University Hospitals Bristol NHS Foundation Trust

PUBLIC TRUST BOARD

Meeting to be held on Thursday 29th June 2017, 11:00 am - 1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Preliminary Business				
1	Apologies for absence	Information	*Chairman*	**Verbal**
2	Declarations of Interest	Information	*Chairman*	**Verbal**
3	Patient Experience Story	Information	*Chief Nurse*	**Verbal**/3
4	Minutes of the last meetings	Approval	*Chairman*	6
5	Matters arising and Action Log	Approval	*Chairman*	18
6	Chief Executives Report	Information	*Chief Executive*	19
Care and Quality				
7	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 and Deputy Chief Executive*	23
8	a) Quality and Outcomes Committee Chair's Report b) Terms of Reference for the Quality and Outcomes Committee	Assurance Approval	*Quality & Outcomes Committee Chair*	**To be tabled**
9	Independent Review of Children's Cardiac Services progress report	Assurance	*Chief Nurse*	82
10	Annual National Inpatient Survey	Assurance	*Chief Nurse*	117
11	Annual Complaints Report	Assurance	*Chief Nurse*	146
12	a) Quarterly Complaints Report b) Quarterly Patient Experience Report	Assurance	*Chief Nurse*	159
13	Volunteering Strategy	Approval	*Chief Nurse*	213
14	Guardian of Safe Working Hours Annual Report	Assurance	*Medical Director/*	223

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
			Guardian of Safe Working Hours	
Financial Performance				
15	Finance Report	Assurance	*Director of Finance & Information*	235
16	Finance Committee Chair's Report	Assurance	*Finance Committee Chair*	**To be tabled**
Governance				
17	Corporate Governance Statement Self Assessment Certification	Approval	*Chief Executive*	253
18	QOC Terms of Reference	Approval	*Trust Secretary*	264
Items for Information				
19	Governors' Log of Communications	Information	*Chairman*	275
Concluding Business				
20	Any Other Urgent Business	Information	*Chairman*	**Verbal**
21	Date and time of next meeting **Friday 28th July 2017, 11:00am - 1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**		*Chairman*	**Verbal**

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Thursday, 29 June 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**	Thursday, 29 June 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

This patient story charts the experience of Mikie , a young adult, who has been monitored by the dental hospital since he was a child, and had a carefully planned operation to realign his jaw in November 2016 at the BRI.

Mikie will be joined by his mother, Helen, and together they will reflect on an exceptionally well-coordinated procedure between several different teams at the dental hospital and the BRI, orthodontics and maxiofacial team. Mikie will explain how he has always been spoken to about his jaw in an age appropriate way, with professionalism and kindness. How he was fitted with braces on his top and bottom teeth, (a process that lasted two years), so that his teeth could be moved into the correct position to line up with the jaw surgery and how both he and his mother, have been so well looked after throughout this long period of time.

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)**

University Hospitals Bristol
NHS Foundation Trust

Minutes of the Public Trust Board Meeting

Held on Thursday 26th May 2017, 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 Director / Vice- Chair
Julian Dennis	Non-Executive Director
Alison Ryan	Non-Executive Director
Jill Youds	Non-Executive Director
David Armstrong	Non-Executive Director
John Moore	Non-Executive Director
Robert Woolley	Chief Executive
Carolyn Mills	Chief Nurse
Mark Smith	Chief Operating Officer/ Deputy Chief Executive
Alex Nestor	Acting Director of Workforce and Organisational Development
Mark Callaway	Deputy Medical Director (attending in absence of Sean O'Kelly)
Paul Mapson	Director of Finance and Information

In Attendance

Name	Job Title/Position
Pam Wenger	Trust Secretary
Tony Watkin	Patient and Public Involvement Lead (for Item 3)
Christine Teller	Patient (for Item 3)
Carole Dacombe	Public Governor
Jonathan Seymour Williams	Public Governor
Ray Phipps	Patient Governor
Clive Hamilton	Public Governor
Bob Bennett	Public Governor
Pauline Beddoes	Public Governor
Jeanette Jones	JUC Governor Lead
Sue Silvey	Public Governor
Fiona Reid	Head of Communications
Rashid Joomun	Patient Governor
Ray Phipps	Public Governor
Mo Schiller	Public Governor
Malcom Watson	Public Governor
Angelo Micciche	Patient Governor
Florene Jordan	Staff Governor
Garry Williams	Patient Governor
Kathy Baxter	Patient Governor

Carole Tookey	Head of Nursing/Assistant Chief Nurse
Annabel Peason	Member of Staff
Jeff Farrar	Member of Public
Nick Sedgemore	Member of the Public

Minutes:

Zainab Gill	Corporate Governance & FOI Administrator

The Chair opened the Meeting at 11:00am

Minute Ref	Item Number	Action
83/05/17	**1. Welcome and Introductions**	
	The Chairman welcomed everyone to the meeting. Apologies for absence were noted from Paula Clarke, Sean O'Kelly, Guy Orpen and Lisa Gardner.	
84/05/17	**2. Declarations of Interest**	
	There were no declarations of interest.	
85/05/17	**3. Patient Experience Story**	
	The meeting began with a patient story, introduced by Carolyn Mills Chief Nurse. In this story the Board heard from Christine Teller who, having sustained a broken wrist in April this year, attended the BRI Emergency Department with subsequent visits to the fracture clinic. Christine Teller reflected on the quality of both the clinical and non-clinical care provided in the Emergency Department including the personal qualities of the staff which had made her feel valued and re-assured. Christine Teller explained how the team responded to her needs and how this "competent, expert care and treatment" continued in the Fracture Clinic. Christine Teller talked about the importance of reflecting this level of nuanced care upon arrival at the BRI Welcome Centre and the importance of this first point of "customer care" contact for many patients. In referring to an experience elsewhere, Christine Teller drew on comparisons which illustrated the detrimental impact a poor patient experience had on her confidence in how a service was run and her subsequent engagement in that service. The Board were pleased with the care Christine Teller had received	

Minute Ref	Item Number	Action
	and thanked her for attending. The Board discussed Christine Teller's story and her experience and were pleased to note that a specific quality objective had been designed around customer service and ensuring that a good experience is consistent throughout the Trust. **Members RESOLVED to:** • **Receive** the patient story.	
86/05/17	**4. Minutes of the last meeting**	
	The minutes of the meetings held on the 28th April 2017 were agreed as a true and accurate record subject to the below amendments: - ***Page 9, minute ref 64/04/17***- amend word, "partially" to "particularly" - ***Page 17, minute ref 72/04/17-*** amend bullet point to read "The Committee had received the Divisional Financial Reports and in particular had reviewed the Women and Children's activity to help them understand their performance this year." - ***Amend*** attendance list to include Clive Hamilton, Public Governor. - ***Page 19, minute ref 75/04/17***- include comment from Clive Hamilton suggesting that " the Trust might not want to proceed with an action which has a risk to quality of care and that the reference be removed as it did not fit well with the trust's vision and values particularly the aspiration to put quality at the heart of everything they do" **Members RESOLVED to:** • **Approve** the minutes as a true and accurate record from the meeting held on 28th April 2017 subject to the above minor amendments.	
87/05/17	**5. Matters arising and Action Log**	
	Members received and reviewed the action log. The progress against completed actions was noted, there were no outstanding actions to review in this meeting. **Members RESOLVED to:** • **Note** the update against the action log.	

Minute Ref	Item Number	Action
88/05/17	**6. Chief Executive's Report**	
	Robert Woolley, Chief Executive, 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>National Critical Threat Level</u> Robert Woolley reported to the Board that the the national threat level was Critical and that the NHS nationally had taken appropriate steps to ensure that all Trusts were in a full state of readiness. He was not aware of any specific threat to Bristol or the South West. <u>NHS Ransomware Cyberattack</u> Robert Woolley reported to the Board that following the recent NHS Cyber-attack the Trust had minimal impact from the attack and had an immediate good response. He confirmed that the IM&T team had experienced 3 similar attacks recently and all had been resolved quickly with no impact on staff or patients. <u>ORLA Virtual Ward Scheme</u> Robert Woolley reported to the Board that the ORLA Virtual Ward Scheme had recently gone into administration and that the Trust's 30 patients who were being managed by the Scheme had been appropriately managed internally and that there was no impact on care. Robert Woolley confirmed that the Trust was looking at other innovative ways to reduce pressure and acuity on the Trust. Mo Schiller asked if any of ORLA staff would be appointed by the Trust, Robert Woolley explained that this was unfortunately not possible as the ORLA Scheme ended unexpectedly which had not allowed for the Trust to consider this approach. <u>Apprenticeships</u> Robert Woolley reported to the Board that the Trust had been awarded apprenticeships main provider status by the educational skills funding agency. This was the highest level of approval for providing apprentice training. The Board noted that this meant the Trust was now able to train their own apprentices and offer training to other employers. <u>Clinical Trials</u> Robert Woolley reported to the Board that the clinical trials team in the haematology and oncology centre had a world first in May 2017 when they had administered the first cellular therapy product to a patient, following a bone marrow transplant. <u>British Medical Journal 2017 Awards</u>	

Minute Ref	Item Number	Action
	Robert Woolley reported to the Board that the Trust had won two awards at the British Medical Journal awards 2017. He confirmed the awards were for prevention team of the year and the palliative and hospice team of the year. <u>Official Opening of the new Rheumatology Department</u> Robert Woolley reported to the Board that the Trust had officially opened its new rheumatology department in the King Edward Building. **Members RESOLVED to:** • **Receive** the Chief Executive report for information.	
89/05/17	**7. Quality and Performance Report** Members agreed to take item 7 and 8 together.	
	Mark Smith, Chief Operating Officer and Deputy Chief Executive presented this report, it was noted that the performance against the national access standards was more mixed this month, with evidence of improvement in some areas, but some significant challenges remaining in others. Whilst performance against the 92% Referral to Treatment (RTT) time standard remained the same in percentage terms, both the total number of ongoing pathways and the number of patients waiting over 18 weeks decreased, with reported performance of 91.1% above the recovery forecast of 90.9%. It was further noted that the recently published 5 year forward view had placed additional emphasis on ongoing pressures relating to patient flow and operational pressures, however that the Trust would continue to work towards achieving the trajectory for RTT. The Board confirmed their commitment to recovering the RTT target and supporting the Trust's approach. *Members noted:* • Performance against the 62-day GP cancer standard also improved and was above the 85% national standard for internally managed pathways. • Disappointingly, performance against the A&E 4-hour standard continued to be below the new in-month performance trajectory. • There was a slight rise in the number of patients on the new outpatient waiting list, in the main due to the shorter working month. However, encouragingly, the number of patients on the elective waiting list fell slightly in April, following three consecutive months of the waiting list rising. • The overall level of emergency admissions into the Bristol Children's Hospital (BCH) fell in April relative to the same period	

Minute Ref	Item Number	Action
	last year. This led to an improvement in 4-hour performance at the BCH, with the 95% A&E 4-hour standard being achieved for the first time since August 2016. • There continues to be a higher than average rate of discharge of long stay patients in the month, the number of current over 14 day stays in hospital at month-end remained high relative to the last two years. • A further improvement was noted in a number of the workforce metrics, including agency rates, which were now Green rated. Levels of staff sickness had, encouragingly, shown a further decrease this month and maintained a Green rating. Turn-over rates had been maintained at the lower levels seen since October 2016, and vacancy rates remained Green rated and continued to fall, reflecting the continued strong internal focus on recruitment and retention of staff. • While Neck of Femur performance was disappointing, it was noted that for the majority of the patients involved the delay was for sound clinical reasons. The Board noted the brief update in relation to the WHO surgical checklist compliance, which had been showing as red on the dashboard since introducing the Bluespier theatre system. He advised that following the appointment of the Bluespier trouble shooter, performance in this area had improved. **Members RESOLVED to**: • **Receive** the Quality and Performance Report for assurance.	
90/05/17	**8. Quality and Outcomes Committee Chair's Report** Members agreed to take item 7 and 8 together.	
	Members received a written report following the meeting of the Quality and Outcomes Committee held on the 30th May 2017. Members also received a verbal account of the meeting held on the 30th May 2017 from Alison Ryan, Non-executive Director and Chair of the Quality and Outcomes Committee (QoC), covering the following key areas: - The Committee received a progress update report on the actions taken since the Royal College of Paediatrics and Child	

Minute Ref	Item Number	Action
	Health (RCPCH) follow-up review visit in February 2016. The progress report was received well and demonstrated the team's positive engagement in relation the action plan. - The Committee had received a detailed progress report and presentation on the delivery of the workforce agenda including progress against the key performance indicators, which were all green for this month. The Board noted that next month the Committee would be receiving a breakdown of workforce in relation to ethnic minorities. - The Committee had received the RTT plan, which anticipated recovering the performance of RTT by the end of July 2017. - The Committee had received a detailed report setting out the actions being taken to address the continued poor performance against the 4hr national target. - The Committee had reviewed 4 serious incidents, 3 relating to patient falls and one relating to a pressure ulcer. - The Committee had received a detailed report on the Volunteering Strategy and felt that there was a strong strategy in place. Julian Dennis asked for assurance in relation to the essential training target; Alex Nestor explained that the figures for April 2017 included additional topics and that all divisions were focussed on ensuring that their staff were compliant. The Board noted that in particular Fire and Information Governance training had a plan in place to ensure full compliance within the next few months, however in addition to this there were new topics, which were affecting the target. Florene Jordan (Public Governor) asked a question in relation to the recording of essential training, as she had been advised by staff that they had encountered problems with the system not logging training they had completed. Alex Nestor agreed to discuss this in detail with Florene Jordan at the end of the meeting. Jill Youds asked for assurance about the recovery of A&E performance, Mark Smith advised that the Trust was working through a new process to help to address the target; however it would take a few weeks to see the effects. The Board noted that the Trust was confident about the training ED staff had, in light of the increased pressures in this area.	

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Receive** the Quality and Outcomes Committee Chair's Report for assurance.	
91/05/17	**9. Independent Review of Children's Cardiac Services progress report**	
	The Board received a progress report relating to the recommendations from the Independent Review of Children's Cardiac Services and a CQC expert review of clinical outcomes of the service published on 30 June 2016. The key highlights from the report were that the April 2017 Steering Group approved the closure of a further six recommendations. However the Board advised that there was a very high risk of non completion of two recommendations; 4 and 5. Carolyn Mills advised that Consultant recruitment is ongoing at both UH Bristol and University Hospital of Wales to support delivery and closure of this recommendation. However due to the timescales for consultant recruitment/start dates this is not going to be achieved by the end of June 2017. The Trust had agreed that as these actions relate to the delivery of a network service improvement they will move into the cardiac network work plan for ongoing monitoring and sign off. It was noted that discussions had already taken place with the Clinical Lead for the Network, Dr Andy Tometski. Following discussion in relation to the outstanding items, it was agreed to receive an impact report in September 2017 at which point the divisional director and the families involved in the implementation of the recommendations would attend a Board meeting to talk about their experiences. The Board noted that NHS England would be formally notified that the Board would close the action plan in June. The Board agreed to receive an update on this action in due course. **Members RESOLVED to:** • **Receive** the Independent Review of Children's Cardiac Services progress report. • **Receive** impact report in September 2017 and arrange for visit from families and staff on their experience with actioning recommendations following the review.	(Chief Nurse)
92/05/17	**10. Finance Report** **(The Board agreed to take questions for item 10 and 11 together.)**	

Minute Ref	Item Number	Action
	Paul Mapson, Finance Director presented the Finance Report. It was noted that the Trust was reporting a deficit of £1.713m (before technical items) at the end of April. The Operational Plan is a deficit of £1.843m and therefore the Trust is £0.130m ahead of plan. This position includes £0.466m sustainability and transformation (S&T) funding but is £0.200m behind the planned receipt of £0.666m. Therefore the Trust is reporting a surplus of £0.330m excluding S&T funding. However the divisional position is an overspend of £0.861m after only one month which is of serious concern and risks delivery of the 2017/18 Control Total. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	
93/05/17	**11. Finance Committee Chair's Report** **(The Board agreed to take questions for item 10 and 11 together.)**	
	Members received reports from the meetings of the Finance Committee held on 22nd May 2017. Members also received a verbal account of the meeting held on the 22nd May 2017 from Emma Woollett, Non-executive Director and vice-chair covering the following key areas: - The Committee had a detailed discussion around the current A&E Performance and RTT position and were provided with assurance that work was underway to address these issues. - The Committee were expecting to receive assurance in relation to theatre staffing at their next meeting, which was an on-going issue for the Trust. - The Committee received the quarterly update report which included an update on the progress against the workforce performance indicators. - The Committee received the report which shows that the Trust has a strong statement of financial position at 30 April 2017, with net current assets of £36.490m, £3.408m higher than the Operational Plan. - The Committee had received a report on the Quarter 3 Service Line Reporting position. It provided the Trust detail in relation to service profitability and efficiency.	

Minute Ref	Item Number	Action
	- The Committee had received the Divisional Financial Reports and it was noted that the Clinical Divisions and Corporate Services had reported an in month deficit of £861k. - The Committee received an update on the progress towards delivering the Trust's Cost Improvement Target for 2016/17. For the month ending 30 April 2017, the Trust achieved savings £0.762m against a plan of £1.001m, leaving a shortfall of £0.239m The Committee received an update in relation to the Trust's contract and activity income and noted that noted that contract income was £0.34m lower than plan in April 2017. - The Committee had received an update and noted that the overall forecast outturn includes unidentified slippage of £16.040m slippage from the previous year and £37.379m of new schemes in 2017/18. John Moore asked a question in relation to sickness in the Estates and Facilities Division, which still seemed to have high levels of sickness. Alex Nestor explained that work was being undertaken to help identify and address the reasons for sickness in this area. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's report for assurance.	
94/05/17	**12. Capital Investment Policy**	
	Members received the report, introduced by Paul Mapson. The policy, which was subject to an annual review, had been reviewed by the Capital Programme Steering Group and the Finance Committee in May 2017. Updates to the policy are subject to Trust Board approval. The Board noted that minor amendments have been made to the policy relating to revised financial thresholds in section 6.5 and the non-financial criteria in section 7.2. The Board had no questions on the policy and were happy to approve it. **Members RESOLVED to:** • **Receive** the revised Capital Investment Policy; and • **Approve** the revised policy.	

Minute Ref	Item Number	Action
95/05/17	**13. Treasury Management Policy**	
	Paul Mapson presented this report, he explained that the Trust Board was required to regularly review the Trust's Treasury Management Policy and recommend any changes for Board approval. The Board noted that the Treasury Management Policy, last reviewed in February 2016, required a number of minor changes primarily to update terminology. The Finance Department keeps the policy under review and will bring to the Board any future required amendments. **Members RESOLVED to:** • **Receive** the Treasury Management Policy; and • **Approve** the Treasury Management Policy.	
96/05/17	**14. NHS Improvement Self-Assessment (General Conditions 6 and 7)**	
	Robert Woolley presented this report. The purpose of this report was to seek the Board's consideration and certification whether or not it has complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. The Board provided confirmation of meeting General Condition 6 (statement 1 and 2) through the robust risk management system in place throughout the Trust and the implementation of the Fit and Proper Persons Test. The Board also confirmed the self-certification in relation to General Condition 7. **Members RESOLVED to:** • **Receive** the NHS Improvement Self-Assessment; and • **Confirm** self-certification against the requirements of General Condition 6 of the Licence; and • **Confirm** self-certification against the requirements of General Condition 7 of the Licence.	
97/05/17	**15. Governors' Log of Communications**	
	The report provided the Board with an update on governors' questions and responses from Executive Directors. **Members RESOLVED to:**	

Minute Ref	Item Number	Action
	• **Note** the Governors' Log of Communications.	
98/05/17	**16. Any Other Business**	
	Medical Director Robert Woolley advised the Board that Sean O'Kelly had been offered post of Medical Director and professional leadership with NHS Improvement, which he had accepted. Timescales for his termination date were still being discussed and a recruitment plan was underway. The Board formally congratulated Sean O'Kelly on his new role. **Governors** - The Board formally thanked Governors who were at their end of term of office and would be leaving their posts as Governors.	
99/05/17	**17. Date of Next Meeting**	
	29th June 2017, 11:00am-1:00pm, Conference Room, Trust HQ, Marlborough Street, Bristol, BS1 3NU.	

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

University Hospitals Bristol
NHS Foundation Trust

Trust Board of Directors meeting held in Public May 2017
Action tracker

Outstanding actions following meeting held in May 2017					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	**91/05/17**	**Independent Review of Children's Cardiac Services progress report** **Receive** the impact report in September 2017 and invite the Divisional Director and the families to the meeting.	Chief Nurse	September 2017	**Work in Progress.** Added to the agenda plan for the report to the Board of Directors in September 2017.

Cover report to the Public Trust Board meeting to be held on Thursday, 29 June 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**	29 June 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 May 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 – JUNE 2017

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in June 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** an update on the financial position for 2017/2018.

3. STRATEGY AND BUSINESS PLANNING

The group **approved** sign-off of the Division of Surgery's Operating Plan.

The group **received** an update on the work being undertaken to develop a Reward and Recognition Framework and **agreed** to receive outputs from that work to enable sign-up to a set of key strategic ambitions.

The group **approved** the revised Register of Interests, Gifts and Hospitality Policy.

The group **received** an update on key issues associated with the recently announced, planned overnight closure of the Weston Emergency Department and contingencies being put in place.

The group **approved** the revised Urgent Care Steering Group Improvement Plan and the principles of professional standards, noting the need for a plan in terms of implementation.

The group **received and approved** the annual report from the Guardian of Safe Working around the 2016 Junior Doctors contract for onward submission to the Trust Board.

The group **received** the Volunteering Strategy on its way to the Trust Board.

4. RISK, FINANCE AND GOVERNANCE

The group **approved** the Quarter 4 Complaints Report for onward submission to the Quality and Outcomes Committee and Trust Board.

The group **approved** the Quarter 4 Patient Experience and Involvement Report for onward submission to the Quality and Outcomes Committee and Trust Board.

The group **approved** the 2016 National Patient Survey Results Analysis Report for onward submission to the Quality and Outcomes Committee and Trust Board.

The Group **approved** the Complaints Annual Report 2016/2017 for onward submission to the Quality and Outcomes Committee and Trust Board.

The group **approved** the Education, Learning and Development Annual Report 2016/2017 and the Education, Learning and Development Delivery Plan for 2017/2018.

The group **received** three medium impact Internal Audit Reports (Immigration Checks, Whistleblowing Policy and the Care Quality Commission Governance and Compliance) and an update on outstanding recommendations.

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

The group **received** an update on the Register of External Visits.

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

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

5. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
June 2017

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Thursday, 29 June 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**	29 June 2017
Report Title	Quality and Performance Report		
Author	• Xanthe Whittaker, Associate Director of Performance • Anne Reader, Head of Quality (Patient Safety) • Heather Toyne, Head of Workforce Strategy & Planning		
Executive Lead	Mark Smith, Chief Operating Officer/Deputy 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 review the Trust's performance on Quality, Workforce and Access standards. Key issues to note Please refer to the Executive Summary in the report.
Recommendations

Members are asked to:

- **Note** 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)**
		27th June 2017		

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

June 2017

Executive Summary

Progress in restoring performance against the national access standards has continued to be variable this month. Performance against the A&E 4-hour standard improved to above trajectory and for this reason is now Amber rated, but remained well below the national 95% standard. Although the recovery trajectory for the Referral to Treatment (RTT) time standard was not met in the month, performance remained the same in percentage terms as that reported in March and April. Performance against the 62-day GP cancer standard deteriorated in the month due to critical care bed pressures and elective capacity constraints. There was a further reduction in the number of Sleep Studies over 6 week waiters, which in addition to a reduction in demand for Cardiac CT scan led to an improvement in performance to 98.8% against the 99% national standard. The Overview page of this report provides further details of the priorities, risks and threats for the coming months, to access, quality and workforce standards, along with noteworthy successes in the period.

The number of patients seen for new outpatient appointments rose in the month, well above the seasonal norm. This offset a 9% rise in new outpatient referrals relative to the same period last year, which would otherwise have resulted in an increase in the size of the outpatient waiting list. As a result of more outpatients being seen, the number of patients being added to the elective waiting list increased, which resulted in a further rise in the overall size of elective waiting list, even though the number of elective admissions in the month was marginally above the seasonal norm. This has resulted in an increase in the number of patients on ongoing RTT pathways, which poses a risk to prompt recovery of the 92% RTT standard. There are also ongoing risks to restoring achievement of the 6-week wait for a diagnostic test, due to the high demand for Cardiac CT scans, for which a sustainable capacity solution will be piloted in July, and recent national publicity over Sleep Studies testing which may lead to increased demand.

The overall level of emergency admissions into the Bristol Children's Hospital (BCH) increased by 5% in May relative to the same period last year. This led to a small deterioration in 4-hour performance at the BCH, although performance was only 1% below the 95% national standard. The number of emergency admissions into the BRI also increased by a similar level, relative to April and the same period last year. However, there was an improvement in 4-hour performance at the BRI of just less than 5% relative to the previous month. This improvement in performance was despite a further rise in bed occupancy. The proportion of patients discharged in the month who had stayed 14 days or more was very high in May. Consistent with this, the number of over 14 day stays in hospital at month-end fell to below the levels seen in the last two years. The percentage of emergency admissions for patients aged 75 years and over, which is a proxy for patient acuity, continued to be below the level seen in the previous two years. This fall in patient acuity should in time lead to a sustained reduction length of stay, and as a result, bed occupancy. This may help to mitigate in part the impact of the overnight closure of Weston's Emergency Department in July, which will lead to an increase in emergency admissions into the BRI.

In contrast to recent months there were a number of changes in performance against the headline measures of quality that sit within the Trust Summary Scorecard in the month. This included the Safety Thermometer measure of No New Harms and the Non-purposeful Omitted doses of Critical Medication being Amber rated for the first time following more than a year of being Green rated. Noteworthy improvements in performance against Quality metrics included a further month of the NEWS deteriorating patient indicator being Green rated and performance against the metric

for patients who have sustained a fractured neck of femur going to theatre within 36 hours, improving to 87% against the 90% national standard. The Trust's Performance against the fracture neck of femur metrics continues to be the focus of significant attention.

The improvements seen in some of the workforce metrics in recent months have been maintained, including a continued Green rating for agency levels and turn-over rates being maintained at the lower levels seen since October 2016. Disappointingly, vacancy rates have increased, but are only marginally above the 5% threshold, and for this reason this indicator is now Red rated. Although there has been a small increase in sickness rates they remain around the seasonal norm.

We continue to work in partnership with other organisations within the community to mitigate system risks which impact on patient flow, workforce indicators and 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
(March 2017)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Medicine	Good	Outstanding	Good	Requires improvement	Outstanding	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Outstanding	Good	Outstanding	Outstanding
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 & Diagnostic Imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Outstanding	Good	Requires improvement	Outstanding	**Outstanding**

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	4.5 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 (i.e. May for A&E, RTT and 6-weeks and April for 62-day GP) the Trust failed to achieve all four standards in the Single Oversight Framework (SOF). Although the national standards were not met for A&E 4 hours and 6-week diagnostics, the recovery trajectory was achieved for the month for A&E 4-hours, and performance against the 6-week diagnostic waits standard improved. The 92% Referral to Treatment (RTT) standard failed to be achieved, but reported performance was maintained at 91.1%. Performance against the 85% national standard for 62-day GP cancer deteriorated in April, mainly due to critical care bed and surgical capacity pressures.

The Trust has been off trajectory with all four standards 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 recently undertook a further visit to the Trust in relation to Emergency Access, for which the Trust received a written report. The recommendations made in this report have informed the latest revision of the Trust's urgent care plan.

Access Key Performance Indicator		Quarter 3 2016/17			Quarter 4 2016/17			Quarter 1 2017/18		
		Oct 16	Nov 16	Jan 17	Feb 17	Mar 17	Dec 16	Apr 17	May 17	Jun 17
A&E 4-hours	Actual	82.9%	78.5%	79.6%	80.4%	80.7%	83.3%	82.3%	84.2%	
	STF trajectory	93.3%	90.0%	89.3%	88.5%	87.4%	91.0%	82.5%	83.5%	85.0%
62-day GP cancer	Actual	79.5%	85.2%	81.5%	84.3%	78.8%	81.2%	76.7%		
	STF trajectory*	85.0%	85.1%	86.9%	83.6%	85.7%	85.9%	81.0%	81.0%	81.0%
Referral to Treatment Time (RTT)	Actual	91.2%	92.0%	92.0%	92.2%	92.0%	91.1%	91.1%	91.1%	
	STF trajectory*	93.4%	93.4%	92.8%	92.8%	92.8%	93.0%	92.0%	92.0%	92.0%
6-week wait diagnostic	Actual	98.9%	99.0%	98.2%	98.4%	98.7%	98.7%	98.6%	98.8%	
	STF trajectory*	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.0%	99.0%	99.0%

*minimum requirement for securing Sustainability & Transformation Funds (STF) 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 AMBER:
- A&E 4-hours
- Outpatient cancellations

GREEN to AMBER:
- Safety Thermometer
- Medication errors
- Sickness absence

AMBER to RED
- Referral to Treatment Times

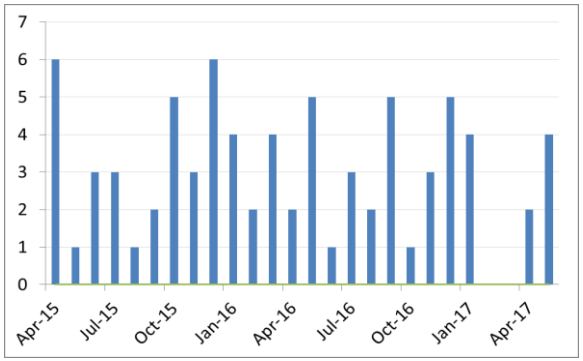
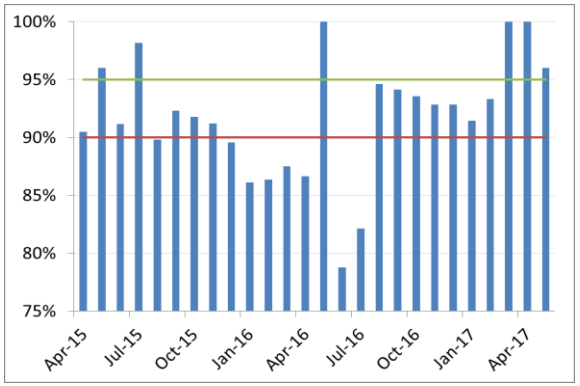
GREEN to RED
- Vacancies

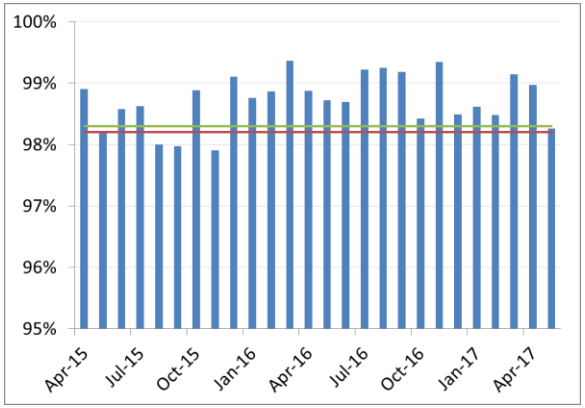
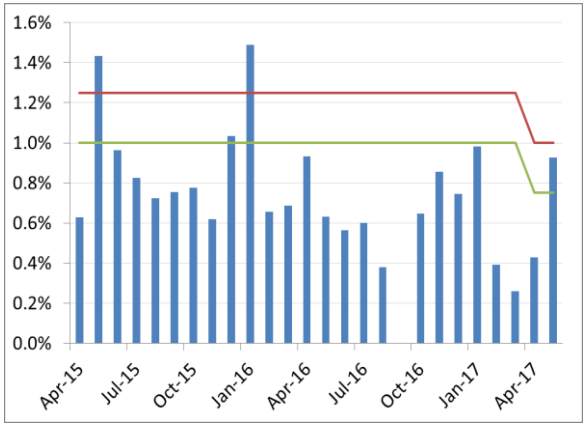
Please note: the Outliers indicator has been left as having a GREEN rating because although a target is still to be agreed performance remains similar to that of March 2017. Also, a new threshold has been agreed for outpatient cancellation rates (see report).

Overview

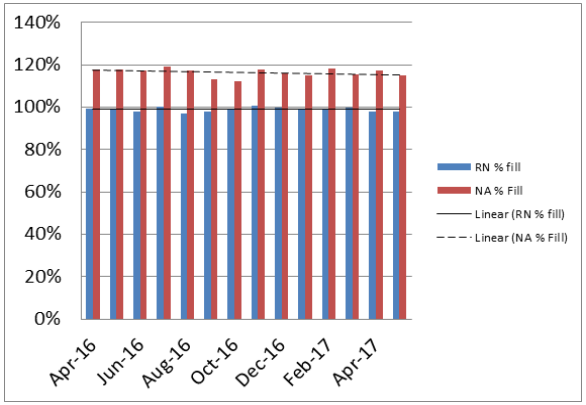
The following summarises the key successes in May 2017, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 1 2017/18.

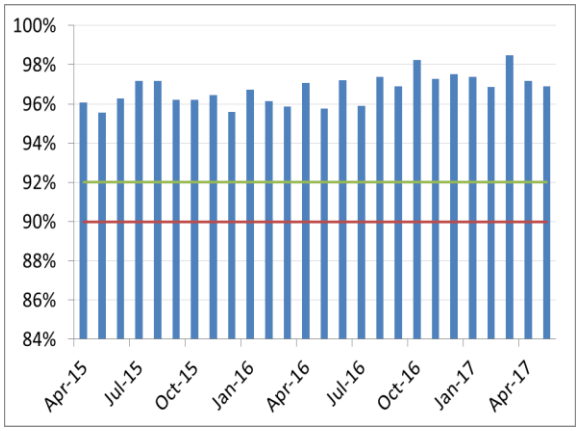
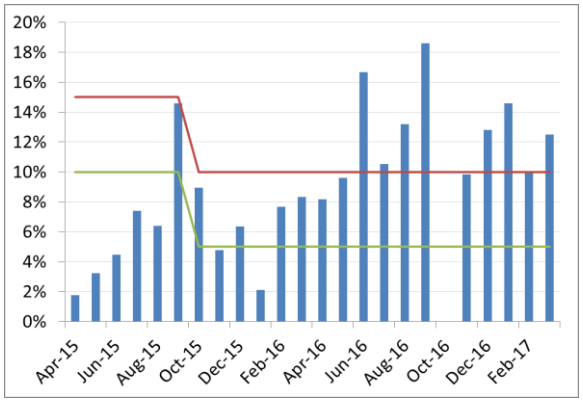
Successes	Priorities
• In May 2017 the reported performance for fracture neck of femur patients going to theatre within 36 hours was 86.7%. Although this figure falls short of the national performance target of 90%, it is the highest reported figure since April 2016. • UH Bristol has been successful in its application to be a main provider of apprenticeships, one of 30 NHS trusts on the Government's register of apprenticeship training providers and one of only seven trusts with main provider status.	• Investigate and learn from the retained foreign object never event reported in May; • The focus on the reduction of turnover, agency usage and sickness absence continues to be an ongoing priority in the operating plans for 2017/18; • Reduction in the number of patients waiting over 18 weeks Referral to Treatment (RTT), by delivering additional activity in June and July; • Sustain performance against the 62-day GP cancer waiting times standard above the national average during quarter 1; • Recovery of performance against the 6-week diagnostic waiting times standard by the end of September, with incremental improvement each month; • Further improvements in A&E 4-hour performance.
Opportunities	**Risks & Threats**
• Inclusion of hospital associated venous thrombo-embolism metrics in the quality dashboards at Trust and Divisional level will make it easier for divisions to track progress of modified root cause analyses and provide opportunity to improve timeliness of identification of any new learning arising from these; • The E-Appraisal system went live in May 2017; this is in response to staff feedback from the staff survey and our commitment to ensuring appraisals are of real value and quality.	• The reduced levels of sickness absence, agency and turnover agreed as workforce targets as part of the 2017/18 operating planning cycle will be challenging to sustain; • Ongoing patient flow pressures could make recovery of achievement of the 92% RTT national waiting times standard challenging, especially in the context of an elective waiting list that is well above the normal seasonal level; • Late referrals from other providers continue to impact on achievement of the 62-day GP cancer waiting times standard; • The number of over 6-week waiters for Cardiac CT scans is expected to remain high in June due to an overall doubling of demand; • Sleep Studies referrals are expected to rise following national publicity about the availability of testing on the NHS, which could impact on 6-week diagnostic wait performance; • Overnight closure of Weston's Emergency Demand will lead to an increase in emergency admissions which could worsen 4-hour performance.

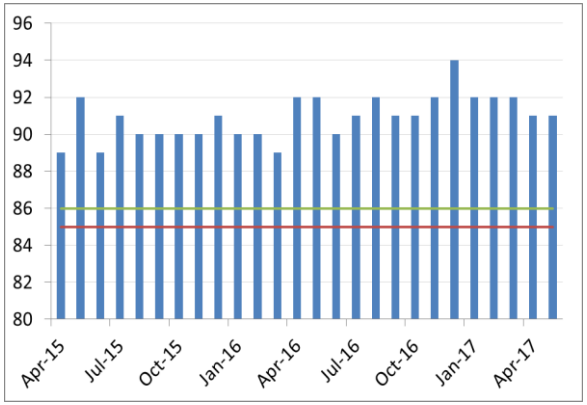
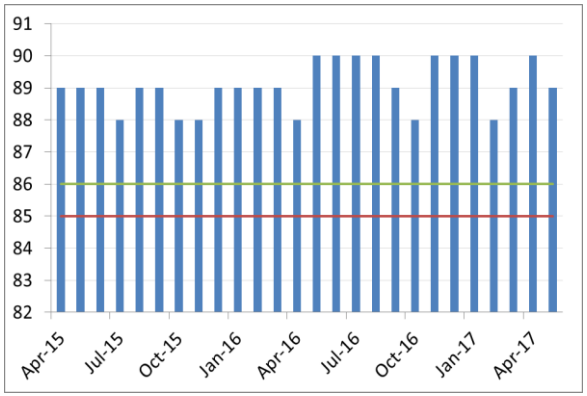
Description	Current Performance	Trend	Comments
Infection control The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16).	There were four cases of *Clostridium difficile* (C. diff) attributed to the Trust in May 2017.	**Total number of C. diff cases**  A total of 6 cases (unavoidable + avoidable) have been reported in the year against a limit of 45 for April 2017 to March 2018.	The annual limit for the Trust for 2017/18 is 45 avoidable cases. The monthly assessment of cases continues with the Clinical Commissioning Group. At the end of May, the Trust had six cases of *Clostridium difficile* awaiting assessment by the Clinical Commissioning Group.
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%.	Performance in May 2017 was 96% (one breach) against a three-year improvement goal of 95%. This is a slight deterioration from April's position of 100%. The breach was recorded against the Surgical Division where it was identified on the day of audit, but occurred within the Division of Medicine prior to the patient's transfer. The patient came to no harm.	**Deteriorating patient: percentage of early warning scores acted upon** 	This is measured by a monthly point prevalence audit. 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 (Action 1A. NB: previously reported completed and ongoing actions have been removed from the report).

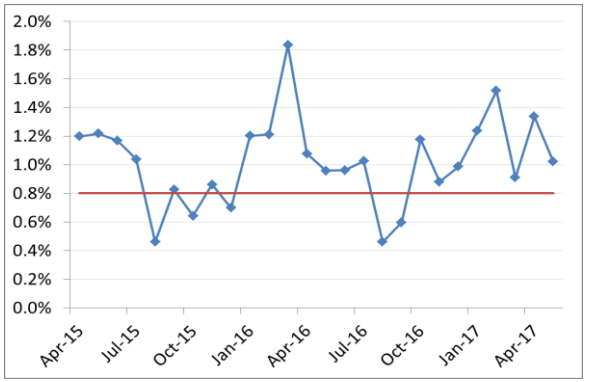
Description	Current Performance	Trend	Comments
Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.	In May 2017, the percentage of patients with no new harms was 98.29% (14 patients had new harms), against an upper quartile target of 98.3% (GREEN threshold) of the NHS Improvement patient safety peer group of Trusts.	**The percentage of patients surveyed showing No New Harm each month** 	The May 2017 Safety Thermometer point prevalence audit showed three new catheter associated urinary tract infections, five falls with harm, three new pressure ulcer and three new venous thrombo-emboli. In addition to the ongoing work on harm reduction, in the coming months the Continence Group is planning to focus on training education and policies in relation to urinary catheterisation.
Non-purposeful omitted doses of listed critical medicines Monthly audits by pharmacy incorporate a review of administration of critical medicines: insulin, anti-coagulants, Parkinson's medicines, injected anti—infectives, anti-convulsants, short acting bronchodilators and 'stat' doses.	In May 2017, 0.90% of patients reviewed (8 out of 885) had one or more omitted critical medications in the past three days. The target for omitted doses is no more than 0.75%. The 0.90% for May 2017 is a deterioration from the April 2017 figure of 0.43% (4 out of 930).	**Percentage of omitted doses of listed critical medicines** 	The target for omitted doses in 2017/2018 has been revised and is now set at 0.75% (previous target was 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>Overall compliance is 89% (excluding Child Protection Level 3). Compliance with each of the reporting categories is provided below
<table>
<tr><th>May 2017</th><th>UH Bristol</th></tr>
<tr><td>Total</td><td>89%</td></tr>
<tr><td>Three Yearly (14 topics)</td><td>89%</td></tr>
<tr><td>Annual (Fire)</td><td>84%</td></tr>
<tr><td>Annual (IG)</td><td>75%</td></tr>
<tr><td>Induction & Orientation</td><td>98%</td></tr>
<tr><td>Induction & Orientation (Med & Dental)</td><td>45%</td></tr>
<tr><td>Resuscitation</td><td>71%</td></tr>
<tr><td>Safeguarding</td><td>90%</td></tr>
</table>
</td>
<td>Divisional action plans are in development to achieve 90% for Safeguarding, Resuscitation, and Fire Safety and 95% for Information Governance.</td>
<td>Dementia Awareness has been excluded from reporting this month, pending a revised assessment of the target group, as agreed at the Education Board in May 2017. Please also see action 3.

