualified.
3.	To review details about insolvency cases in England	**Insolvency Service Register**: held by the Insolvency Service	The Register lists directors who were disqualified in the last 3 months

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
	and Wales, including bankruptcies	To provide details about insolvency cases in England and Wales, including: bankruptcies, e.g. the date of a discharge (when someone is freed) from debts; Debt Relief Orders; Fast Track or Individual Voluntary Arrangements https://www.insolvencydirect.bis.gov.uk/IESdatabase/viewdirectorsummary-new.asp	Contact the Insolvency Service for details of directors who were disqualified more than 3 months ago
4.	To review details about insolvency cases in Scotland	**Register of Insolvencies**: held by Scotland's Insolvency Service To maintain a statutory register about the insolvency of individuals and businesses in Scotland http://roi.aib.gov.uk/roi/	The Register includes: details of sequestrations awarded in Scotland; details of trust deeds, and details of limited companies which are in receivership or liquidation
5.	To review details of County Court judgments, and credit refusals	**Register of Judgments**: held by Trust Online http://www.trustonline.org.uk/	The registers cover CCJ, Administration Orders, Child Support Agency Liability Orders, High Court judgments, fines defaults from the Magistrates Courts and tribunal awards in England & Wales. In addition it includes small claims and summary causes money decrees from Scotland; money judgments from the Petty Debts and Royal Court in Jersey; undefended default and small claims judgments in Northern Ireland; and money judgments from circuit and district courts in the Republic of Ireland.
6.	To review Debt Relief Orders, Bankruptcy Relief Orders, and Individual Voluntary Arrangements	**Debt Relief Order, Bankruptcy Relief Order, and Individual Voluntary Arrangement Register**: held by Department of Enterprise, Trade and Investment NI: Insolvency Service Online	
7.	In the event the individual worked in an organisation regulated by the FCA: To review the public record of all the firms, individuals and other bodies in the financial services that the	**Financial Service Register** held by the Financial Conduct Authority (FCA)	This has information on all firms that are, or have been: authorised by the FCA; registered with FCA to conduct regulated activities; or provide certain regulated products or services in the UK As well as authorising firms to conduct

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
	FCA regulate		regulated activities, the Register includes individuals in firms who are approved to carry out particular functions. The FCA must approve an individual before they are able to conduct certain types of business, such as selling or advising on investments like personal or stakeholder pensions, life assurance policies, shares or collective investment schemes
8.	In the event the individual worked in a consumer credit business: To review the public record of firms that have interim permission to carry out consumer credit activities	**Consumer Credit Register**: held by the FCA http://www.fca.org.uk/firms/systems-reporting/consumer-credit-register	Regulation of consumer credit has been taken by the FCA from the Office of Fair Trading

16. Appendix C – Information Retention for Inspection by the CQC

Key Document References:

NHS Employers 'Identity Checks' dated July 2013.

NHS Employers 'Right to Work Checks' dated June 2014.

NHS Employers 'Employment History and Reference Checks' dated July 2013.

NHS Employers 'Work Health Assessments' dated July 2013.

NHS Employers 'Criminal Record and Barring Checks' dated July 2013.

NHS Employers 'Professional Registration and Qualification Checks' dated July 2013.

16.1 Regulatory Requirement.

Certain information regarding individuals covered by the Regulation must be available to be supplied to the CQC, to include that specified by Schedule 3 or that set out under any enactment which is relevant to the individual concerned.

16.2 Barred Lists.

Where a director meets the eligibility criteria, UHB should establish whether the person is on the children's and/or adults safeguarding barred list and whether they are prohibited from holding the office in question under other laws such as the Companies Act or Charities Act. CQC expect providers to undertake an enhanced DBS check for directors to

check that they are on the children's and / or safeguarding barred list where they meet the eligibility criteria.

16.3 Key Test.

CQC guidance is that 'satisfactory' will be construed in the opinion of the CQC.

16.4 Compliance and Procedure:

a) The information to be retained will be secured whilst carrying out the specified requirements and checks. It will provide evidence of several different aspects of Regulation 5 for example good character (Check 1), qualifications, skills and experience (Check 2), and health (Check 3).

b) The responsibility for retaining the information requirements in the appropriate format, and providing the information at CQC's request lies with the Head of the HR Service Centre.

c) The information will be held and audited annually.

d) Individuals are to be informed when the CQC requests information on an individual.