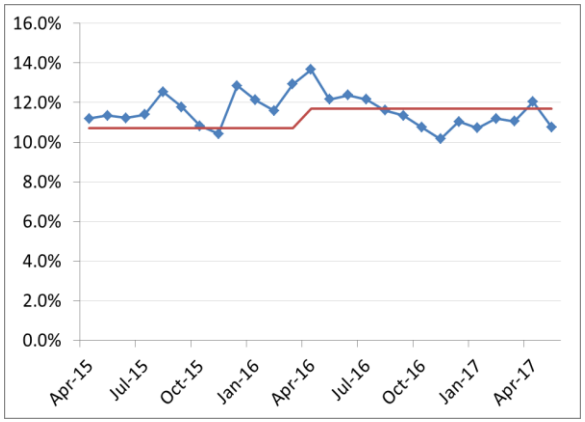
Performance against trajectories and target for Fire and Information Governance are included in appendix 2.</td>
</tr>
<tr>
<td>Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.</td>
<td>The report shows that in May 2017 the Trust had rostered 223,806 expected nursing hours, with the number of actual hours worked of 229,552. This gave a fill rate of 102.6%.
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>63,233</td><td>58,353</td><td>+4,880</td></tr>
<tr><td>Specialised Services</td><td>41,926</td><td>40,702</td><td>+1224</td></tr>
<tr><td>Surgery</td><td>45,625</td><td>42,636,</td><td>+2,990</td></tr>
<tr><td>Women’s & Children’s</td><td>78,768</td><td>82,115</td><td>-3347</td></tr>
<tr><td>Trust</td><td>229,552</td><td>223,806</td><td>+5,746</td></tr>
</table>
</td>
<td>The percentage overall staffing fill rate by month
 
</td>
<td>Overall for the month of May 2017, the Trust had 97% cover for Registered Nurses (RN) on days and 99% RN cover for nights. The unregistered level of 112% for days and 119% for nights reflects the activity seen in May 2017. This was due primarily to Nurse Assistant specialist assignments to safely care for confused or mentally unwell patients in adults, particularly at night. Close monitoring continues (Action 4).</td>
</tr>
</table>

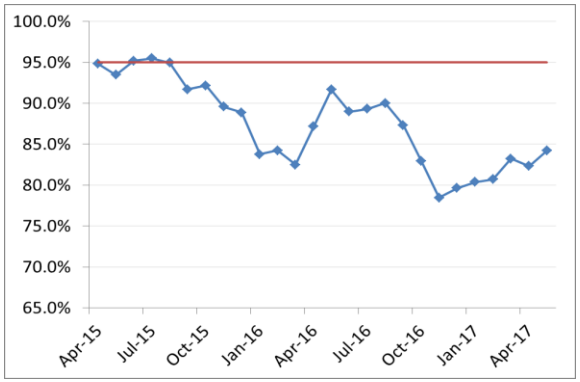
Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for May 2017 was 96.9%. 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.	Dissatisfied cases are now measured as a proportion of complaints sent out in any given month and are reported two months in arrears. This means that the latest data in the board dashboard is for the month of March 2017. As of 15th June 2017, 6 of the 48 responses sent out in March had resulted in dissatisfied replies (12.5% against a target of 5%).	**Percentage of compliantaints dissatisfied with the complaint response each month** 	Sixty-three of the formal complaints responded to in 2016/17 expressed dissatisfaction with one or more aspects of our response to their concerns; this represents a small increase on 59 for responses sent in 2015/16 (measured in May each year and published in our annual Quality Report). Informal Benchmarking with other NHS Trusts suggests that the rates of dissatisfied complainants are typically in the range of 8% to 12%. Actions continue as previously reported to the Board (Actions 5A to 5E).

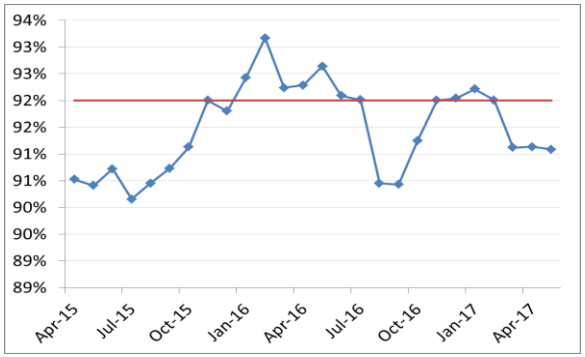
Description	Current Performance	Trend	Comments
Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as "key drivers" of patient satisfaction via analysis and focus groups.	For the month of May 2017, the score was 91 out of a possible score of 100, and 91 for Q4 as a whole. Divisional level scores are provided on a quarterly basis to ensure sample sizes are sufficiently reliable. Trust: Q3 2016/2017: 92; Q4 2016/2017: 91 Medicine: 90; 90 Surgery: 92; 91 Specialised Services: 92; 92 Women's & Children's (Bristol Royal Hospital for Children): 94; 92 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 89 in May 2017 (out of score of 100). Divisional scores for quarter 4 are provided as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful. Trust: Q3 2016/2017: 90; Q4 2016/2017: 89 Medicine: 89; 90 Specialised Services: 89; 86 Surgery: 88; 89 Women's & Children's (Bristol Royal Hospital for Children): 85; 87 Diagnostics & Therapies: 96; 93	**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 May the Trust cancelled 67 (1.02% of) operations at last-minute for non-clinical reasons. The reasons for the cancellations are shown below:
<table>
<tr><th>Cancellation reason</th><th>Number</th></tr>
<tr><td>No HDU/ITU/CICU bed available</td><td>13 (19%)</td></tr>
<tr><td>Emergency patient prioritised</td><td>12 (18%)</td></tr>
<tr><td>Surgeon/anaesthetist unavailable</td><td>12 (18%)</td></tr>
<tr><td>Lack of time (over-run)</td><td>11 (16%)</td></tr>
<tr><td>No ward bed available</td><td>6 (9%)</td></tr>
<tr><td>Other causes (6 reasons)</td><td>13 (19%)</td></tr>
</table>
Six patients cancelled in April were readmitted outside of 28 days. This equates to 92.5% 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
 

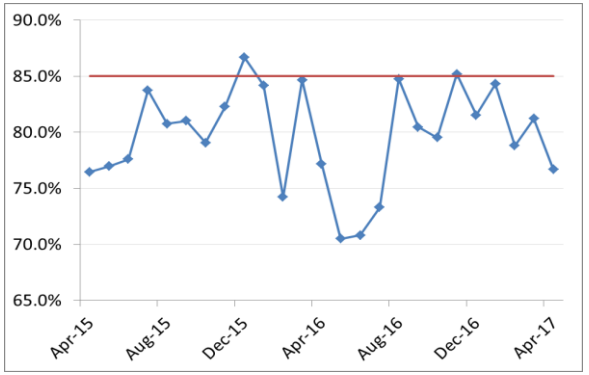
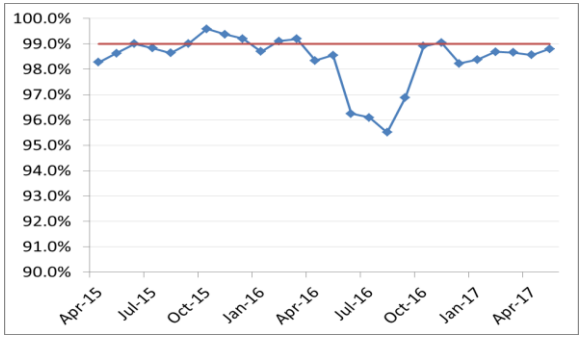
The national 0.8% standard is currently not forecast to be met in June due to continued high bed occupancy levels.</td>
<td>Emergency pressures continued to be the predominant cause of cancellations, with critical care bed availability, ward bed availability and emergency patients needing to be prioritised, making-up 46% of all cancellations. However, there were a greater proportion of cancellations for potentially avoidable reasons, than seen earlier this year. 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 8I) 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 May 10.8% of outpatient appointments were cancelled by the hospital, which is below the revised Red threshold of 11.7%. This is a 1.2% decrease on last month. The level of cancellation remains lower than the same period last year.

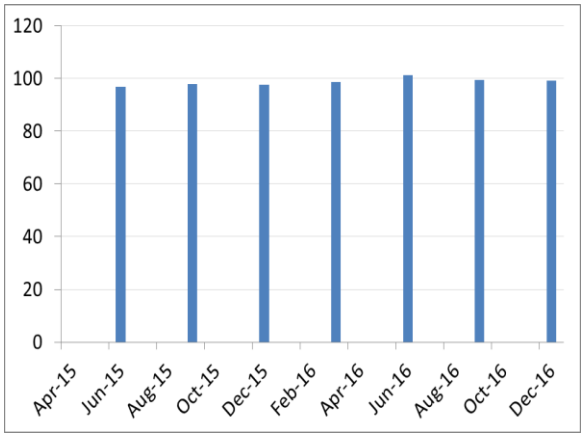
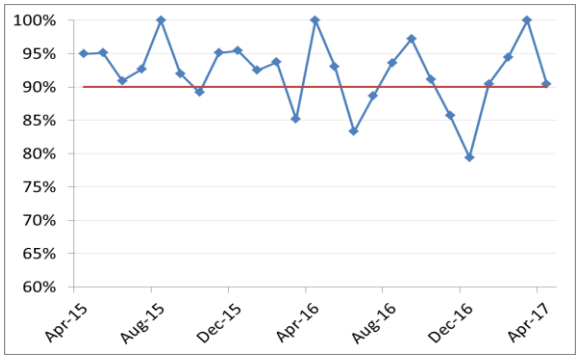
Please note: the RED and GREEN thresholds have been revised for 2017/18, with the Green threshold representing a 2% improvement on 2015/16, and the RED threshold being the same average performance in 2015/16 of 11.7%.</td>
<td>Percentage of outpatient appointments cancelled by the hospital
 
</td>
<td>Ensuring outpatient capacity is effectively managed on a day-to-day basis is a core part of the improvement work overseen by the Outpatients Steering Group. The improvement plan for this key performance indicator has been refreshed for 2017/18, prioritising those actions that are likely to reduce the current underlying rate of cancellation by the hospital. These actions are based upon our current analysis of the causes of cancellations (Actions 7A to 7D).</td>
</tr>
</table>

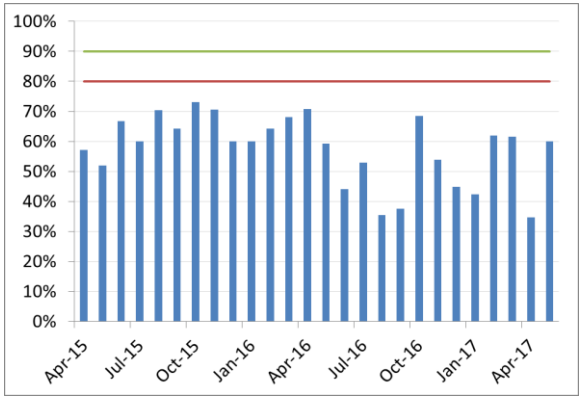
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% national standard was not achieved in May. Trust-level performance improved to 84.2%, and was above the in-month trajectory (83.5%). Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>May 2016</th><th>Apr 2017</th><th>May 2017</th></tr>
<tr><td>Attendances</td><td>5,834</td><td>5,510</td><td>5,812</td></tr>
<tr><td>Emergency Admissions</td><td>1,842</td><td>1,897</td><td>1,910</td></tr>
<tr><td>Patients managed < 4 hours</td><td>5118
87.7%</td><td>3811
69.2%</td><td>4287
73.8%</td></tr>
<tr><th>BCH</th><th>May 2016</th><th>Apr 2017</th><th>May 2017</th></tr>
<tr><td>Attendances</td><td>3,475</td><td>3,277</td><td>3,646</td></tr>
<tr><td>Emergency Admissions</td><td>830</td><td>714</td><td>836</td></tr>
<tr><td>Patients managed < 4 hours</td><td>3261
93.8%</td><td>3277
96.8%</td><td>3646
94.0%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments
 

The trajectory of 85.0% is forecast to be met in June.</td>
<td>Whilst emergency admissions via the BRI ED are 3.7% up on the same period last year, total emergency admissions into the BRI are up by 5.7%. Bed occupancy remains un-seasonally high despite a decrease in 14 day stays and an ongoing reduction in admissions for patients aged 75 years and over. The current low level of outlier bed-days, combined with lower patient acuity, should help to reduce length of stay. However, the overnight closure of Weston's ED will increase demand. Actions continue to be taken to reduce length of stay (Actions 8A to 8I).</td>
</tr>
<tr>
<td>Referral to Treatment (RTT) is a measure of the length of wait from referral through to treatment. The target is for at least 92% of patients, who have not yet received treatment, and whose pathway is considered to be incomplete (or ongoing), to be waiting less than 18 weeks at month-end.</td>
<td>The 92% national standard was not met at the end of May, with performance remaining the same as reported in March and April, at 91.1%. This is marginally below the recovery trajectory of 91.4% (see Appendix 3). The number of patients waiting over 40 weeks RTT has increased, mainly due to capacity pressures in Women's & Children's. There were eleven over 52-week waiters, the majority due to patient choice to wait longer than offered.
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>133</td><td>153</td><td>165</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>2</td><td>5</td><td>11</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 

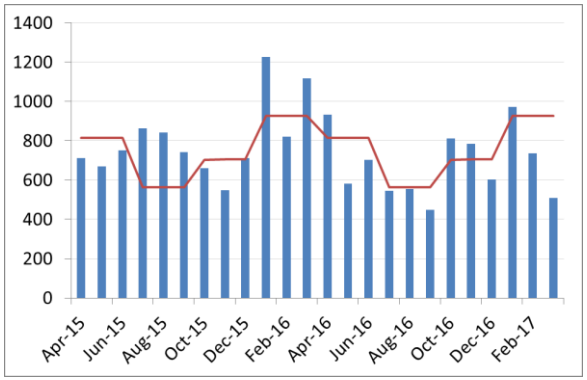
Forecast performance for June is 91.8%, with performance due to be restored above 92% by the end of July.</td>
<td>The percentage performance against the RTT standard remained the same as in March and April. However, the total number of patients on an incomplete RTT pathway increased slightly, as did the number of patients waiting over 18 weeks. The size of the elective waiting list also increased, which poses risks to recovery of the 92% standard. The recovery of the RTT standard will continue to be monitored through fortnightly meetings with Divisions (Action 9A to 9C).</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.	April's performance was 76.7% against the 85% 62-day GP standard, and a trajectory of 81.0%. The 85% standard was not met for internally managed pathways with performance at 82.9%. The main reasons for failure to achieve the 85% 62-day GP standard is shown below. **Breach reason** / **Apr 17** Late referral by/delays at other provider: 7.0 Medical deferral/clinical complexity: 3.5 Patient choice: 2.0 Delayed diagnostic: 2.0 Insufficient surgical capacity/cancellation: 3.0 Other causes (four reasons): 3.5 **TOTAL**: **21.0** There was one breach of the 62-day screening standard, due to elective surgical capacity.	**Percentage of patients treated within 62 days of GP referral**  The 31-day first definitive and 31-day subsequent surgery standards were also failed in April, due to critical care bed capacity constraints, impacting from Q4 2016/17.	April's performance was impacted by surgical capacity issues and elective cancellations due to bed issues. Performance also continued to be heavily impacted by factors outside of the Trust's control. A CQUIN came into effect on the 1st October, along with a national policy for 'automatic' breach reallocation of late referrals. However, adjusted performance based upon these rules was 77.8%. An improvement plan continues to be implemented to minimise avoidable delays (Action 10A to 10D).
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 was 98.8% in May, which is below the 99% national standard, but an improvement on April's performance of 98.6%. The number and percentage of over 6-week waiters at month-end, is shown below: **Diagnostic test** / **Mar** / **Apr** / **May** MRI: 5 / 9 / 15 Sleep: 32 / 11 / 2 Endoscopies: 23 / 30 / 23 CT: 60 / 72 / 59 Echo: 0 / 0 / 0 Other: 1 / 1 / 3 **TOTAL**: **121** / **123** / **102** Percentage: **98.7%** / **98.6%** / **98.8%** Recovery trajectory: 98.7% / 99.0% / 99.0%	**Percentage of patients waiting under 6 weeks at month-end**  The current forecast is to restore performance above 99% by the end of September.	The number of patients waiting over 6 weeks for a Sleep Studies test continued to reduce in May. Demand for Cardiac CT fell slightly in April, following the rise earlier in the year as a result of implementation of recent NICE guidelines. A pilot commences next month, which should increase the throughput on Cardiac CT scanners. If successful, the backlog of routine over six week waiters should be cleared in August and September (Actions 11A and 11D).

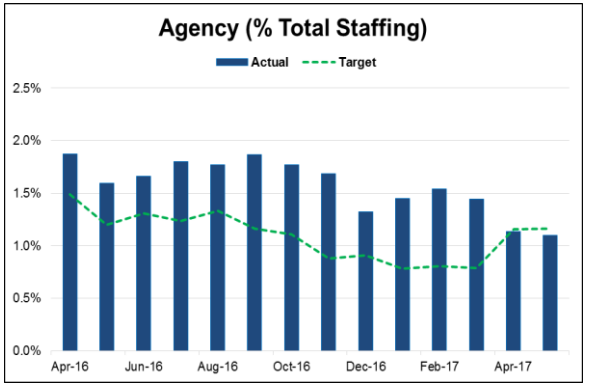
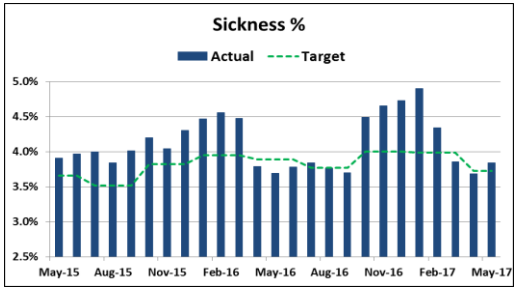
Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator is the ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors. This is nationally published quarterly, six months in arrears.	Summary Hospital Mortality Indicator (SHMI) for December 2016 was 99.1 This statistical approach estimates that there were 15 fewer actual deaths than 'expected' deaths in the 12-month period up to December 2016.	**Summary Hospital Mortality Indicator (SHMI) for in hospital deaths each month** 	Our overall performance continues to indicate that fewer patients died in our hospitals than would have been expected given their specific risk factors. The Quality Intelligence Group continues to conduct assurance reviews of any specialties that have an adverse SHMI score in a given quarter. We will continue to track Hospital Standardised Mortality Indicator monthly to give earlier warning of a potential concern.
Door to balloon times measures the percentage of patients receiving cardiac reperfusion (inflation of a balloon in a blood vessel feeding the heart to clear a blockage) within 90 minutes of arriving at the Bristol Heart Institute.	In April (latest data), 38 out of 42 patients (90.5%) were treated within 90 minutes of arrival in the hospital. Performance for 2016/17 as a whole ended above the 90% standard at 91.7%.	**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. There were no emerging themes in April.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In May 2017 we achieved 60% (18/ 30 patients) overall performance in Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 86.7% (26/30 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number of patients</th></tr>
<tr><td>Patients not well enough to attend theatre with 36 hour timeframe.</td><td>2</td></tr>
<tr><td>Procedure delayed due to lack of theatre capacity.</td><td>2</td></tr>
</table>
Eight patients did not receive any ortho-geriatrician review due to sickness and the clinician having to cover the Older Person Assessment Unit.</td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.
 
</td>
<td>The latest National Hip Fracture Database data indicates that the ‘Hours to Operation’ performance for the Trust is now in line with national average performance. The Trust’s performance previously tracked below the national average.

Actions are being taken to establish a future service model across Trauma & Orthopaedics, and ensure that consistent, sustainable cover is provided (Actions 12A to 12E).</td>
</tr>
<tr>
<td>Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.</td>
<td>In May 2017 there were 655 outlier bed-days against a target of 815 outlier bed-days.

Performance showed a continued improvement despite ongoing operational pressure on the hospital. However there was a slight deterioration of 149 bed-days from April (506).
<table>
<tr><th>Outlier bed-days</th><th>May 2017</th></tr>
<tr><td>Medicine</td><td>422</td></tr>
<tr><td>Surgery</td><td>147</td></tr>
<tr><td>Specialised Services</td><td>74</td></tr>
<tr><td>Women's & Children's Division</td><td>9</td></tr>
<tr><td>Diagnostics and Therapies</td><td>3</td></tr>
<tr><td>Total</td><td>655</td></tr>
</table></td>
<td>Number of days patients spent outlying from their specialty wards
 
</td>
<td>The quarter one target has been set at 815 bed days per month and this was achieved in May 2017 by 160 bed days.

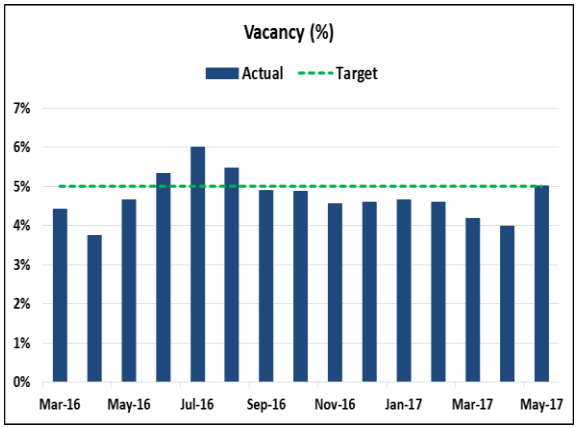
Ongoing actions are shown in the action plan section of this report. (Action 13).</td>
</tr>
</table>

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Agency usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2015/16. The red threshold is 10% over the monthly target.</td>
<td>Agency usage reduced by 2.6 FTE overall due to reductions in Allied Health Professional and Administrative and Clerical staff group usage, but Nursing & Midwifery usage increased by 5.7 FTE in month.
<table>
<tr><th>May 2017</th><th>FTE</th><th>Actual %</th><th>KPI</th></tr>
<tr><td>UH Bristol</td><td>94.1</td><td>1.1%</td><td>1.2%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>7.5</td><td>0.8%</td><td>0.7%</td></tr>
<tr><td>Medicine</td><td>31.9</td><td>2.5%</td><td>1.5%</td></tr>
<tr><td>Specialised Services</td><td>10.3</td><td>1.0%</td><td>2.0%</td></tr>
<tr><td>Surgical</td><td>21.4</td><td>1.2%</td><td>0.9%</td></tr>
<tr><td>Women’s & Children’s</td><td>12.2</td><td>0.6%</td><td>0.5%</td></tr>
<tr><td>Trust Services</td><td>3.8</td><td>0.5%</td><td>2.1%</td></tr>
<tr><td>Facilities & Estates</td><td>7.0</td><td>0.9%</td><td>1.4%</td></tr>
</table>
</td>
<td>Agency usage as a percentage of total staffing by month
 
</td>
<td>A summary of compliance with agency caps is attached in Appendix 2. See action 14 for a summary of key actions to target agency use.</td>
</tr>
<tr>
<td>Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2015/16. The red threshold is 0.5% over the monthly target.</td>
<td>Sickness absence increased from 3.7% to 3.8%. There have been slight increases across all Divisions with the exception of Trust Services and the Surgical Division. The biggest rise in reasons for absence was gastro-intestinal related sickness.
<table>
<tr><th>May 2017</th><th>Actual</th><th>KPI</th></tr>
<tr><td>UH Bristol</td><td>3.8%</td><td>3.7%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>3.5%</td><td>2.5%</td></tr>
<tr><td>Medicine</td><td>4.0%</td><td>4.7%</td></tr>
<tr><td>Specialised Services</td><td>3.6%</td><td>3.5%</td></tr>
<tr><td>Surgical</td><td>3.7%</td><td>3.6%</td></tr>
<tr><td>Women's & Children's</td><td>3.7%</td><td>3.4%</td></tr>
<tr><td>Trust Services</td><td>3.0%</td><td>3.1%</td></tr>
<tr><td>Facilities & Estates</td><td>5.8%</td><td>5.8%</td></tr>
</table>
</td>
<td>Sickness absence as a percentage of full time equivalents by month
 

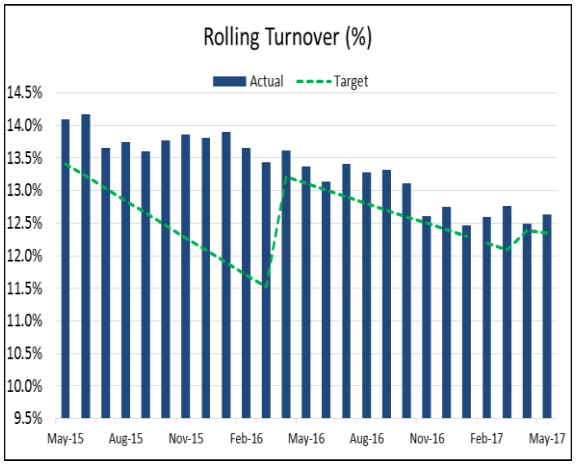
Please note: Sickness data is refreshed retrospectively to capture late data entry, and to ensure the data is consistent with the Trust’s final submission for national publication.</td>
<td>See action 15 for the sickness action plan.</td>
</tr>
</table>

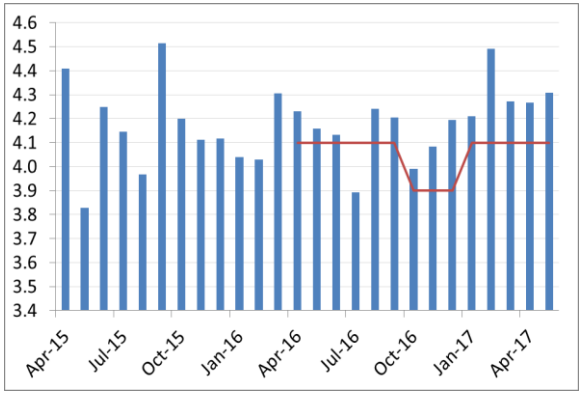
Description	Current Performance	Trend	Comments
Vacancies - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.	Overall vacancies increased from 4.0% to 5.0%, rising in each main staff group. Nursing & Midwifery vacancies increased by 31.4 FTE from 5.3% to 6.2% (196.70 FTE) due in part to Ward 518 adding an additional 24 FTE to the funded establishment for the Division of Medicine.	**Vacancies rate by month**	See Action 16 for further details of the plans that continue to be implemented to reduce the vacancy rate.
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 increased from 12.5% to 12.6%. There were increases among Administrative & Clerical, Allied Health Professionals and Unregistered Nursing staff groups.	**Staff turnover rate by month**	See Action 17 for further details of the plans that continue to be implemented to reduce turn-over.

May 2017	Rate
UH Bristol	**5.0%**
Diagnostics & Therapies	6.8%
Medicine	8.7%
Specialised Services	4.4%
Surgical	4.4%
Women's & Children's	2.0%
Trust Services	4.8%
Facilities & Estates	6.5%



May 2017	Actual	KPI
UH Bristol	**12.6%**	**12.4%**
Diagnostics & Therapies	11.1%	11.6%
Medicine	13.9%	14.6%
Specialised Services	12.9%	12.2%
Surgical	12.2%	11.5%
Women's & Children's	12.1%	11.3%
Trust Services	12.2%	12.6%
Facilities & Estates	14.7%	14.5%



Description	Current Performance	Trend	Comments
Length of Stay (LOS) measures the number of days inpatients on average spent in hospital. This measure excludes day-cases. LOS is measured at the point at which patients are discharged from hospital.	In May the average length of stay for inpatients was 4.31 days, which is above the quarter 4 RED threshold of 4.1 days. This is similar to the length of stay reported for March and April. The percentage of patients discharged in the month who were long-stay stay patients (14 day plus stays) was very high. Consistent with this, there was a decrease in the number of long stay patients in hospital at month-end, down from 268 at the end of April to 240 at the end of May. This is the lowest level of in-hospital 14 day plus stays since October 2016.	**Average length of stay (days)**  Length of stay is forecast to remain above the RED threshold in June.	The total number of Green to Go (delayed discharge) patients in hospital remains just less than double the jointly agreed planning assumption of 30 patients. The number of 14-day stays has reduced, but remains above the level required to maintain effective flow and meet the 95% standard for A&E 4-hour waits. Work to reduce delayed discharges and over 14 days stays continues as part of the emergency access community-wide plan (Actions 8A to 8I and 13).

Improvement Plan

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Safe					
Deteriorating patient Early warning scores for acted upon.	1A	Procurement of e observations system to enable automatic calculation of NEWS and notification of elevated NEWS to responder.	To be confirmed.	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 February 2017 and ongoing	Improvement under development	Maintain current improvement and sustain performance below 0.75%
	2B	Teaching session to be run for new Pharmacists on data collection and background	Commenced February 2017 and ongoing	Teaching session under development	Maintain current improvement and sustain performance below 0.75%
Essential Training	3	Continue to drive compliance including increasing e-learning functionality. Divisional action plans are in development to achieve 90% for Safeguarding, Resuscitation, and Fire Safety and 95% for Information Governance. Communication to staff to highlight the importance of essential training is ongoing.	Ongoing June 2017 Ongoing	Oversight of training compliance by the Education Group. Monthly and quarterly Divisional Performance Review meetings. Oversight of training compliance by the Education Group.	Trajectories to achieve compliance for Safeguarding, Resuscitation, Information Governance and Fire Safety by March 2017 have not been achieved. Divisional action plans are in place to achieve compliance. Performance against trajectory and target are included in Appendix 2. Target audiences for Dementia Awareness Training are under review and will be agreed at the end of July by the Education Group.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
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.	Achieve and maintain a green RAG rating for this indicator
	5C	Dissatisfied responses are now routinely checked by the Head of Quality (Patient Experience & Clinical Effectiveness) to identify learning where appropriate. All cases where a complaint is dissatisfied for a second time are escalated to and reviewed by the Chief Nurse.	Implemented September 2015 and ongoing		Achieve and maintain a green RAG rating for this indicator
	5D	In January 2017, the Head of Quality (Patient Experience and	Findings discussed by the Patient	Learning has been shared with Divisions via the Patient	Achieve and maintain a green RAG rating for this indicator

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Clinical Effectiveness) and Acting Patient Support and Complaints Manager undertook a detailed review of all dissatisfied cases from August and September 2016.	Experience Group on 23rd February 2017.	Experience Group. In five of the 12 cases, the opinion of the reviewers was that opportunities were missed which may have had a bearing on the dissatisfied outcome. Heads of Nursing have committed to review these cases for local learning. No common themes.	
	5E	The Trust will be establishing a new complaints review panel in 2017.	Terms of Reference established March 2017	Evidence that the panel is in place and learning identified and shared with Divisions	Achieve and maintain a green RAG rating for this indicator
Last minute cancelled operations	6A	Continued focus on recruitment and retention of staff to enable all adult BRI HDU/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 Mid July	Monthly Divisional Review Meetings; Clinical Strategy Group.	Sustained reduction in critical care related cancellations in 2017/18. As above.
	6B	Specialty specific actions to reduce the likelihood of cancellations.	Ongoing	Monthly review of plan with Divisions by Associate Director of Operations.	As above.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Outpatient appointments cancelled by hospital	7A	Explore option of increasing required notice of annual leave from six to eight weeks to reduce the number of cancelled clinics	To be confirmed	Senior Leadership Team	Amber threshold expected to be achieved again by the end of September.
	7B	Full service-level review of the electronic Referral Service (eRS) Directory of Services, to limit the number of required re-bookings	To be confirmed	Outpatient Steering Group	
	7C	Implement changes to the way capacity is managed to support eRS appointment bookings and limit cancellations.	To be confirmed	Outpatient Steering Group	
	7D	eRS Improvement Plan to be developed, following review by NHS Digital, to help improve eRS access for patients and reduce un-necessary re-arrangement of outpatient appointments.	End June	Outpatient Steering Group	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Responsive					
A&E 4-hours	8A	Extended escalation capacity (A518) likely to end of quarter 4, and continued use of ORLA. Escalation capacity has remained open during quarter 4 and agreement has been given for this to be included in Medicine's substantive bed base. Orla Healthcare went into administration at the end of April 2017 and no longer provide a service to UH Bristol. Options for replacement of this service are being developed.	Ongoing	Monitoring of expected improvement in relevant KPI through the Emergency Access Improvement Group (EAPIG)	Achievement of recovery trajectory in each month of Q1 2017/18.
	8B	Flexible use of community beds via system partners: Integrated Discharge Service (IDS) continues to pursue flexible use of available care home and reablement capacity to facilitate discharge on a daily basis. Work is being undertaken within the IDS to improve and optimise internal processes with the service being part of the Flow Coaching Programme supported by the West of England Academic Health Science Network (AHSN) which is being formally launched on 23 Mat	Ongoing	Progress monitored through daily ALAMAC calls. Actions expected to reduce and/or smooth demand. Monitoring of expected improvement in relevant KPI through the Emergency Access Improvement Group (AEPIG)	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		2017.			
	8C	Additional GP Support Unit and Urgent care capacity: Future requirements for GPSU will be incorporated into the proposed model for Front-Door Primary Care Streaming which has to be operational by October 2017 at the latest. The UCSG will undertake a further review of all direct access admission pathways during quarter 2 2017/18 to ensure that these are as effective as possible and reduce the reliance on the Emergency Department (ED) as a gateway for all admissions. The pilot for medically expected patients to be admitted via Ambulatory Care Unit has been extended.	End September 2017		
	8D	Proposals for a different Urgent and Emergency Care staffing model is being developed for presentation to the UCSG and SLT in July 2017.	Ongoing		
	8E	Commissioning of Pulse to provide domiciliary care packages, to support early supported discharge: Pulse commissioned and operational from 20th February	End July 2017	Contract monitoring	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		2017 and has reduced the number of patients delayed waiting for a package of care. Formal evaluation to be presented to SLT in July for decision about continuation of the initiative.			
	8F	Review of formal feedback from NHS Improvement Critical Friend Visit, to feed into refresh of the action plan. Formal feedback reviewed and has been incorporated into the Urgent Care Steering Group action plan which will be presented to the May 2017 meeting.	Complete	Review and monitoring of agreed actions by EAPIG.	
	8G	Division of Medicine to embed new medical model of Acute Physicians and develop clear strategy of medical admissions flow from ED, learning from their first two weeks in post. Acute physicians are now in post and early indications are that there has been an increase in the 0-2 day length of stay and a reduction in overall length of stay. The Medicine Division is developing an urgent and emergency care strategy which will now look to develop the acute medicine model further for	End July 2017	Review and monitoring of agreed actions by EAPIG.	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		presentation to the UCSG and SLT in July 2017.			
	8H	ED to pilot escalation of delayed speciality review of patients in ED to Silver (operational meetings) for respective divisions (Surgery and Specialised Services) using ipods. This is Monday to Friday with the purpose of capturing in real-time what the issues are, and looking for innovative ways to improve access to speciality review. Contributes to implementation of refreshed professional standards. Professional standards approved at April UCSG and will be taken to June SLT for formal sign off.	End June 2017		
	8I	Consideration of strategic solutions to potential bed capacity shortfalls for 2017/18, including ways of increasing early supported discharge. Paper detailing the next steps for out of hospital care options presented to SLT in April. Detailed analysis and work with system partners is now been undertaken to develop potential future models of care which are formally costed and assessed.	End June	Review of options to be considered at Senior Leadership Team	Achievement of STF trajectory in 2017/18

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Referral to Treatment Time (RTT)	9A	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory. Continued weekly review of management of longest waiting patients through RTT Operations Group.	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review meetings.	Achievement of 92% standard from the end of July onwards.
	9B	RTT Plan for the first half of 2017/18, focusing on areas of recent growth and those specialties whose backlogs are still above sustainable levels	Complete	RTT Steering Group	
	9C	Refresh of IMAS Capacity and Demand modelling for key specialties (including Clinical Genetics, Paediatric Cardiology and Sleep Studies).	End June	Modelling to be reviewed by Associate Director of Performance	
Cancer waiting times	10A	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 85% for internally managed pathways and 85% with application of CQUIN. Sustain performance above national average each quarter.
	10B	Ring-fencing of step-down beds to reduce Critical Care related cancellations of cancer surgery.	End June	Cancer Steering Group	Achievement of 85% standard by the end of 2017/18
	10C	Completion of transfer from Taunton & Somerset Trust of skin cancer service.	End march	Cancer Steering Group	Achievement of 85% standard by the end of 2017/18

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	10D	Explore options relating to the re-provisioning / re-commissioning of cancer 62-day GP pathways, in order to reduce inter-provider transfer delays.	End October	Cancer Steering Group	Achievement of 85% standard by the end of 2017/18
Diagnostic waits	11A	Additional Sleep Studies waiting list sessions to be established to minimise residual backlog of long waiters.	End June	Weekly monitoring by Associate Director of Performance, with escalation to monthly Divisional Review meetings as required.	Achievement of 99% standard again for this diagnostic modality by the end of June.
	11B	Changes to be made to Cardiac CT scanning sessions to improve utilisation. Pilot to be run in the first instance to determine impact.	End July	Weekly monitoring by Associate Director of Performance, with escalation to monthly Divisional Review meetings as required.	Achievement of 99% standard again for this diagnostic modality by the end of June (subject to confirmation).
	11C	Reasons for the increase in demand for Cardiac CT and Stress echo to be investigated.	Complete	Divisional Review Meeting	As above.
	11D	Additional stress echo sessions to be established to replace lost capacity in May and meet high levels of demand.	Complete	Weekly monitoring by Associate Director of Performance, with escalation to monthly Divisional Review meetings as required.	Achievement of 99% standard again for this diagnostic modality by the end of May.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Effective					
Fracture neck of femur Best Practice Tariff (BPT)	12A	**Middle grade orthogeriatric support** – to submit a proposal to establish a dedicated middle grade orthogeriatric role (ST3+) to provide additional support to the orthogeriatric consultants and wards. This post will also contribute to improvements in cross-cover.	Pending approval and further discussion with executive colleagues	Proposal for investment included in BOA business case. Recruitment lead time difficult to determine as this may be a difficult role to recruit to	Successful funding bid and subsequent recruitment to post
	12B	**Consultant orthogeriatric consultant cover** – to support a return to work for the consultant that has been on extended long term sick.	To be confirmed	Reduction in variability in cross-cover arrangements. The current shortfall of 3.5 Care of the Elderly consultant posts is having a significant adverse impact on ortho-geriatric capacity.	Improvements in time to review by an orthogeriatrician.
	12C	**Establishment of an elderly trauma and hip fracture ward** – to cohort frail elderly trauma patients on A604. To facilitate direct admission from ED to ring-fenced fractured neck of femurs beds.	This is contingent upon amending care pathways and admission protocols.	There also needs to be sufficient capacity to maintain ring fenced admission beds and medical ward capacity to accommodate step down patients	Improvements to the quality and coordination of patient care.
	12D	**Physiotherapy the day after surgery** – to ensure that there is physiotherapy support available to the orthopaedic wards on Sundays	To be incorporated in revised costings for the business case following discussions with D&T Division.	There are potential benefits associated with reduction in patient length of stay with earlier mobilisation.	Improvements against the new quality standard measure of therapy review the day after surgery.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	12E	**Time to surgery** – to improve trauma throughput and to expedite the surgery of fractured neck of femurs patients within 36 hours.	Ongoing	The number of patients that do not meet this standard is relatively small. There is work being undertaken to refine the process for escalation of patients that are not anticipated to meet the standard to ensure that proactive steps are taken	Improvements against time to theatre standard
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. See also actions 8A to 8J.	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**: • "Healthroster" - implementation • KPIs agreed and in place.	End June 2017 End June 2017	KPI Performance monitored through Nursing Controls Group. Nursing agency: oversight by Savings Board. Medical agency: oversight through the Medical Efficiencies Group.	A KPI has been agreed for 2017/18 of 1% through the Divisional Operating Planning Process. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings. Marketing activity now being actively deployed.
		Controls and efficiency: • New agency rules in place for Nursing from April • Nurse agency suppliers still under consideration through the wider BNSSG group. • Operating plan agency trajectories monitored by divisional reviews.	Ongoing End June 2017 Monthly/quarterly reviews		
		Enhancing bank provision: • Recruitment and marketing plan for all staff groups in place for 2017/18. • Staff able to book shifts from home on Healthroster. • Extended Temporary Staffing Bureau opening hours.	Ongoing End June 2017 End June 2017		
Sickness Absence	15	**Supporting Attendance Policy:** Revised policy to Policy Group April 2017; implementation and training	August/September 2017	Oversight by Workforce and Organisational Development (OD) Group via the Staff	A KPI has been agreed for 2017/18 of 3.8% Divisional Operating Planning Process.

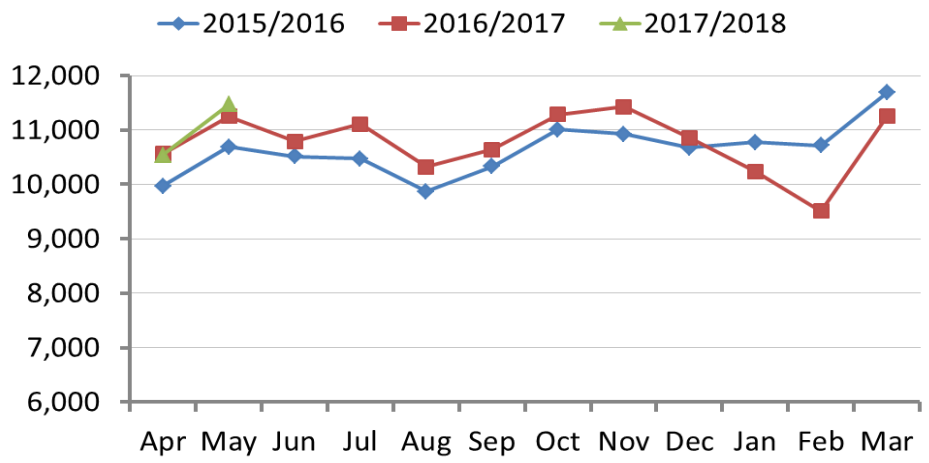
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		from September 2017.		Health and Well Being Sub Group	Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings.
		Supporting Attendance Surgeries: To expedite cases where possible.	Ongoing		
		Musculo-skeletal: Interventions by Occupational Health, Physio Direct, and Manual Handling Team.	Ongoing	Workplace Wellbeing Steering Group (quarterly) /CQUIN Delivery Group	
		Mental health: Draft Stress management strategy framework.	Senior Leadership October 2017		
		Staff Health and Well Being: Trust review of model for well-being including healthy food and beverages.	January 2016 to March 2019		
Vacancies	16	**Recruitment Performance:** • Divisional Performance and Operational Review Meetings monitor vacancies and performance against KPI of 45 days to recruit.	Reviewed quarterly	Workforce and OD Group /Recruitment Sub Group.	The target for vacancies continues to be 5% in 2017/18. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings.
		Marketing and advertising: • Recruitment and marketing plan for nursing in place for 2016/17. • Marketing for Radiology in place 2016/17 maximising new recruitment website.	Ongoing Ongoing	Divisional Performance and Operational Review Meetings.	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		• Divisional Nurse Recruitment Leads in bed-holding divisions. • "Head-hunter" agency approach has been extended to hard to fill areas e.g. Sonography, Trauma & Orthopaedics and Care of the Elderly nursing.	April 2017-18 From April 2017		
Turnover	17	**Complete review of appraisal**: Including: • Updated policy • E-Appraisal • Revised Training	May 2017	Transformation Board.	A KPI has been agreed for 2017/18 of 12% through the Divisional Operating Planning Process. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance reviews meetings.
		Transformational Engagement and Retention: Leadership Behaviours workshops complete. SLT Sub-group developing Framework for June 2017.	End June 2017	Senior Leadership Team/Board.	
		Engagement (Staff Survey): Results and heat maps disseminated, detailed staff action plans being developed at divisional level. HR BPs developing Improving Staff Experience Plans for 2017/2018.	End of June 2017	Divisional Boards/ Senior Leadership Team/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.

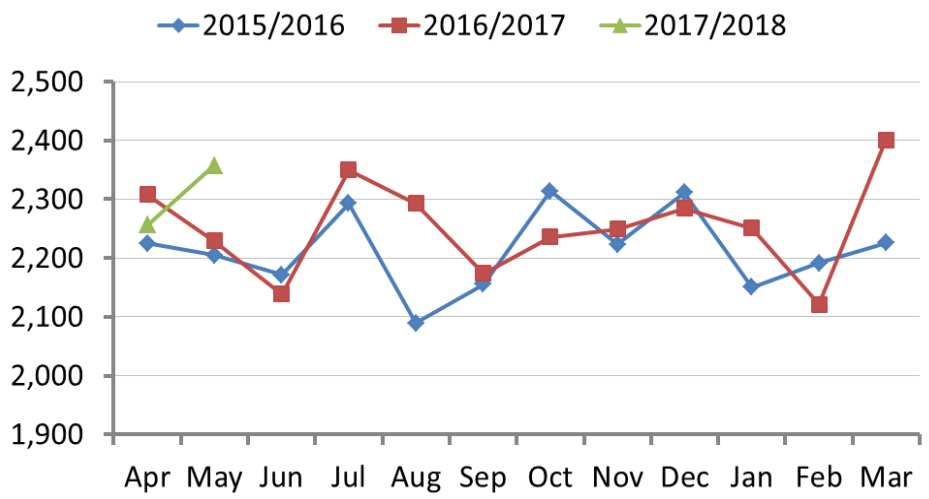
Emergency Department (ED) attendances



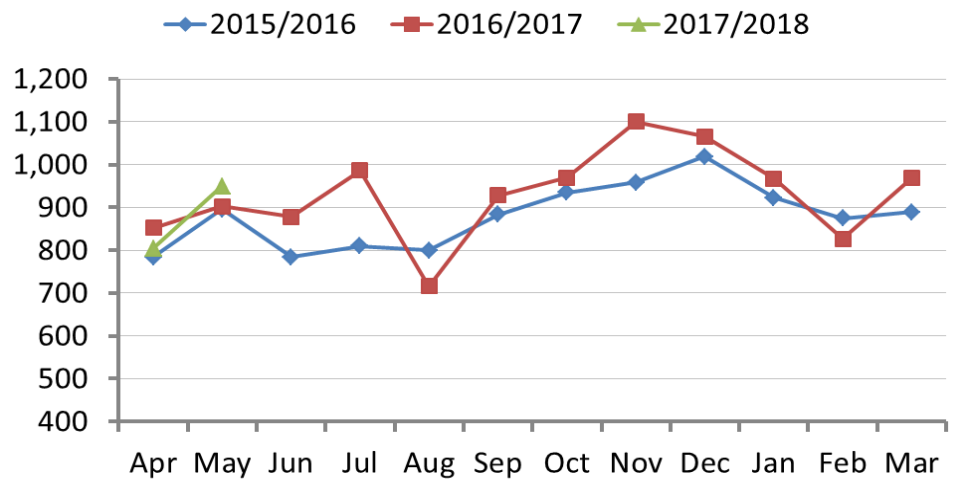
Summary points:

- Emergency Department attendances are similar to last year's levels;
- The total number of emergency admissions into the BRI has increased to the levels usually seen in July;
- The number of new outpatient attendances has risen significantly above the seasonal norm;
- The number of elective admissions has also increased to above the seasonal norm;
- The number of patients waiting over 18 weeks for treatment has increased, as has the total number of pathways; the elective waiting list has increased in size again, which means there continues to be a 'bulge' in the waiting list that will need to be met to prevent an increase in over 18 week waiters in future months (see Assurance and Leading Indicators section).

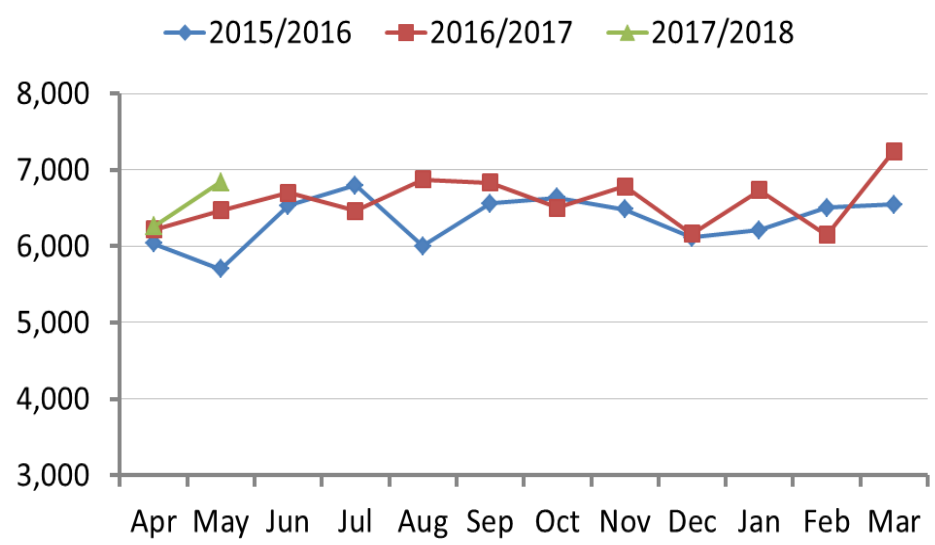
Emergency admissions (BRI)



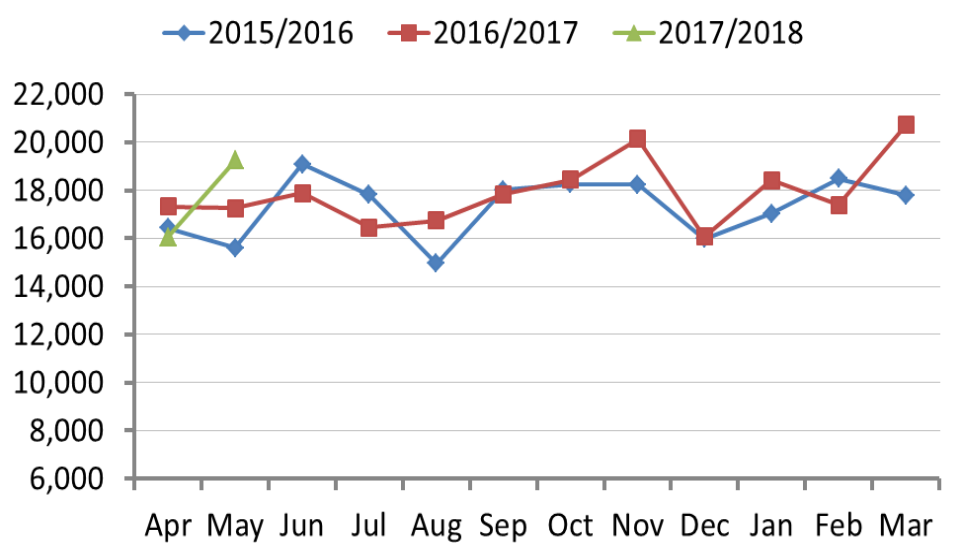
Emergency admissions (BCH)



Elective admissions



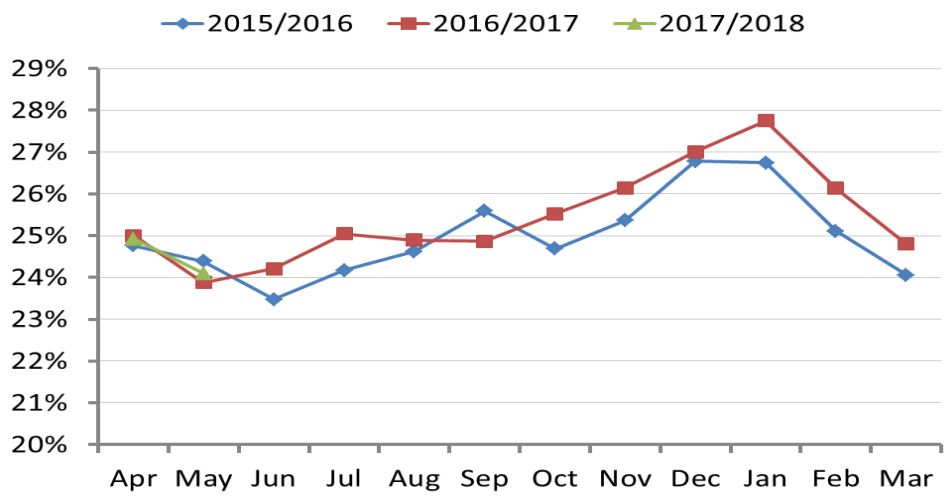
New outpatient attendances



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.

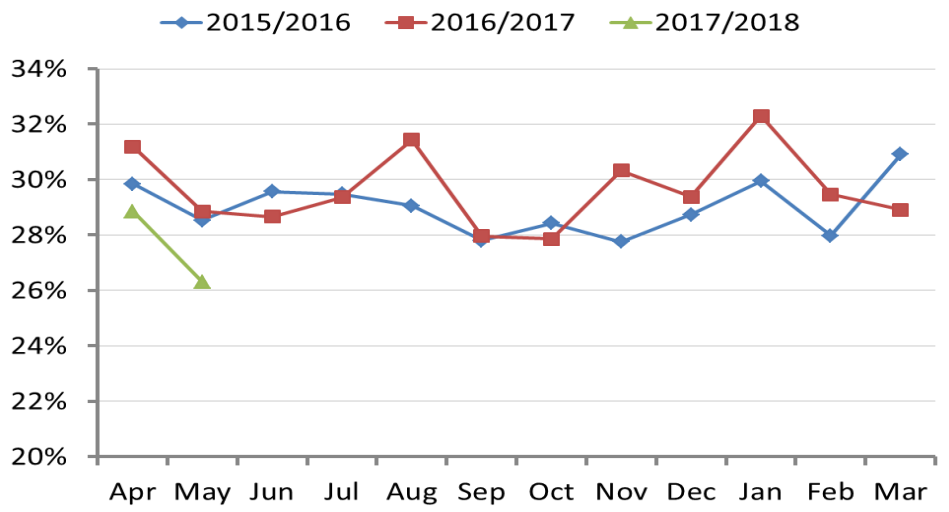
Percentage ED attendances resulting in admission



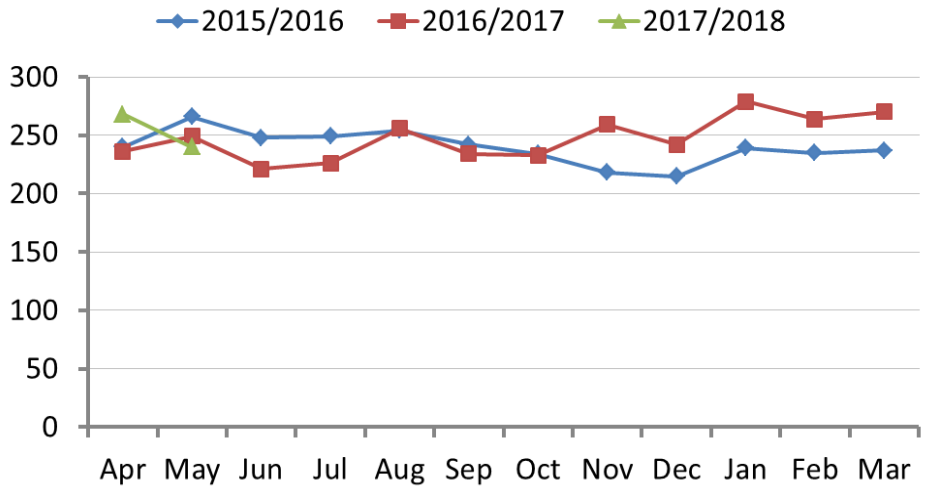
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission is at the seasonal norm; the percentage of patients admitted aged 75 years and over continues, however, to be well below the levels seen in the last two years;
- The number of over 14 days stays is now slightly below that of the last two years' levels; the BRI bed occupancy level has, however risen, likely due to the increase in emergency admissions;
- The number of patients on the outpatient waiting list remains similar to that of last year, despite an increase in new attendances in the period; the elective waiting list has risen again, even with the increase in elective admissions, likely due to more outpatients being seen and having a decision to admit;
- The number of patients referred by their GP with a suspected cancer (2-week waits) remains slightly above the seasonal norm.

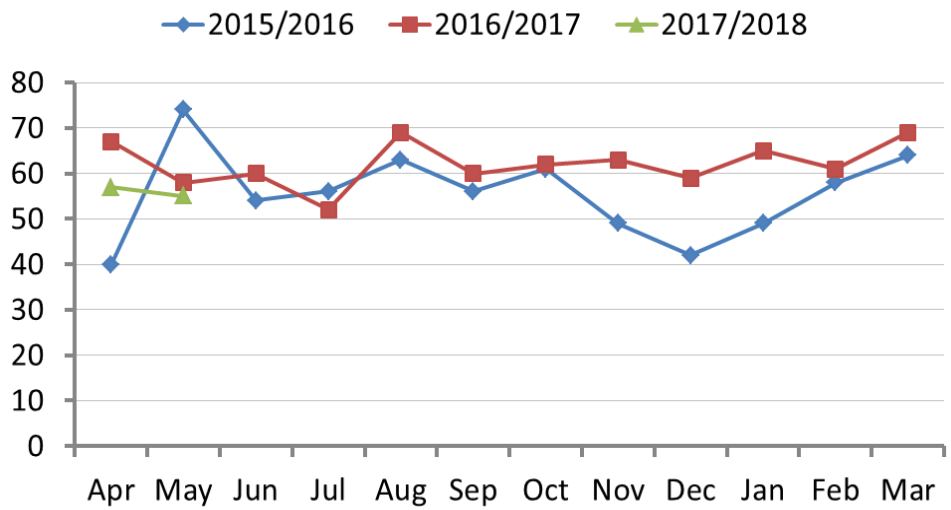
Percentage of Emergency BRI spells patients aged 75 years and over



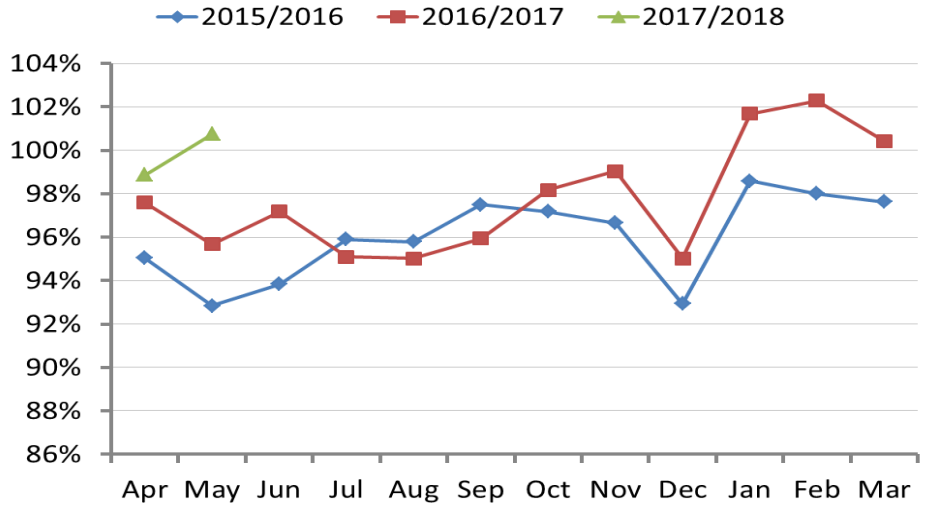
Over 14 day stays



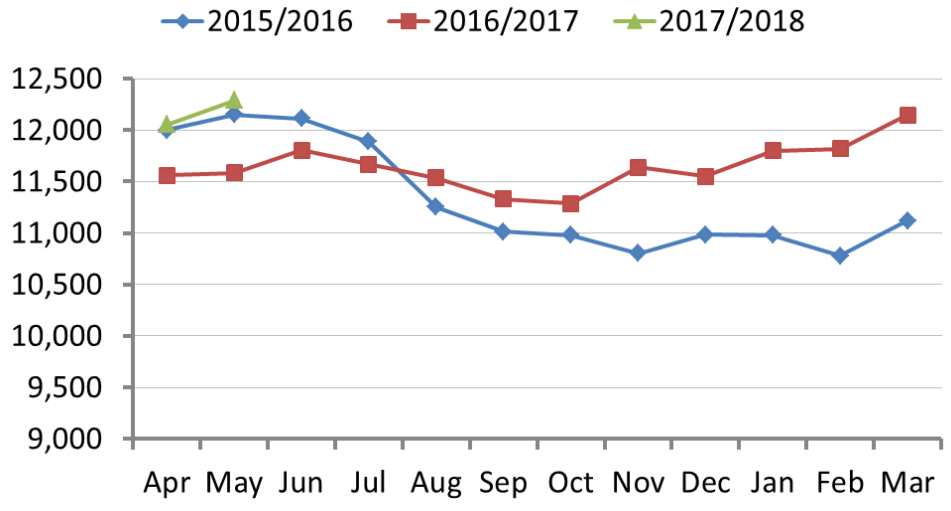
Delayed discharges (Green to Go)



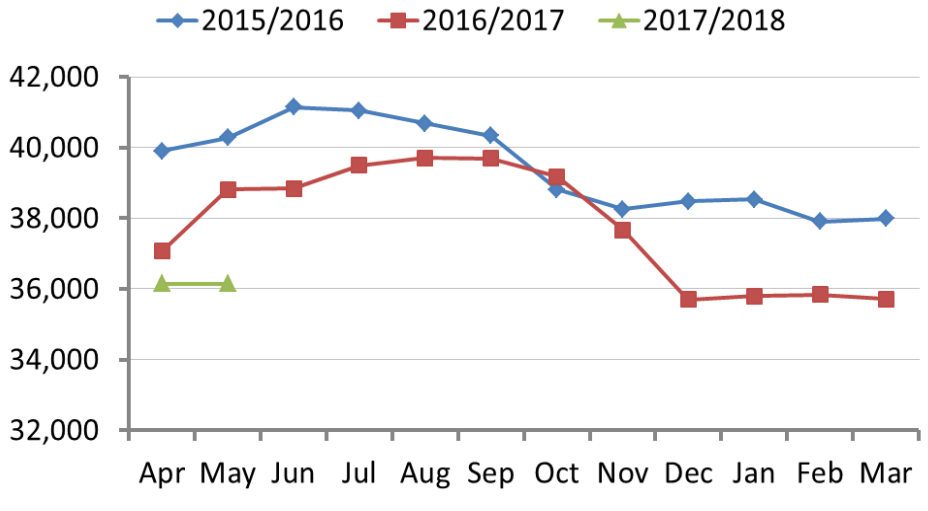
BRI Bed Occupancy



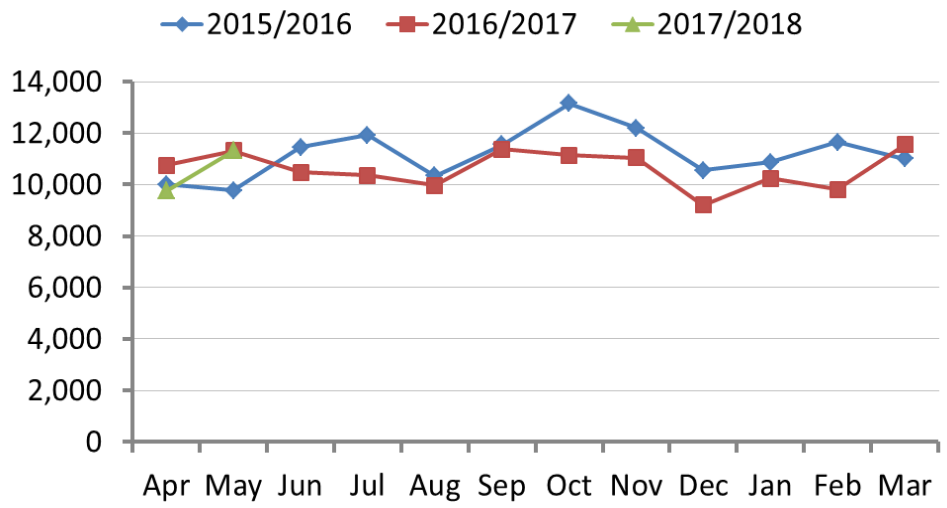
Elective waiting list size



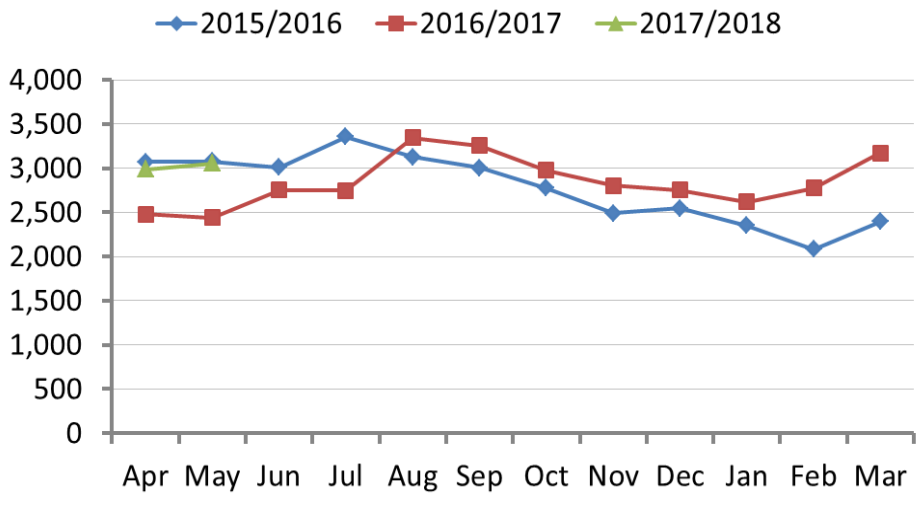
Outpatient waiting list size



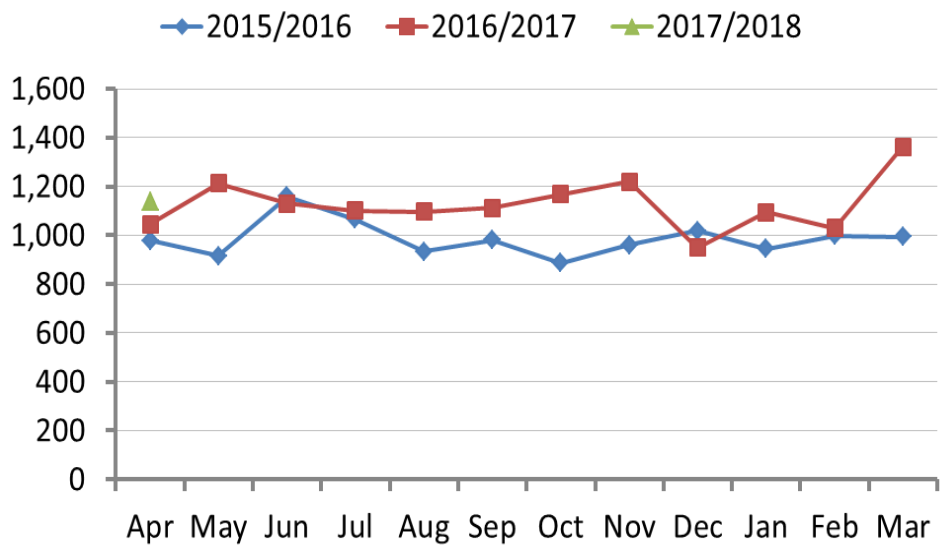
Number of RTT pathways stopped (i.e. treatments)



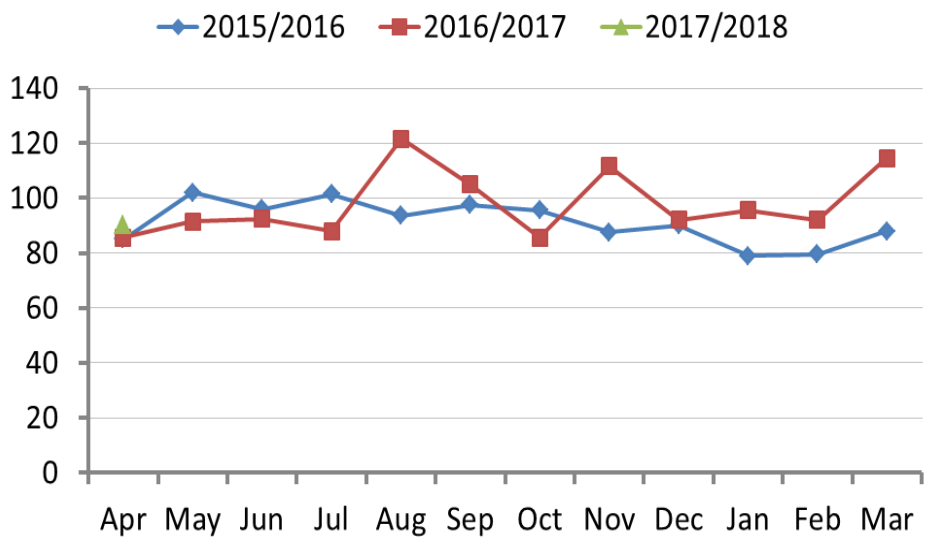
Number of RTT pathways over 18 weeks



Cancer 2-week wait – urgent GP – referrals seen



Cancer 62-day GP referred treatments



Trust Scorecards

SAFE, CARING & EFFECTIVE

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	16/17	17/18 YTD	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	0	0	0	0	0	1	1	1	1	1	1	1	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	1	1	0	0	0	0	0	1	0	0	0	0	1	0	0	1	0	1
	DA03	C.Diff Cases - Monthly Totals	31	6	1	3	2	5	1	3	5	4	0	0	2	4	10	9	4	6
	DA02	MSSA Cases - Monthly Totals	37	1	3	7	4	2	0	6	2	3	3	2	0	1	13	8	8	1
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	2	3	4	5	5	8	9	10	10	10	-	-	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	96.6%	98.2%	98%	96.9%	98.4%	94.9%	97%	96.5%	95.7%	95.5%	95.4%	97%	98.4%	98.1%	96.8%	96.4%	96%	98.2%
	DB02	Antibiotic Compliance	88.3%	88.8%	83.9%	88.2%	86.5%	86.8%	90.9%	90.3%	91.2%	91.7%	92%	88.1%	87.7%	89.6%	87.4%	90.8%	90.8%	88.8%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	95%	96%	97%	95%	95%	96%	96%	96%	94%	95%	96%	96%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	98%	98%	98%	97%	97%	97%	98%	97%	97%	98%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	96%	96%	97%	97%	96%	96%	97%	96%	96%	95%	96%	96%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	52	9	2	6	8	1	4	5	3	5	2	5	2	7	15	12	12	9
	S02a	Number of Confirmed Serious Incidents	45	-	2	5	7	1	4	5	3	5	2	1	-	-	13	12	8	-
	S02b	Number of Serious Incidents Still Open	4	9	-	-	-	-	-	-	-	-	-	4	2	7	-	-	4	9
	S03	Serious Incidents Reported Within 48 Hours	94.2%	100%	100%	83.3%	87.5%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86.7%	100%	100%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	90.4%	100%	100%	100%	87.5%	100%	75%	80%	66.7%	100%	100%	100%	100%	100%	93.3%	75%	100%	100%
	S04	Serious Incident Investigations Completed Within Timescale	98%	85.7%	100%	100%	100%	100%	100%	100%	75%	100%	100%	100%	100%	75%	100%	93.3%	100%	85.7%
	S04a	Overdue Exec Commissioned Non-SI Investigations	-	3	-	-	-	-	-	-	-	-	-	-	1	2	-	-	-	3
Never Events	S01	Total Never Events	2	1	0	1	0	0	1	0	0	0	0	0	0	1	1	1	0	1
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	14866	1203	1258	1173	1139	1263	1220	1389	1185	1335	1211	1332	1203	-	3575	3794	3878	1203
	S06b	Patient Safety Incidents Per 1000 Beddays	47.82	47.02	50.22	45.32	44.67	50.77	45.61	52.93	46.21	48.94	48.67	48.47	47.02	-	46.88	48.25	48.69	47.02
	S07	Number of Patient Safety Incidents - Severe Harm	95	7	9	10	10	2	10	12	10	10	7	5	7	-	22	32	22	7
Patient Falls	AB01	Falls Per 1,000 Beddays	4.23	4.37	4.59	4.6	3.84	4.42	4.86	4.04	3.74	3.74	4.9	3.89	4.85	3.91	4.29	4.22	4.16	4.37
	AB06a	Total Number of Patient Falls Resulting in Harm	36	5	3	3	3	3	2	2	4	3	3	5	2	3	9	8	11	5
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.148	0.077	0.04	0.077	0.196	0.161	0.075	0.114	0.195	0.11	0.201	0.182	0.078	0.076	0.144	0.127	0.163	0.077
	DE02	Pressure Ulcers - Grade 2	40	2	1	2	5	4	1	3	5	3	3	3	1	1	11	9	9	2
	DE04A	Pressure Ulcers - Grade 3 or 4	6	2	0	0	0	0	1	0	0	0	2	2	1	1	0	1	4	2
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	99.1%	98.9%	99%	99.1%	99.1%	99%	99%	99.4%	99%	99.1%	98.9%	99.1%	98.9%	98.9%	99.1%	99.1%	99%	98.9%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	96.4%	95.9%	96.6%	97.3%	95.7%	94.1%	97%	96.5%	97%	97.8%	98%	96.6%	94.5%	97.5%	95.8%	96.8%	97.4%	95.9%
	N04	Number of Hospital Associated VTEs	63	-	4	5	5	5	2	9	7	11	3	2	-	-	15	18	16	-
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	7	-	0	0	0	1	1	0	1	2	0	0	-	-	1	2	2	-
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	13	-	0	0	1	1	0	4	2	3	1	0	-	-	2	6	4	-
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	89.6%	88.8%	86.3%	89.4%	89.8%	89.7%	86.5%	87.1%	94.3%	92.7%	89.1%	90.2%	89.9%	87.7%	89.6%	89.4%	90.6%	88.8%
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	86.9%	-	80.8%	-	-	88%	-	-	91.2%	-	-	87.9%	-	-	88%	91.2%	87.9%	-
Safety	Y01	WHO Surgical Checklist Compliance	99.1%	99.6%	98.9%	99.6%	99.9%	100%	99.6%	-	97.7%	98.4%	98%	97.8%	99.5%	99.7%	99.9%	98.7%	98.1%	99.6%

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual 16/17	Annual 17/18 YTD	Monthly Totals Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Quarterly Totals 16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Patient Safety																				
Medicines	WA01	Medication Incidents Resulting in Harm	0.37%	0.98%	0%	0.55%	0%	1.01%	0.55%	1.19%	0%	0%	0.53%	0%	0.98%	-	0.51%	0.64%	0.16%	0.98%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.59%	0.66%	0.56%	0.6%	0.38%	0%	0.65%	0.86%	0.74%	0.98%	0.39%	0.26%	0.43%	0.9%	0.33%	0.75%	0.52%	0.66%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.9%	97.6%	98.3%	98.4%	98.6%	98.6%	97.6%	97.5%	97.4%	98%	97.3%	98.3%	97.9%	97.3%	98.6%	97.5%	97.9%	97.6%
	AK04	Safety Thermometer - No New Harms	98.9%	98.6%	98.7%	99.2%	99.2%	99.2%	98.4%	99.3%	98.5%	98.6%	98.5%	99.1%	99%	98.3%	99.2%	98.7%	98.7%	98.6%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	92%	98%	79%	82%	95%	94%	94%	93%	93%	91%	93%	100%	100%	96%	90%	93%	95%	98%
Out of Hours	TD05	Out of Hours Departures	7.8%	8.3%	7.2%	7.9%	8.8%	7.4%	7.2%	7.8%	8.1%	8.4%	9.2%	6.5%	8.5%	8.2%	8%	7.7%	8%	8.3%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	22.1%	22.2%	23.4%	23.1%	21%	22.1%	21.8%	22.3%	22.1%	21.6%	21.4%	21.1%	22%	22.3%	22.1%	22.1%	21.3%	22.2%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	11293	1856	989	1006	907	932	974	970	935	905	816	934	885	971	2845	2879	2655	1856
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.7%	104.5%	103.1%	104.3%	102.7%	101.9%	102.6%	105.3%	104.2%	103.6%	104.5%	104.1%	107.1%	102.6%	103%	104%	104%	104.5%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	99.9	-	101.2	-	-	99.4	-	-	99.1	-	-	-	-	-	99.4	99.1	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	91.4	-	89.8	100.4	88	81.2	91.3	110.4	92.2	87.6	90.9	91.2	-	-	89.9	97.9	89.8	-
Mortality Review	tbc	Number of Deaths																		
	tbc	Number of Deaths Subject to Casenote Review																		
	tbc	Number of Deaths Reviewed Under Serious Incident Framework																		
	tbc	Number of Deaths With More Than 50:50 Chance of Being Avoidable																		
Readmissions	C01	Emergency Readmissions Percentage	1.77%	1.71%	1.7%	1.76%	2%	2.29%	1.48%	1.7%	1.93%	1.75%	1.84%	1.47%	1.71%	-	2.01%	1.7%	1.68%	1.71%
Sepsis (Inpatients)	AG02a	Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	21.6%	38.1%	-	7.1%	11.1%	16.7%	20%	21.7%	27.3%	27.8%	28.6%	41.7%	38.5%	-	12%	22%	31.8%	38.1%
	AG03a	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatien	65.7%	71.4%	-	33.3%	80%	33.3%	66.7%	85.7%	71.4%	100%	50%	42.9%	100%	-	54.5%	73.9%	68%	71.4%
	AG04a	Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	100%	100%	-	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	100%	100%	100%	100%
Sepsis (Emergency Department)	AG02b	Percentage of Patients Meeting Criteria Screened for Sepsis (ED)	74.4%	80%	-	30%	50%	100%	60%	80%	80%	90%	80%	100%	80%	-	60%	73.3%	90%	80%
	AG03b	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (ED)	56.3%	100%	-	30%	60%	90%	40%	50%	60%	77.8%	70%	25%	100%	-	60%	50%	59.3%	100%
	AG04b	Sepsis Patients Percentage with a 72 Hour Review (ED)	94.3%	100%	-	100%	100%	100%	100%	100%	70%	100%	100%	100%	100%	-	100%	84.2%	100%	100%
Maternity	G01	Percentage of Low Weight Babies	2.7%	2.3%	2.9%	3.3%	2.3%	2.6%	3.1%	3.3%	2.3%	2.4%	3.9%	3.3%	2.3%	-	2.7%	2.9%	3.2%	2.3%
	G01A	Number of Low Weight Babies	137	9	12	14	10	11	14	13	9	10	14	14	9	-	35	36	38	9

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			16/17	17/18 YTD	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Patient Safety																				
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	70.5%	73.2%	72%	73.5%	61.3%	58.3%	73.7%	69.2%	51.7%	69.2%	81%	80.8%	57.7%	86.7%	65.2%	63.5%	76.7%	73.2%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	74%	73.2%	72%	79.4%	64.5%	58.3%	89.5%	69.2%	86.2%	61.5%	71.4%	73.1%	73.1%	73.3%	68.5%	81.1%	68.5%	73.2%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	51.9%	48.2%	44%	52.9%	35.5%	37.5%	68.4%	53.8%	44.8%	42.3%	61.9%	61.5%	34.6%	60%	42.7%	54.1%	54.8%	48.2%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	44.1	44.4	72.2	53.5	49.4	51.7	53.2	48.8	43.3	37.3	67.4	38	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	58.6%	61.5%	65.9%	59%	51.4%	63.4%	56.8%	61.8%	35.3%	52.4%	50%	64.3%	61.5%	-	58.3%	51.4%	55.5%	61.5%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90.2%	90.9%	93.2%	92.3%	85.7%	92.7%	97.3%	88.2%	94.1%	90.5%	84.1%	88.6%	90.9%	-	90.4%	93.3%	87.7%	90.9%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.8%	52.9%	61.5%	76.5%	71.4%	80%	60%	65.2%	81.8%	51.7%	72.2%	61.5%	56.3%	50%	76.5%	68.2%	60%	52.9%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	90.4%	87.7%	94.1%	98%	96.3%	93.2%	93.1%	88.9%	89.1%	80.8%	80.1%	84%	87.2%	88.3%	96%	90.2%	81.6%	87.7%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	97.2%	97.5%	98.1%	98.1%	97.8%	100%	96.8%	94.1%	97.6%	97.6%	88.9%	100%	97.3%	97.6%	98.6%	96.3%	96.2%	97.5%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	94.7%	80%	100%	100%	100%	85.7%	100%	100%	71.4%	100%	100%	100%	100%	66.7%	92.3%	88.2%	100%	80%
	AC04	Percentage of Dementia Carers Feeling Supported	75%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	8178	1161	702	545	554	447	811	784	602	972	735	510	506	655	1546	2197	2217	1161
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	90	91	92	91	91	92	94	92	92	92	91	91	91	92	91	91
	P01g	Patient Survey - Kindness and Understanding	-	-	94	93	96	96	95	96	97	96	95	96	96	97	95	95	95	96
	P01h	Patient Survey - Outpatient Tracker Score	-	-	90	90	90	89	88	90	90	90	88	89	89	89	90	90	89	89
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35.5%	36.5%	40.5%	36.5%	36.8%	30.7%	33.7%	35.9%	30.6%	31.7%	34.8%	36.8%	34.6%	38.3%	34.6%	33.5%	34.5%	36.5%
	P03b	Friends and Family Test ED Coverage	16.4%	16%	15.5%	12%	16.8%	15.5%	17.3%	18.9%	15.4%	21.2%	17.7%	18.4%	15.9%	16.1%	14.7%	17.2%	19.1%	16%
	P03c	Friends and Family Test MAT Coverage	22.5%	20.2%	19%	24.4%	20.4%	21.1%	22.6%	22.1%	19.8%	24.6%	29.7%	25.3%	23.6%	17.1%	21.9%	21.6%	26.4%	20.2%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	97.2%	97%	97.2%	95.9%	97.4%	96.9%	98.2%	97.3%	97.5%	97.4%	96.9%	98.5%	97.2%	96.9%	96.7%	97.7%	97.6%	97%
	P04b	Friends and Family Test Score - ED	78.2%	79.9%	74.4%	71.8%	79.6%	78.6%	79.3%	78.9%	74.1%	80.8%	79.6%	80.2%	83.2%	77%	77.1%	77.6%	80.2%	79.9%
	P04c	Friends and Family Test Score - Maternity	96.8%	96.4%	95.5%	96.2%	97.8%	97.3%	97.7%	94.3%	94.5%	98.2%	96.2%	97.4%	96.9%	95.8%	97%	95.6%	97.3%	96.4%
Patient Complaints	T01	Number of Patient Complaints	1875	405	198	200	155	162	140	139	118	129	144	168	247	158	517	397	441	405
	T01a	Patient Complaints as a Proportion of Activity	0.232%	0.402%	0.296%	0.315%	0.246%	0.24%	0.204%	0.19%	0.19%	0.186%	0.222%	0.22%	0.402%	-	0.266%	0.195%	0.21%	0.402%
	T03a	Complaints Responded To Within Trust Timeframe	86.1%	83.5%	73.8%	86.8%	90.6%	86%	92.3%	93.4%	97.4%	87.5%	87.5%	83.3%	76.3%	89.4%	88.1%	94.2%	86%	83.5%
	T03b	Complaints Responded To Within Divisional Timeframe	86.6%	80%	95.2%	89.5%	94.3%	81.4%	92.3%	85.2%	76.9%	85.4%	85%	72.9%	76.3%	83%	88.8%	84.9%	80.9%	80%
	T04c	Percentage of Responses where Complainant is Dissatisfied	11.41%	-	16.67%	10.53%	13.21%	18.61%	0%	9.84%	12.82%	14.58%	10%	12.5%	-	-	14.18%	7.91%	-	-
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	0.98%	1.17%	0.96%	1.03%	0.46%	0.6%	1.18%	0.88%	0.99%	1.24%	1.52%	0.91%	1.34%	1.02%	0.69%	1.01%	1.2%	1.17%
	F01a	Number of Last Minute Cancelled Operations	734	147	61	63	30	39	73	57	58	79	89	63	80	67	132	188	231	147

Please note:

As reported last month, a number of changes have been made to the quality dashboard for 2017/18 as agreed by the Quality and Outcome Committee. These new measures will mostly report two months in arrears or quarterly. The dashboard for these new measures will start to be populated from next month as data becomes available.