16.5 Information Requirements,

The information to be retained is set out in the form below:

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
Requirement 1 - Proof of Identity Including a Recent Photograph: • To minimise the risk of employing or engaging a person in any activity within the NHS who is an illegal worker, or person that is impersonating another. • All identity checks should comply as required with the NHS Employers 'Identity Checks' standard. • The process involves checking two elements of a person's identity: the attributable and the biographical. This is achieved through: receiving original documents, checking the document authenticity, and validating the individual's personal details. • Biometric identity, such as fingerprints, voice and DNA is not a required part of NHS identity checks. • Post holders need to provide either two forms of photographic personal identification and one document confirming their address, or one form of photographic personal identification and two documents confirming their address.			
1.	To determine that the individual's identity is genuine and relates to a real person To establish that the individual owns and is rightfully using that identity.	UK (Channel Islands, Isle of Man or Irish) passport or EU/other nationalities passport	The NHS uses three methods for verifying identity: - receiving original documents; - checking document authenticity; - validating an individual's personal details against external reliable sources, including information held by previous employers (subject to the individual providing relevant consent that

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
			such information can be accessed).
2.		Passports of non-EU nationals and other valid evidence relating to their immigration status and permission to work	
3.		UK full or provisional photo-card driving licence (must include counterpart, except Jersey)	
4.		EU/other nationalities photo-card driving licence (valid up to 12 months up to the date of when the individual entered the UK and providing that the person checking is confident that non-UK photo-card driving licences are bona fide)	
5.		Biometric Residence Permit (formerly known as identity cards for foreign nationals) (UK)	
6.		HM Armed Forces Identity card	
7.		ID cards carrying the PASS accreditation logo (UK and Channel Islands), for example a UK Citizen ID card. This card can be applied for by residents of the UK and is verifiable with similar security marks to UK passports and driving licences.	
Requirement 2 - A Copy of a Criminal Record Certificate: • Where required for the purposes of an exempted question in accordance with the Police Act 1997 s113A(2)(b), a copy of a criminal record certificate, and • Where applicable the information mentioned in the Safeguarding Vulnerable Groups Act 2006 s30A(3)			
8.	See **Check 1**		
Requirement 3 - A Copy of an Enhanced Criminal Record Certificate: • Where required for the purposes of an exempted question asked for a prescribed purpose under the Police Act 1997 s113B(2)(b) an enhanced criminal record certificate, and • Where applicable suitability information relating to children or vulnerable adults.			
9.	See **Check 1**		
Requirement 4 - Satisfactory Evidence of Conduct in Previous Employment: • Where concerned with the provision of services relating to (a) health or social care or, (b) children or vulnerable			

Ser (a)	Addressing the Regulatory Requirement (b)	Data Sources and Purpose (c)	Comments (d)
	adults		
10.	See **Check 2**		
Requirement 5 - Satisfactory Verification so far as Reasonably Practicable of the Reason for Ending of Employment: • Where the person has been previously employed in a position whose duties involved work with children or vulnerable adults.			
11.	See **Check 2**		
Requirement 6 - Satisfactory Documentary Evidence of Relevant Qualifications in so far as it is Reasonably Practicable to Obtain It: • Where relevant to the duties for which the person is employed or appointed to perform.			
12.	See **Check 2**		
Requirement 7 - Full Employment History and Satisfactory Written Explanation of Gaps in Employment: • Employers risk breaking the law if they do not check the entitlement to work in the UK for all prospective post holders before they start in post. • If the individual is not permitted to work in the UK he / she must not be allowed to take up the post.			
13.	See **Check 2**		
14.	To confirm prospective post holder has the right to work in the UK	Employers must see one of the documents or a combination of documents as listed by the 'Right To Work Checks' dated June 2014. No other combinations are permitted.	Failure to check an employee's status could result in a civil penalty of up to £20,000 per illegal worker. For staff in ongoing employment, the checks that should have been undertaken before amendments made to the Immigration, Asylum and Nationality Acton 29 February 2008 will depend on when the employee was recruited. A partial right to work check is not a mitigating factor in the calculation of a civil penalty. Employees must request the right to work documents, validate the documents in the presence pf the holder, and copy and store documents (securely).
Requirement 8 - Satisfactory Information Regarding Any Physical or Mental Health Conditions: 1. Where relevant to the person's capability, after reasonable adjustments are made, 2. To properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity.			
15.	See **Check 3**		

17. Appendix D – FPPR Checklist

FIT AND PROPER PERSONS CHECKLIST

No	Check and Evidence Required	Lead Officer	Date Obtained	Initials
Procedural Checks 1 and 4: Good Character, and Misconduct or Mismanagement				
1	Signed Declaration of Fitness from candidate (Form A or B, according to whether DBS checks required)	HR Service Centre		
2	DBS checks - as appropriate to the post - in line with NHS Employment Check Standards.	HR Service Centre		
3	Undertake police check/certificate of good character – only needed if individual has spent 6 months or more outside the UK in the last 5 years before application.	HR Service Centre		
4	Where post requires the individual to be a registered health professional – check professional body's register for: • Confirmation that individual is registered to carry out the proposed role • Details of any limitation on their registration that might affect the duties proposed • Details of any current or previous fitness to practice proceedings/professional disciplinary proceedings.	HR Service Centre		
5	Search of CQC records: http://www.cqc.org.uk/ • Check if any provider for whom the individual has worked has had registration suspended/cancelled due to failings in care in the last 5 years (or longer if available) • Check the involvement of the individual or any providers in previous inspections (Investigate further if inspection rating is 'requires improvement', or 'inadequate').	Trust Secretary		
6	Search for involvement of individual or providers in serious care issues/investigations. Check the following websites:	Trust Secretary		

No	Check and Evidence Required	Lead Officer	Date Obtained	Initials
	• Public Inquiry Reports - http://www.nationalarchives.gov.uk/webarchive/inquiries-inquests-royal-commissions.htm# • Serious Case Reviews - http://www.nspcc.org.uk/preventing-abuse/child-protection-system/england/serious-case-reviews/ • Homicide investigations for mental health trusts (if employed previously by mental health trust) - http://www.england.nhs.uk/publications/invest-reports/			
7	Review Parliamentary and Health Service Ombudsman reports relating to providers to identify whether these give rise to further lines of enquiry regarding the individual: http://www.ombudsman.org.uk/	Trust Secretary		
Procedural Check 2: Qualifications, Competence, Skills and Experience				
8	A full employment history, together with a satisfactory written explanation of any gaps in employment in line with NHS Employment Check Standards.	HR Service Centre		
9	At least two references - one of which must be most recent employer, in line with NHS Employment Check Standards	HR Service Centre		
10	Academic and professional qualifications check - checked against job description/person specification - in line with NHS Employment Check Standards	HR Service Centre		
Procedural Check 3: Health				
11	Occupational health clearance in line with NHS Employment Check Standards	HR Service Centre		
Procedural Checks 4: Misconduct or Mismanagement *See Procedural Check 1 above.*				
Procedural Check 5: Grounds of Unfitness				
12	Check Register of Insolvent Companies for any company for whom the individual had a previous/current director role, that have become insolvent: http://wck2.companieshouse.gov.uk//wcframe?name=accessCompanyInfo	Trust Secretary		

No	Check and Evidence Required	Lead Officer	Date Obtained	Initials
13	Check Disqualified Directors Register to identify whether individual has been disqualified through a court order/by an undertaking of the Insolvency Service from being a director of a company or a member of an LLP.: http://wck2.companieshouse.gov.uk//wcframe?name=accessCompanyInfo	Trust Secretary		
14	Check the Individual Insolvency Register to identify whether the individual is insolvent: https://www.insolvencydirect.bis.gov.uk/IESdatabase/viewdirectorsummary-new.asp http://roi.aib.gov.uk/roi/	Trust Secretary		
15	Check Register of Judgments to review details of County Court judgments, and credit refusals: http://www.trustonline.org.uk/	Trust Secretary		
16	Check Bankruptcy or Debt Relief Restrictions Register: https://www.insolvencydirect.bis.gov.uk/IESdatabase/viewbrobrusummary-new.asp	Trust Secretary		
17	If individual has worked for an organisation regulated by the Financial Conduct Authority (FCA), check Financial Service Register: https://register.fca.org.uk/	Trust Secretary		
18	If individual has worked in a consumer credit business check the business name on the Consumer Credit Register: http://fca-consumer-credit-interim.force.com/CS_RegisterSearchPageNew	Trust Secretary		
Additional Checks				
19	Proof of identity (including recent photograph) and proof of address which can be in the form of a utility bill (within the last three months) in line with NHS Employment Check Standards	HR Service Centre		

No	Check and Evidence Required	Lead Officer	Date Obtained	Initials
20	Confirmation of right to work in the UK in line with NHS Employment Check Standards	HR Service Centre		

Copies of all the documentation are to be sent to the Trust Secretary who will retain the Fit and Proper Persons Documentation.

Cover report to the Trust Board meeting to be held on Tuesday, 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	19
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Research and Innovation Quarterly Update Report		
Author	David Wynick, Consultant, BRI		
Executive Lead	Sean O'Kelly, Medical Director		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☐

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

Executive Summary

Purpose

The purpose of this report is to provide an update on performance and governance for the Board.

Key issues to note

See executive summary in report.

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

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

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☒	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

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

Impact Upon Corporate Risk
N/A

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

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

Executive Summary

Performance:

The percentage of studies meeting the 70d benchmark remains good, at 84% (validated figure for Q2) although this is a slight reduction on previous performance (Q1 88%). We believe that this reduction is primarily due to the impact of the Health Research Authority changes to the processes to approve research in England. Close oversight of this indicator will be maintained.

We have focussed our efforts on increasing the percentage of commercial and non-commercial trials that recruit to time and target. For closed commercial trials our validated performance has increased from 31% to 40% (Q1 vs Q2 validated figures). A project work stream is underway to introduce more robust oversight of the delivery performance of commercial and non-commercial trials and to review and maintain a balanced portfolio to ensure that we carefully assess that trials we choose to open are feasible. We also continue to work with the Clinical Research Network: West of England (LCRN) to receive intelligence on best practice in other trusts which can be adopted locally.

We are awaiting indicative funding allocations from the LCRN, pending actual allocations late in Q4. We are planning for a 5% reduction in delivery funding for 2017/18, based on the data we have sight of, and intelligence from the LCRN. Contingency planning is underway whilst we await information on the funding allocation. A review of open studies across the divisions has identified an imbalance in our portfolio with a higher proportion of complex high intensive trials opened leading to lower recruitment rates. Areas for potential of increased recruitment have been identified and plans are in place to improve study selection. Close oversight of recruitment for 17/18 will be maintained.