RESPONSIVE

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	16/17	17/18 YTD	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.7%	91.1%	92.1%	92%	90.5%	90.4%	91.2%	92%	92%	92.2%	92%	91.1%	91.1%	91.1%	91%	91.8%	91.8%	91.1%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	2753	2749	3344	3256	2978	2805	2751	2619	2777	3171	2985	3056	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	11	16	0	0	0	1	0	1	1	3	3	2	5	11	1	2	8	16
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	696	318	14	27	33	27	53	78	93	86	106	133	153	165	87	224	325	318
New Outpatient Wait List	L02L	New Outpatient List - Numbers Waiting 12+ Weeks	-	-	-	-	13502	14255	14992	15454	14984	13605	13592	13073	12361	11151	11744	12400	-	-	-	-
	L02M	New Outpatient List - Percentage Waiting 12+ Weeks	-	-	-	-	33.1%	34.4%	35.8%	36.9%	35.4%	32.8%	34.2%	33.1%	32.7%	30.3%	30.5%	32%	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	94.8%	95.1%	93.5%	95.4%	93.7%	91.6%	94.3%	96.2%	96%	95.9%	95.5%	96.3%	95.1%	-	93.6%	95.5%	95.9%	95.1%
	E01c	Cancer - Urgent Referrals Stretch Target	80%	80%	68.4%	52.7%	65.3%	67.6%	68.4%	67%	55.1%	71%	60.8%	75.3%	76%	79.7%	52.7%	-	67.6%	62.4%	77.2%	52.7%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	96.7%	91.2%	96.7%	99.1%	96.5%	97.4%	97.8%	98.3%	96.1%	96.5%	96.8%	97.4%	91.2%	-	97.6%	97.4%	96.9%	91.2%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.7%	99.1%	97.3%	97.5%	97.7%	99.1%	97.5%	100%	99.1%	100%	100%	98.4%	99.1%	-	98.1%	98.9%	99.5%	99.1%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.4%	82.6%	97.7%	97.1%	92.6%	98.4%	96.4%	98%	95.9%	93.8%	92.3%	96.5%	82.6%	-	96.1%	96.8%	94.3%	82.6%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	96.6%	98.1%	96.8%	96.7%	95.2%	92%	95.4%	98.1%	98.2%	96.9%	97.6%	96.7%	98.1%	-	94.5%	97.3%	97%	98.1%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	79.3%	76.7%	70.8%	73.3%	84.8%	80.5%	79.5%	85.2%	81.5%	84.3%	78.8%	81.2%	76.7%	-	80.1%	82.4%	81.5%	76.7%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	69.4%	66.7%	85.7%	66.7%	55.6%	44.4%	100%	83.3%	100%	57.1%	100%	83.3%	66.7%	-	55.6%	94.3%	77.8%	66.7%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	87.9%	93.1%	96.9%	89.3%	91.1%	92.5%	88%	90.1%	82.1%	93.2%	77.8%	88.4%	93.1%	-	90.8%	86.5%	86.8%	93.1%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	-	-	62	4	7	3	2.5	5	4	6.5	4	5.5	4.5	7.5	4	-	10.5	14.5	17.5	4
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	0.98%	1.17%	0.96%	1.03%	0.46%	0.6%	1.18%	0.88%	0.99%	1.24%	1.52%	0.91%	1.34%	1.02%	0.69%	1.01%	1.2%	1.17%
	F01a	Number of Last Minute Cancelled Operations	-	-	734	147	61	63	30	39	73	57	58	79	89	63	80	67	132	188	231	147
	F02c	Number of LMCs Not Re-admitted Within 28 Days	7	7	72	10	2	4	3	0	3	6	4	4	6	15	4	6	7	13	25	10
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.36%	1.47%	1.14%	1.5%	1.12%	1.33%	2.11%	1.61%	1.38%	0.67%	1.16%	1.13%	1.05%	1.86%	1.31%	1.7%	0.99%	1.47%
	F07a	Number of Admissions Cancelled Day Before	-	-	1020	185	72	92	73	87	131	104	81	43	68	78	63	122	252	316	189	185
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	72.4%	83.3%	66.7%	70.5%	76.6%	75%	73.5%	57.1%	64.7%	69%	86.1%	83.3%	83.3%	-	74%	65%	79.2%	83.3%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	91.7%	90.5%	83.3%	88.6%	93.6%	97.2%	91.2%	85.7%	79.4%	90.5%	94.4%	100%	90.5%	-	92.9%	85.4%	95%	90.5%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	97.79%	98.68%	96.25%	96.09%	95.51%	96.88%	98.91%	99.05%	98.23%	98.38%	98.69%	98.65%	98.56%	98.8%	96.17%	98.74%	98.58%	98.68%
Outpatients	R03	Outpatient Hospital Cancellation Rate	9.7%	11.7%	11.5%	11.3%	12.4%	12.2%	11.6%	11.4%	10.7%	10.2%	11%	10.7%	11.2%	11.1%	12%	10.8%	11.7%	10.6%	11%	11.3%
	R05	Outpatient DNA Rate	5%	10%	7.3%	7.2%	7.5%	8%	7.1%	7.9%	7.7%	6.9%	7.8%	7.3%	6.9%	6.9%	7.1%	7.2%	7.7%	7.4%	7%	7.2%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.03	2.03	2.24	2.23	2.23	2.23	2.22	2.25	2.17	2.17	2.2	2.29	2.3	2.27	2.2	2.25	2.24	2.18	2.28	2.23
ERS	BC01	ERS - Available Slot Issues Percentage	-	-	31%	24.4%	39.9%	39.2%	41.1%	35.8%	21.6%	25.3%	34.3%	26.1%	25.2%	26.4%	24.4%	-	38.6%	26.2%	25.9%	24.4%

RESPONSIVE (continued)

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 16/17	Annual 17/18 YTD	Monthly Totals Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Quarterly Totals 16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	22	29	31	25	30	28	28	29	29	29	19	24	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	4	5	6	5	4	2	3	4	2	16	8	6	-	-	-	-
	Q01B	Acute Delayed Transfers of Care - Beddays	-	-	10232	1259	711	776	963	889	927	802	834	891	750	809	655	604	2628	2563	2450	1259
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	-	-	2167	451	238	183	193	184	233	138	131	106	183	252	306	145	560	502	541	451
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	-	-	50	43	56	44	55	54	51	59	52	47	43	42	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	-	-	10	9	13	16	6	8	8	6	9	22	14	13	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	-	-	1437	1563	1679	1505	1706	1864	1691	1937	1575	1716	1400	1371	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	-	-	532	343	344	396	372	249	270	189	334	450	503	383	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.17	4.29	4.13	3.89	4.24	4.2	3.99	4.08	4.19	4.21	4.49	4.27	4.27	4.31	4.11	4.09	4.32	4.29
	J04D	Percentage Length of Stay 14+ Days	-	-	7%	7.5%	7.5%	6.5%	6.7%	7%	6.3%	6.6%	7.2%	6.9%	7.9%	7.4%	7.3%	7.8%	6.7%	6.7%	7.4%	7.5%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	-	-	221	226	256	234	233	259	242	279	264	270	268	240	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	2.6%	3.1%	6.2%	5.1%	6.2%	4.8%	5.6%	2.8%	2.8%	2.2%	4.1%	1.4%	3.9%	5.8%	4.4%	3.1%	2.6%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	39%	61.9%	52.4%	29.2%	25%	37.2%	30.3%	52.6%	33.3%	55%	57.1%	44.1%	63.6%	61.3%	30.5%	40.2%	50%	61.9%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	85.01%	83.3%	88.99%	89.33%	90.01%	87.33%	82.94%	78.45%	79.64%	80.37%	80.73%	83.25%	82.31%	84.21%	88.89%	80.35%	81.53%	83.3%
	This is measured against the national standard of 95%																					
ED - Time in Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	-	-	85.01%	83.3%	88.99%	89.33%	90.01%	87.33%	82.94%	78.45%	79.64%	80.37%	80.73%	83.25%	82.31%	84.21%	88.89%	80.35%	81.53%	83.3%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	77.42%	71.52%	81.8%	83.73%	83.71%	80.78%	73.39%	71.69%	73.47%	68.86%	68.15%	73.89%	69.16%	73.76%	82.77%	72.85%	70.4%	71.52%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	89.89%	95.36%	95.11%	93.58%	97.29%	91.57%	90.65%	78.6%	79.38%	90.19%	92.11%	88.92%	96.83%	94.05%	93.94%	82.63%	90.28%	95.36%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	98.97%	96.55%	99.24%	98.65%	98.61%	99.26%	98.06%	99.06%	99.15%	98.56%	99%	99.18%	96.52%	96.57%	98.84%	98.74%	98.93%	96.55%
	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	40	0	0	0	0	1	2	1	11	19	5	0	0	0	1	14	24	0
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	97.6%	97.6%	94.7%	97%	97.9%	97.3%	98.3%	97.9%	97.9%	98%	98.5%	98.8%	98.9%	96.3%	97.4%	98%	98.4%	97.6%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	92.8%	91.8%	92.1%	91.7%	91.8%	91.2%	91.8%	92.7%	93.7%	93.6%	94.1%	93.9%	92.1%	91.6%	91.6%	92.7%	93.8%	91.8%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.6%	51.6%	51.7%	51.1%	56.5%	55.2%	52.8%	48.2%	50.5%	53.3%	54.3%	51%	50.8%	52.3%	54.2%	50.5%	52.8%	51.6%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.5%	97.5%	98.5%	98.3%	98.9%	98.5%	98%	98.5%	98.3%	98.7%	98.1%	98.1%	97.8%	97.2%	98.6%	98.3%	98.3%	97.5%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.6%	2.6%	2.3%	2.2%	2.2%	2.3%	2.4%	2.5%	3.3%	2.5%	3.1%	2.5%	2.6%	2.6%	2.3%	2.7%	2.7%	2.6%
	B05	ED Left Without Being Seen Rate	5%	5%	2.2%	2.7%	2.5%	2.9%	1.8%	2.2%	2.6%	2.2%	2.4%	1.4%	1.8%	2%	2.8%	2.6%	2.3%	2.4%	1.8%	2.7%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1216	193	114	77	125	140	161	119	114	138	83	11	111	82	342	394	232	193
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	2.6%	3.1%	6.2%	5.1%	6.2%	4.8%	5.6%	2.8%	2.8%	2.2%	4.1%	1.4%	3.9%	5.8%	4.4%	3.1%	2.6%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	39%	61.9%	52.4%	29.2%	25%	37.2%	30.3%	52.6%	33.3%	55%	57.1%	44.1%	63.6%	61.3%	30.5%	40.2%	50%	61.9%

EFFICIENT

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			16/17	17/18 YTD	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Sickness	AF02	Sickness Rate	3.9%	3.8%	3.8%	3.8%	3.8%	3.7%	4.5%	4.7%	4.7%	5%	4.4%	3.9%	3.7%	3.8%	3.7%	4.7%	3.9%	
		For 2017/18, the Trust average for the year is 3.8%. Divisional targets are: 2.7% (DAT), 5.7% (FAE), 4.5% (MDC), 3.6% (SPS), 3.6% (SHN), 3.7% (WAC), 3.1% (THQ). 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 by quarter.																		
Staffing Numbers	AF08	Funded Establishment FTE	8446.1	8479.3	8304	8334.2	8364.5	8364.5	8393.1	8402.2	8407.6	8434.2	8436	8446.1	8367.1	8479.3	8364.5	8407.6	8446.1	
	AF09A	Actual Staff FTE (Including Bank & Agency)	8566.5	8546.3	8315.7	8322.1	8398.3	8436.4	8427.7	8468.8	8412.7	8458.1	8496.4	8566.5	8510.5	8546.3	8436.4	8412.7	8566.5	
	AF13	Percentage Over Funded Establishment	1.4%	0.8%	0.1%	-0.1%	0.4%	0.9%	0.4%	0.8%	0.1%	0.3%	0.7%	1.4%	1.7%	0.8%	0.9%	0.1%	1.4%	
		Green is below 0.5%. Amber is 0.5% to below 1% and Red is 1% or above																		
Bank Usage	AF04	Workforce Bank Usage	427.9	476.6	394.7	429.9	437.9	410.7	376.3	387	358.5	378.3	398.9	427.9	446.7	476.6	410.7	358.5	427.9	
	AF11A	Percentage Bank Usage	5%	5.6%	4.7%	5.2%	5.2%	4.9%	4.5%	4.6%	4.3%	4.5%	4.7%	5%	5.2%	5.6%	4.9%	4.3%	5%	
		Bank Percentage is Bank usage as a percentage of total staff (bank+agency+substantive). Trust annual average for 17/18 is 3.9% with separate divisional averages.																		
Agency Usage	AF05	Workforce Agency Usage	123.7	94.1	138.3	149.8	148.5	157.4	149.1	142.7	111.5	122.5	131	123.7	96.7	94.1	157.4	111.5	123.7	
	AF11B	Percentage Agency Usage	1.4%	1.1%	1.7%	1.8%	1.8%	1.9%	1.8%	1.7%	1.3%	1.4%	1.5%	1.4%	1.1%	1.1%	1.9%	1.3%	1.4%	
		Agency Percentage is Agency usage as a percentage of total staff (bank+agency+substantive). Trust annual average for 17/18 is 1.0% with separate divisional averages.																		
Vacancy	AF06	Vacancy FTE (Funded minus Actual)	349.8	420.4	439.2	494.8	452.7	404.5	404.5	379.6	383.7	389.4	384	349.8	331.4	420.4	404.5	383.7	349.8	
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.2%	5%	5.3%	6%	5.5%	4.9%	4.9%	4.6%	4.6%	4.7%	4.6%	4.2%	4%	5%	4.9%	4.6%	4.2%	
		Vacancy is Funded Establishment minus Staff as a percentage of Funded Establishment. Before Apr-15, this was all Funded Establishment; from Apr-15 it was substantive staff only. Green is < 5% with Red >= 5%																		
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	146	162	137	169	367	205	128	109	133	165	111	146	173	162	205	133	146	
	AF10	Workforce Turnover Rate	12.8%	12.6%	13.1%	13.4%	13.3%	13.3%	13.1%	12.6%	12.7%	12.5%	12.6%	12.8%	12.5%	12.6%	13.3%	12.7%	12.8%	
		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.																		
Essential Training 2016/17	AF21a	Core Essential Training (Three Yearly)	85%	89%	88%	88%	85%	88%	88%	88%	89%	89%	89%	85%	85%	89%	88%	89%	85%	
	AF21b	Essential Training Compliance - Annual Training (Fire & IG)	-	-	63%	66%	67%	73%	75%	-	-	-	-	-	-	-	73%	-	-	
	AF21f	Essential Training Compliance - Fire Safety	83%	84%	-	-	-	-	-	80%	81%	82%	82%	83%	82%	84%	-	81%	83%	
	AF21g	Essential Training Compliance - Information Governance	76%	75%	-	-	-	-	-	76%	76%	76%	77%	76%	75%	75%	-	76%	76%	
	AF21c	Essential Training Compliance - Induction	97%	98%	95%	96%	94%	96%	96%	96%	96%	96%	97%	97%	98%	98%	96%	96%	97%	
	AF21d	Essential Training Compliance - Resuscitation Training	75%	71%	79%	79%	77%	81%	81%	81%	83%	85%	85%	75%	75%	71%	81%	83%	75%	
	AF21e	Essential Training Compliance - Safeguarding Training	91%	90%	88%	89%	86%	88%	89%	90%	90%	90%	90%	91%	90%	90%	88%	90%	91%	
		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
AHP	Allied Health Professional
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
BOA	British Orthopaedic Association
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 May 2017:

All Essential Training

	UH Bristol	Diagnostic & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgical	Trust Services	Women's & Children's
Three Yearly	89%	90%	87%	91%	90%	91%	86%	86%
Annual Fire	84%	81%	83%	81%	87%	87%	84%	82%
Annual IG	75%	75%	67%	71%	77%	82%	80%	73%
Induction & Orientation	98%	99%	99%	97%	97%	98%	98%	97%
Induction & Orientation (Medical & Dental)	45%	33%	N/A	56%	13%	48%	N/A	47%
Resuscitation	71%	63%	N/A	78%	76%	73%	57%	68%
Safeguarding	90%	93%	86%	92%	89%	89%	90%	88%

Timeline of Trust Essential Training Compliance:

	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Compliance	85%	86%	87%	85%	86%	87%	88%	88%	89%	87%	87%	89%

Safeguarding Adults and Children

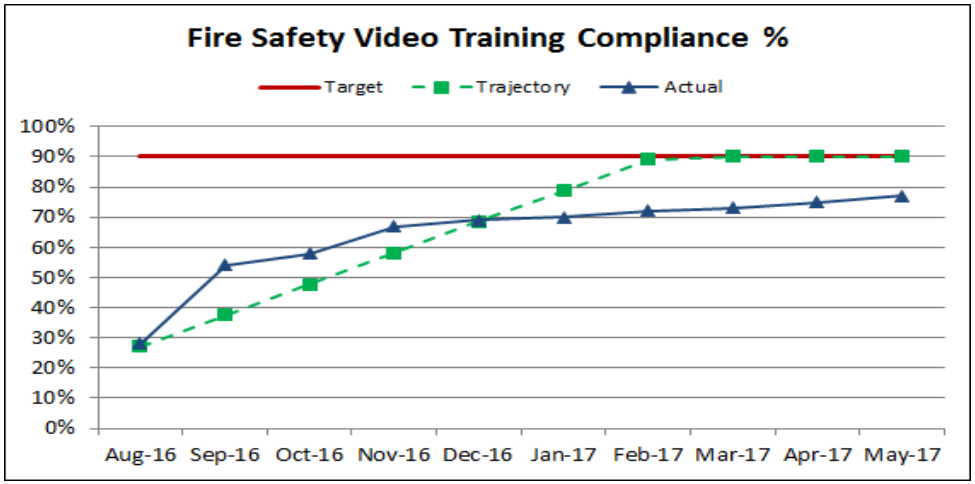
	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgical	Trust Services	Women's & Children's
Safeguarding Adults L1	**89%**	94%	88%	88%	88%	85%	90%	90%
Safeguarding Adults L2	**90%**	93%	78%	94%	91%	91%	87%	87%
Safeguarding Adults L3	**80%**	50%	N/A	83%	100%	73%	88%	58%
Safeguarding Children L1	**90%**	95%	86%	91%	92%	89%	92%	N/A
Safeguarding Children L2	**89%**	91%	86%	92%	86%	89%	84%	95%

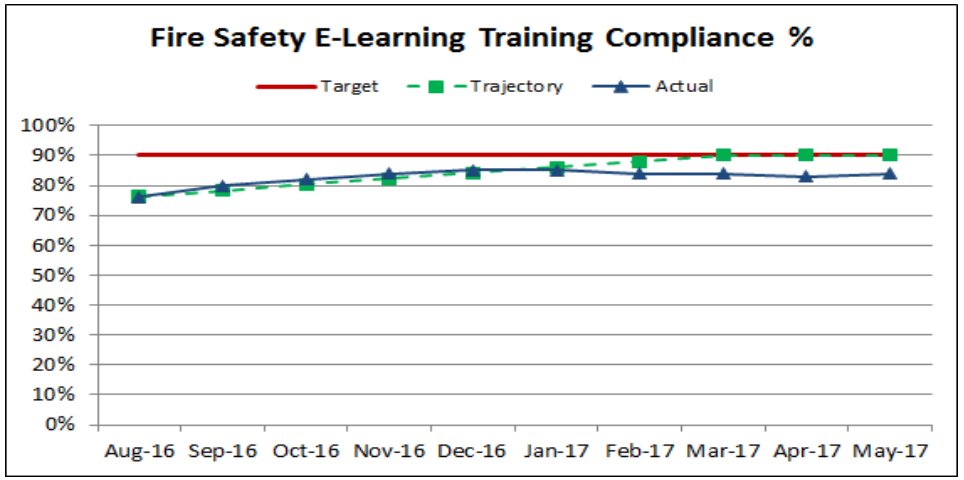
Child Protection Level 3

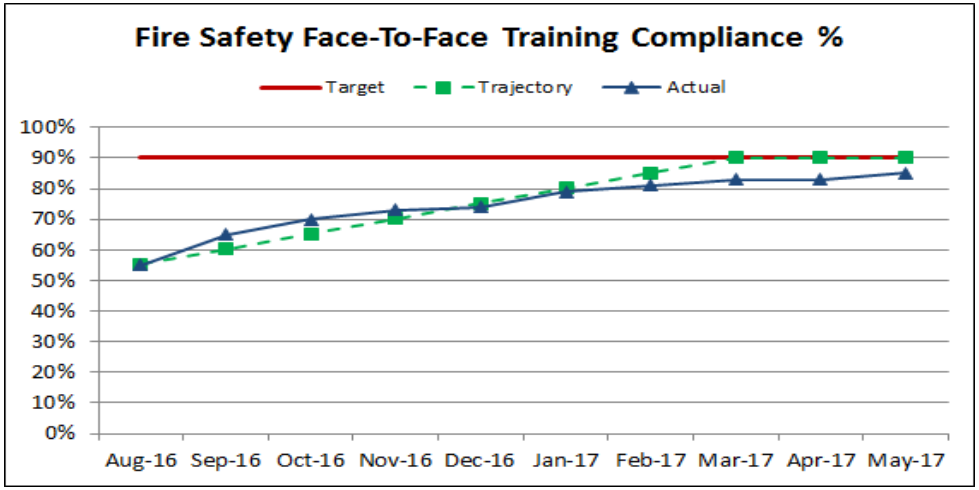
	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgical	Trust Services	Women`s & Children`s
Core	**77%**	77%	62%	92%	81%	100%	79%
Specialist	**75%**	N/A	N/A	N/A	N/A	100%	75%

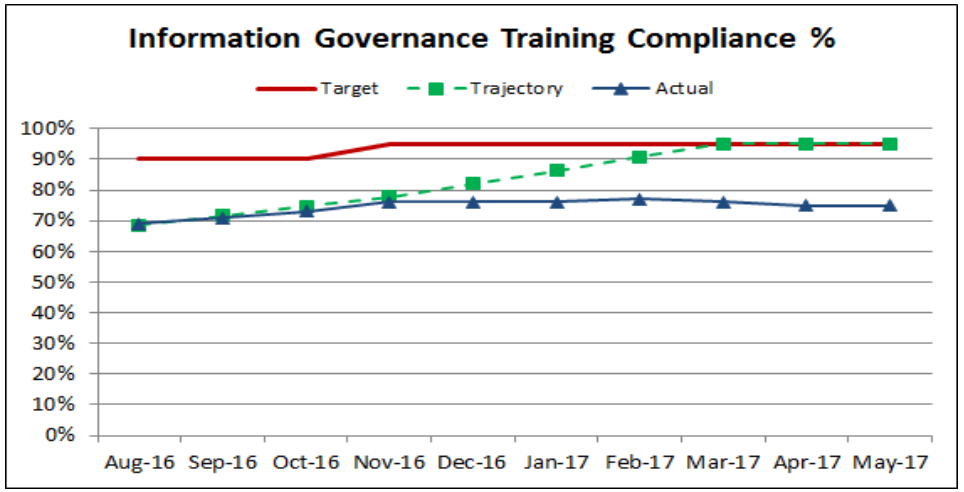
Appendix 2 (continued)

Performance against Trajectory for Fire and Information Governance









Note: there are two types of fire training represented in these graphs, two yearly and annual, with different target audiences. In addition, there are a number of staff who require an additional training video under the previous fire training requirements. 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 10th April to 7th May

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	3	29	7	159	642	840
Health Care Assistant & other Support	50	5	3	0	0	58
Medical & Dental					42	42
Scientific, therapeutic / technical Allied Health Professional (AHP) & Healthcare Science			26			26
Administrative & Clerical and Estates	949					949

Appendix 3

Access standards – further breakdown of figures

A) 62-day GP standard – performance against the 85% standard at a tumour-site level for April 2017, including national average performance for the same tumour site

Tumour Site	UH Bristol	Internal operational target	National
Breast†	100	-	94.6
Gynaecology	90.9	85%	82.1
Haematology (excluding acute leukaemia)	83.3	85%	77.5
Head and Neck	55.0	79%	67.4
Lower Gastrointestinal	50.0	79%	72.6
Lung	27.3	79%	75.3
Other*	100	-	67.6
Skin	100	96%	96.3
Upper Gastrointestinal	58.3	79%	76.1
Urology*†	33.3	-	77.3
Total (all tumour sites)	**76.7%**	**85.0%**	**82.7%**
Improvement trajectory	**81.0%**		
Performance for internally managed pathways	**82.9%**		
Performance for shared care pathways	**55.0%**		
Performance with breach reallocation applied	**77.8%**		

*3 or fewer patients treated in accountability terms

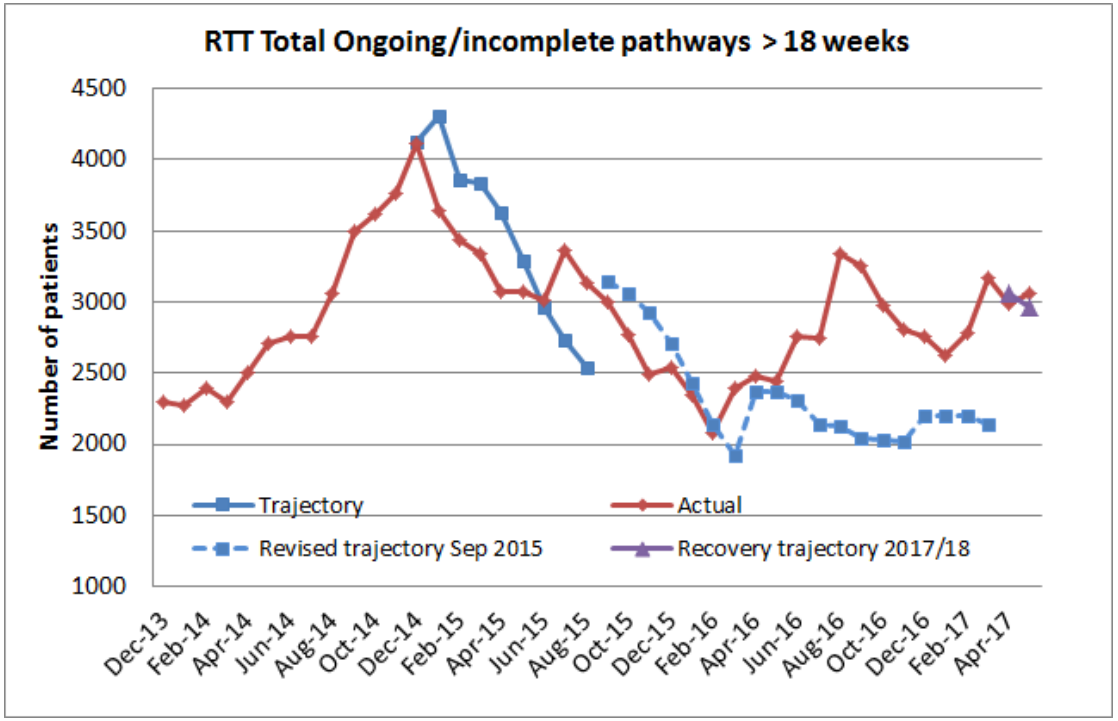
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

Appendix 3 (continued)

Access standards – further breakdown of figures

B) RTT Incomplete/Ongoing pathways standard – numbers and percentage waiting over 18 weeks by national RTT specialty in May 2017

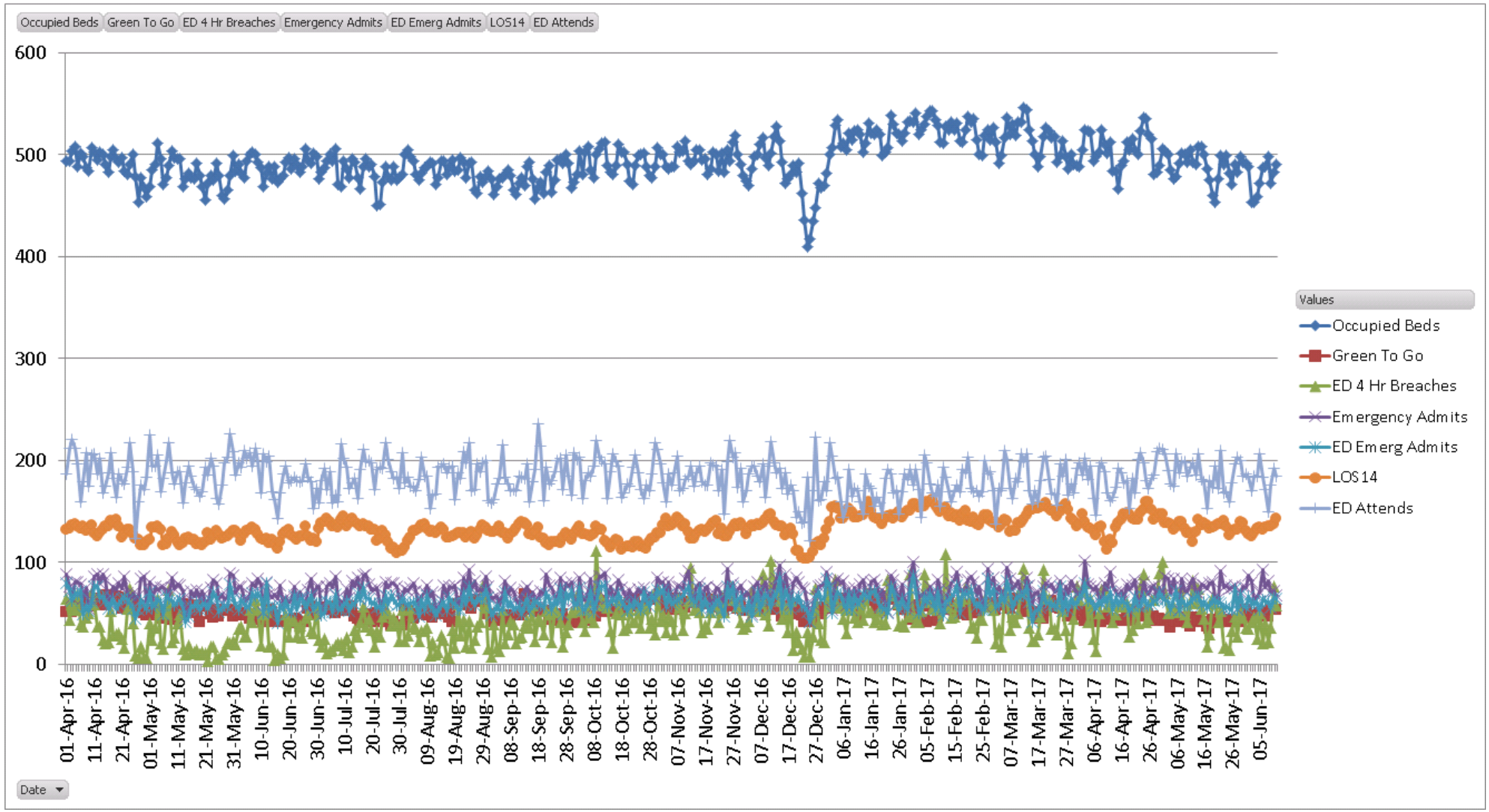
RTT Specialty	Ongoing Over 18 Weeks	Ongoing Pathways	Ongoing Performance
Cardiology	323	2,265	85.7%
Cardiothoracic Surgery	27	299	91.0%
Dermatology	70	2,401	97.1%
E.N.T.	51	2,176	97.7%
Gastroenterology	40	449	91.1%
General Medicine	0	70	100.0%
Geriatric Medicine	0	193	100.0%
Gynaecology	94	1,415	93.4%
Neurology	70	395	82.3%
Ophthalmology	256	4,977	94.9%
Oral Surgery	176	1,790	90.2%
Other	1,817	15,335	88.2%
Rheumatology	15	578	97.4%
Thoracic Medicine	5	944	99.5%
Trauma & Orthopaedics	112	999	88.8%
Urology	0	1	100.0%
Grand Total	**3,056**	**34,287**	**91.1%**



	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17
Non-admitted pathways > 18 weeks	1677	1594	1528	1592	1826	1705	1744		
Admitted pathways > 18 weeks	1128	1157	1091	1185	1345	1280	1312		
Total pathways > 18 weeks	2805	2751	2619	2777	3171	2895	3056		
Actual target % incomplete < 18 weeks	92.0%	92.0%	92.2%	92.0%	91.1%	91.1%	91.1%		
Recovery forecast	91.4%	91.6%	92.0%	92.0%	92.0%	90.9%	91.4%	91.8%	92.0%

Appendix 3 (continued)

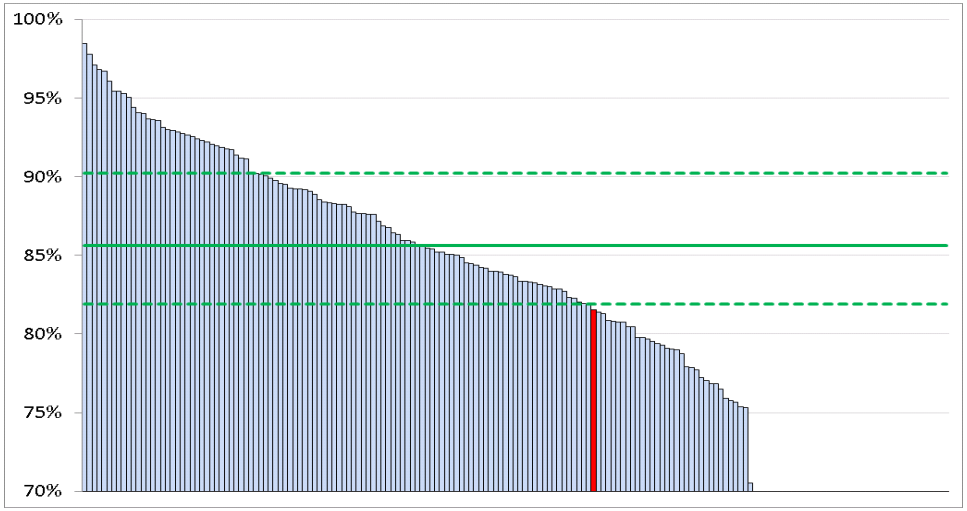
BRI Flow metrics



Appendix 4

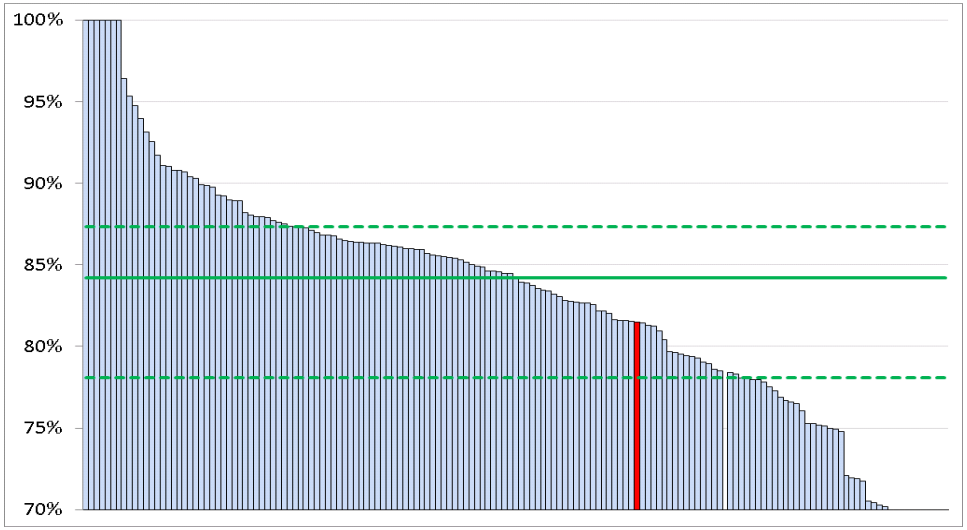
Benchmarking Reports

A&E 4-hours (Quarter 4 2016/17)

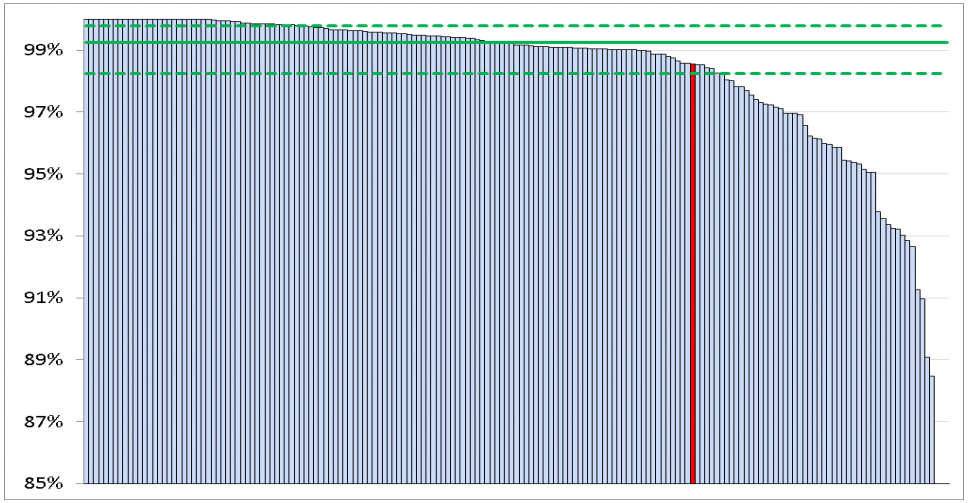


Referral to Treatment Time (April 2017)

62-day GP cancer (Quarter 4 2016/17)



6-week diagnostic (April 2017)

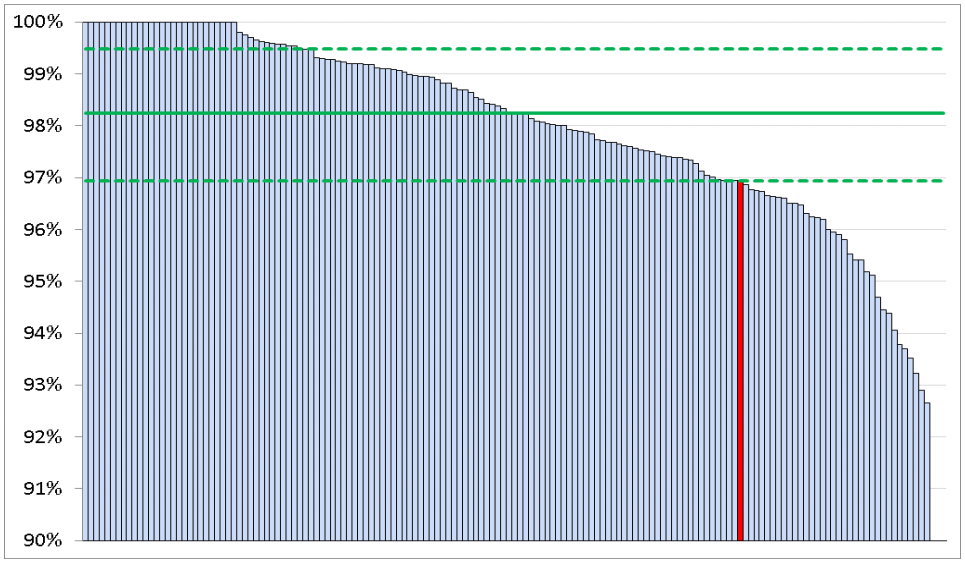


Appendix 4 (continued)

Benchmarking Reports

2-Week wait (Quarter 4 2016/17)

31-day first definitive cancer (Quarter 4 2016/17)



In the above graphs the Trust is shown by the Red bar, with other trusts being shown as pale blue bars. For the A&E 4-hour benchmarking graph, only those trust reporting type 1 (major) level activity are shown.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Thursday, 29 June 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**	29 June 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

Purpose

This paper provides an update to Board members on the delivery 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

Key issues to note

- The June 2017 Steering Group approved the closure of three further recommendations
- There are three remaining recommendations to close, it is anticipated that these will be closed or transferred to the paediatric cardiac network work plan following the July 26th meeting.
- The Board will receive a final report on the delivery of the recommendations at the September meeting of the Trust Board. This will detail ongoing assurance work planned.

Internal audit have been commissioned to undertake two audits to provide additional assurance to Trust Board members, on the robustness of the sign off process of completed recommendations and in 6 months the completion of ongoing follow up/audit actions.

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)**
				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 of delivery against the agreed programme plan for the three delivery groups. The plan shows the progress of the work that is ongoing to deliver the actions to support the closure of the recommendations. It also shows where delivery of the actions is not within the initially set timescales.

Please see below update via delivery groups:

Table 1: 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	2 of 32
Jan'17	0	9	3	6	0	0	5 of 32
Feb'17	6	3	3	6	0	0	5 of 32
Mar'17	3	2	2	11	0	0	11 of 32
Apr'17	3	2	2	11	0	0	11 0f 32
May'17	2	1	0	15	0	0	13 of 32

Table 2: 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**
Jan'17	0	4	1	0	0	0	**0 of 32**
Feb'17	4	0	1	0	0	0	**0 of 32**
Mar'17	0	0	1	4	0	0	**4 of 32**
Apr'17	0	0	1	4	0	0	**4 of 32**
May'17	0	0	0	5	0	0	**5 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**
Jan'17	0	3	2	0	0	0	**0 of 32**
Feb'17	1	2	2	0	0	0	**0 of 32**
Mar'17	0	2	1	2	0	0	**2 of 32**
Apr'17	1	1	1	2	0	0	**2 of 32**
May'17	1	0	0	4	0	0	**4 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**
Jan'17	0	2	0	2	0	0	**0 of 32**
Feb'17	1	0	0	3	0	0	**3 of 32**
Mar'17	1	0	0	3	0	0	**3 of 32**

Apr'17	1	0	0	3	0	0	**3 of 32**
May'17	0	0	0	4	0	0	**4 of 32**

Exception report- Red actions

Recommendation 7 – (Management of follow up appointments) All actions to deliver the recommendation have been completed as has the validation of the outpatient backlog and the development of a recovery trajectory to address the backlog. The recommendation was not supported for closure by the delivery group as the actions in the plan to address the backlog had not yet all commenced. The risk relating to the potential impact on delivery of the recommendation remains on the risk register rated a 6. The plan is to present for closure at the July steering group meeting.

Recommendation 18 – (risk assessment of cancellations) was discussed at the May delivery group meeting however a request to close was not submitted to the steering group because the delivery group did not receive the assurance that they required of the embeddedness of the action to review data weekly at the designated meeting The plan is to present at the June/July meeting for closure.

Exception report – Amber actions

Recommendation 4 - Support for women accessing fetal services between Wales and Bristol; this recommendation is due for closure in June, following one date revision, and is anticipated to be ready for closure at this time. The fetal survey results have been received and are being reviewed; in view of vacancies in the cardiac fetal service on both sites it is expected that some elements of the work required will transfer into the Network work plan for completion.

3.0 Risks to Delivery

No further risks to delivery were added to the project risk register.
Risk ICR1: risk of commitment to changes required for ensure closer working with UHBristol and University Hospital Wales (UHW) and relevant commission organisations was reduced from a risk rating of 12 to 4 as a result of funding being agreed to support additional consultant sessions in UHW.
Risk ICR2: risk of delivery to fetal cardiology service in UHW due to lack of substantive/vacant consultant positions was reduced from a risk rating of 12 to 8 following an agreement on the operational requirements to meet the service need. The rating was not reduced further as the positions have not yet been recruited to.

4.0 Recommendations closed

The June 2017 Steering Group approved the closure of three recommendations:

- recommendation 5
- recommendation 30
- CQC Action 2

This leaves three outstanding recommendations 7,18,CQC 2 requiring completion.

5.0 Family involvement update

The majority of actions on the original plan have been completed.

Work in progress includes:
- Listening events in peripheral clinics
- Fetal pathway satisfaction questionnaire
- Listening event in collaboration with the Welsh commissioners and service providers.

PROGRESS REPORT AGAINST UH BRISTOL RECOMMENDATIONS FROM THE INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SERVICES – 23rd May 2017 Delivery Group update

1. Women's and Children's Delivery Group Action Plan

W&C Recommendation's delivery timeframe

MONTH	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '17	Jun '17
Recommendations	**8-** Outpatients experience **Approved as closed by Steering Group (09/01/17)**	18- Cancelled Operations risk assessment - timescale change request to Feb'17 Change req to Mar'17 Final SOP and new Next steps SOP with transformation team. March'17 delivery group felt unable to sign off recommendation; all documentation has been produced to support the process however we have been unable to evidence that the process is being followed robustly; request for a further delay to May 17 to enable the demonstration of embedding in practice. April'17 Process in place to record all cancelled patients, presented to cardiac clinicians weekly at JCC meeting. All discussions when patients are cancelled are captured here. Further work to provide assurance that the meeting oversees the record of cancelled patients. RT to ensure that all clinicians are aware of the importance of reviewing the list. Reviewing JCC attendance to ensure appropriate oversight. May Delivery – need more data to demonstrate sustained commitment to holding and recording the discussion on risk	16- communication with families about team working/ involvement of other operators timescale change request to Feb'17 Change request to Mar'17 Intervention leaflet amendment & printing as a trial pending additions Mar'17 information booklets complete and approved through the divisional assurance process; some FI comments to include and then print, trial and evaluate; RTC supported by delivery group. Subject to steering group sign off an official launch date will be established and communicated to all staff. **Approved as closed by Steering group 4/4/17**	**7-** periodic audit of follow up care timescale change request to Feb'17 Change request to May'17 in view of numbers of outpatients and inpatients requiring validation to establish risk – added to RR Mar'17 initial validation of data completed; next steps to return to April mtg to consider alternative accommodation for additional clinics and associated costs and equipment requirements before rtc in May '17 April'17 Significant work undertaken to identify capacity gap (backlog and ongoing), locum advert going out, outpatient space being identified, additional clinics being planned. Trajectory of the outcome of this work for May delivery mtg with a view to closing recommendation. May 17 plan devised to address backlog, elements still requiring work before confidence to sign off, return to June delivery		**21-** (Commissioner) - provision of a comprehensive service of Psychological support, Trust-Expression of Interest submission **(green-provider actions)** Mar'17 RTC supported by the delivery group in view of successful recruitment **Approved as closed by Steering group 4/4/17**	**2-** NCHDA data team staffing Mar'17 recommendation added to IR risk register (is also on divisional risk register) as no current solution in place to provide additional resource to the data collection team. Mar'17 EOI unsuccessful, plan outstanding final actions at present, to review current resource and finalise a plan for April '17 mtg- added to risk register in view of no plan Apr'17 current paediatric resource reviewed, additional resource added into fetal service already so the team are able to absorb this additional workload with minimal additional support from paediatric team. Original bid reviewed and agreement received to fund additional paediatric admin and nursing time on a fixed term basis from within the division to allow for a full review of all data teams to establish whether any further economies or efficiencies can be identified. Data team have approved that this will be sufficient for the current workload and supporting the fetal team. Commitment from management team to review the team resource on a quarterly basis and external review pending Sept'17. Further sign off received at joint cardiac board (26/04/17) to ensure no impact on adult services. Sign off by lead consultant for cardiac data confirmed additional input is sufficient for current requirements with ongoing review required. RTC agreed by delivery group. May steering group accepted for closure		
		20- End of life care and bereavement support **(approved as closed by Steering group 07/02/17)**	23- reporting and grading of patient safety issues **(approved as closed by Steering group 07/02/17)**	**9 &11-** Benchmarking exercise (gaps/actions/implement plan) timescale change request			**3 & CQC 5-** review access to information – diagnosis and pathway of care Mar'17 rec. 3 progressing to plan CQC 5 supported for closure in view of the production of information sheets to support		

				to Feb'17 Change request Mar'17 – benchmarking almost complete – action plan to be devised Mar'17 feedback provided to support the RTC of recommendations with the caveat that, as the action plan is a work in progress it would be held and progressed by the cardiac business meeting. **Approved as closed by Steering group 4/4/17**			over 33 different operations; FI comments to be incorporated and then print, trial and evaluate **Rec 5 Approved as closed by Steering group 4/4/17** April'17 template front sheets presented to group; have been to listening events and cardiac governance for review and comment which have been incorporated. To go back to governance on Friday 28th for final approval and agreement on a go live date, location on website (BRHC or Network or both). Links added to patient letters to guide families to website. Patient information leaflets updated and in circulation. RTC approved by delivery group pending governance sign off for visual pathways and caveats as above. May steering group accepted for closure		
		CQC 3- Pain and comfort scores **Approved as closed by Steering Group (06/12/16)**	CQC 4 CNS recording of discussions with families in notes timescale change request to Feb'17 Change request to Apr 17 to allow for additional training Mar17 delivery group supported RTC in view of provision of medway communications page in use and accessible to all appropriate staff; plan to audit quality of records and return to delivery group. **Approved as closed by Steering group 4/4/17**	**CQC 6-** Discharge planning to include AHP advice **(approved as closed by Steering group 07/02/17)**			**4-** Support for women accessing fetal services between Wales and Bristol – *timescale change request to Jun '17* Mar'17 update, FI review of questionnaire complete. April'17 letter sent to all families, questionnaire going out to respondees by end April. Improvements will be identified and planned and are anticipated to be sufficient to sign off recommendation by June however both sites have fetal vacancies and therefore this will impact on the timescale for the delivery of the total plan. May'17 on track for June closure, fetal survey results received.		
		CQC 2 Formal ECHO report during surgery change request to Mar'17 to allow re-audit Mar'17 re-audit shows an improvement in the use of the echo forms however they are still not in use 100% of times. Request to amend delivery date to May'17 to allow for reaudit. Apr'17 Further audit in May to come to delivery group end of May. RT to highlight to cardiologists and IJ to highlight to intensivists. May'17 request to close supported for June steering					**5-** Improved pathways of care paed. cardiology services between Wales and Bristol – timescale change request to May '17 April '17 improvements identified, corresponding with Wales re implementation, awaiting a response. Recommendation on target to close at May delivery meeting May'17 request to close supported for June steering.		