Partnerships and Governance:

Following the award of the Biomedical Research Centre, the Bristol BRC Chief Operating Officer will commence in post on 20 February, ahead of the Centre start date of 1st April 2017. Her role during that period will be to focus on the setup of the Centre, supported by the newly formed management group. Key tasks include HR arrangements for Centre staff, agreeing the main contract and managing the development and sign-off of the collaboration agreements. The project board continues to oversee the setup of the Centre, and will be dissolved at commencement of the Centre as full governance structures are put in place.

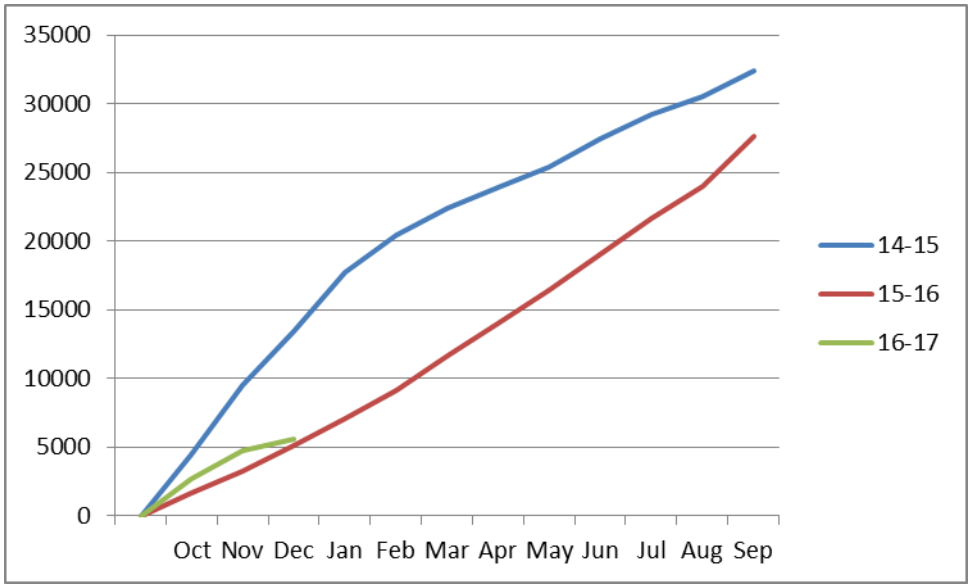
Overview

Successes	Priorities
• Rapid appointment of the Bristol BRC Chief Operating Officer has permitted the successful candidate to start work before the start of the centre. This will support the setup and good governance of the centre. • Performance in initiating and delivering research continues to be maintained at a good level for 5 successive quarters. Performance in delivering commercial research has improved with renewed focus on that indicator.	• Focus attention on optimising our performance in delivering research to time and target, for both commercial and non commercial trials. • Support the new BRC COO in her role so that she can work effectively • Develop communications activities in order to raise the profile of research for both staff and patients.
Opportunities	**Risks and Threats**
• Work with divisional staff to identify important clinical questions that might be developed to generate high quality grants for submission to NIHR and other funding bodies. Longer term this will help support our research infrastructure through research capability funding and delivery funding. • Undertake work with neighbouring trusts, in particular NBT, to identify areas of research/studies already being carried out that can be opened in UHBristol. Introduce systems to allow easy identification of such studies as we receive them, and flag to other partners. • Review our portfolio and aim to increase the proportion of band 2 research taking place (observational), compared to band 3 (complex, interventional). • Identify clinical areas where commercial research activities might be exploited in order to generate income.	• Lower levels of weighted recruitment than previous years may impact on delivery funding for 2017/18. The size of the reduction is not yet known. • Delay in receipt of the contract for the BRC will delay the start of work on collaboration agreements and could impact on how soon staff can be appointed in partner organisations. This will be managed closely by the BRC COO on a partner by partner basis in order to minimise this risk.

Performance Overview

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

a) Cumulative weighted recruitment into NIHR portfolio studies in 16-17. [NB. There is a 6 week lag in recruitment data becoming visible on the system.]



Please note the reporting period in this graph is based on that which is used by the NIHR to determine funding allocations.

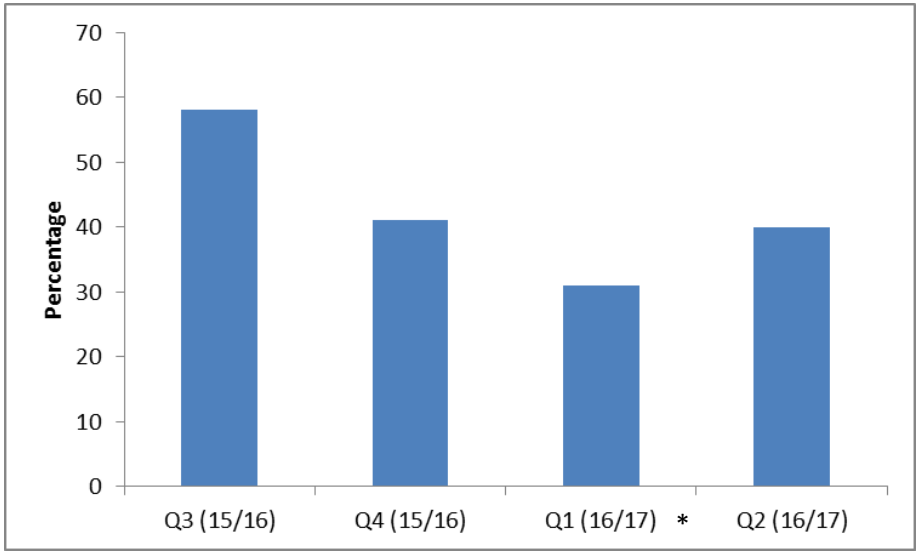
b) Performance in meeting the 70 day first patient first visit benchmark adjusted by NIHR in comparison to other Trusts

NIHR PID report- latest received Q1 16/17

92%	91%	88%	84%
Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17

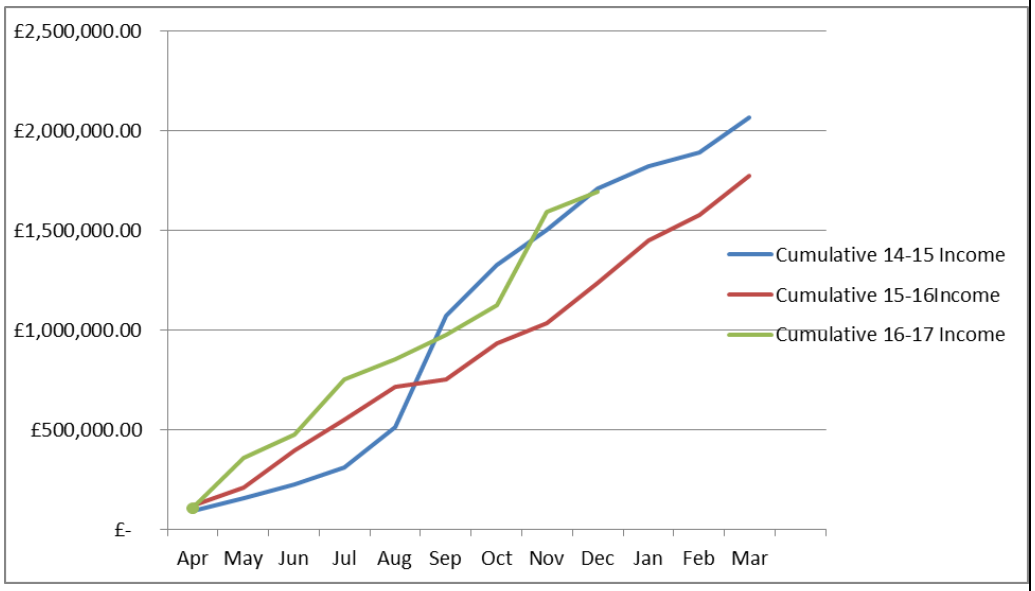
Green: >81.4% (Upper Quartile)
Red: <70.7% (Median)