	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	**Green-complete**	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	**Green-complete**	Expression of interest form and Women's and Children's Operating Plan Feb Meeting – review of current resources (FU/VM) Mar'17 added to IR RR in view of concerns over ability to meet recommendation requirements due to lack of support for additional resource Apr'17 review complete, additional resource funded by division, RTC submitted

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
3	That the Trust should review the information given to families at the point of diagnosis (whether antenatal or post-natal), to ensure that it covers not only diagnosis but also the proposed pathway of care. Attention should be paid to the means by which such information is conveyed, and the use of internet and electronic resources to supplement leaflets and letters.	Specialist Clinical Psychologist	Apr '17	**Green-complete**			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	**Green - Complete**	Clinic letter with links (examples Feb mtg docs)
							Review and amendment of Catheter and Discharge leaflet	Cardiac CNS team	Feb' 17	**Green - Complete**	Revised Catheter and Discharge leaflet Feb mtg – this may replicate work in recomm 16 CNS team to check (JH/ST)
							Enhance existing information with a visual diagram displaying pathways of care (FI).	Specialist Clinical Psychologist	Apr' 17	**Green-complete**	Pathways of Care devised – update to come to Mar'17 mtg re opportunities to link with Network website to enable interactive functionality VG/LS to discuss timescales to share with Virtual group Mar'17 visual pathways shared at listening event – supportive of structure and content; charitable funding secured; designer commissioned with a timescale of draft drawings by April 17 mtg for RTC

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											April'17 visual pathway designs received, RTC approved caveated by sign off by cardiac governance meeting
							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 baby in Wales should be offered the	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 in delivery of the fetal	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 Update from May delivery group – significant work completed, survey complete and results returned. Pt counselling and CNS cover addressed. Offer in place for families to visit Bristol when antenatal

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	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				cardiology service in UHW prevent focus on the achievement of this recommendation business plan						diagnosis made. Vacancies in both main sites will mean that the full extent of the work planned in this area will move to the Network work plan going forward. Plan to request closure in June 2017
							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**	
							University Hospital Wales to define how additional foetal sessions will be delivered and who from foetal 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~~ Revised to Mar '17. UHW have appointed lead, but have not yet resolved operational issues	**Green - Complete**	Feb mtg – outline plan for foetal sessions, process to manage referral through acceptance criteria in short term
							Foetal working group to define changes / new pathways, taking account of patient feedback	Working group	~~Jan '17~~ Revised to Feb '17. Working group established, but	**Amber – behind plan**	Feb mtg - Changes defined; joint review of approach to counselling; establishment of joint service review meeting

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
									struggling to coordinate diaries for meeting		Outstanding – patient feedback; survey complete ready to go to QIS group before circulation Mar'17 foetal survey being sent out having been for FI feedback which has been incorporated. April'17 letter sent to all identified families to pre-warn and request agreement to receive survey, survey out this week. On target for June closure
							Undertake patient survey and focus groups (FI).	CHD Network Manager	~~Jan '17~~ Revised to Jun 17due to delay in engagement with UHW and the operational challenges in their fetal service	**Amber – behind plan**	As above
							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	**Amber – behind plan**	Feb mtg -Focus group to come from survey results

	Progress overview						Detailed actions				
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											Mar'17 as above
							New pathways in place	CHD Network Clinical Director and Network Manager	~~Apr '17~~ Revised to Jun 17	**Amber – behind plan**	Feb mtg - Summary paper showing previous and new ways of working, detailing an assessment of the benefits; Pathways to follow completion of actions above
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	**Green-complete**	Minutes of meeting and action plan
							To define the opportunities for improvement in coordination and the actions to achieve this	CHD Network Manager	Dec 16	**Green-complete**	Action plan
							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	**Green - complete**	Feb mtg - Proposal sent to virtual ref group, 1 response to date which will be incorporated into plans; any further feedback received will be incorporated
							Deliver actions to improve coordination	CHD Network Manager	May 17	**Blue- on target**	Feb mtg - improved in-pt transfer process; joint audit and training; improved

	Progress overview						Detailed actions				
No.	Recommendation	Lead Officer	Completion date	Status	Delivery Risks	Revised timescale & reason	Actions to deliver recommendations	By	When	Status	Evidence
											IT for sharing images; standardised patient information; further changes required to meet recommendation April'17 work ongoing, improvements identified, awaiting contact from UHW on target for May closure May'17 RTC presented and approved by delivery group; work plan for network devised and approved by network board; reviewed quarterly by trust board and annually by commissioners. Welsh cons now have JCC in their job plans to support attendance. Review of process at JCC req to ensure that appropriate clinicians are present for discussions. CNS work plan being reviewed to support peripheral services.

	Progress overview						Detailed actions				
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											Commitment to provide CNS cover for all additional outpatient services at UHW
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	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	None	Timescale change request to Feb'17 to provide assurance about backlog validation Timescale change request to May 17 in view of requirement to validate backlog to establish risk – item added to risk register	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 Feb mtg – validation work ongoing; added to RR (VM/FU) action can be RTC once complete and any risks established Mar'17 validation complete; options for delivering additional activity being scoped as described above. April'17 validation ongoing, capacity gap identified, locum advert,

	Progress overview						Detailed actions				
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											space being identified. Trajectory will be in place for May closure. May'17 RTC presented to group. Clear trajectory presented for what is required to happen to address the backlog and also recurrent capacity gaps. RTC rejected on the basis of the requirement for more progress on the proposed plans to address the backlog in view of remaining risks re: funding; clinic space; clinician agreement to undertake WLI. To return to June mtg when there will be more clarity on these elements.
8	The Trust should monitor the experience of children and families to ensure that improvements in the	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

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	organisation of outpatient clinics have been effective.			**22/11/16- approved for closure by W&C delivery group**			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**	Reference 2. Outpatients and Clinical Investigations Unit Service Delivery Group 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)
							Systems in place for regular and specific monitoring, and reviewing and acting on results (FI)	Outpatients & CIU Service Delivery Group	Oct '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**
9	In the light of concerns about the continuing pressure on cardiologists and the facilities and resources available, the Children's Hospital should benchmark itself against comparable centres and make the necessary changes which such an exercise demonstrates as being necessary.	Divisional Director	Jan'17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Risk that other sites are unable to share data 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.	Request to delay to Feb '17 due to late return of benchmarking Request to delay to Mar'17 as some benchmarking data received late; analysis ongoing with visits to be planned by Mar'17	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	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Feb mtg - Benchmarking data collection analysis ongoing Site visits dates to be agreed for Mar mtg (JD) Mar'17 RTC supported by delivery group with the caveat that the action plan is held by the cardiac business meeting for completion
							Identification of actions required to address the gaps	CHD Network Manager	Jan '17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Gaps to be identified from completion of analysis; action held by Cardiac business group (JD)
							Progress to implementing any changes in practice that are deemed necessary	CHD Network Manager and Divisional Director	Jan '17 Revised to Feb '17. Delayed responses from other centres	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	As above, change implementation plan to be devised following gap analysis (JD)

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
11	That the paediatric cardiac service benchmarks its current arrangements against other comparable centres, to ensure that its ability, as a tertiary 'Level 1' centre under the NCHD Standards, to communicate with a 'Level 2' centre, are adequate and sufficiently resourced. Benchmarking would require a study both of the technical resources underpinning good communication, and the physical capacity of clinicians to attend planning meetings such as the JCC (Links to recommendation no. 5)	CHD Network Clinical Director	Jan'17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	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 Mar'17 benchmarking complete; RTC supported by delivery group						
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	Clinical Lead for Cardiac Services and Consultant Paediatric Cardiac Surgeon	Dec '16	**Red – second revision of timescales**		Request delay to Feb'17 to allow update of catheter leaflets in line with surgery ones Request delay to Mar'17 to allow completion of intervention leaflet and consideration	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	**Green-complete**	Revised 'Preparing for Surgery' leaflet and email to surgeons about new guidance VG/LS to add updated leaflets to website Consider revision of ward 32's leaflet to replicate changes made

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	operators or team members.					for any others requiring this information to be included.					(ST) Complete changes to interventional leaflet (AP) and produce in draft as a trial for use with patients (ST). Mar'17 Booklets produced and formatted; shared widely for family input; signed off by business meeting with all comments incorporated prior to printing, trial and evaluation – RTC supported by delivery group
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	**Red – second revision of timescales**		Request delay to Feb'17 to allow implementation of new cancellation policy Request delay to Mar'17 to allow development of next steps SOP to support process Request to delay to May '17 to enable the demonstration of the implementation of the process to risk assess	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 Sops for cancellation and next steps being reviewed/devised for presentation at Mar'17 mtg (ST) March'17 delivery group felt unable to sign off recommendation;

	Progress overview						Detailed actions				
No.	Recommendation	Lead Officer	Completion date	Status	Delivery Risks	Revised timescale & reason	Actions to deliver recommendations	By	When	Status	Evidence
						patients adequately					all documentation has been produced to support the process however we have been unable to evidence that the process is being followed robustly April'17 process in place to risk assessment cancelled patients, assurance process during May with a view to closing at May mtg. May'17 not presented for closure as process in place and being documented however only 2 weeks documentation available to support closure and therefore agreement to defer to June mtg to ensure sufficient evidence to support process embedded in practice. Consider incorporating some of the processes used at the Evelina re

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											cancellation and performance oversight (VM/RT)
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 Mar 17 update Recruitment completed RTC supported by delivery group
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	**Green-complete**	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	**Green-complete**	Training plan and log of attendance

	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.2	Provision of a formal report of transoesophageal or epicardial echocardiography performed during surgery	Clinical Lead for Cardiac Services	Nov '16	**Red – second revision of timescales**		Mar '17 Delayed to allow audit to demonstrate improvement Mar'17 Request to delay to May '17 to enable the demonstration of robust and consistent implementation	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 Revised to Mar 17~~ Revised to May 17	**Red – second revision of timescales**	Repeat audit results expected at Mar'17 delivery group with a view to proposing closure of recommendation (JM/BS) Mar'17 audit shows improvement however not 100% compliance at present therefore further communication to clinicians and reaudit prior to closure April'17 reaudit planned for May 17 with a view to closure at May delivery group; comms going out to all teams re the importance of these records and location on electronic patient record system May'17 RTC presented in view of further audit; approved for closure in view of significant improvement in completion of forms, use of

	Progress overview						Detailed actions				
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											correct forms, consistent filing position on Evolve. 100% compliance for the small cohort of patients able to be audited since the previous audit. Plan to reaudit in Aug 17 to ensure process embedded in practice.
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	**Amber-behind target**		Request delay to Feb'17 to ensure process is robust Request delay to Apr'17 in view of potential training needs for staff	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~~ Feb 17 revised timescale for wider issue	**Green-complete**	Examples of stickers in notes and Heartsuite entries Audit of compliance to be undertaken by MG/VG pre Mar mtg Process to provide consistent recording in accessible patient records to be established (ST) Mar'17 Medway record in place and in use; RTC supported by delivery group subject to audit of

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											quality of records to return to delivery group April 17 (MG/VG)
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 Mar'17 Information sheets produced and formatted; shared widely for family input; signed off by governance meeting with all comments incorporated prior to printing, trial and evaluation; RTC supported by delivery group.						
CQ C.6	Ensuring that advice from all professionals involved with individual children is included in discharge planning to ensure that all needs are addressed.	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Jan '17	**Green-complete**		Agreed mechanism for including AHP advice into discharge planning for children within Cardiac Services	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
							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	**Green-complete**	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

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

TW Incidents and complaints delivery timeframe – May 2017

MONTH	Oct '16	Nov	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '17	Jun '17

		'16							
Recommendations			**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. *Request to delay to Feb ' 17* *Feb mtg – sufficient evidence to complete recommendation to close for March meeting but now red as did not meet revised date;* *Evidence complete, RTC to Apr steering – recommendation supported for closure 4/4/17*	**26-** Development of an integrated process for the management of complaints and all related investigations- *timescale changed from Jan '17 to Jun '17*Mar mtg progress noted; work still to do re integrating adult information and further FI following inclusion of their comments to date April'17 all documentation complete, some documents require ratification however these have already had executive oversight therefore RTC to be submitted to Steering 2/5/17 May'17 accepted for closure by May steering			**29 -** 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. Mar mtg – evidence complete; awaiting outcome of QAC to recommend next steps before RTC April'17 QAC approved training option and evaluate impact, CS to investigate other options; HM to discuss procurement/trust wide process with CM for agreement to progress to mediation. Recommendation requirements met therefore RTC to be submitted to Steering 2/5/17 May'17 accepted for closure by May steering		**27-** Design of the processes (26) should take account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue Mar mtg – evidence complete; action plans for ongoing monitoring in place therefore RTC to be submitted to the Apr steering group and supported for closure 4/4/17
			30 - Review its procedures to ensure that patients or families are offered not only information about any changes in practice, seek feedback on its						

			effectiveness, but also the opportunity to be involved in designing those changes and overseeing their implementation- timescale changed from Dec '16 to Apr'16 Mar mtg progress noted; work still to do **May'17 work all completed, documents produced to support closure of recommendation; review by VRG and ratification through Clinical Quality Group completed, supported by delivery group for closure.**						

	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	Chief Nurse	Jan '17	**Green-Complete**		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	**Green – complete. 10.01.17 5/8 members approved remainder virtually.**	Document approved within the Division via Quality Assurance Group. Monitored weekly at the Bereavement Group. Audit Apr 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**
	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.										Audit of compliance complete; action plan sits with bereavement group
							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. **Supplementary**	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	**Green action complete Mar mtg action complete**	Unformatted version sent to VRG group for comment on content with an associated leaflet to demonstrate format; comments incorporated to add in adult version and resend to VRG
							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	**Green action complete Due for presentation at February 17 meeting Now rated red as not approved at meeting Mar mtg – action**	Draft guidance presented; comments from group members to be incorporated and represented at March 2017 meeting SOP completed; to go to Mar QAC and implement; audit initially at

	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**
										complete	6/12 but then annually. Laura Westaway identified lead for audit.
							26.6 Develop the above **staff** guidance for **adult** patients and families (minus CDR) - **Supplementary**	Head of Quality (Patient Safety)	Dec '16	**Green – action complete**	As above Complete, signed off by CQG
							26.7 Develop the above **family** guidance for **adult** patients and families (minus CDR) **(FI). - Supplementary**	Head of Quality (Patient Safety)	Apr '17	**Green – action complete**	Leaflet produced but ongoing discussion around the process of sharing a draft RCA with family Links to rec 30 Apr'17 guidance complete, for ratification at CQG 4/4/17
							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	**Green – action complete**	As above Apr'17 guidance complete, for ratification at CQG 4/4/17
							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	**Green – action complete**	Ongoing work on how to achieve this Apr'17 process complete, for ratification at CQG 4/4/17
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	Chief Nurse	Apr '17	**Green - completed**			**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 Action approved 10.01.17 pending any further comments within 1 week.**	Guidance for the Preparation and Conduct of Meetings with Parents/Families to discuss concerns and/or adverse event feedback, June 2016

	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**
	dialogue.										
							As per actions 26.4 and 26.5, included in recommendation no. 26 to develop guidance for staff				
							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**	Training updated for pt safety, RCA, induction and complaints – add link to new documents developed as part of this action plan and then complete. BRHC training programme complete Plans for next steps to combine training for pt safety for BRHC and adults. Evidence to be provided for where & to whom training is being delivered then RTC
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	Apr '17	**Green - completed**		Request to delay to Feb ' 17	**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 Action approved 10.01.17**	Reports of the Reviews undertaken and available in evidence folder
							28.2 Develop guidance for when to access 'independent advise / review' for - Complaints	Head of Quality (Patient Experience and Clinical Effectivenes	Oct '16	**Green – Complete Action approved 14.2.17**	Complaints policy

	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**
							- SI RCAs	s) And Head of Quality (Patient Safety)	Dec '16		Serious Incident Policy (appendix 9, pg. 33) Email from CS to all divisions on 6th February 2017
							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 February 2017.	Head of Quality (Patient Experience and Clinical Effectiveness)	Mar '17	**Green – complete**	Focus meeting planned but not until May 17 due to pt assoc availability; letter of invitation to be added to evidence; ongoing assurance to be held by PEG RTC to be completed
							28.4 Consider how an independent review can be introduced for 2nd time dissatisfied complainants / involve users in developing a solution.	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green-complete**	This action has been completed
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	Chief Nurse	Apr '17	**Green-Complete**			29.0 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. - Action reviewed and agreed to receive a presentation from the Medical Mediation Foundation who provide the Evelina service.	SRO for I&C	Feb 17	**Green - Complete**	Medical Mediation Foundation meeting completed on 9/3/17. Feedback written up and sent to BRHC Quality Assurance

	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**
	early as possible, alternative forms of dispute resolution, such as medical mediation.										Committee 17/3/17 for recommendation re next steps; April'17 QAC approved training option and evaluate impact. CS to continue work to investigate other options, including work with patients Association; Recommendation requirements met therefore RTC to be submitted to Steering 2/5/17
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	**Red – Delivery revised twice**		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)	Apr '17	**Green - completed**	Links to other engagement work; likely to be completed in conjunction Mar mtg discussed all actions link to Rec 26 (points 4,7,8 & 9) Process exists within Being open policy/Duty of Candour policy. Adult sheet to be added to options available for April 17 Del group RTCApr'17 adult sheet produced to go alongside

	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**
											the paediatric ones already in place and agreed by BRHC QAC,, sent to VRG and to go to CQG 4/4/17 for ratification; agreed RTC May 17 once feedback and ratification & closure of rec 26. May'17 work all completed, documents produced to support closure of recommendation; review by VRG and ratification through Clinical Quality Group completed, supported by delivery group for closure.
							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**	Evidence pro forma of questions used. Agreed additional action 30.3 before closing. Mar mtg - Audit data to date shows process in place and in use – more detailed audit to sit within the complaints work plan & feed

	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**
											into Patient Experience Group
							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	**Green-complete**	Audit results due to be presented at March 2017 delivery group Mar mtg - Audit data to date shows process in place and in use – more detailed audit to sit with the complaints work plan
							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. Supplementary	Head of Quality (Patient Experience and Clinical Effectiveness)	April '17	**Green-complete**	Mar mtg – action out with original scope of Rec and will enhance effectiveness but not fundamental to completion. Process in place to ensure that complainants are asked to attend focus group. First focus group scheduled for May 17 and ongoing will sit within the complaints work plan for ongoing work and scrutiny through PEG

Key	
R	Red - Milestone behind plan, requirement to revise delivery date on more than one occasion; impact on recommendation delivery date and/or benefits delivery

A	Amber - Milestone behind plan, delivery date revised on one occasion
B	Blue - Activities on plan to achieve milestone
TBC	To be confirmed
G	Complete / Closed
FI	Indicates family involvement in the action(s)

Cover report to the Public Trust Board meeting to be held on Thursday, 29 June 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**	29 June 2017
Report Title	Annual National Patient Survey		
Author	Paul Lewis, Patient Experience and Involvement Team Manager		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

To share the results of the 2016 Care Quality Commission annual national inpatient survey with the Board.

Key issues to note

For UH Bristol, 547 survey responses were received from inpatients who attended in July 2016 - a response rate of 46%, compared to a response rate nationally of 44%.

The 2016 results represent a significant, positive step-change for UH Bristol in terms of performance in this survey, putting the Trust among the very best nationally:

- UH Bristol inpatients' overall rating of their experience in hospital was the best of any

general acute trust in the country
- UH Bristol was classed as being better than the national average on 20 out of 65 survey question scores (all of the Trust's remaining scores were in line with the national average)
- UH Bristol's best scores in 2016, as in previous years, primarily relate to themes of patients having their privacy and dignity respected, and the quality of care delivered by staff

The local analysis report provides insight on the Trust's results, summarises improvement activity in relation to the lowest scores, and outlines the Trust's plans for further improving patient experience during 2017/18.

The Care Quality Commission's "benchmark report" is provided for information.

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)**
		27/6/17		Senior Leadership Team

University Hospitals Bristol
NHS Foundation Trust

2016 National Inpatient Survey Results

1. Purpose of this paper

This paper provides an overview of UH Bristol's performance in the Care Quality Commission's 2016 national inpatient survey. This analysis should be read in conjunction with the Trust's latest Quarterly Complaints Report[1] and Quarterly Patient Experience and Involvement Report[2], which provide a detailed and current view of patient-reported experience down to a service / ward level.

2. National Inpatient Survey Methodology

A questionnaire was sent by post to 1,250 adults (aged 16+) who attended UH Bristol during the latter half of July 2016. In total, 547 responses were received - a response rate of 46%, compared to a response rate nationally of 44%[3]. The results were released on 31 May 2017. This is an annual survey.

3. Executive Summary

- UH Bristol achieved a performance among the best trusts nationally in this survey, with 20 out of 65 scores being classed as better than the national average
- UH Bristol received the best score of any general acute trust on the survey question relating to patients' overall rating of their experience
- In previous years, UH Bristol has tended to perform in line with the national average in this survey and so the 2016 results are a significant step forward for the Trust
- UH Bristol's best scores in 2016, as in previous years, primarily relate to themes of patients having their privacy and dignity respected, and the quality of care delivered by staff
- UH Bristol's two lowest scores in this survey were in line with other trusts nationally and are the subject of existing improvement plans / activity:
    - *During your hospital stay, were you ever asked to give your views on the quality of your care?* UH Bristol has a comprehensive patient survey programme in place. These surveys have helped to drive the Trust's patient experience focus and target improvements, but are administered at the end of / after the hospital stay. In 2017/18 this programme will be extended to increase opportunities for people to give feedback in "real-time" during their hospital stay.
    - *Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?* This score improved significantly for UH Bristol between the 2015 and 2016 surveys. Further work has taken place that will positively impact on the Trust's next (2017) results - including installing a large framed poster on every ward, the launch of the new Welcome Guide, and a redesign of the complaints external web page.
- A range of patient experience related developments will take place at UH Bristol during 2017/18, including the procurement of a new real-time feedback and reporting system, the extension of feedback opportunities in outpatient services, improvement work related to delivering a consistently positive customer service, and developing professional marketing to encourage service-users to give feedback / raise issues

[1] http://www.uhbristol.nhs.uk/patients-and-visitors/support-for-patients/patient-support-and-complaints/
[2] http://www.uhbristol.nhs.uk/patients-and-visitors/patient-experience-and-involvement/what-patients-tell-us-about-uh-bristol/
[3] The response rate calculation takes into account any postal surveys that could not be delivered.

4. Summary of results

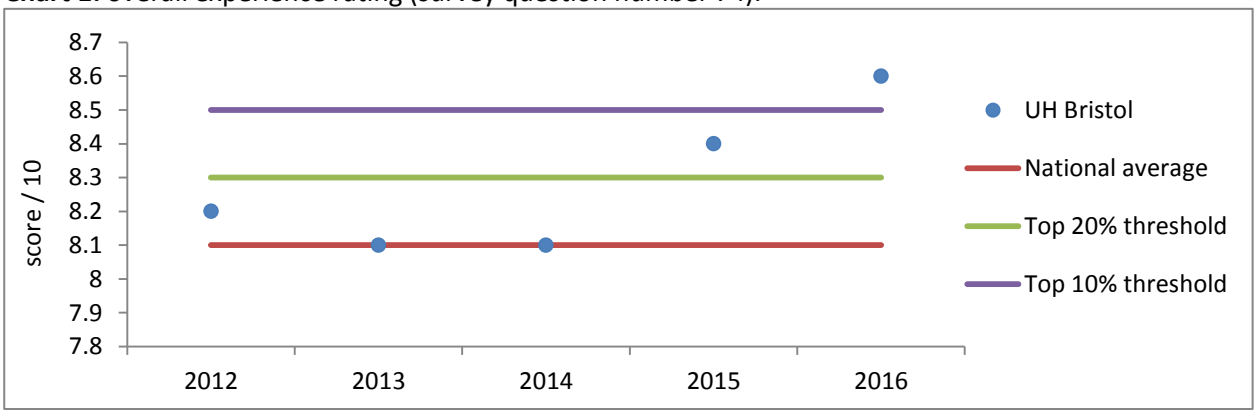
The 2016 results represent a significant step-change for UH Bristol in terms of performance in this survey, putting the Trust among the very best nationally:

- UH Bristol inpatients' overall rating of their experience in hospital was the best of any general acute trust in the country (jointly with the Royal Devon and Exeter NHS Foundation Trust)[4]
- UH Bristol was classed as being better than the national average on 20 out of 65 survey question scores (all of the Trust's remaining scores were in line with the national average).
- Only two other general acute trusts exceeded this total[5]: Newcastle Upon Tyne Hospitals NHS Foundation Trust (22 "better than average" scores) and Northumbria Healthcare NHS Foundation Trust (25). All of the remaining general acute trusts in the country received less than ten "better than average" scores, with the average being one per trust
- In the previous (2015) national inpatient survey, UH Bristol achieved one "better than average" score (this was broadly in line with UH Bristol's results in previous years)
- Between the 2015 and 2016 surveys, 14 UH Bristol scores improved to a statistically significant degree (none declined to a significant degree).

In survey terms, the jump from having one "better than average" score to twenty scores in this category merits caution. However, although the margin of error (i.e. chance variation) in survey data is always a potential factor, there are a number of things that suggest these results are reliable:

- This isn't a one-off improvement: a larger improvement in UH Bristol's scores actually occurred between 2014 and 2015 (Chart 1). At the time this didn't translate into more "better than national average" scores for the Trust[6], but the further improvement in 2016 appears to have been the tipping point in this respect
- A steady positive improvement in UH Bristol's local inpatient survey headline satisfaction score has also been evident
- These improvements correlate with other sources of insight, such as the Trust moving from a Care Quality Commission inspection rating of "requires improvement" in 2014, to "outstanding" in 2016

Chart 1: overall experience rating (survey question number 74).



Note: national thresholds are for 2014-16 to aid comparison between years.

[4] UH Bristol was twelfth overall on this question nationally: all trusts who exceeded this score were specialist trusts
[5] Nine specialist trusts received more scores in this category, with The Royal Marsden NHS Foundation Trust being the best performer with 53 "better than average" scores.
[6] Note: there was a sampling error in the 2014 data, but this was not of a magnitude that could account for the improved performance in 2015.

5. Highest and lowest UH Bristol scores

UH Bristol's highest (best) scores in 2016, as in previous years, primarily relate to themes of patients having their privacy and dignity respected, and the overall quality of care (Table 1).

Table 1: Best and lowest UH Bristol scores (out of 10)

	UH Bristol	National average
Did you feel threatened during your stay in hospital by other patients or visitors?	9.8	9.8
Were you given enough privacy when being examined or treated?	9.8*	9.6
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.6*	9.3
When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?	9.6	9.1
In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	9.5*	9.3
In your opinion, how clean was the hospital room or ward that you were in?	9.5*	9.2
Did you have confidence and trust in the doctors treating you?	9.5*	9.2
During your time in hospital did you feel well looked after by hospital staff?	9.5*	9.1
Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	3.0	2.7
During your hospital stay, were you ever asked to give your views on the quality of your care?	2.0	2.3

** denotes a score that was better than average to a statistically significant degree (none were significantly worse)*

UH Bristol's lowest scores are also shown in Table 1. It is important to note that these two scores were in line with national norms and that there is limited variation nationally (i.e. no trusts are scoring highly on these questions).

Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

This score improved significantly for UH Bristol between 2015 and 2016. In the Trust's response to the 2015 survey results, it was predicted that this might be the case due to the more prominent location of the Patient Support and Complaints Team in the Bristol Royal Infirmary from December 2015. Specific improvements were also undertaken based on the 2015 results, including ensuring that every ward has a large framed poster signposting people to the Patient Support and Complaints Team, the launch of the new inpatient Welcome Guide, and a redesign of the complaints section of the Trust external website. Given the timings around the national inpatient survey, the impact of these changes would not have been reflected in the 2016 data, but should have an impact on the Trust's next set of results[7].

The best performing general acute trust on this question (Leeds Teaching Hospitals NHS Trust), achieved a score that was slightly better than UH Bristol's (3.3 and 3.0 respectively). The Patient Support and

[7]The national survey data is always around a year "out of date" by the time it is released by the Care Quality Commission. In this case the 2016 data has been analysed in June 2017, but we are already almost at the point of drawing our sample for the next national inpatient survey (July 2017). Therefore the changes / improvements we carry out are likely to make an impact from the 2018 sample of patients onwards.

Complaints Team Manager will therefore contact this trust to identify learning that might be adopted at UH Bristol. In addition, part of UH Bristol's plans around patient feedback in 2017/18 include developing professional marketing / messaging across the Trust around the theme of "we want to hear your feedback" (see Section 6 of this report).

During your hospital stay, were you ever asked to give your views on the quality of your care?

UH Bristol has a comprehensive survey programme that provides in-depth patient-reported experience data, down to a ward-level. The existence of this data drives local change and ensures that the patient perspective of care remains at the heart of UH Bristol's vision for high quality services. This targeted local focus helps to feed through into positive results in the more generic / headline level national surveys. Nevertheless, it is recognised that there are opportunities to expand feedback opportunities at UH Bristol whilst patients are in hospital. Section 6 of this report outlines how this theme will be developed in 2017/18.

6. Looking forward: sustaining an excellent patient experience at UH Bristol

As described in the UH Bristol Quality Strategy (2016-20)[8], the Trust has ambitious plans for developing patient feedback and experience. Three important work streams are being undertaken in 2017/18 by the Trust's Patient Experience and Involvement Team in relation to this:

Real-time patient feedback and reporting system

The Trust will invest in a new real-time feedback and reporting system, with a tender exercise scheduled to take place over the summer of 2017. The key features of this system will be:

- The ability to receive feedback via touchscreens located in key locations around the Trust, such as hospital entrance areas[9], and via the patient / visitors own mobile devices. (Comment cards will also continue to be available in clinics / wards)
- If negative feedback is received electronically about a specific issue, this will be automatically and immediately directed to a relevant staff member by email
- The reporting element of the system will enable us to more effectively use our wealth of patient feedback data and ensure our wards / departments have easy access to this

Trust funding has been allocated for this system and the procurement specification is currently being finalised.

Marketing our feedback opportunities / listening culture

Linked to the real-time system, the Patient Experience and Involvement Team will work with a professional agency to develop new marketing materials that will signpost people to these feedback opportunities. This will also support the message that our staff want to hear if someone isn't happy with their experience, so that it can be resolved before it escalates into a complaint.

Developing a consistent customer-service mind set

We know from local and national surveys that overall patient satisfaction with UH Bristol services is very high. However, the data shows that there is a degree of inconsistency in providing the very best care to every patient at all times. The Trust has adopted a corporate quality objective for 2017/18 around

[8] http://www.uhbristol.nhs.uk/media/2793418/quality_strategy_jan17_final.pdf
[9] The exact locations will be identified in due course.

delivering a consistently positive “customer service”. This objective is currently in development and will be taken forward in collaboration between the Patient Experience and Involvement Team and the Transformation Team. To date, two workshops have been held to inform this objective: a patient and public engagement event in January and a staff workshop in April (the latter was attended by a senior customer service consultant who works across the private sector). An initial steering group meeting to finalise the content and means of delivery of this corporate quality objective, chaired by the Chief Nurse, is scheduled to take place in June 2017.

7. Overall summary

UH Bristol received excellent scores in the 2016 national inpatient survey, with the highest overall satisfaction rating of any general acute trust, and twenty scores that were better than the national average. Looking forward, the Trust has ambitious plans to enhance patient feedback opportunities, enable staff to better access this feedback, and to deliver a consistently positive experience for all patients at all times.

Patient survey report 2016

Survey of adult inpatients 2016

University Hospitals Bristol NHS Foundation Trust

NHS patient survey programme
Survey of adult inpatients 2016

The Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and we encourage care services to improve. Our role is to register care providers, and to monitor, inspect and rate services. If a service needs to improve, we take action to make sure this happens. We speak with an independent voice, publishing regional and national views of the major quality issues in health and social care.

Survey of adult inpatients 2016

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences.

The fourteenth survey of adult inpatients involved 149 acute and specialist NHS trusts. Responses were received from 77,850 people, a response rate of 44%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts sampled patients discharged during July 2016[1]. Trusts counted back from the last day of July 2016, including every consecutive discharge, until they had selected 1250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2016). Fieldwork took place between September 2016 and January 2017.

Similar surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2015. They are part of a wider programme of NHS patient surveys, which cover a range of topics including A&E services, children's inpatient and day-case services, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

The Care Quality Commission will use the results from this survey in our regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of CQC Insight, which provides inspectors with an assessment of risk in areas of care within an NHS trust that need to be followed up. The survey data will also be included in the data packs that we produce for inspections. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health will hold them to account for the outcomes they achieve. The NHS Trust Development Authority will use the results to inform quality and governance activities as part of their Oversight Model for NHS Trusts.

Interpreting the report

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part. It uses an analysis technique called the '**expected range**' to determine if your trust is performing 'about the same', 'better' or 'worse' compared with other trusts. For more information, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

A 'section' score is also provided, labelled S1-S11 in the 'section scores'. The scores for each question are grouped according to the sections of the questionnaire, for example, 'the hospital and ward', 'doctors', 'nurses' and so forth.

This report shows the same data as published on the CQC website (http://www.cqc.org.uk/surveys/inpatient). The CQC website displays the data in a simplified way, identifying whether a trust performed 'better', 'worse' or 'about the same' as the majority of other trusts for each question and section.

[1] 43 trusts sampled additional months because of small patient throughputs or data quality issues.

Standardisation

Trusts have differing profiles of people who use their services. For example, one trust may have more male inpatients than another trust. This can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of people.

To account for this, we standardise the data. Results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-sex-admission type profile reflects the national age-sex-admission type distribution (based on all of the respondents to the survey). Standardisation therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts. For example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q45 "During your stay in hospital, did you have an operation or procedure?" For full details of the scoring please see the technical document (see further information section).

Graphs

The graphs in this report show how the score for the trust compares to the range of scores achieved by all trusts taking part in the survey. The black diamond shows the score for your trust. The graph is divided into three sections:

- If your trust's score lies in the orange section of the graph, its result is 'about the same' as most other trusts in the survey.
- If your trust's score lies in the red section of the graph, its result is 'worse' compared with most other trusts in the survey.
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey. If there is no text the score is 'about the same'. These groupings are based on a rigorous statistical analysis of the data, as described in the following 'methodology' section.

Methodology

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the '**expected range**' which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust and the scores for all other trusts. If the trust's performance is outside of this range, it means that it performs significantly above/below what would be expected. If it is within this range, we say that its performance is 'about the same'. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance.

In some cases there will be no red and/or no green area in the graph. This happens when the expected range for your trust is so broad it encompasses either the highest possible score for all trusts (no green section) or the lowest possible for all trusts score (no red section). This could be because there were few respondents and / or a lot of variation in their answers.

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (or the corresponding section). This is because the uncertainty around the result is too great. A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see further information section).

Tables

At the end of the report you will find tables containing the data used to create the graphs. These tables also show the response rate for your trust and background information about the people that responded.

Scores from last year's survey are also displayed. The column called 'change from 2015' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2015. A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test.

Where a result for 2015 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance. Comparisons are also not able to be shown if a trust has merged with other trusts since the 2015 survey, or if a trust committed a sampling error in 2015. Please note that comparative data are not shown for sections as the questions contained in each section can change year on year.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to some trusts.

All trusts

Q11 and Q13: The information collected by Q11 "When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?" and Q13 "After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" are presented together to show whether the patient has ever shared a sleeping area with patients of the opposite sex. The combined question is numbered in this report as Q11 and has been reworded as "Did you ever share a sleeping area with patients of the opposite sex?" Please note that the information based on Q11 cannot be compared to similar information collected from surveys prior to 2006. This is due to a change in the question's wording and because the results for 2006 onwards have excluded patients who have stayed in a critical care area, which almost always accommodates patients of both sexes.

Q20: This question (Q20 in 2015 inpatient questionnaire), "Were hand-wash gels available for patients and visitors to use?" was removed from the 2016 survey because it was found there was very little differentiation between trusts, as well as the fact that there had been little movement over time.

Q20, Q21 and Q32: "Did you get enough help from staff to wash or keep yourself clean?", "If you brought your own medication with you to hospital, were you able to take it when you needed to?" and "Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)" are new questions in 2016 and it is therefore not possible to compare with 2015.

Q55 and Q56: The information collected by Q55 "On the day you left hospital, was your discharge delayed for any reason?" and Q56 "What was the main reason for the delay?" are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q56 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

Q57: Information from Q55 and Q56 has been used to score Q57 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q60: "When you left hospital, did you know what would happen next with your care?" was part of the 2015 survey and was redeveloped for 2016 (Q58 in the 2015 inpatient questionnaire).

Trusts with female patients only

Q11, Q13 and Q14: If your trust offers services to women only, a trust score for Q11 "Did you ever share a sleeping area with patients of the opposite sex?", Q13 “After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?” and Q14 "While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?" is not shown.

Trusts with no A&E Department

Q3 and Q4: The results to these questions are not shown for trusts that do not have an A&E Department.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
http://www.cqc.org.uk/inpatientsurvey

The results for the adult inpatient surveys from 2002 to 2015 can be found at:
http://www.nhssurveys.org/surveys/425

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/935

More information on the programme of NHS patient surveys is available at:
http://www.cqc.org.uk/content/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/content/monitoring-nhs-acute-hospitals

Survey of adult inpatients 2016

University Hospitals Bristol NHS Foundation Trust

Section scores

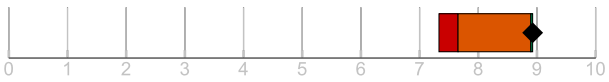
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016

University Hospitals Bristol NHS Foundation Trust

The Emergency/A&E Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?



Better

Q4. Were you given enough privacy when being examined or treated in the A&E Department?

Waiting list and planned admissions (answered by those referred to hospital)

Q6. How do you feel about the length of time you were on the waiting list?

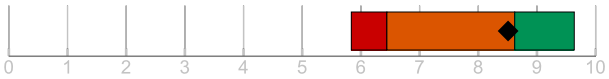
Q7. Was your admission date changed by the hospital?