c) Percentage of closed commercial studies recruiting to time and target

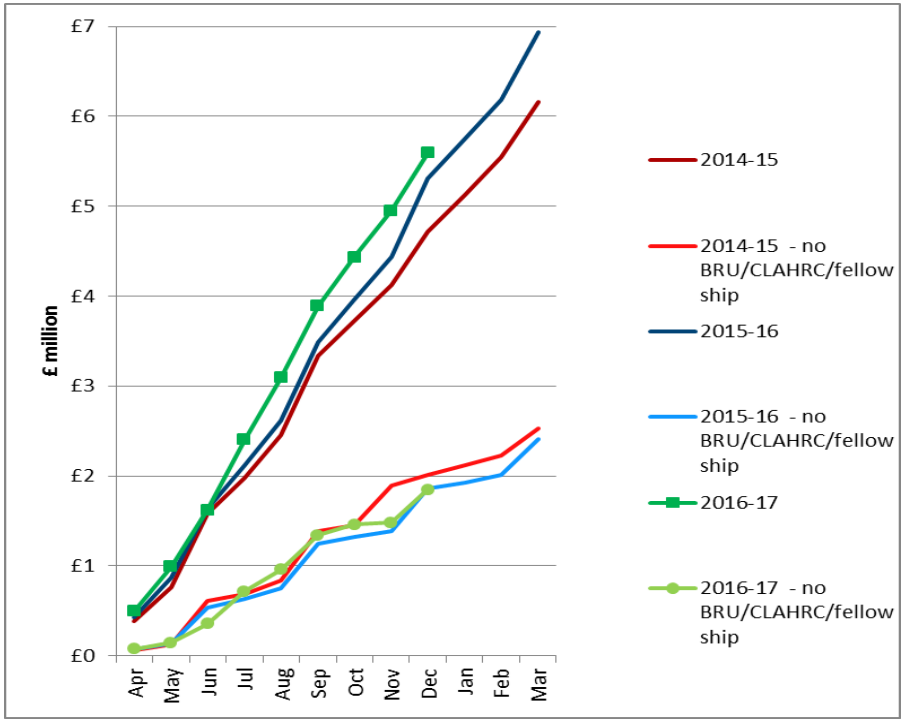


*DH changed the way the reporting metrics were analysed, effective Q1 16/17

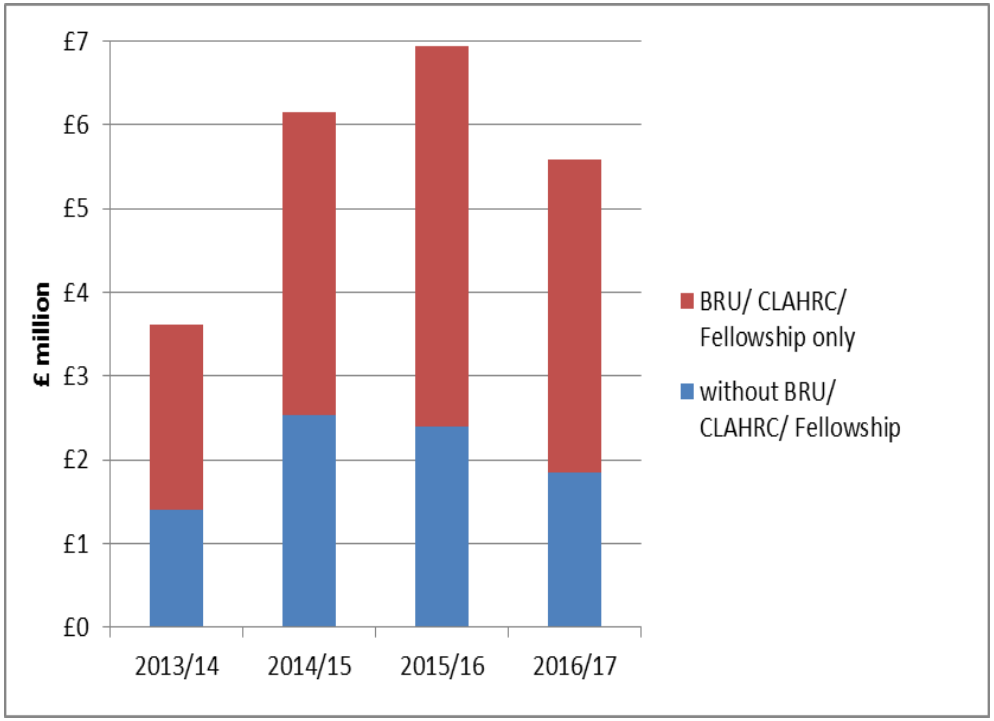
d) Monthly commercial income



NIHR monthly grant income – year on year comparison



NIHR grant income – drives research capability funding.



University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Trust Board meeting to be held on Tuesday, 31 January 2017 in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	20
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	West of England Academic Health Science Network Board		
Author	Robert Woolley, Chief Executive		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

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

Executive Summary

Purpose

To update the Boards of the member organisations of the West of England Academic Health Science Network of the decisions, discussions and activities of the Network Board.

Key issues to note

There are no key issues to note.

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

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

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

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

Impact Upon Corporate Risk
N/A

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

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

Report from West of England Academic Health Science Network Board, 7 December 2016

1. Purpose

This is the thirteenth 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 2 2016/17

- The Parliamentary launch of "MINDset" was on Monday 5th December. This is a quality improvement website for people involved with providing or commissioning services for people with mental health problems. MINDset is the product of a partnership led by West of England AHSN which includes NHS Improvement and a number of other partners including the South of England mental health patient safety collaborative which we also host. Visit the website at www.mindsetqi.net. We have also produced a MINDset QI handbook.

- Suzette Woodward, Director of Sign Up to Safety was guest speaker at our second Primary Care Patient Safety Collaborative meeting - with 13 GP practices drawn from across the West of England. We are planning to recruit a second cohort of practices for 2017/18. Contact Kevin.hunter@weahsn.net for details.

- The Royal College of Physicians launched the acute hospital mortality review programme on 22nd November. West of England and Yorkshire and Humber are the only two areas where acute Trusts are working together to understand and act on the themes arising from mortality reviews. We are the only group who is involving primary care and public contributors. Three of our Trusts have had their trainers trained and the second training day will be in April 2017.

- We are supporting the 5 Community Education Provider Networks in the West of England to develop and test new models of primary care workforce. Each CEPN now has proposals it want to test and these are part of the STP workforce planning. We will also support sharing and learning across the South West.

- We are stimulating early stage innovation in primary care through our latest Small Business Research Initiative call. "GP of the Future" was designed by local GPs and asks companies to respond with the innovations under three themes: demand management; earlier triage and self-care and diagnostics. Over 250 companies have applied.

- We are on track to recruit the first 500 people into our Diabetes Digital coach test bed with Swindon and Gloucestershire practices leading the way. 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.

3. Future of AHSNs

NHS England has confirmed that AHSNs will have a second five year licence running from April 2018. Discussions are underway about how we can support innovation and improvement into the future. At a national level, the Accelerated Access Review sets out many potential roles for AHSNs and NHS England is also keen to explore how we can support STPS as they develop.

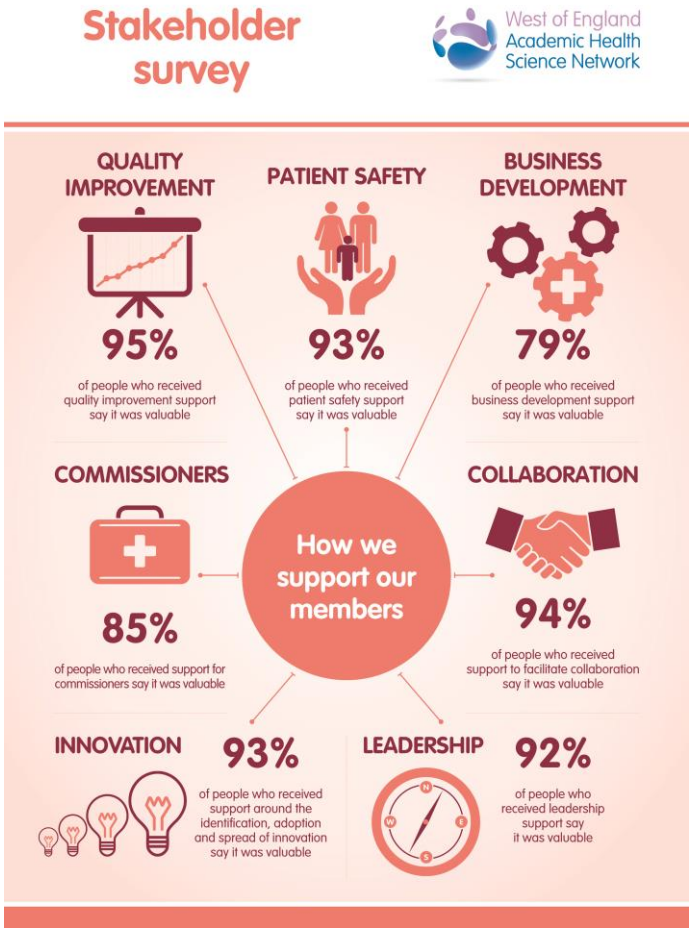
Patient Safety Collaboratives will continue their first mandate until March 2019 and are expected to continue beyond that, with closer involvement of NHS Improvement

4. Stakeholder survey

The AHSN had 212 responses to the stakeholder survey, which is almost double last year's numbers (125) and was the highest in the country. As was the case last year a very high percentages of people who had received patient safety, quality improvement or business development support said it was valuable. We had a wealth of free text comments which are highly positive and which recognise the contribution we are making to STPs in particular.
The infographic showing our results is attached.

Deborah Evans,
Managing Director
December 2016


Stakeholder survey
West of England Academic Health Science Network
PARTNERSHIP CULTURE
76%
say we are building a strong culture of partnership and collaboration
PROMOTING CHANGE
70%
say we are good at promoting change in the local health economy
KNOWLEDGE OF THE LOCAL LANDSCAPE
73%
say we have a good knowledge of the local landscape
Our strengths as identified by our members
INNOVATION INTO PRACTICE
64%
say we are speeding up the adoption of innovation into practice
PATIENT NEED
68%
say we are effective at focusing on the needs of patients and local populations


Stakeholder survey
West of England Academic Health Science Network
QUALITY IMPROVEMENT
95%
of people who received quality improvement support say it was valuable
PATIENT SAFETY
93%
of people who received patient safety support say it was valuable
BUSINESS DEVELOPMENT
79%
of people who received business development support say it was valuable
COMMISSIONERS
85%
of people who received support for commissioners say it was valuable
How we support our members
COLLABORATION
94%
of people who received support to facilitate collaboration say it was valuable
INNOVATION
93%
of people who received support around the identification, adoption and spread of innovation say it was valuable
LEADERSHIP
92%
of people who received leadership support say it was valuable

Cover report to the Trust Board meeting to be held on Tuesday, 31 January 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	21
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 January 2017
Report Title	Governors Log of Communication		
Author	Kate Hanlon, Interim Head of Governance and Membership		
Executive Lead	John Savage, Chairman		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

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

Executive Summary

Purpose

The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous Board.

The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust. The log is distributed to all Board members, including Non-executive Directors when new items are received and when new responses have been provided.

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

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

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

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

Impact Upon Corporate Risk
N/A

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

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

ID	Governor Name		
176	Sue Milestone	***Theme:*** Patient advocate	***Source:*** From Constituency/ Members

Query **16/01/2017**

Who is the Patient advocate at UH Bristol? Where can the Advocate be found in the Trust hospitals?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

175	Sue Milestone	***Theme:*** Orthopaedic surgery at BRHC	***Source:*** From Constituency/ Members

Query **10/01/2017**

I understand there are delays to orthopaedic surgery for children with acute spinal conditions e.g. scoliosis. What are the current waiting times for children listed for surgery with acute spinal conditions and can you give reasons for any delays?