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

Better

Waiting to get to a bed on a ward

Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016
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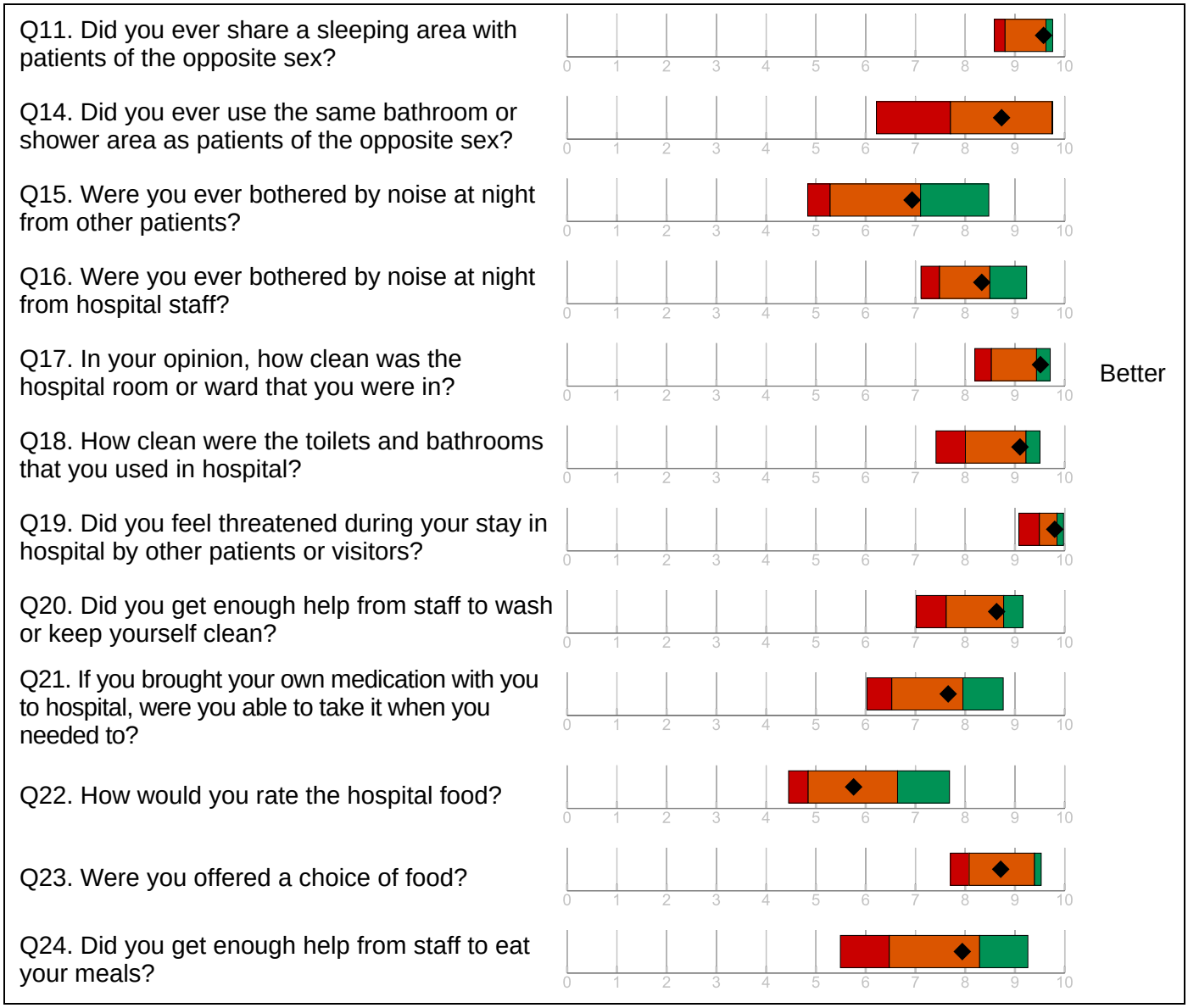
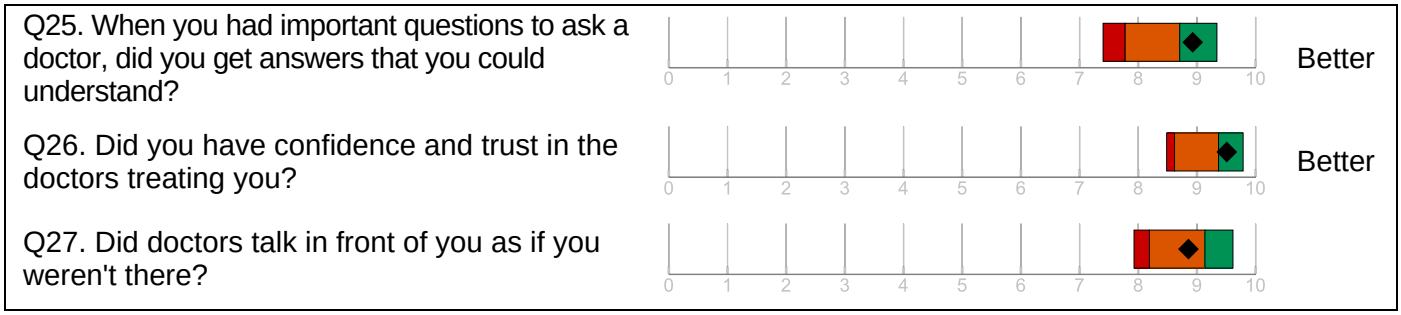
The hospital and ward



Doctors

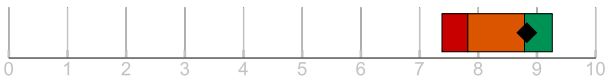
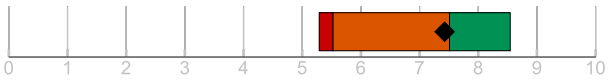


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016

University Hospitals Bristol NHS Foundation Trust

Nurses

Q28. When you had important questions to ask a nurse, did you get answers that you could understand?		Better
Q29. Did you have confidence and trust in the nurses treating you?		
Q30. Did nurses talk in front of you as if you weren't there?		
Q31. In your opinion, were there enough nurses on duty to care for you in hospital?		Better
Q32. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)		

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

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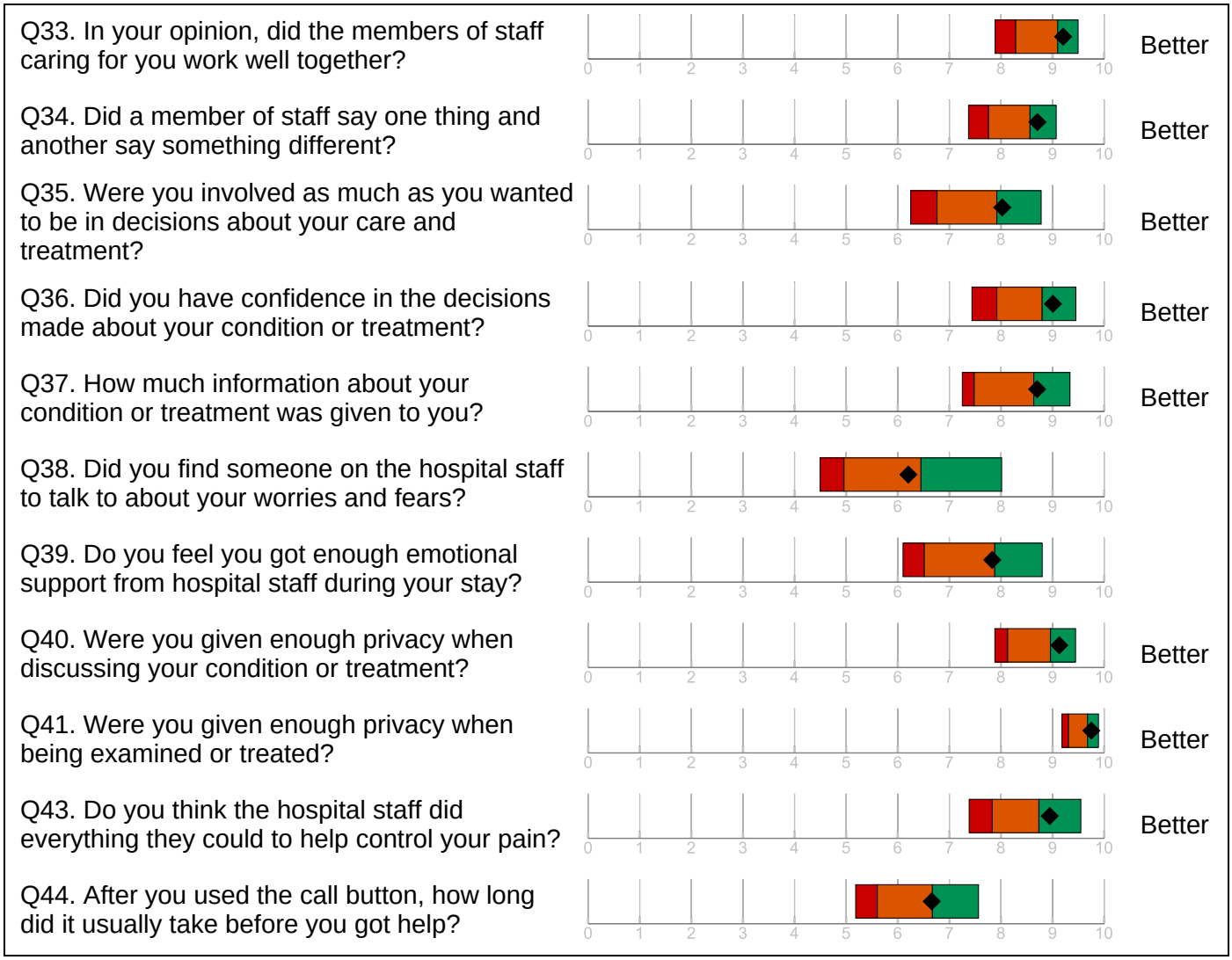
University Hospitals Bristol NHS Foundation Trust

Care and treatment



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

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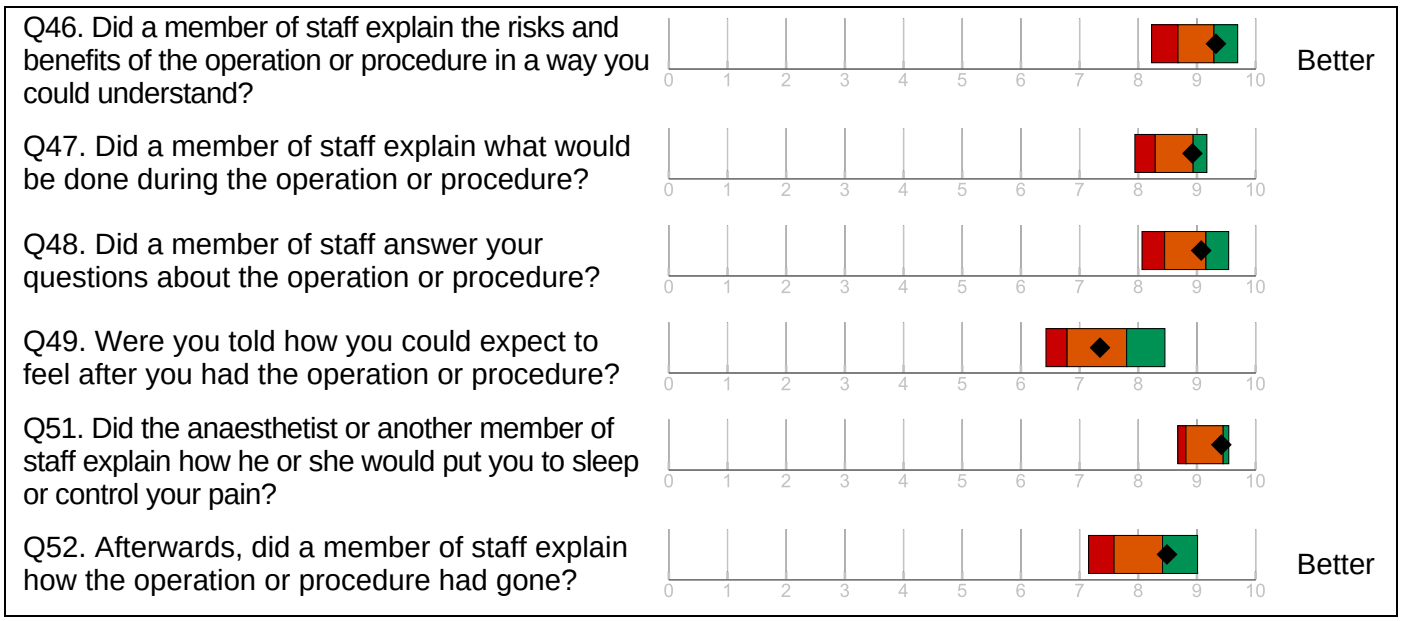
University Hospitals Bristol NHS Foundation Trust

Operations and procedures (answered by patients who had an operation or procedure)

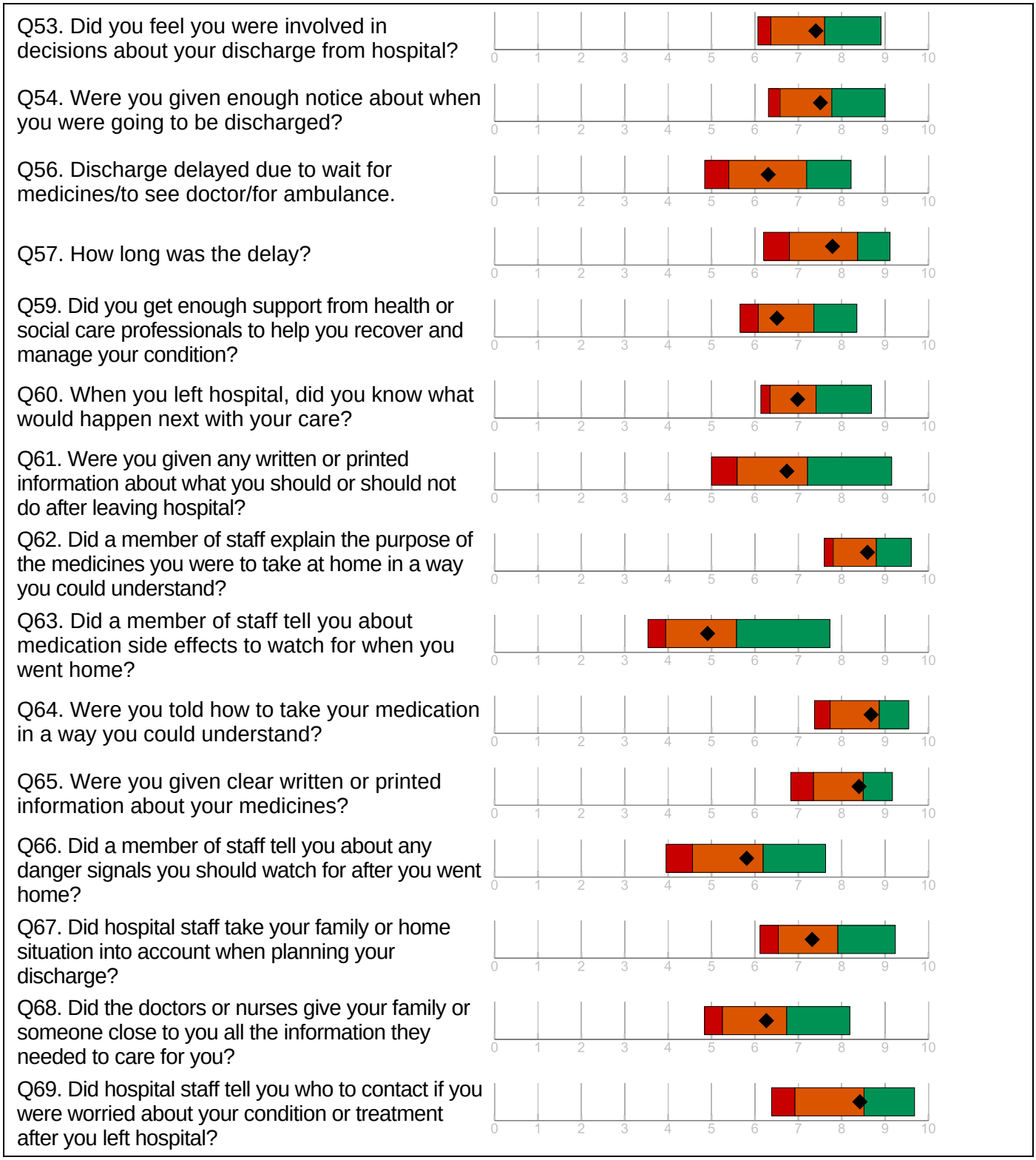


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016

University Hospitals Bristol NHS Foundation Trust

Leaving hospital



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

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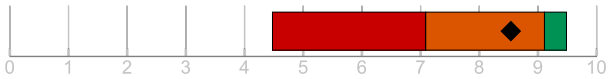
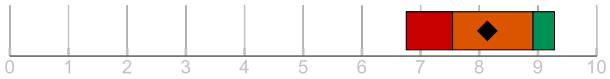
Q70. Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?



Q71. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



Overall views of care and services

Q72. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

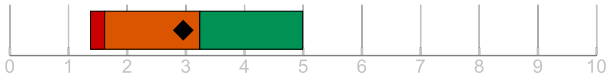
Better

Q73. During your time in hospital did you feel well looked after by hospital staff?

Better

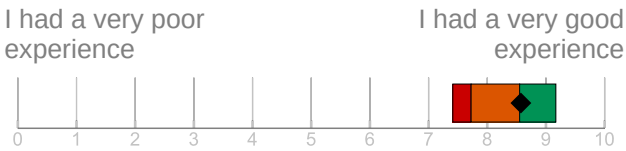
Q75. During your hospital stay, were you ever asked to give your views on the quality of your care?

Q76. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Overall experience

Q74. Overall...



Better

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2016

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	9.0	7.7	9.0			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.9	7.3	8.9	246	8.8	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	9.1	7.8	9.4	258	8.9	
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	9.1	8.2	9.6			
Q6	How do you feel about the length of time you were on the waiting list?	8.7	6.9	9.7	230	8.3	
Q7	Was your admission date changed by the hospital?	9.0	8.2	9.7	238	9.0	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.5	8.4	9.6	233	9.2	↑
Waiting to get to a bed on a ward							
S3	Section score	8.5	5.8	9.6			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	8.5	5.8	9.6	536	8.5	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
The hospital and ward							
S4	Section score	8.4	7.3	9.0			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.6	8.6	9.8	378	9.2	↑
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.7	6.2	9.8	485	8.8	
Q15	Were you ever bothered by noise at night from other patients?	6.9	4.8	8.5	539	6.9	
Q16	Were you ever bothered by noise at night from hospital staff?	8.3	7.1	9.2	534	8.1	
Q17	In your opinion, how clean was the hospital room or ward that you were in?	9.5	8.2	9.7	532	9.3	↑
Q18	How clean were the toilets and bathrooms that you used in hospital?	9.1	7.4	9.5	519	9.1	
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.8	9.1	10.0	527	9.7	
Q20	Did you get enough help from staff to wash or keep yourself clean?	8.6	7.0	9.2	296		
Q21	If you brought your own medication with you to hospital, were you able to take it when you needed to?	7.7	6.0	8.8	259		
Q22	How would you rate the hospital food?	5.8	4.5	7.7	498	5.9	
Q23	Were you offered a choice of food?	8.7	7.7	9.5	520	8.8	
Q24	Did you get enough help from staff to eat your meals?	7.9	5.5	9.3	117	7.9	
Doctors							
S5	Section score	9.1	8.0	9.5			
Q25	When you had important questions to ask a doctor, did you get answers that you could understand?	8.9	7.4	9.3	477	8.5	↑
Q26	Did you have confidence and trust in the doctors treating you?	9.5	8.5	9.8	528	9.3	↑
Q27	Did doctors talk in front of you as if you weren't there?	8.9	7.9	9.6	529	8.6	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Nurses							
S6	Section score	8.6	7.3	9.1			
Q28	When you had important questions to ask a nurse, did you get answers that you could understand?	8.8	7.4	9.3	473	8.6	
Q29	Did you have confidence and trust in the nurses treating you?	9.2	8.2	9.5	532	8.9	↑
Q30	Did nurses talk in front of you as if you weren't there?	9.1	8.1	9.7	531	8.9	
Q31	In your opinion, were there enough nurses on duty to care for you in hospital?	8.4	6.4	9.0	531	8.0	↑
Q32	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	7.4	5.3	8.5	531		
Care and treatment							
S7	Section score	8.4	7.1	8.9			
Q33	In your opinion, did the members of staff caring for you work well together?	9.2	7.9	9.5	519	9.1	
Q34	Did a member of staff say one thing and another say something different?	8.7	7.4	9.1	529	8.4	
Q35	Were you involved as much as you wanted to be in decisions about your care and treatment?	8.0	6.3	8.8	529	7.9	
Q36	Did you have confidence in the decisions made about your condition or treatment?	9.0	7.4	9.5	530	8.7	↑
Q37	How much information about your condition or treatment was given to you?	8.7	7.3	9.3	536	8.4	
Q38	Did you find someone on the hospital staff to talk to about your worries and fears?	6.2	4.5	8.0	344	6.1	
Q39	Do you feel you got enough emotional support from hospital staff during your stay?	7.8	6.1	8.8	358	7.5	
Q40	Were you given enough privacy when discussing your condition or treatment?	9.1	7.9	9.4	538	9.0	
Q41	Were you given enough privacy when being examined or treated?	9.8	9.2	9.9	538	9.6	
Q43	Do you think the hospital staff did everything they could to help control your pain?	8.9	7.4	9.5	349	8.7	
Q44	After you used the call button, how long did it usually take before you got help?	6.7	5.2	7.6	324	6.2	↑

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.8	7.9	9.1			
Q46	Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	9.3	8.2	9.7	342	9.1	
Q47	Did a member of staff explain what would be done during the operation or procedure?	8.9	7.9	9.2	340	8.9	
Q48	Did a member of staff answer your questions about the operation or procedure?	9.1	8.1	9.5	298	8.8	
Q49	Were you told how you could expect to feel after you had the operation or procedure?	7.3	6.4	8.5	347	7.3	
Q51	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	9.4	8.7	9.5	295	8.9	↑
Q52	Afterwards, did a member of staff explain how the operation or procedure had gone?	8.5	7.2	9.0	348	8.1	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Leaving hospital							
S9	Section score	7.3	6.3	8.5			
Q53	Did you feel you were involved in decisions about your discharge from hospital?	7.4	6.1	8.9	522	7.3	
Q54	Were you given enough notice about when you were going to be discharged?	7.5	6.3	9.0	537	7.5	
Q56	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.3	4.8	8.2	505	6.2	
Q57	How long was the delay?	7.8	6.2	9.1	502	7.6	
Q59	Did you get enough support from health or social care professionals to help you recover and manage your condition?	6.5	5.7	8.3	272	6.5	
Q60	When you left hospital, did you know what would happen next with your care?	7.0	6.1	8.7	465		
Q61	Were you given any written or printed information about what you should or should not do after leaving hospital?	6.7	5.0	9.2	521	6.6	
Q62	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.6	7.6	9.6	419	8.4	
Q63	Did a member of staff tell you about medication side effects to watch for when you went home?	4.9	3.5	7.7	368	4.8	
Q64	Were you told how to take your medication in a way you could understand?	8.7	7.4	9.5	385	8.3	
Q65	Were you given clear written or printed information about your medicines?	8.4	6.8	9.2	397	8.4	
Q66	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.8	4.0	7.6	411	5.5	
Q67	Did hospital staff take your family or home situation into account when planning your discharge?	7.3	6.1	9.2	362	6.9	
Q68	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	6.3	4.8	8.2	364	6.0	
Q69	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.4	6.4	9.7	478	8.0	
Q70	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.5	4.5	9.5	104	8.0	
Q71	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.1	6.8	9.3	263	8.1	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2015 scores for this NHS trust	Change from 2015
Overall views of care and services							
S10	Section score	6.0	4.8	6.9			
Q72	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.6	8.5	9.8	538	9.3	↑
Q73	During your time in hospital did you feel well looked after by hospital staff?	9.5	8.3	9.7	538	9.2	↑
Q75	During your hospital stay, were you ever asked to give your views on the quality of your care?	2.0	0.9	4.4	458	1.5	↑
Q76	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	3.0	1.4	5.0	404	2.3	↑
Overall experience							
S11	Section score	8.6	7.4	9.2			
Q74	Overall...	8.6	7.4	9.2	519	8.4	

↑ or ↓	Indicates where 2016 score is significantly higher or lower than 2015 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2015 data is available.

Survey of adult inpatients 2016
University Hospitals Bristol NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	547	77850
Response Rate (percentage)	46	44

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	52	47
Female	48	53
Age group (percentage)	(%)	(%)
Aged 16-35	9	5
Aged 36-50	10	9
Aged 51-65	22	23
Aged 66 and older	59	63
Ethnic group (percentage)	(%)	(%)
White	93	90
Multiple ethnic group	0	1
Asian or Asian British	3	3
Black or Black British	1	1
Arab or other ethnic group	0	0
Not known	3	5
Religion (percentage)	(%)	(%)
No religion	25	16
Buddhist	1	0
Christian	71	77
Hindu	0	1
Jewish	0	0
Muslim	1	2
Sikh	0	0
Other religion	1	1
Prefer not to say	1	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	95	94
Gay/lesbian	1	1
Bisexual	0	0
Other	0	1
Prefer not to say	4	4

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Thursday, 29 June 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**	29 June 2017
Report Title	Annual Complaints Report		
Author	Louise Townsend, Acting Patient Support & Complaints Manager		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

This report fulfils a statutory requirement for the Trust to publish a summary of complaints received during the year. The Board has previously reviewed the data included in the report via detailed quarterly reports, and in summary form via the Trust's annual Quality Report (Account).

Key issues to note

- 1,875 complaints were received by the Trust in the year 2016/2017, averaging 156 per month. Of these, 487 were managed through the formal investigation process and 1,388 through the informal investigation process. This compares with a total of 1,941 complaints received in 2015/2016, a decrease of 3%. During 2016/17, the volume of complaints received by the Trust as a proportion of patient activity was 0.23%: a decrease on 2015/2016, when 0.25% of patient episodes resulted in a complaint.

- In addition, the Patient Support and Complaints Team dealt with 814 other enquiries, including compliments, requests for support and requests for information and advice: a substantial increase on the 599 enquiries dealt with in 2015/2016.

- The Trust had eight complaints referred to the Parliamentary and Health Service Ombudsman in 2016/17, compared with 15 in 2015/16 and 12 in 2014/15. Two of the complaints referred during 2016/17 were not upheld and two were partially upheld; the remaining four cases were still being considered by the Ombudsman as of 8 May 2017.

- 86.1% of formal complaints were responded to within the agreed timescale, an increase on the 75.2% achieved in 2015/16 and higher than the 85.9% recorded for 2014/15.

- At the time of writing the annual report, 65 complainants had expressed dissatisfaction with complaints responses sent out during 2016/17. This equates to 11.0% of the total responses sent out. This compares with 59 (9.1%) dissatisfied complaints received in 2015/16 (measured at the same point in time).

- During the year, the Trust's complaints service received inspections/reviews from NHS Improvement and the Care Quality Commission, both with positive outcomes.

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)**
		27/6/17		Patient Experience Group, Senior Leadership Team

University Hospitals Bristol
NHS Foundation Trust

ANNUAL COMPLAINTS REPORT 2016/2017

Author: Louise Townsend, Acting Patient Support and Complaints Manager - May 2017

Contents

Executive Summary

In accordance with NHS Complaints Regulations (2009), this report sets out a detailed analysis of the number and nature of complaints received by University Hospitals Bristol NHS Foundation Trust in 2016/2017. The report also records other support provided by the Trust's Patient Support and Complaints Team[1] during the year.

In summary:

- 1,875 complaints were received by the Trust in the year 2016/2017, averaging 156 per month. Of these, 487 were managed through the formal investigation process and 1,388 through the informal investigation process. This compares with a total of 1,941 complaints received in 2015/2016, a decrease of 3%. During 2016/17, the volume of complaints received by the Trust as a proportion of patient activity was 0.23%: a decrease on 2015/2016, when 0.25% of patient episodes resulted in a complaint.

- In addition, the Patient Support and Complaints Team dealt with 814 other enquiries, including compliments, requests for support and requests for information and advice: a substantial increase on the 599 enquiries dealt with in 2015/2016.

- The Trust had eight complaints referred to the Parliamentary and Health Service Ombudsman in 2016/17, compared with 15 in 2015/16 and 12 in 2014/15. Two of the complaints referred during 2016/17 were not upheld and two were partially upheld; the remaining four cases are still being considered by the Ombudsman (as of 8 May 2017).

- 86.1% of formal complaints were responded to within the agreed timescale, an increase on the 75.2% achieved in 2015/16 and higher than the 85.9% recorded for 2014/15.

- At the time of writing, 65 complainants have expressed dissatisfaction with complaints responses sent out during 2016/17. This equates to 11.0% of the total responses sent out. This compares with 59 (9.1%) dissatisfied complaints received in 2015/16.

- During the year, the Trust's complaints service has received inspections from NHS Improvement and the Care Quality Commission, but with positive outcomes.

- In 2016/17, the Trust's Complaints Policy was comprehensively reviewed, introducing new guidance about situations in which staff may wish to seek independent input into the investigation of patients and families' concerns.

- In 2016/17 the Trust changed its complaints management system/software. As a consequence, we are not in a position to report reliable complaints equalities monitoring data for the year, however steps have been taken to ensure that comprehensive data is collected for 2017/18.

[1] UH Bristol's integrated 'PALS' and complaints team

1. Accountability for complaints management

The Board of Directors has corporate responsibility for the quality of care and the management and monitoring of complaints. The Chief Executive delegates responsibility for the management of complaints to the Chief Nurse.

The Trust's Patient Support and Complaints Manager is responsible for ensuring that:

- All complaints are fully investigated in a manner appropriate to the seriousness and complexity of the complaint, in line with the complainants wishes;
- All formal complaints receive a comprehensive written response from the Chief Executive or his nominated deputy or a local resolution meeting with a senior clinician and senior member of the divisional management team;
- Complaints are resolved within the timescale agreed with each complainant at a local level wherever possible;
- Where a timescale cannot be met, an explanation is provided and an extension agreed with the complainant; and
- When a complainant requests a review by the Parliamentary and Health Service Ombudsman, all enquiries received from the Ombudsman's office are responded to in a prompt, co-operative and open manner.

The Patient Support and Complaints Manager line manages a team which consists of one full time Band 6 Deputy Manager, two full-time (one post is a fixed term contact until March 2018) and three part-time complaints officers/caseworkers (Band 5) and three part-time administrators (Band 3). The total team resource, including the manager, is currently 8.5 WTE.

2. Complaints reporting

Each month, the Patient Support and Complaints Manager reports the following information to the Trust Board:

- Percentage of complaints per patient attendance
- Percentage of complaints responded to within the agreed timescale
- Percentage of cases where the complainant is dissatisfied with the original response

In addition, the following information is reported to the Patient Experience Group, which meets every three months:

- Validated complaints data for the Trust as a whole and also for each Division
- Quarterly Complaints Report, identifying themes and trends
- Annual Complaints Report (which is also received by the Board).

The Quarterly Complaints Report provides an overview of the numbers and types of complaints received, including any trends or themes that may have arisen, including analysis by Division and information about how the Trust is responding. The Quarterly Complaints Report is also reported to the Trust Board and published on the Trust's web site.

3. Total complaints received in 2016/2017

In 2016/17, the Trust's target was that the volume of complaints received should not exceed 0.21% of patient activity – in other words, that no more than approximately 1 in 500 patients complain about our service. We achieved 0.23% in 2016/17, compared with 0.25% in 2015/16 (see Figure 1). The total number of complaints received during the year was 1,875, a decrease of 3.4% on the 1,941 complaints received the previous year. Of these, 487 (26.0%) were managed through the formal investigation process and 1,388 through the informal investigation process; this compares with 647 (33.3%) complaints managed formally in 2015/16 and 1,294 managed formally.

Compared with 2016/17, there was a decrease of 24.7% in the number of complaints managed through the formal investigation process and a 7.4% increase in the number of complaints managed through the informal investigation process. This continues a pattern noted in last year's annual report and is a positive change – we want to address concerns quickly and as close to the point of care as possible.

A formal complaint is classed as one where an investigation by the Division is required in order to respond to the complaint. A senior manager is appointed to carry out the investigation and gather statements from the appropriate staff. These statements are then used as the basis for either a written response to, or a meeting with, the complainant (or sometimes a telephone call from the manager). The method of feedback is agreed with the complainant and is their choice. The Trust's target is that this process should take no more than 30 working days in total.

An informal complaint is one where the concerns raised can usually be addressed quickly by means of an investigation by the divisional management team and a telephone call to the complainant. The figures below do not include informal complaints and concerns which are dealt with directly by staff in our Divisions. We are currently investigating how systems might be put in place to record and report this information in the future.

Figure 1 - Monthly complaints as a percentage of patient activity 2015/16 and 2016/17

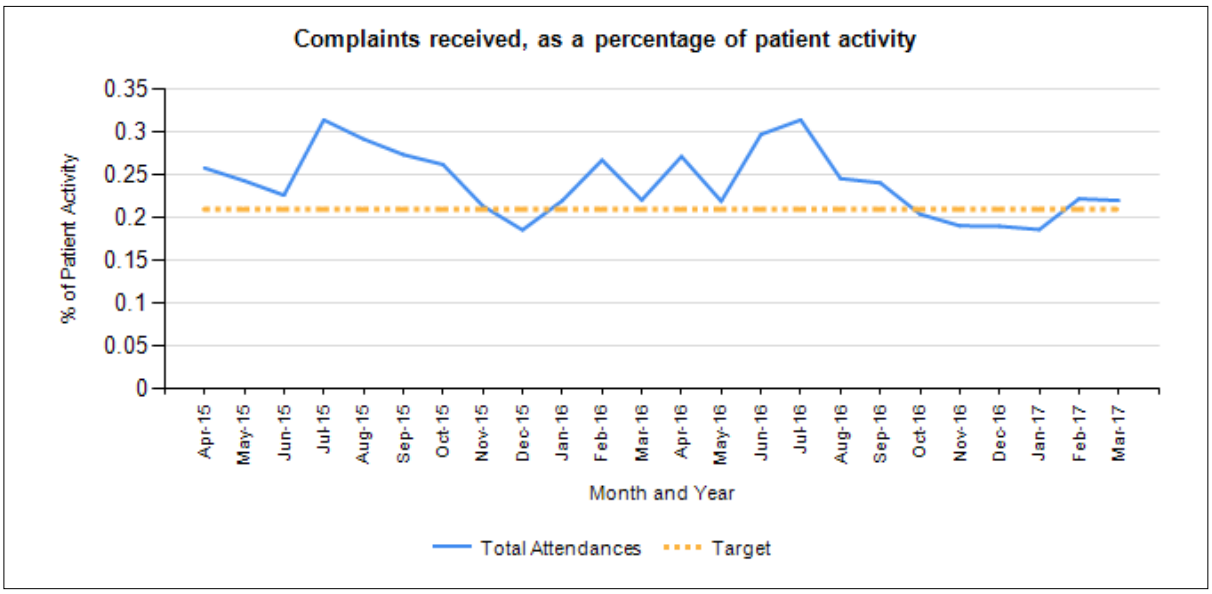


Table 1 below shows the number of complaints received by each of the Trust's clinical divisions compared with the previous year. Directional arrows indicate change compared to the previous financial year.

Table 1 - Breakdown of complaints by Division

Division	Informal Complaints 2016/2017	Formal Complaints 2016/2017	Divisional Total 2016/17	Informal Complaints 2015/2016	Formal Complaints 2015/2016	Divisional Total 2015/16
Surgery, Head and Neck	553 ↓	127 ↓	680 ↓	583 ↑	212 ↓	795 ↑
Medicine	301 ↑	122 ↓	423 ↑	244 ↑	162 ↓	406 ↑
Specialised Services	209 ↑	84 ↑	293 ↑	172 ↓	66 ↓	238 ↓
Women and Children	156 ↑	121 ↓	277 ↓	142 ↓	157 ↓	299 ↓
Diagnostics and Therapies	56 =	15 ↓	71 ↓	56 ↓	24↓	80 ↓
Trust Services (including Facilities & Estates)	113 ↑	18 ↓	133 ↑	97 ↑	26 ↓	123↑
TOTAL	**1388 ↑**	**487 ↓**	**1877↓**	**1294 ↑**	**647↓**	**1941 ↑**

Table 1 shows a decrease in formal complaints received by all clinical Divisions in 2016/17 compared with 2015/16 and an increase in informal complaints received by all clinical Divisions, with the exception the Division of Surgery, Head and Neck. Complaints about the Divisions of Medicine and Trust Services have risen for consecutive years; complaints about the Division of Women's & Children's Services have fallen for consecutive years.

4. Complaint themes

In 2016/17 the Trust increased the number of high level reporting themes from six to eight, adding Discharge/Transfer/Transport and Documentation. A number of new reporting categories have also been created within each theme. A complaint may be recorded under more than one category, depending upon the nature and complexity of the complaint. This data helps us to identify whether any trends or themes are developing when matched against hospital sites, departments, clinics and wards.

Table 2 and Figure 2 show complaints received by theme, compared to 2015/16 and 2014/15.

Table 2 - Complaint themes – Trust totals

Complaint Theme	Total Complaints 2016/17	Total Complaints 2015/16	Total Complaints 2014/15
Access	16 ↓	40 ↓	56 ↑
Appointments and Admissions	589 ↓	661 ↑	656 ↑
Attitude and Communication	454 ↓	552 ↑	444 ↑
Clinical Care	490 ↑	469 ↓	528 ↑
Facilities and Environment	89 ↓	99 ↓	116 ↑
Discharge/Transfer/Transport	89	Not available (new reporting category)	Not available (new reporting category)
Documentation	12	Not available (new reporting category)	Not available (new reporting category)
Information and Support	136 ↑	120 ↑	83 ↑
TOTAL	**1875 ↓**	**1941 ↑**	**1883 ↑**

In 2016/17, the total number of complaints received under the theme of Attitude and Communication decreased by 17.6%. This theme covers such categories of complaints as attitude of

medical staff, attitude of administrative staff, communication with patient/relative and communication (administrative).

Of the 454 complaints recorded under this theme, the largest sub-category was 'failure to answer the telephones' (107) followed by 'communication with patient/relative' (102), and 'attitude of medical staff' (81). Some examples of the complaints categorised as 'communication with patient/relative' were: family members not being given enough information about the patient's treatment pathway; patients not receiving adequate explanation of their diagnosis or treatment; and patients not being contacted to be advised that their appointment or procedure had been cancelled resulting in a wasted journey to the hospital. The hospital departments receiving the highest numbers of complaints relating to attitude and communication were Trauma & Orthopaedics (25), the Outpatient Department at the Bristol Heart Institute (15), and the Bristol Royal Infirmary Emergency Department (15).

Four of the previous six main complaints themes saw a decrease when compared with the previous year, including a significant reduction in complaints about Access to services, in part reflecting an initiative to remove restrictions on visiting hours throughout the Trust.

In respect of Clinical Care, the total number of complaints received by the Trust increased from 469 in 2015/16 to 490 in 2016/17. The largest numbers of complaints under this theme were in the category of 'clinical care (medical/surgical)' with 254 (192 in 2015/16). The Associate Medical Director (AMD) oversees a system to monitor complaints where individual doctors or surgeons are cited; staff are interviewed by the AMD or Medical Director if patterns of repeated behaviour are identified which give cause for concern.

Finally, there was a notable decrease in complaints received about Appointments and Admissions in 2016/17 compared to 2015/16. The highest numbers of complaints received by the Trust under this theme were in respect of cancelled or delayed appointments and operations (264). .

5. Performance in responding to complaints

In addition to monitoring the volume of complaints received, the Trust also measures its performance in responding to complainants within agreed timescales, and the number of complainants who are dissatisfied with responses.

5.1 Proportion of complaints responded to within timescale

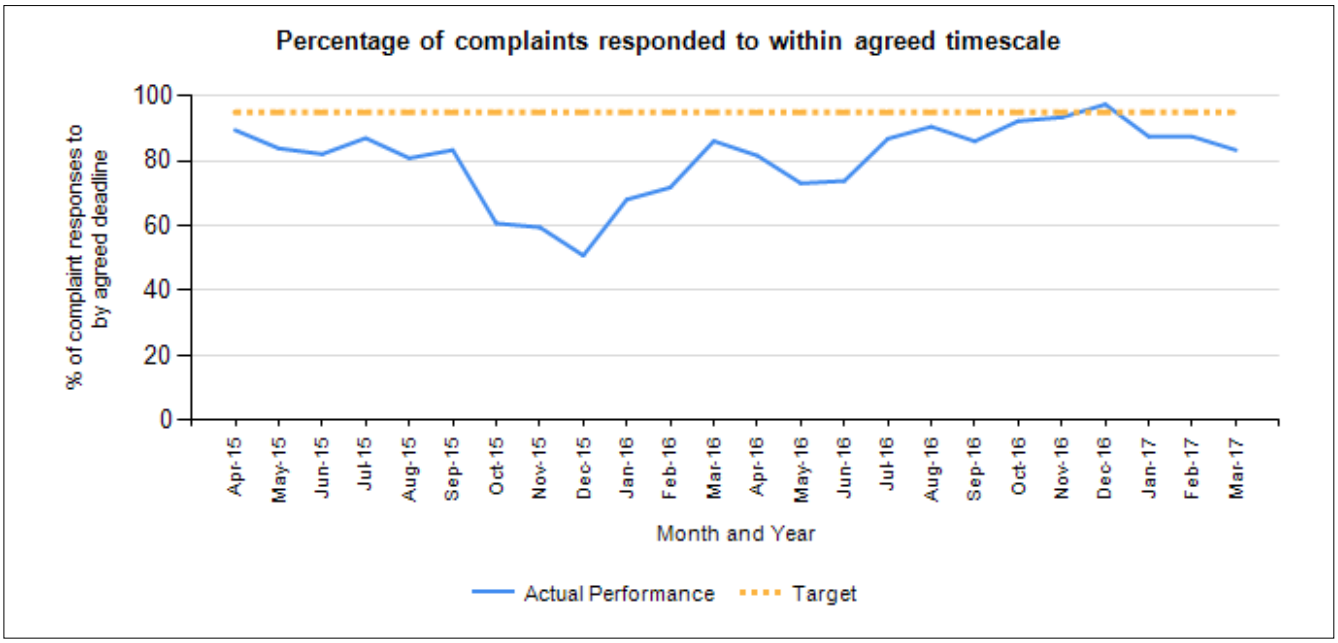
The Trust's expectation is that all complaints will be acknowledged within two working days for telephone enquiries and within three working days for written enquiries. The complainant's concerns are confirmed and the most appropriate way in which to address their complaint is agreed. A realistic timescale in which the complaint is to be resolved is agreed, based on the complexity of the complaint whilst responding in a timely manner.

The time limit for making a complaint, as laid down in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, is currently 12 months after the date on which the subject of the complaint occurred or the date on which the matter came to the attention of the complainant. These regulations and guidance from the Parliamentary and Health Service Ombudsman indicate that the Trust must investigate a complaint 'in a manner appropriate to resolve it speedily and efficiently and keep the complainant informed.' When a response is not possible within the agreed timescale, the Trust must inform the complainant of the reason for the delay and agree a new date by which the response will be sent.

The Trust captures data about the numbers of complaints responded to within the agreed timescale. The Trust's performance target for this in 2016/17 was 95% compliance. Over the course of the year 2016/17, 86.1% of responses were responded to within the agreed timescale, an increase on the 75.2% achieved in 2015/16 and higher than the 85.9% achieved in 2014/15.

Performance in responding to formal complaints within agreed timescales continues to be monitored closely by the Patient Experience Group and the Quality and Outcomes Committee of the Board. Towards the end of 2016/17, a new standard operating procedure was introduced to govern the circumstances in which divisions can legitimately request extensions to investigation timescales, and how this is recorded. This is designed to avoid the potential for extensions to be used inappropriately to avoid breaching agreed timescales.

Figure 3. Percentage of complaints responded to within agreed timescale



5.2 Numbers of complainants who are dissatisfied with our response

The Trust also measures performance in respect of the number of complainants who are dissatisfied with the response provided to their complaint due to the original investigation being incomplete or inaccurate (which we differentiate from follow-up enquiries where a complainant raises additional questions).

At the time of writing, 65 complainants have expressed dissatisfaction with complaints responses sent out during 2016/17. This equates to 11.0% of the total responses sent out, compared to 59 (9.1%) in 2015/16. Informal benchmarking against other NHS trusts indicates that a dissatisfaction rate of 8-12% is typical. Nonetheless, our aspiration is for nobody to be unhappy with the quality of our original response.

6. Parliamentary and Health Service Ombudsman (PHSO)

If a complainant is unhappy with the way in which their complaint has been dealt with by the Trust and feels that local resolution of their complaint has not been satisfactory, they have the option of asking the PHSO to carry out an independent review of their complaint.

The Trust had eight complaints referred to the Parliamentary and Health Service Ombudsman in 2016/17, compared with 15 in 2015/16 and 12 in 2014/15. Two of the complaints referred during 2016/17 were not upheld and two were partially upheld; the remaining four cases are still being considered by the Ombudsman (as at 8 May 2017). In respect of the two partially upheld complaints, the Trust has complied fully with the PHSO's recommendations.

7. Information, advice and support

In addition to managing complaints, the Patient Support and Complaints Team also deal with information, advice and support requests. The total number of enquiries received during 2016/17 is shown below, together with the numbers from 2015/16 and 2014/15 for comparative purposes:

Table 3:

Type of enquiry	**Total Number 2016/17**	**Total Number 2015/16**	**Total Number 2014/15**
Request for advice / information	504	375	389
Request for support	20	24	43
Compliments	290	200	187
Total	**814**	**599**	**619**

Many service users will contact the team for reasons other than complaints. This may be about:

- Services which the Trust provides
- Signposting to other local or voluntary services
- Outpatient clinic appointments (patients may occasionally ask a member of the team to attend with them)
- Liaison for carers and patients who have additional support needs and complex health problems
- Communication with patients' healthcare teams to facilitate both parties being able to work together in the future.
- Assisting families who arrive in Bristol with a patient but do not live locally and require local orientation and signposting to further help about finding somewhere to stay.

Examples of typical enquiries about advice and information include:

- 'What is the waiting time for xxx procedure?'
- 'Who do I contact to discuss xxx?'
- 'Can I have my treatment at a different hospital/location?'
- 'Is it true that my operation has been cancelled due to cost cuts?'
- 'I'm having an operation soon, who do I speak to about some concerns/questions that I have?'
- 'I need a letter from my consultant in order that I can get my driving licence back.'
- 'How do I make a complaint about my GP?'
- 'My transport hasn't arrived and I'm going to miss my appointment. Who do I contact?'

- ‘I’m on the ward and I need to know the password for the Wi-Fi.’
- ‘I was an inpatient last week and lost my glasses. What do I need to do?’

Examples of typical enquiries about support include:

- ‘I would like someone to come to my outpatient appointment with me for support.’
- ‘I’ve arranged to meet with my consultant, would you be able to come with me?’
- ‘I need to arrange for a translator/interpreter to be available at my mother’s appointment, can you help?’
- ‘Are you able to help me get hold of my consultant’s secretary?’
- ‘Who do I need to contact to arrange hospital transport?’

8. Looking back and ahead

University Hospitals Bristol NHS Foundation Trust continues to be proactive in its management of complaints and enquiries, recognising that the way we respond to concerns is part of our commitment to excellence in customer service and acknowledging that all complaints are a valuable source of learning.

During 2016/17, we carried out a comprehensive review of our Complaints Policy, introducing new guidance about situations in which staff may wish to seek independent input into the investigation of patients’ and families’ concerns. The Trust also put in place new guidance about the need to identify a ‘case manager’ as a single point of contact for families in situations where multiple investigatory processes are running concurrently (for example, complaints investigations, serious incident investigations and child death reviews).

In 2016/17, the Trust’s complaints service was inspected by both NHS Improvement and the Care Quality Commission. The reports from these visits were very positive whilst also highlighting opportunities to make further improvements to the service, which have been taken into our work plan for 2017/18. Our Patient Experience Group has continued to receive regular reports providing assurance of compliance with Regulation 16 of the Health and Social Care Act (Care Quality Commission).

Looking ahead to 2017/18, we will continue a strong focus on getting the quality and tone of our complaints response letters right. As part of this work, we will be establishing a new bi-monthly Executive-led complaints review panel; each of our divisions will attend the panel once a year to reflect on learning from both successful and challenging complaints investigations and to work collectively with corporate leads to improve how we handle complaints. Alongside this, we are holding exploratory talks with the Patients Association about whether and how they might have ongoing input into the resolution of challenging complaints.

Our detailed complaints work plan for 2017/18 is available upon request.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Thursday, 29 June 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**	29 June 2017
Report Title	a) Quarterly Complaints Report b) Quarterly Patient Experience Report		
Authors	a) Louise Townsend, Acting Patient Support & Complaints Manager, and Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness) b) Paul Lewis, Patient Experience & Involvement Team Manager		
Executive Lead	Carolyn Mills, Chief Nurse		

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	☐		☐

Freedom of Information Status	Open

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 the Board with information about what our patients said about our services during the final quarter of 2016/17 via complaints and other forms of feedback, and assurance of how Divisions have been responding to any 'hot spots' identified.