Division: Women's & Children's Services ***Executive Lead:*** *Medical Director* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

ID	Governor Name		
174	Kathy Baxter	***Theme:*** Carers	***Source:*** From Constituency/ Members

Query **20/12/2016**

What provision is there for the paid carers of a child patient to remain with the patient to attend to their general, rather than medical needs, while they are in hospital – in particular where the patient has complex needs?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

173	Garry Williams	***Theme:*** GP Specialists	***Source:*** Governor Direct

Query **20/12/2016**

Years ago the concept of GP Specialists (GPSIs) performing surgery etc. on a local practice level was actively floated. Is there any intention to make appropriate procedures available locally? Could this idea be developed at South Bristol Community Hospital?

Division: Surgery, Head & Neck ***Executive Lead:*** *Medical Director* ***Response requested:***

Response **22/12/2016**

GPs with special interests still work in some areas, for example cardiology and dermatology, but this work tends to be mainly delivered in primary care settings. GPs do not generally perform surgical procedures, except for occasional minor procedures under local anaesthetic in some minor injury units, since Royal Collage guidance and organisational governance stipulates minimum patient numbers and the degree of training required. As Governors may be aware, the Trust's plan for South Bristol Community Hospital will be refreshed in the course of 2017/18 and will be aligned with STP strategy for the configuration of clinical services.

Status: *Closed*

ID	Governor Name		
172	Malcolm Watson	***Theme:*** Workforce planning	***Source:*** Governor Direct

Query **20/12/2016**

An important aspect of staff recruitment and retention is the overall size of the pool from which staff may be recruited. The size of the pool is in part due to workforce planning, and on ensuring an adequate input of newly qualified staff to this pool. What, if any, powers or influence does the board have over these areas, and how is the board using any such powers and influence that it may have?

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

Response **12/01/2017**

Prior to 2016, Health Education England systematically co-ordinated the process of workforce planning across NHS providers to forecast future numbers and then commissioned training places for nursing and allied health professional on this basis. Accordingly, we have produced detailed workforce plans for 2015/16 to 2020/21which show numbers of staff required for the next five years, and these have been submitted to Health Education England and also form the basis of our 5 year plan which we submitted to NHS Improvement in December 2016.

In the 2015 Spending Review, the Chancellor announced that current bursary and fee arrangements for undergraduate nursing, midwifery, AHPs, and other clinical groups would be replaced by student loans for new students from 2017, and that training places would no longer be commissioned centrally by Health Education England. Following this change, we are working in close partnership with local universities to ensure we attract sufficient numbers of students to undertake training, with regular meetings and close liaison. There is an active UWE stakeholder group which includes leads from UH Bristol – providing opportunities to modify the University-based learning, placement offers etc. Feedback to date from UWE and Plymouth concerning the Allied Health Professional intakes from 2017 is that they are currently continuing to receive the usual level of enquiries and interest, despite the removal of bursaries. The impact of the removal of bursaries for nursing is yet unknown.

We actively encourage and support work experience placements so any young student (15-18) interested in a health career can have some exposure to the realities of the various roles, and we also ensure that our Trust is seen as an attractive place to live, train and work for both prospective and existing trainees.

In addition, there have been changes to apprenticeships which mean in future it may be possible to develop our future supply of staff through the apprenticeship route. We are in the process of exploring the potential for developing these new routes to training our staff, and ensuring that future supply matches demand.

Status: *Awaiting Governor Response*

ID	Governor Name		
171	Malcolm Watson	***Theme:*** Pathology services	***Source:*** From Constituency/ Members

Query **20/12/2016**

Inquests into neonatal deaths currently have to be conducted away from Bristol, which can cause greater anxiety and distress for parents. What assurance does the Trust have that NBT has taken the appropriate steps to recruit a paediatric histopathologist for the combined UH Bristol and North Bristol histopathology service?

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:***

Response **03/01/2017**

The Trust has been informed by NBT that they have advertised for a Paediatric/Perinatal Histopathologist, but that there is currently a shortage nationally of pathologists qualified in this field. There are however, four applicants for a position of general Consultant Histopathologist, one of whom currently participates in perinatal work. It is possible, NBT inform us, that if this candidate is successful in the selection process, they might undertake perinatal histopathology work in addition to other histopathology work.

NBT inform us that some neonatal post mortems are carried out at Great Ormond Street Hospital in London, where there is particular expertise in neonatal cardiac pathology, at the request of the Bristol clinical teams. Other Coroner's post-mortems are also carried out in other centres on occasions, due to the mortuary's capacity to meet fluctuation in demand with current staff numbers.

Status: *Closed*

ID	Governor Name		
170	Malcolm Watson	***Theme:*** Pathology services	***Source:*** From Constituency/ Members

Query **20/12/2016**

The only aspect of pathology services not currently provided by Severn Pathology is blood sciences. When was the last time a cost-benefit analysis was undertaken to see if it would be better to buy these services rather than have our own. Is this option periodically reviewed?

Division: Trust-wide ***Executive Lead:*** *Director of Finance* ***Response requested:***

Response **21/12/2016**

The last time we reviewed this aspect of our pathology services was ahead of the approval of the business case for Severn Pathology in December 2014. It was a non-viable proposition at this time. However, the National Carter Review is collating pathology benchmarking so we can test the cost effectiveness of our services against other Trusts nationally going forwards.

Status: *Awaiting Governor Response*