Key issues to note

Complaints

Improvements in Q4:

- Although the total number of complaints received in Quarter was 11% more than in Quarter 3, it was significantly less than in Quarter 2, and 8% less than the corresponding quarter one year previously.
- In Quarter 4, complaints about cancelled/delayed appointments and operations fell to a historical low of 54. The Trust had also received only 66 complaints in quarter 3; this was the first time the quarterly total for this reporting theme had fallen below 100 since the third quarter of 2013/14.
- Complaints about failure to answer telephones fell for a third consecutive quarter, returning to its lowest (best) point since the third quarter of 2015/16.
- Complaints about Trauma and Orthopaedics fell significantly to 14 in quarter 4 compared to 37 in quarter 3.
- No formal complaints were received by the Diagnostics and Therapies division in February and March 2017.
- No cases referred to the Ombudsman were upheld against the Trust in quarter 4.

However:

- Complaints about Specialised Services division increased significantly in Q4, driven largely by increases in complaints about outpatient services and the waiting list office, both at the Bristol Heart Institute.
- Complaints about Bristol Dental Hospital rose in quarter 4 following previous reductions. This was largely driven by increases in complaints about the Administration Department and Oral Surgery Department.

Patient experience and involvement:

- All of the UH Bristol's Trust-level patient survey measures remained above target - demonstrating the continued provision of a high quality patient experience.
- UH Bristol has a contractual obligation with the Bristol Clinical Commissioning Group to meet specified Friends and Family Test response rate targets. In Quarter 4 the Trust continued to meet these targets. There was an improvement in the response rate for the inpatient and day case element of this survey during Quarter 4, having only just been meeting the 30% target in Quarter 3.
- Ward C808 (care of the elderly) had the lowest score across the headline survey measures. It has been a consistent feature of the survey data that care of the elderly areas tend to attract lower patient experience scores. This has led to additional analysis and exploration of the data, which suggests that the scores are a realistic reflection of the challenges of caring for patients (and being a patient / carer) in this setting - rather than a reflection of the quality of care being provided. To further test this theory, in Quarter 1 the Patient Experience and Involvement Team have been carrying out a range of activities on care of the elderly wards.
- Ward A602 (trauma and orthopaedics) had a relatively low survey score on two key survey measures. This was an unusual result for this ward, further analysis did not identify any specific improvement issues, and the number of complaints actually fell over this period. The most likely explanation at present is that this was a statistical "blip", but the ward Sister has been alerted to the result and the score will continue to be monitored to look for any consistent trend.

Recommendations
Members are asked to: • **Note** the reports.

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)**
		27/6/17		Patient Experience Group, Senior Leadership Team

University Hospitals Bristol
NHS Foundation Trust

Complaints Report

Quarter 4, 2016/2017

(1 January 2017 to 31 March 2017)

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

Overview

Successes	Priorities
• Although the total number of complaints received in Quarter was 11% more than in Quarter 3, it was significantly less than in Quarter 2, and 8% less than the corresponding quarter one year previously. • In quarter 4, complaints about cancelled/delayed appointments and operations fell to a historical low of 54. The Trust also received only 66 complaints in quarter 3; this was the first time the quarterly total for this reporting theme had fallen below 100 since the third quarter of 2013/14. • Complaints about failure to answer telephones fell for a third consecutive quarter, returning to its lowest (best) point since the third quarter of 2015/16. • Complaints about Trauma and Orthopaedics fell significantly to 14 in quarter 4 compared to 37 in quarter 3. • No formal complaints were received by the Diagnostics and Therapies division in February and March 2017. • No cases referred to the Ombudsman were upheld against the Trust in quarter 4.	• To re-focus on ensuring timely complaints responses – in quarter 4, 86.0% of formal complaints were responded to within the agreed timeframe. • To continue to focus on getting the tone and substance of response letters right. Despite our efforts, in 2016/17 as a whole, more complainants expressed dissatisfaction with our initial response to their formal complaints than in 2015/16 (65 compared to 59).
Opportunities	**Risks & Threats**
• To bring more detailed monitoring of informal complaints into the quarterly reporting process. From Quarter 1 2017/18 onwards, we will start to report on divisional performance in responding to informal complaints within timescale. • To establish a new complaint review panel. • To continue to work with the Patients Association to develop a potential model for external patient advocacy for high-risk complaints.	• Complaints about Specialised Services division increased significantly in Q4, driven largely by increases in complaints about outpatient services and the waiting list office, both at the Bristol Heart Institute. • Complaints about Bristol Dental Hospital rose in quarter 4 following previous reductions. This was largely driven by increases in complaints about the Administration Department and Oral Surgery Department.

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.

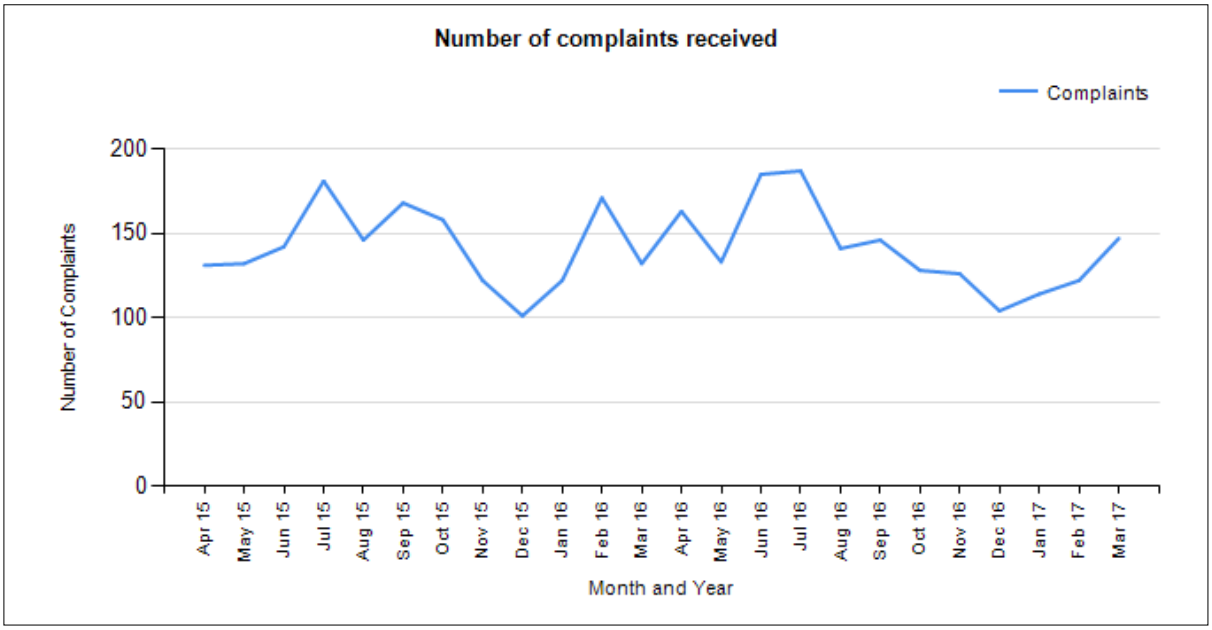
1.1 Total complaints received

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 441 complaints in Q4, which equates to 0.20% of patient activity. This includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1]. This figure does not include concerns which may have been raised by patients and dealt with immediately by front line staff. The number of complaints received in Q4 represents an increase of 11% compared to Q3 and an 8% decrease on the corresponding period one year previously.

Figure 1 shows the pattern of complaints received in the last 22 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.

Figure 1: Number of complaints received



[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.

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

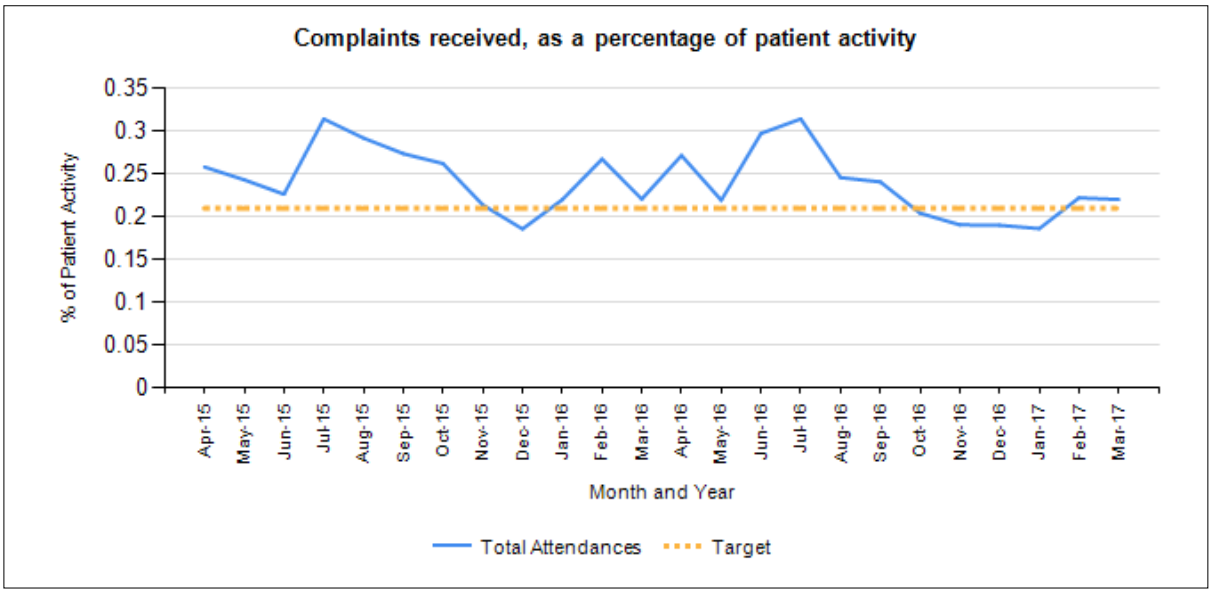
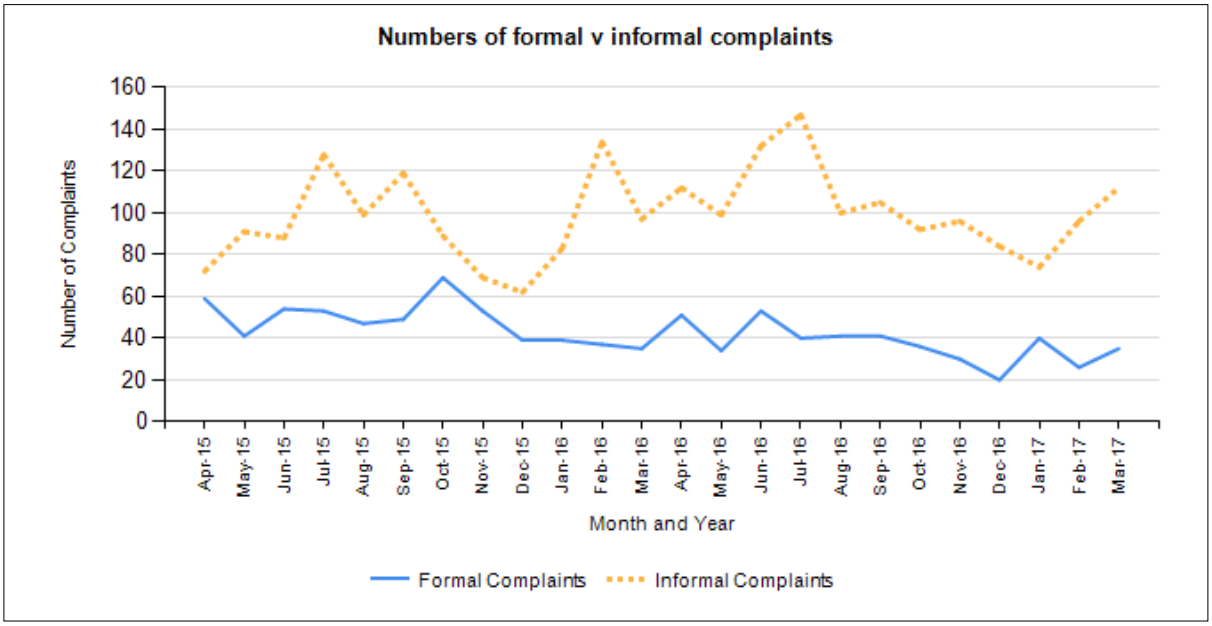


Figure 3: Numbers of formal v informal complaints



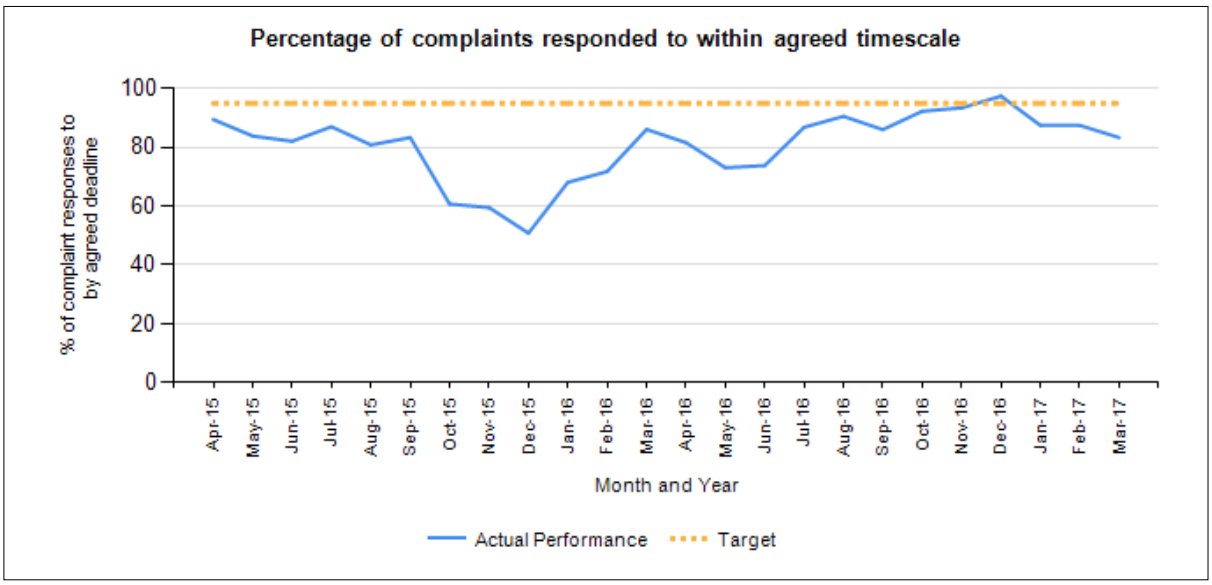
1.2 Complaints responses within agreed timescale

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

The Trust's target is to respond to at least 95% of complaints within the agreed timescale. The end point is measured as the date when the Trust's response is posted to the complainant. In Q4, 86.0% of responses were posted within the agreed timescale, compared to 94.2% in Q3, 88.1% in Q2, and 76.2% in Q1. This represents 19 breaches out of 136 formal complaints which were due to receive a

response during Q4[2]. Figure 4 shows the Trust's performance in responding to complaints since February 2016.

Figure 4: Percentage of complaints responded to within agreed timescale



1.3 Dissatisfied complaints

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

The way in which dissatisfied cases are reported is expressed as a percentage of the responses the Trust has sent out in any given month. Since Q3 2015/16, 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 Q4, of the 48 responses sent out in January 2017 and by the cut-off point of mid-April 2017 (the date on which the dissatisfied data for January 2017 was finalised), seven people had contacted us to say they were dissatisfied. This represents 14.6% of the responses sent out that month. Previously, in Q3, of a total of 139 responses sent out in the quarter, 15 had received a dissatisfied response at the point when monthly data was frozen for board reporting. This represents 10.1% of the responses sent out.

Figure 5 shows the percentage of complainants who were dissatisfied with aspects of our complaints response up until January 2017.

[2] Note that this will be a different figure to the number of complainants who *made* a complaint in that quarter.
[3] Please note that we differentiate this from complainants who may raise new issues or questions as a result of our response.

Table 2: Complaints performance

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

		Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total complaints received (inc. TS and F&E from April 2013)	TOTAL	150	176	147	199	200	155	162	140	139	118	129	144	168
	Formal	39	54	36	57	44	45	45	41	32	24	40	30	39
	Informal	111	122	111	142	156	110	117	99	107	94	89	114	129
Number & % of complaints per patient attendance in the month	*%*	*0.22%*	*0.27%*	*0.22%*	*0.30%*	*0.31%*	*0.25%*	*0.24%*	*0.20%*	*0.19%*	*0.19%*	*0.19%*	*0.22%*	*0.22%*
	Complaints	*150*	*176*	*147*	*199*	*200*	*155*	*162*	*140*	*139*	*118*	*129*	*144*	*168*
	Attendances	*67,932*	*64,750*	*66,973*	*66,816*	*63,580*	*63,073*	*67,371*	*68,647*	*73,004*	*62,047*	*69,202*	*64,798*	*76,321*
% responded to within the agreed timescale (i.e. response posted to complainant)	*%*	*86.1%*	*81.6%*	*73.1%*	*73.8%*	*86.8%*	*90.6%*	*86.0%*	*92.3%*	*93.4%*	*97.4%*	*87.5%*	*87.5%*	*83.3%*
	Within timescale	*31*	*40*	*38*	*31*	*33*	*48*	*37*	*36*	*57*	*38*	*42*	*35*	*40*
	Total	*36*	*49*	*52*	*42*	*38*	*53*	*43*	*39*	*61*	*39*	*48*	*40*	*48*
% responded to by Division within required timescale for executive review	%	100.0%	87.8%	92.3%	95.2%	89.5%	94.3%	81.4%	92.3%	85.2%	76.9%	85.4%	85.0%	72.9%
	Within timescale	36	43	48	40	34	50	35	36	52	30	41	34	35
	Total	36	49	52	42	38	53	43	39	61	39	48	40	48
Number of breached cases where the breached deadline is attributable to Division	Attibutable to Division	5	3	8	7	4	4	4	2	3	1	3	1	5
	Total Breaches	5	9	14	11	5	5	6	3	4	1	6	5	8
Number of extensions to originally agreed timescale (formal investigation process only)		25	21	8	11	15	18	12	15	16	13	16	11	15
Informal Complaints														
% responded to within the agreed timescale (i.e. Division to make contact with the complainant)	%	-	-	-	-	-	-	-	-	-	-	-	-	-
	Within timescale	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total	-	-	-	-	-	-	-	-	-	-	-	-	-
Number of breached cases	Total Breaches	-	-	-	-	-	-	-	-	-	-	-	-	-
Number of extensions to originally agreed timescale *(Informal investigation process only)*		-	-	-	-	-	-	-	-	-	-	-	-	-
"% of complainants dissatisfied with response and case re-opened	%	8.3%	8.2%	9.6%	16.7%	10.5%	13.2%	18.6%	0.0%	14.8%	12.8%	14.6%	10.0%	-
	Reopened Dissatisfied	3	4	5	7	4	7	8	0	9	5	7	4	-
	Total Responses Due	36	49	52	42	38	53	43	39	61	39	48	40	-

For each case where a complainant advises they are dissatisfied, the case is reviewed by a Patient Support and Complaints Officer, leading to one of the following courses of action, according to the complainant's preference:

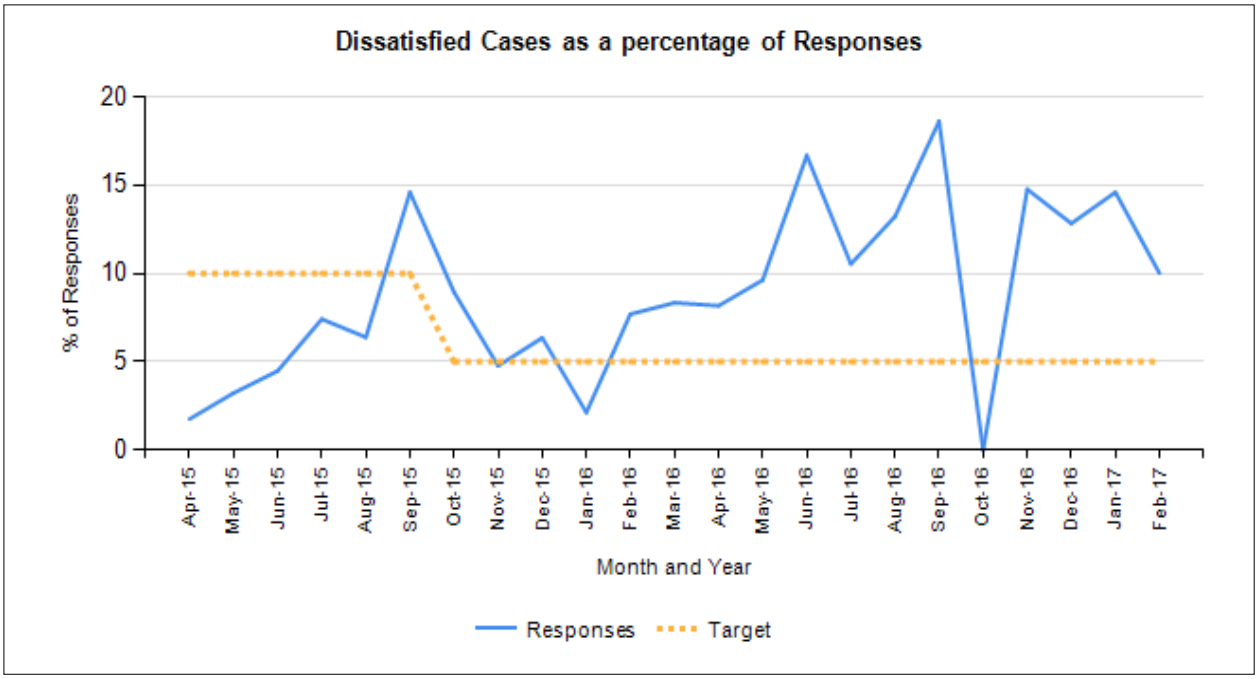
- The lead Division is asked to reinvestigate the outstanding concerns and send a further response letter to the complainant addressing these issues;
- The lead Division is asked to reinvestigate the outstanding concerns and arrange to meet with the complainant to address these issues
- On rare occasions, 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 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 an Executive Director (usually the Chief Nurse) to review. As part of the escalation, Divisions are asked to consider whether some form of independent input might assist with achieving resolution and to discuss this with the Executive Director.

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 3 provides a breakdown of complaints received in Q4 2016/17 compared to Q3 2016/17. In Q4, complaints in most of the major categories/themes increased, including appointments and admissions (increased from 118 complaints to 132), attitude and communication (99 to 104) and clinical care (104 to 126). Complaints about discharge/transfer/transport reduced in Q4 (20 to 15). However the level of complaints reported in each category was lower than in Q2, when a total of 517 complaints were received.

Table 3: Complaints by category/theme

Category/Theme	Number of complaints received in Q4 (2016/17)	Number of complaints received in Q3 (2016/17)
Access	0 (0%) ↓	1 (0.2%) ↓
Appointments & Admissions	132 (29.9%) ↑	118 (29.7%) ↓
Attitude & Communication	104 (23.6%) ↑	99 (24.9%) ↓
Clinical Care	126 (28.6%) ↑	104 (26.2%) ↓
Discharge/Transfer/Transport	15 (3.4%) ↓	20 (5.3%) ↓
Documentation	4 (0.9%) ↑	3 (0.7%) =
Facilities & Environment	21 (4.8%) ↑	20 (5.3%) ↓
Information & Support	39 (8.8%) ↑	32 (8.6%) =
Total	**441**	**397**

Each complaint is also assigned to a more specific sub-category, for which there are over 100. Table 4 lists the ten most consistently reported sub-categories. In total, these sub-categories account for approximately two thirds of the complaints received in Q4 (397/517).

Table 4: Complaints by sub-category

Sub-category	Number of complaints received in Q4 (2016/17)	Q3 (2016/17)	Q2 (2016/17)	Q1 (2016/17)
Cancelled/delayed appointments and operations	54 ↓ (18.2% decrease compared to Q3)	66	106	142
Communication with patient/relative	20 ↓ (20% decrease compared to Q3)	25	23	34
Clinical Care (Medical/Surgical)	70 ↑ (29.6% increase compared to Q3)	54	60	70
Failure to answer telephones/failure to respond	22 ↓ (8.3% decrease compared to Q3)	24	27	34
Clinical Care (Nursing/Midwifery)	13 =	13	19	22
Attitude of Medical Staff	27 ↑ (92.8% increase compared to Q3)	14	24	23
Attitude of Admin/Clerical Staff	18 ↑ (63.6% increase compared to Q3)	11	11	16

Attitude of Nursing Staff	4 ↓ (20% decrease compared to Q3)	5	17	12
Appointment Administration Issues *(new sub-category)*	35 ↑ (57.1% increase compared to Q3)	15	38	20
Transport (Late/Non Arrival/Inappropriate)	2 =	2	11	6

Complaints about 'cancelled or delayed appointments or operations/procedures' and 'failure to answer telephones/failure to respond' have reduced for three consecutive quarters. In other sub-categories, levels of complaints in Q4 tended to revert to those reported prior to Q3. The data in Table 3 suggests a possible upturn in complaints about staff attitude – we will continue to monitor this and will undertake a more detailed analysis if the reporting pattern is sustained in Q1 of 2017/18.

Figures 6, 7, and 8 show the four most commonly recorded sub-categories of complaint as detailed above, tracked since March 2016.

Figure 6: Cancelled or delayed appointments and operations

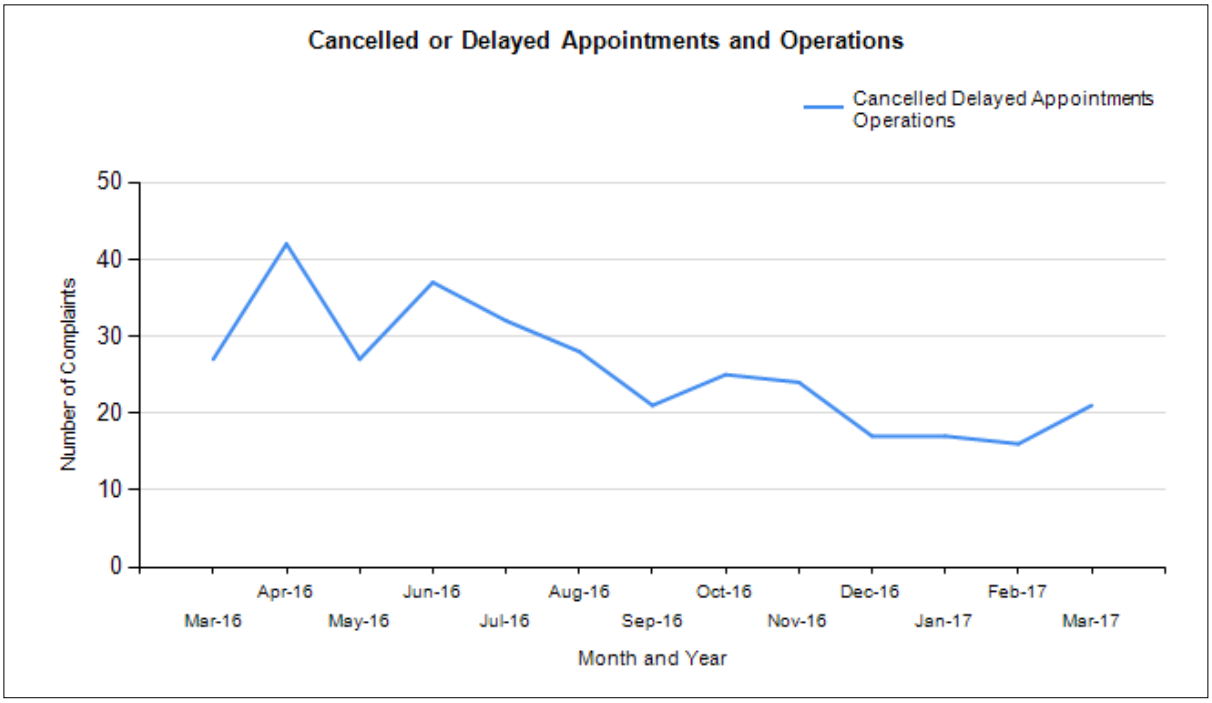


Figure 7: Clinical care – Medical/Surgical

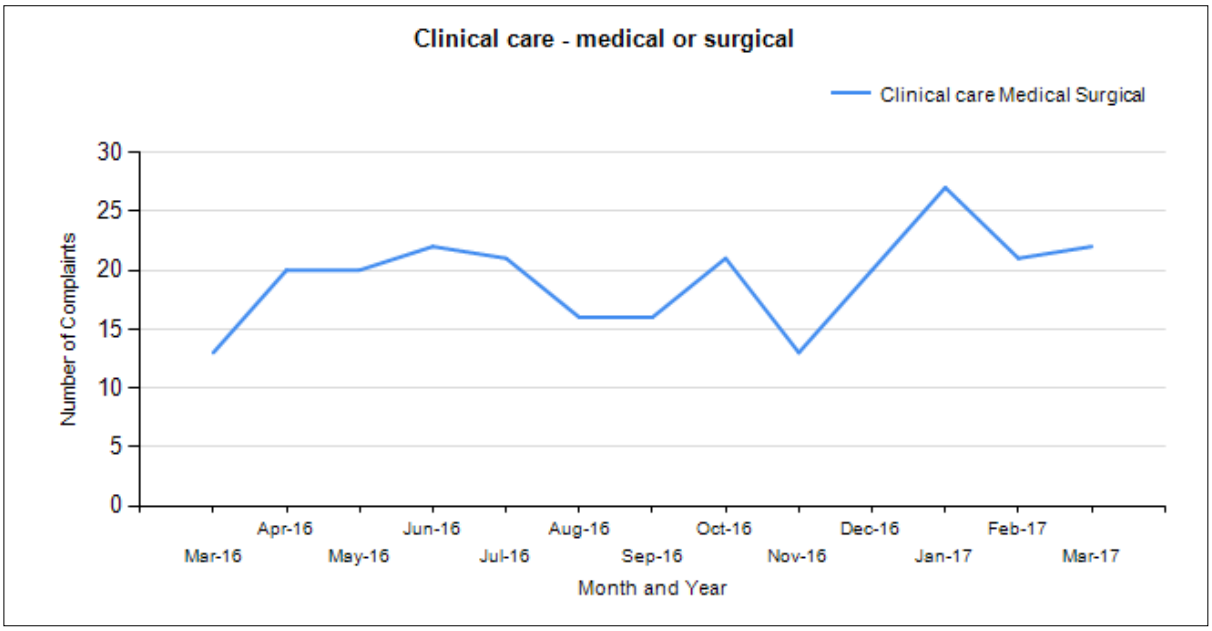
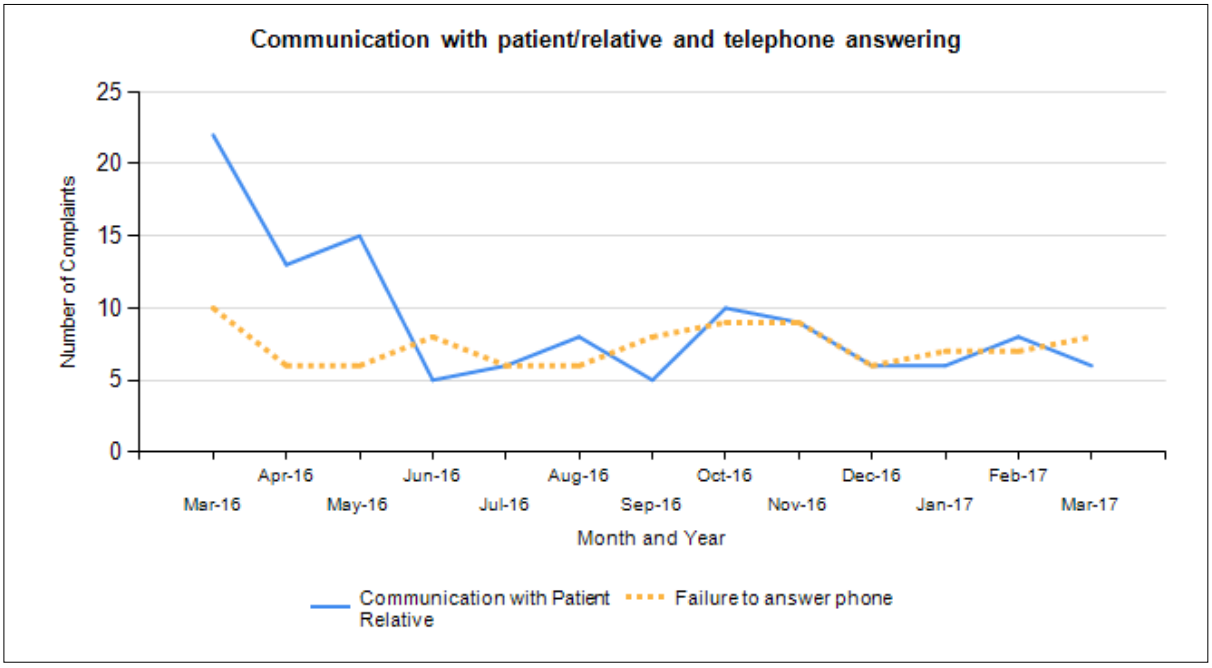


Figure 8: Communication with patient/relative and telephone answering

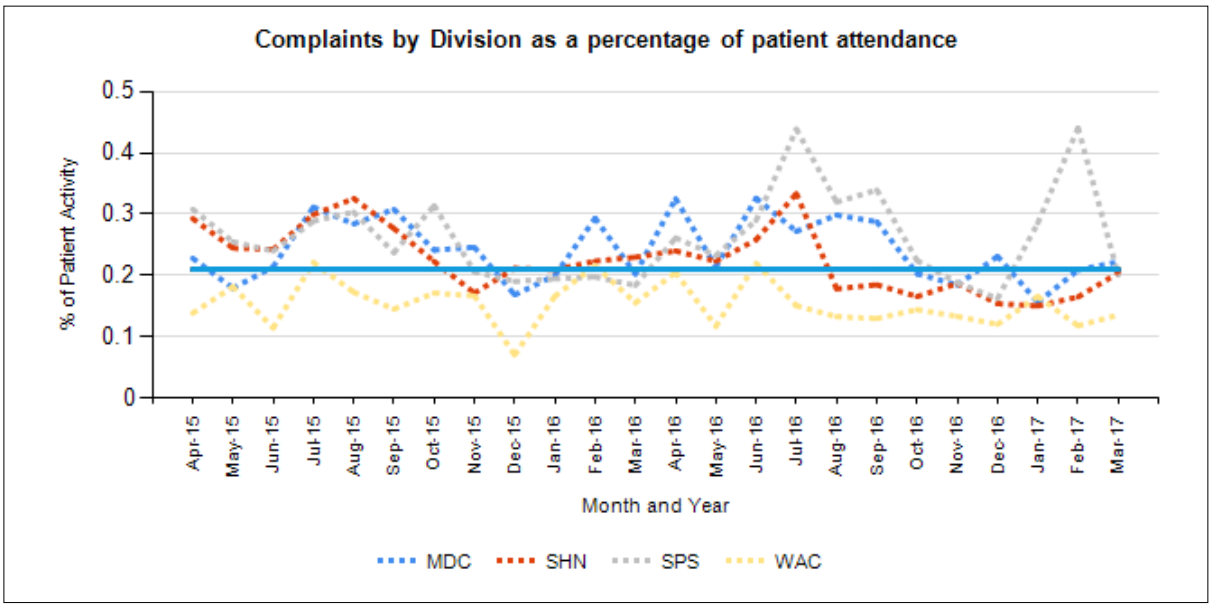


3. Divisional performance

3.1 Total complaints received

A divisional breakdown of the percentage of complaints per patient attendance is provided in Figure 9. The overall increase in complaints received by the bed holding Divisions during Q4 was driven largely by an increase in complaints about Specialised Services (see analysis later in this report).

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 January 2016, the number of complaints received by the division has been as follows:

Table 5: Complaints received by Division of Diagnostics and Therapies

	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
No. of complaints received	5	13	6	5	7	12	4	9	6	7	3	7	3	4	3

3.2 Divisional analysis of complaints received

Table 6 provides an analysis of Q4 complaints performance by Division. 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 6	Surgery, Head & Neck	Medicine	Specialised Services	Women & Children	Diagnostics & Therapies
Total number of complaints received	155 (145) ↑	88 (89) ↓	82 (49) ↑	67 (64) ↑	11 (17) ↓
Total complaints received as a proportion of patient activity	44.6% (0.19%) ↑	22.4% (0.21%) ↑	13.6% (0.2%) ↑	23.9% (0.13%) ↑	1% (0) ↑
Number of complaints about appointments and admissions	72 (60) ↑	19 (20) ↓	17 (11) ↑	15 (15) =	7 (11) ↓
Number of complaints about staff attitude and communication	37 (41) ↓	17 (25) ↓	17 (7) ↑	22 (15) ↑	2 (3) ↓
Number of complaints about clinical care	29 (28) ↑	34 (30) ↑	35 (21) ↑	27 (23) ↑	1 (2) ↓
Area where the most complaints have been received in Q4	Bristol Dental Hospital – 48 (29) Bristol Eye Hospital – 44 (33) Trauma & Orthopaedics – 15 (37) ENT – 10 (13) Upper GI – 12 (10)	Emergency Department (BRI) – 18 (20) Dermatology – 10(9) Sleep Unit 7 (5) Ward A300 (AMU) – 5(5)	BHI (all) – 64(41) BHI Outpatients – 20 (11) BHI Waiting List Office 8 (5) Ward C708 – 6 (5) GUCH Services – 0 (7)	Children's ED & Ward 39 (BRHC) – 9 (9) Gynaecology Outpatients (StMH) – 7 (9) Paediatric Orthopaedics –7 (5)	Radiology – 3 (3) Physiotherapy – 2 (5) Audiology – 1 (3)
Notable deteriorations compared to Q3	Bristol Eye Hospital 44 (33) Bristol Dental Hospital 48 (31)	None	BHI (all) 64(41) BHI Outpatients 20 (11) BHI Waiting List Office 8 (5)	None	None
Notable improvements compared to Q3	Trauma & Orthopaedics – 14 (37)	None	None[4]	None	Physiotherapy – 2 (5) Audiology – 1 (3)

[4] Complaints about GUCH Services appear as a reduction however this is due to a change in reporting categories: GUCH is now recorded as a speciality rather than a sub category.

3.2.1 Division of Surgery, Head & Neck

In Q4, the Division of Surgery Head & Neck experienced an increase in complaints about appointments and admissions, but an improvement in complaints about cancelled or delayed appointments and operations. There was a significant decrease in complaints about trauma and orthopedics (previously down from 37 in Q3 to 14 in Q4). Complaints relating to the Bristol Eye Hospital and the Bristol Dental Hospital both rose in Q4, breaking previous long term downwards (improving) trends.

Table 7: Complaints by category type

Category Type	Number and % of complaints received – Q4 2016/17	Number and % of complaints received – Q3 2016/17
Access	0 (0% of total complaints) =	0 (0% of total complaints) ↓
Appointments & Admissions	72 (46.6%) ↑	60 (41.4%) ↓
Attitude & Communication	37 (23.9%) ↓	41 (28.3%) ↑
Clinical Care	29 (18.7%) ↑	28 (19.3%) ↓
Facilities & Environment	2 (1.29%) =	2 (1.4%) ↓
Information & Support	13 (8.39%) ↑	8 (5.5%) ↑
Discharge/Transfer/ Transport	1 (0.64%) ↓	6 (4.1%) ↓
Documentation	1 (0.64%) ↑	0 (0%) ↓
Total	**155**	**145**

Table 8: Top sub-categories

Category	Number of complaints received – Q4 2016/17	Number of complaints received – Q3 2016/17
Cancelled or delayed appointments and operations	30 ↓	35 ↓
Clinical Care (Medical/Surgical)	16 =	16 =
Communication with patient/relative	6 ↓	15 ↑
Attitude of Medical Staff	10 ↑	4 =
Attitude of Nursing/Midwifery	0 ↓	1 ↓
Attitude of Admin/Clerical Staff	7 ↑	2 ↓
Clinical Care (Nursing/Midwifery)	0 ↓	1 ↓
Failure to answer telephones	9 ↓	14 ↑
Transport (late/non arrival/inappropriate	0 ↓	2

Table 9: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Complaints about the Bristol Dental Hospital increased in Q4 (31 to 50). Of these the most noticeable single increases related to the Administration Department (8 to 17) and the	A number of BDH's formal complaints Quarter 4 related to communication about dental care and treatment plans, however there were no common themes in terms of	All complaints are shared monthly with the BDH team. As part of the monthly validation process, all informal complaints continue to be shared with the divisional teams, for accuracy,

Oral Surgery Department (5 to 12).	the precise circumstances and staff involved. An increase with informal complaints during Quarter 4 related to appointments and referrals.	learning/themes of if there are any actions to be taken/prevention.

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

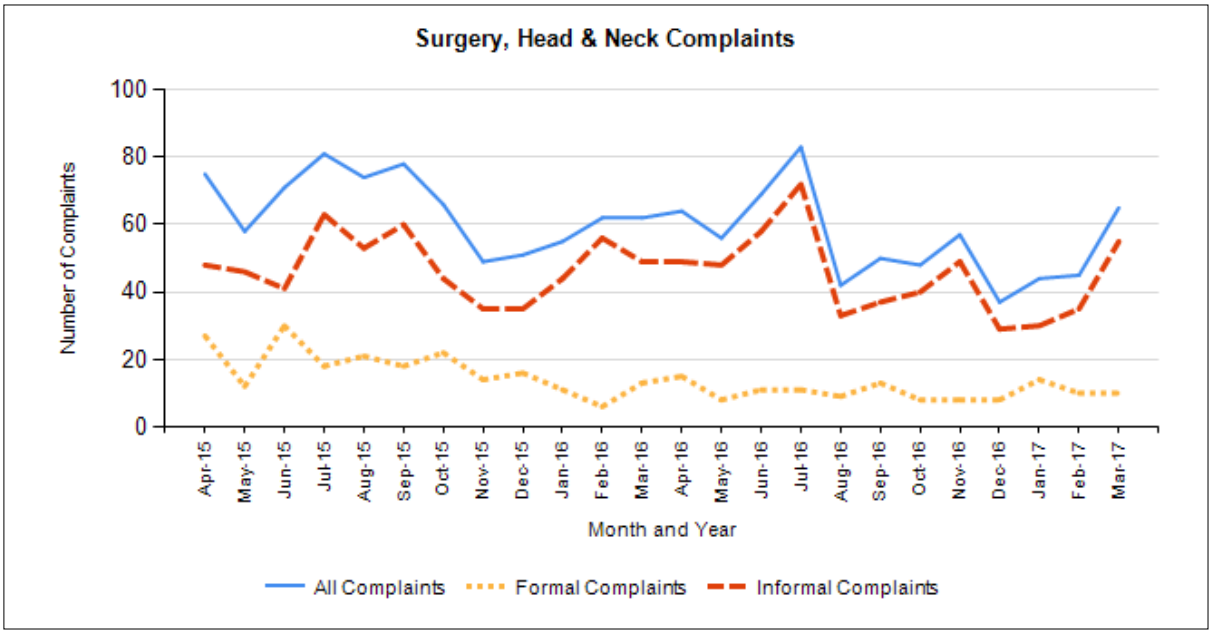
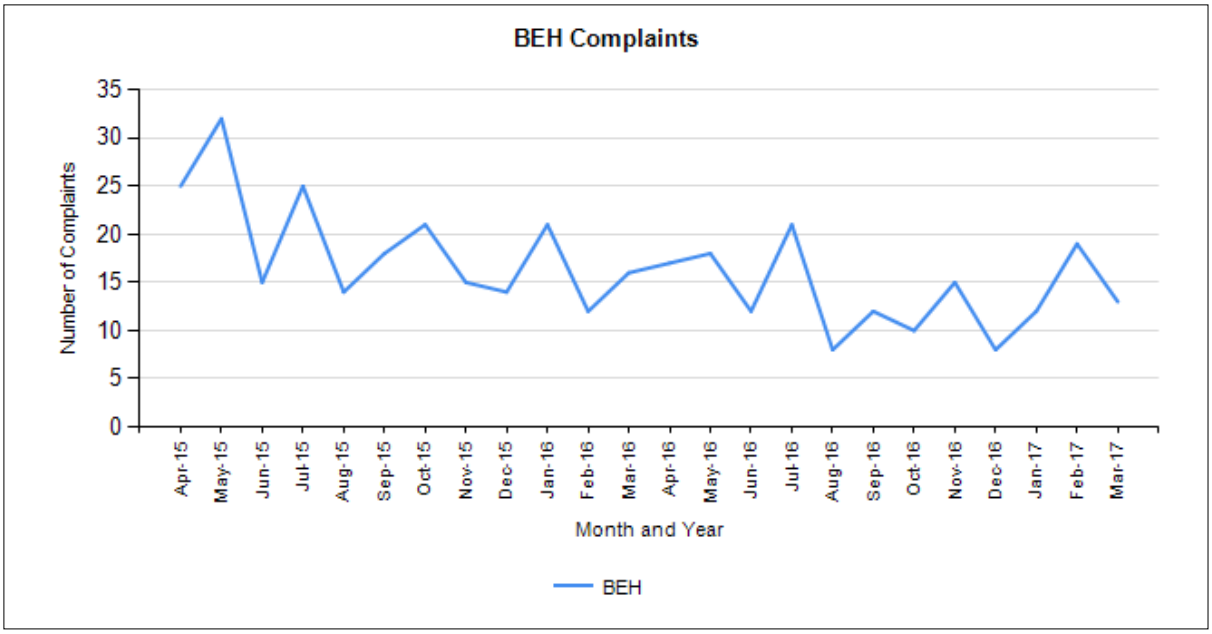


Figure 11: Complaints received by Bristol Eye Hospital



3.2.2 Division of Medicine

In Q4, the pattern of complaints received by the Division of Medicine was similar to Q3 across all major reporting categories. Q4 data also shows a continued concerted shift toward informal resolution of concerns.

Table 10: Complaints by category type

Category Type	Number and % of complaints received – Q4 2016/17	Number and % of complaints received – Q3 2016/17
Access	0 (0%) =	0 (0%) ↓
Appointments & Admissions	19 (21.6%) ↓	20 (22.5%) ↓
Attitude & Communication	17 (19.3%) ↓	25 (28.1%) ↓
Clinical Care	34 (38.6%) ↑	30 (33.7%) ↑
Facilities & Environment	6 (6.8%) =	6 (6.7%) ↓
Information & Support	4 (4.5%) ↑	3 (3.4%) ↓
Discharge/Transfer/ Transport	6 (6.8%) ↑	5 (5.6%) ↓
Documentation	2 (2.3%) ↑	0 (0%) ↓
Total	**88**	**89**

Table 11: Top sub-categories

Category	Number of complaints received – Q4 2016/17	Number of complaints received – Q3 2016/17
Cancelled or delayed appointments and operations	6 ↓	9 ↓
Clinical Care (Medical/Surgical)	17 ↑	15 ↑
Communication with patient/relative	3 ↓	4 ↓
Attitude of Medical Staff	7 ↑	3 ↓
Attitude of Nursing/Midwifery	0 ↓	1 ↓
Attitude of Admin/Clerical Staff	2 ↓	3 ↓
Clinical Care (Nursing/Midwifery)	4 ↓	6 ↓
Failure to answer telephones	4 ↓	5 ↓

Figure 12: Medicine – formal and informal complaints received

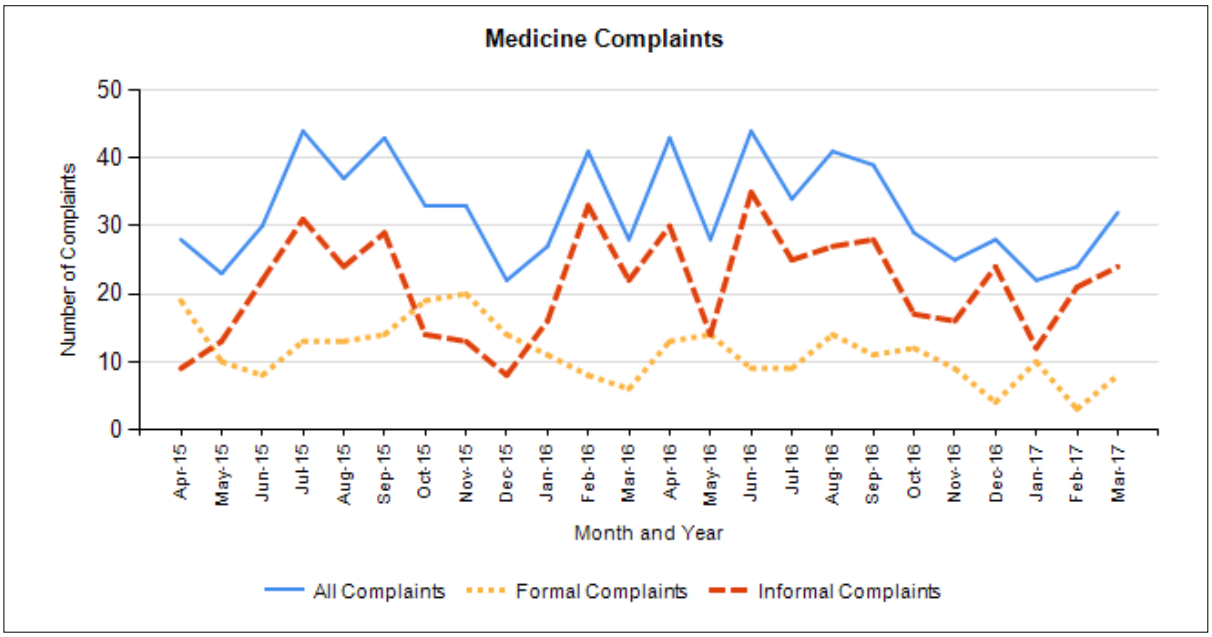
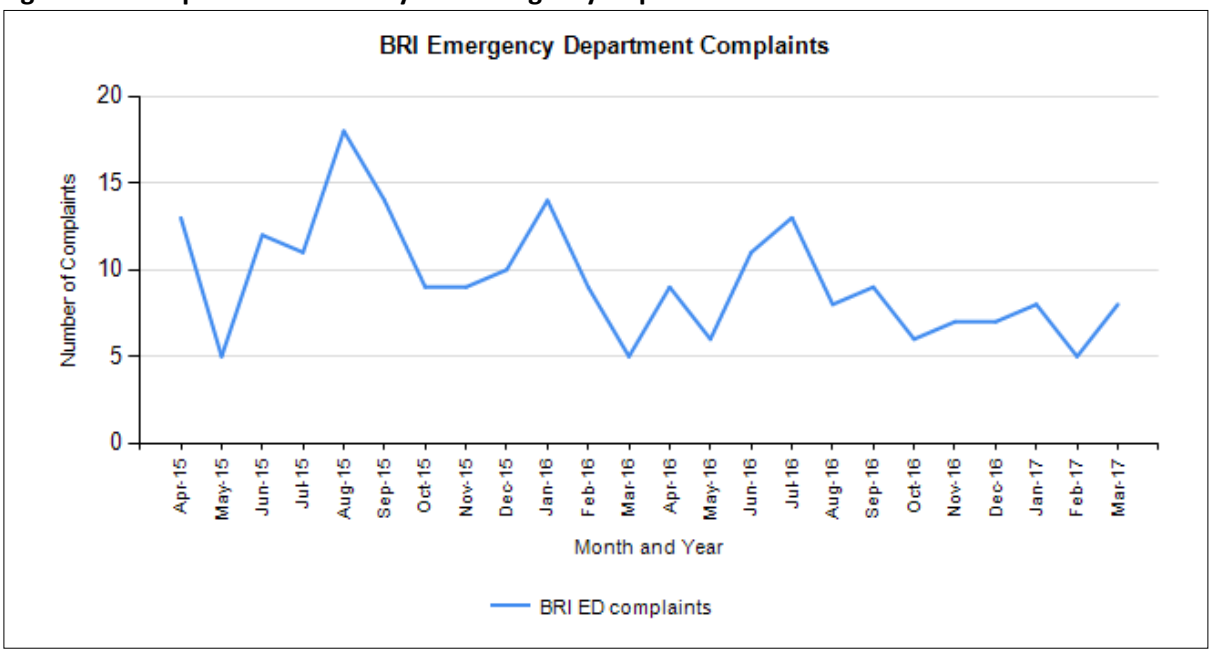


Figure 13: Complaints received by BRI Emergency Department



3.2.3 Division of Specialised Services

In Q4, the Division of Specialised Services experienced a significant increase in complaints from 49 in Q3 to 82 in Q4, including a notable spike in February 2017. This follows a correspondingly large fall in Q3 which suggests we may simply be seeing natural fluctuation in reporting data rather than significant changes in patient experience.

Table 12: Complaints by category type

Category Type	Number and % of complaints received – Q4 2016/17	Number and % of complaints received – Q3 2016/17
Access	0 (0% of total complaints) =	0 (0% of total complaints) ↓
Appointments & Admissions	17 (20.7%) ↑	11 (22.4%) ↓
Attitude & Communication	17 (20.7%) ↑	7 (14.3%) ↓
Clinical Care	35 (42.7%) ↑	21 (43.8%) ↓
Facilities & Environment	1 (1.2%) ↓	2 (4.0%) ↓
Information & Support	7 ↓	4 (8.2%) ↓
Discharge/Transfer/Transport	5 ↓	4 (8.2%) ↓
Documentation	0 =	0 (0%) ↓
Total	**82**	**49**

Table 13: Top sub-categories

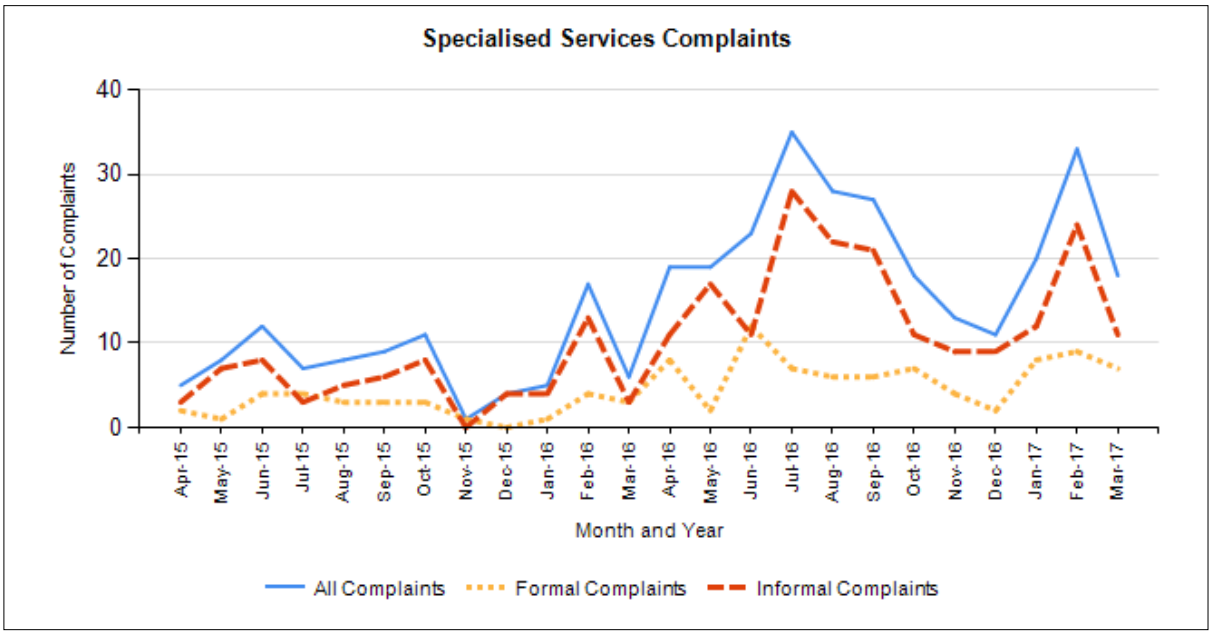
Category	Number of complaints received – Q4 2016/17	Number of complaints Q3
Appointment & Administration Issues	3 =	3
Cancelled or delayed appointments and operations	8 =	8 ↓
Clinical Care (Medical/Surgical)	3 ↓	10 ↓
Communication with patient/relative	5 ↑	3 ↓
Attitude of Medical Staff	3 ↑	2 ↓
Attitude of Nursing/Midwifery	1 ↑	0 ↓
Attitude of Admin/Clerical Staff	0 =	0 ↓
Clinical Care (Nursing/Midwifery)	1 ↓	3 ↓
Failure to answer telephones	7 ↑	0 ↓

Table 14: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Complaints about the BHI (all) increased in Q4 (41 to 64). The most noticeable increases related to the Outpatients Department 20 (11). 5 (5) complaints related to the Waiting List Office.	Delays in accessing mobile cardiac monitoring systems and in accessing subsequent test results increased within the BHI outpatients department across Q4.	The division has invested in a number of new cardiac monitors to reduce the delays for patients. Further to this, the General Manager is currently reviewing the processes for analysing these tests and communicating these results with the senior medical staff.

	Unexpected staff shortages within the waiting list office led to significant issues with the staff's ability to respond to questions and queries from patients during a period within Q4.	Although action was taken immediately and staff were moved to support the waiting list office, there remained a shortage of staff over a period of time. Short term staffing issues have now been resolved within the department.

Figure 14: Specialised Services – formal and informal complaints received



3.2.4 Division of Women's and Children's Services

In Q4, the Division of Women's and Children's Services received a similar number of complaints to Q3. Complaints about Attitude and Communication rose (up from 15 to 22), however, there were no discernable patterns within this group of complaints.

Table 15: Complaints by category type

Category Type	Number and % of complaints received – Q4 2016/17	Number and % of complaints received – Q3 2016/17
Access	0 (0% of total complaints) =	0 (0% of total complaints) ↓
Appointments & Admissions	15 (22.4%) =	15 (23.4%) ↓
Attitude & Communication	22 (32.8%) ↑	15 (23.4%) =
Clinical Care	27 (40.3%) ↑	23 (35.9%) ↑
Facilities & Environment	1 (1.5%) =	1 (1.6%) ↓
Information & Support	1 (1.5%) ↓	6 (9.4%) ↑
Discharge/Transfer/Transport	0 (0%) ↓	4 (6.2%) ↑
Documentation	1 (1.5%) ↑	0 (0%) ↓
Total	**67**	**64**

Table 16: Top sub-categories

Category	Number of complaints received – Q4 2016/17	Number of complaints received – Q3 2016/17
Cancelled or delayed appointments and operations	8 ↑	7 ↓
Clinical Care (Medical/Surgical)	15 ↑	13 ↓
Communication with patient/relative	6 ↑	2 ↓
Attitude of Medical Staff	6 ↑	5 ↓
Attitude of Nursing/Midwifery	3 =	3 ↓
Attitude of Admin/Clerical Staff	3 ↑	2 ↑
Clinical Care (Nursing/Midwifery)	8 ↑	3 ↓
Failure to answer telephones	1 =	1 =

Figure 15: Women & Children – formal and informal complaints received

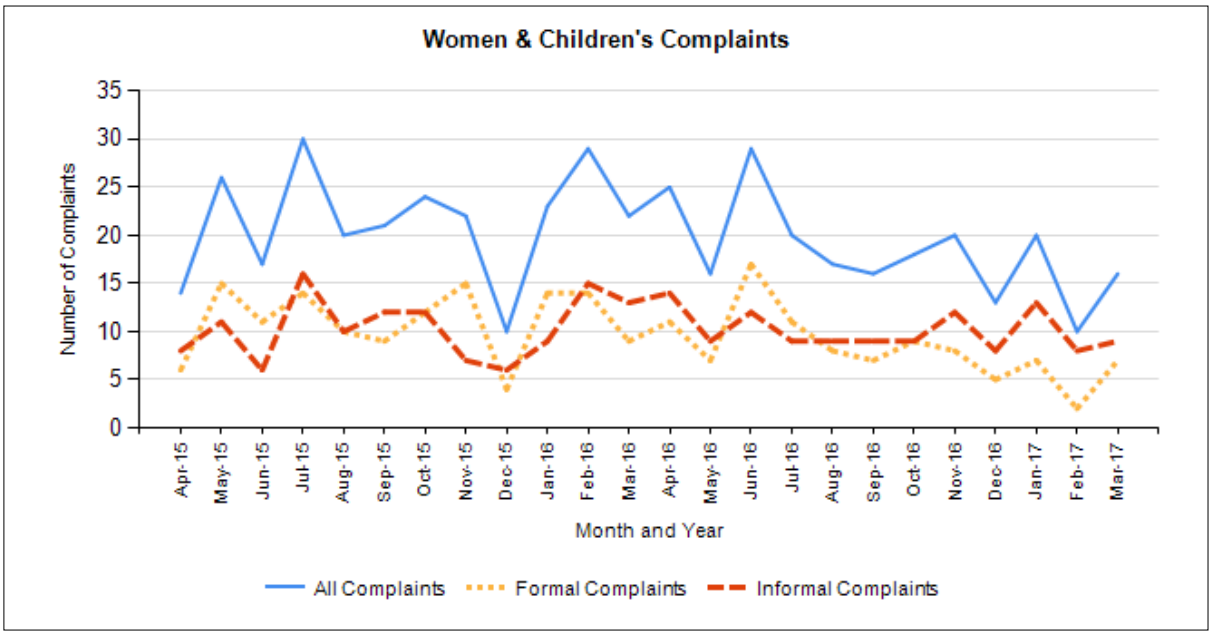
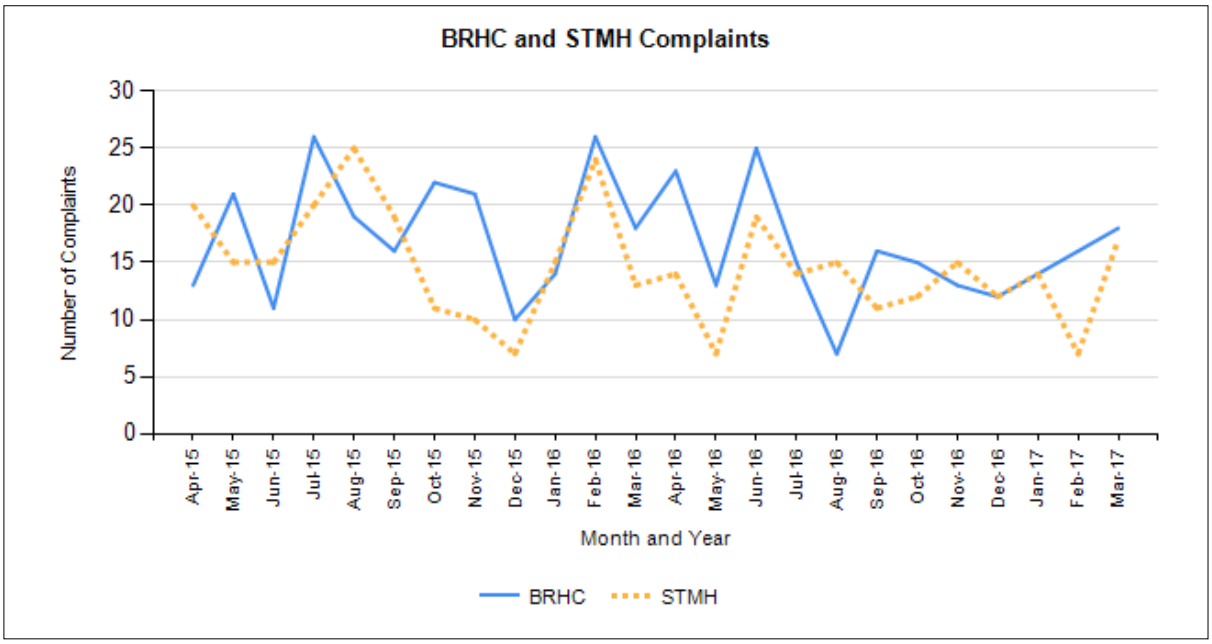


Figure 16: Complaints received by Bristol Royal Hospital for Children and St Michael's Hospital



3.2.5 Division of Diagnostics & Therapies

In Q4, complaints received by the Diagnostics and Therapies Division continued to fall; 11 in Q4, compared to 17 in Q3 and 19 in Q4. In February and March the division received zero formal complaints.

Table 17: Complaints by category type

Category Type	**Number and % of complaints received – Q4 2016/17**	**Number and % of complaints received – Q3 2016/17**
Access	0 (0% of total complaints) =	0 (0% of total complaints) ↓
Appointments & Admissions	7 (63.6%) ↓	11 (64.7%) ↑
Attitude & Communication	2 (18.9%) ↓	3 (17.6%) =
Clinical Care	1 (9%) ↓	2 (11.7%) ↓
Facilities & Environment	0 (0%) =	0 (0%) ↓
Information & Support	0 (0%) ↓	1 (5.9%)
Discharge/Transfer/Transport	1 (9%) ↑	0 (0%) ↓
Documentation	0 (0%) =	0 (0%) =
Total	**11**	**17**

Figure 17: Diagnostics and Therapies – formal and informal complaints received

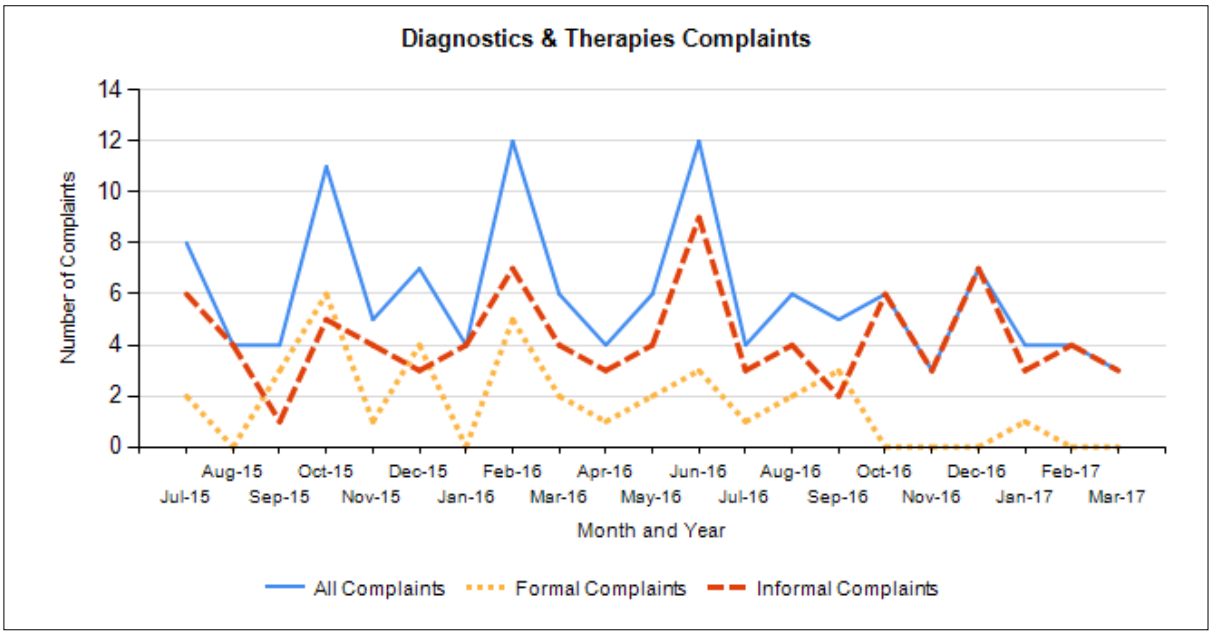
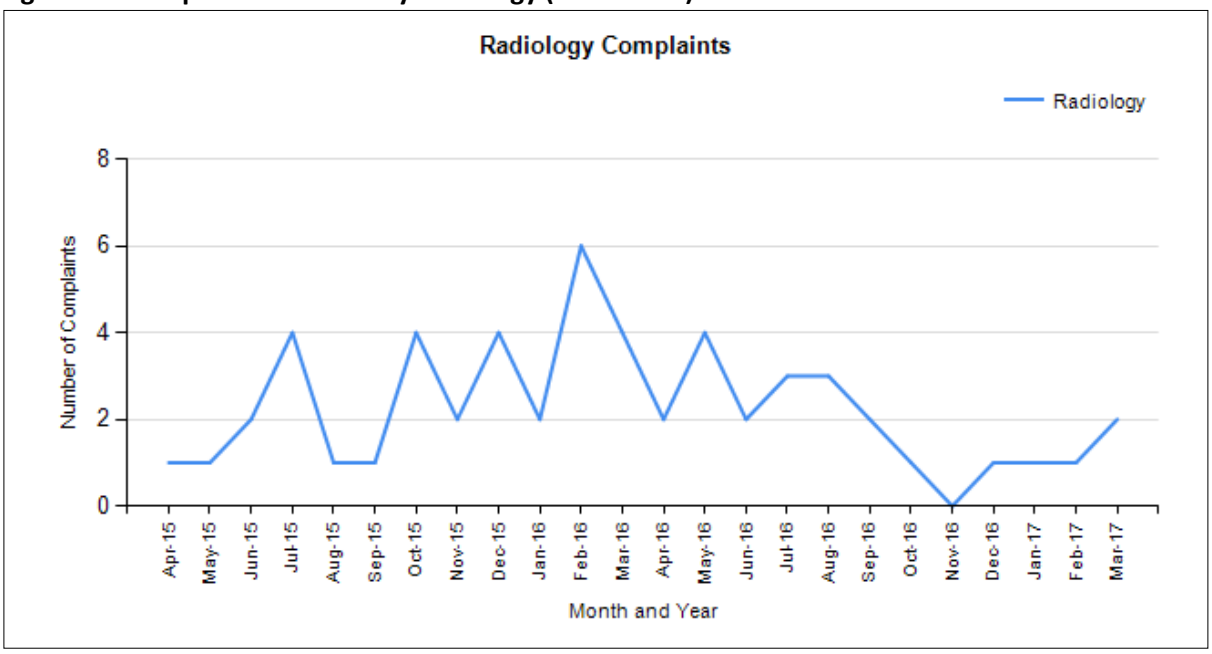


Figure 18: Complaints received by Radiology (Trust-wide)



3.3 Complaints by hospital site

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

Table 18: Breakdown of complaints by hospital site

Hospital/Site	Number and % of complaints received in Q4 2016/17	Number and % of complaints received in Q3 2016/17
Bristol Royal Infirmary (BRI)	164 (37.2%) ↓	178 (44.9%) ↓
Bristol Eye Hospital (BEH)	44 (9.8%) ↑	33 (8.3%) ↓
Bristol Dental Hospital (BDH)	48 (10.9%) ↑	29 (7.3%) ↓
St Michael's Hospital (StMH)	38 (8.6%) ↓	39 (9.8%) ↓
Bristol Heart Institute (BHI)	64 (14.5%) ↑	41 (10.3%) ↓
Bristol Haematology & Oncology Centre (BHOC)	20 (4.5%) ↑	13 (3.3%) ↓
Bristol Royal Hospital for Children (BRHC)	48 (10.9%) ↑	40 (10.1%)
South Bristol Community Hospital (SBCH)	7 (1.6%) ↓	11 (2.8%) ↓
Trust Headquarters	1 (0.2%) ↓	2 (0.5%) ↑
Southmead Hospital (UH Bristol services)	0 (0%) ↓	1 (0.2%) ↑
Central Health Clinic	3 (0.7%) ↑	2 (0.5%) ↓
Car parks	2 (0.4%) =	2 (0.5%)
Community Midwifery Services	1 (0.2%) ↑	0 (0%) ↓
Community Sexual Health	0 (0%) =	0 (0%) ↓
Community Dental Service	1 (0.2%) ↑	0 (0%) =
Other Trust Concerns	0 (0%) ↓	6 (1.5%) ↑
Total	**441**	**397**

Table 19 below breaks this information down further, showing the complaints rate as a percentage of patient activity for each site and whether the number of complaints each hospital site receives is broadly in line with its proportion of attendances. For example, in Q4, the BRI accounted for 30.2% of all attendances and 37.2% of all complaints.

Table 19: Complaints rates by main hospital sites

Site	No. of complaints	No. of attendances	Complaints rate	Proportion of all attendances	Proportion of all complaints
BRI	164	63,467	0.26%	30.2%	37.2%
BEH	44	34,511	0.13%	16.4%	10.0%
BDH	48	23,902	0.20%	11.4%	10.9%
StMH	38	23,728	0.16%	11.3%	8.6%
BHI	64	5,518	1.24%	2.6%	14.5%
BHOC	20	19,496	0.10%	9.3%	4.5%
BRHC	48	32,176	0.15%	15.3%	10.9%
SBCH	7	7,895	0.09%	3.8%	1.6%
Other	8				
Total	**441**	**210,333**			

Figures 19 and 20 below show that the Bristol Royal Infirmary consistently receives more complaints than other UH Bristol sites, measured in terms of total complaints received. However the Bristol Heart Institute receives more complaints than other sites when measured as a proportion of patient attendances. Reasons for this longstanding difference at the BHI continue to be explored, one hypothesis being that this may be statistical artefact of a different inpatient to outpatient activity ratio (inpatients are statistically more likely to make a complaint than outpatients). However patient feedback scores for the BHI (reported in the Trust's quarterly Patient Experience & Involvement report) are positive; we therefore do not believe that the pattern of complaints is a reflection of poor patient experience per se.

Figure 19: Complaints received by hospital site

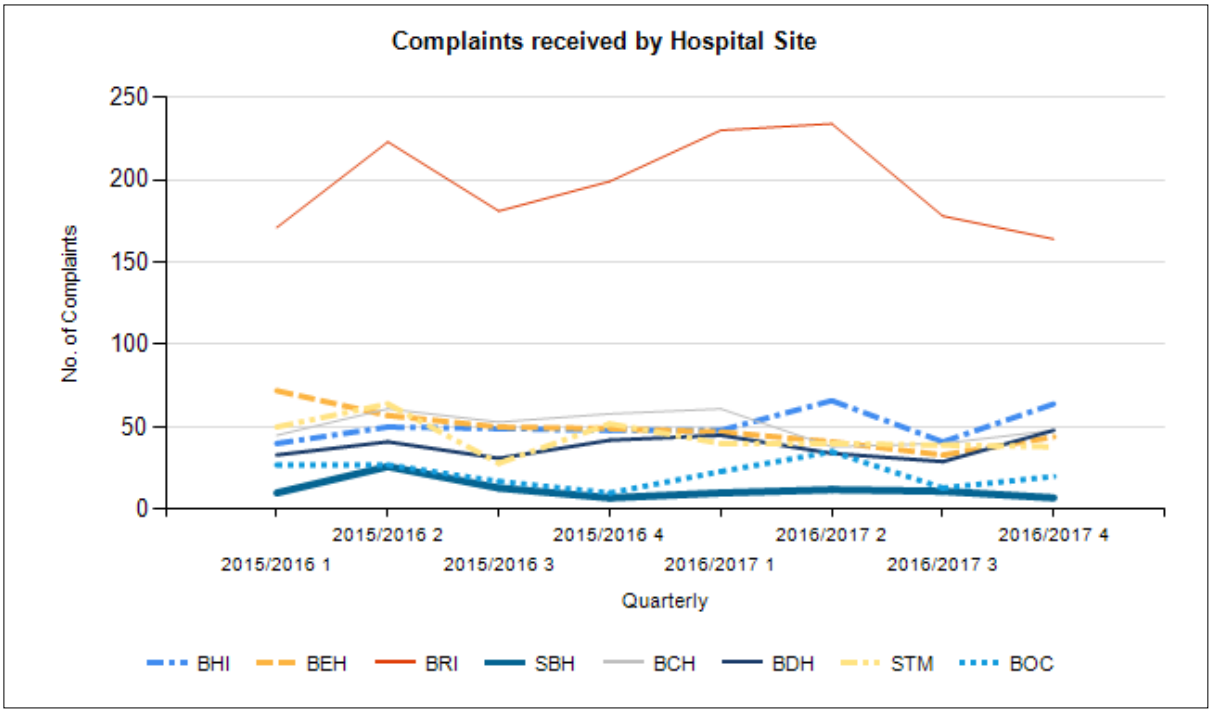
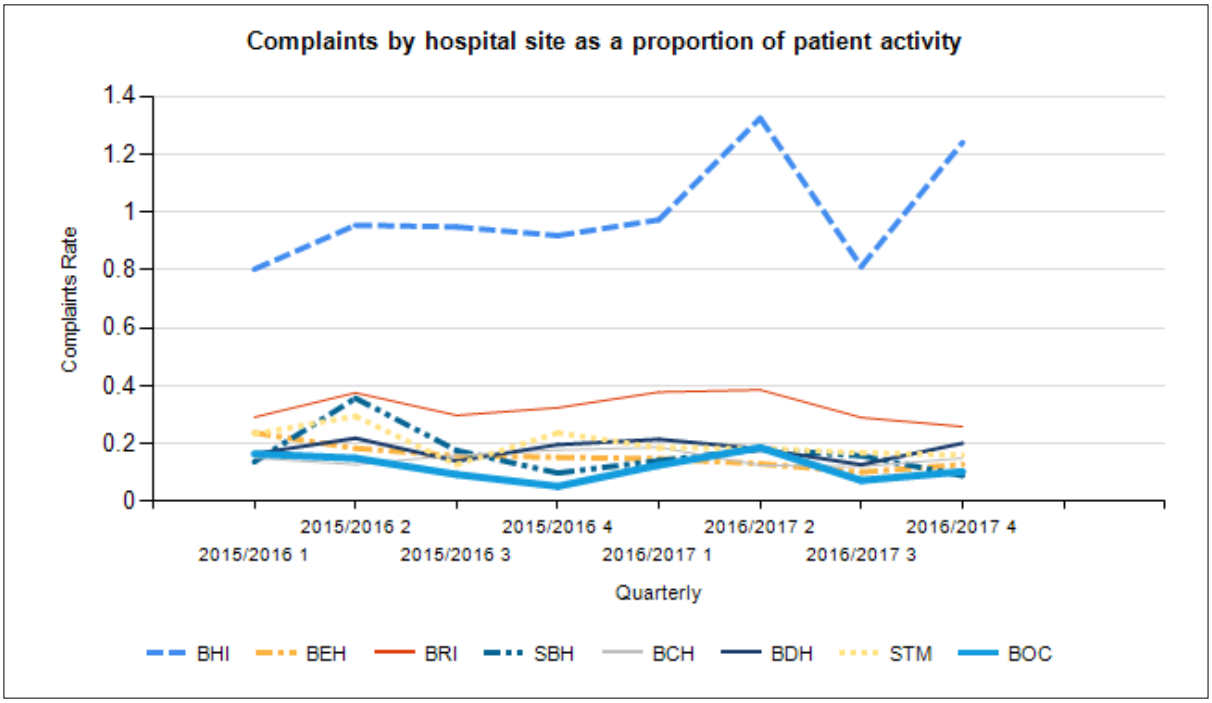


Figure 20 – Complaints rate by hospital site as a proportion of patient activity



3.4 Complaints responded to within agreed timescale

The Divisions of Surgery, Head and Neck, Medicine, Specialised Services and Women and Children reported breaches in Q4, totalling 19, which is an increase on the eight breaches recorded in Q3.

Table 20: Breakdown of breached deadlines

Division	Q4 (2016/17)	Q3 (2016/17)	Q2 (2016/17)	Q1 2016/17
Surgery, Head & Neck	7 (14.3%)	1 (0.69%)	0 (0%)	6 (14.6%)
Medicine	4 (15.4%)	0 (0%)	4 (11.1%)	12 (36.4%)
Specialised Services	2 (6.4%)	4 (8.9%)	1 (4.5%)	2 (15.4%)
Women & Children	6 (24%)	3 (4.7%)	5 (16.7%)	12 (30.8%)
Diagnostics & Therapies	0 (0%)	0 (0%)	0 (0%)	2 (18.2%)
Trust Services	0 (0%)	0 (0%)	2 (66.7%)	0 (0%)
All	**19 breaches**	**8 breaches**	**12 breaches**	**34 breaches**

(So, as an example, there were seven breaches of timescale in the division of Medicine in Q4, which constituted 15.4% of the complaints responses which had been due in that division in Q4).

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

Table 21: Source of delays

	Source of delays in Q4 2016/17				Totals
	Division	**PSCT**	**Executive sign-off**	**Other**	
Surgery, Head & Neck	3	2	2	0	**7**
Medicine	1	2	1	0	**4**
Specialised Services	2	0	0	0	**2**
Women & Children	3	1	2	0	**6**
Diagnostics & Therapies	0	0	0	0	**0**
Trust Services	0	0	0	0	**0**
All	**9**	**5**	**5**	**0**	**19 breaches**

Ongoing actions to improve the quality of responses and reduce the number of breaches include have been described in previous quarterly reports.

3.5 Outcome of formal Complaints

In Q4 we responded to 136 formal complaints[5]. Table 22 below shows a breakdown, by Division, of how many cases were upheld, partially upheld or not upheld.

Table 22: Outcome of formal complaints

	Upheld	Partially Upheld	Not Upheld
Surgery, Head & Neck	3	31	12
Medicine	3	21	2
Specialised Services	1	26	4
Women & Children	2	17	6
Diagnostics & Therapies	0	1	1
Trust Services	0	3	1
Total	**9**	**99**	**28**

4. Information, advice and support

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

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

In Q4, the team dealt with 193 such enquiries, compared to 151 in Q3. These enquiries can be categorised as:

- 142 requests for advice and information (117 in Q3)
- 47 compliments (34 in Q3)[6]
- 4 request for support (1 in Q3)

The table below shows a breakdown of the 142 requests for advice, information and support dealt with by the team in Q4.

Table 23: Enquiries by category

Category	Number of enquiries
Hospital information request	42
Information about patient	24
Signposting	12
Appointments administration issues	12
Clinical care	9
Medical records requested	7
Clinical information request	3

[5] Note: this is different to the number of formal complaints we *received* in the quarter
[6] This figure includes compliments added directly to the Datix system by Divisions.

Accommodation enquiry	3
Transport request	2
Employment and volunteering	2
Communication with patient/relative	2
Benefits and social care	2
Personal property	2
Patient choice information	2
Failure to answer phone	2
Admissions arrangements	2
Delayed operation	2
Freedom of information request	1
Support with access	1
Confidentiality	1
Aids and appliances	1
Cancelled appointments	1
Car park	1
Delayed procedure	1
Delayed treatment	1
Diagnosis incorrect	1
Lost/misplaced test results	1
Disability Support	1
Family support referral	1
Total	**142**

In addition to the enquiries detailed above, in Q4 the Patient Support and Complaints team recorded 167 enquiries that did not proceed. This is where someone contacts the department to make a complaint but does not leave enough information to enable the team to carry out an investigation, or they subsequently decide that they no longer wish to proceed with the complaint.

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

One of the Key Performance Indicators (KPIs) used to monitor the performance of 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.

The NHS Complaints Procedure (2009) states that complaints must be acknowledged within three working days. This is also a requirement of the NHS Constitution. The Trust's own policy states that complaints made in writing (including emails) will be acknowledged within three working days and

that complaints made orally (via the telephone or in person) will be acknowledged within two working days.

In Q4, 261 complaints were received in writing (email, letter or complaint form) and 180 were received orally (44 in person via drop-in service and 136 by telephone). Of the 180 oral complaints, 175 (97.2%) met the Trust's standard of being acknowledged within two working days. Of the 261 complaints received in writing, 246 (94.3%) met the NHS standard of being acknowledged within three working days (the remaining 15 cases were all acknowledged within four working days). Overall compliance in Quarter 4 was therefore 96.6% (426/441).

The reasons why 15 cases submitted in writing missed the NHS standard have been investigated. Although the Patient Support and Complaints Team ensure that an acknowledgement letter is sent for all complaints received in writing, it has become apparent that when a complaint letter or email has been forwarded to the team via another department in the Trust or if the Trust has received website feedback raising a complaint, these complaints have not been directly acknowledged by the complainant. Processes have now been put in place to ensure that all written complaint communications receive an acknowledgement letter or email.

6. PHSO cases

During Q4, the Trust was advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in two complaints. During the same period, one existing case was closed (the Trust was removed from the investigation). As of 31 March 2017, the PHSO had ongoing interest in five other UH Bristol complaints, as detailed below.

Table 24: Complaints opened by the PHSO in Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
3604	GV	PV	16/9/16 [17/1/17]	BRI/St Michael's	Lower GI/Ward 78	Surgery, Head & Neck and Women and Children
Copy of complaint file and medical records sent to the PHSO. The PHSO have advised the Trust that their draft decision is not to uphold this complaint. Pending the PHSO's final report.						
2870	AM	PM	3/11/16 [7/3/17]	BHOC	Ward D603	Specialised Services
Copy of complaint file and medical records sent to the PHSO. Pending further contact from the PHSO.						

Table 25: Complaints ongoing with the PHSO during Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
2095	NH	MH	16/6/16 [26/10/16]	BRI	Lower GI	Surgery, Head and Neck
Copy of complaint file and medical records sent to the PHSO. Pending further contact from the PHSO.						
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. The PHSO have advised the Trust that their draft decision is not to uphold this complaint. Pending the PHSO's final report.						
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.						
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. The PHSO have advised the Trust that their draft decision is not to uphold this complaint. Pending the PHSO's final report.						

Table 26: Complaints formally closed by the PHSO in Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
984	MR		24/3/16 [27/2/17]	BEH	Administration	Surgery, Head and Neck
The PHSO advised the Trust on 27 March 2017 that they have decided to remove the Trust from this complaint and will be liaising directly with Royal Cornwall Hospitals NHS Trust. No further action required by the Trust.						

University Hospitals Bristol
NHS Foundation Trust

Quarterly Patient Experience and Involvement Report

Incorporating current Patient and Public Involvement activity and patient survey data received up to Quarter 4 2016/17

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

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

Successes	Priorities
• Consistently high service-user satisfaction scores were achieved in Quarter 4. For example, 98% of inpatients would recommend the care to their friends and family • The Trust met all of its Friends and Family Test response rate targets in Quarter 4 • Praise for UH Bristol staff remains by far the most frequent form of feedback received from patients	For 2017/18, the Trust has been set a 6% response rate target for the outpatient Friends and Family Test by the Bristol Clinical Commissioning Group. To achieve this it will be necessary to survey in the region of 20,000 outpatients *per month*. An options appraisal supported the introduction of a proactive SMS (text message) based approach, operating alongside existing feedback methods (e.g. card, e-kiosk, online and telephone). The new SMS survey commenced in April 2017. The response rate for April did not meet the target (3.5%, up from 1.9% in March), but this was primarily because a number of days were "lost" due to bank holidays and a relatively late start to the survey whilst operational details were finalised. The survey went fully live in May 2017 and the target was exceeded during this month (7.6%). This survey process will continue to be evaluated / refined so that it consistently delivers the required response rate.
Opportunities	**Risks & Threats**
• Trust funding has been secured to deliver a real-time feedback system at UH Bristol. The system will have the ability to collect feedback and send email alerts where a respondent states that they require a response. The system will also serve as a reporting hub for staff to better utilise the wealth of feedback that is already collected in the Trust. A formal procurement process will take place over the summer of 2017. • A Trust corporate quality objective for 2017/18 will focus on instilling consistently positive "customer service" at UH Bristol. A staff workshop on this theme was successfully held in April, building on a similar stakeholder event in January. The outcomes from these workshops are currently being developed to form specific work streams.	The following wards received relatively low survey scores in Quarter 4 (a full exploration of these results is provided in Section 3 of the current report): • Ward C808 (care of the elderly) had the lowest score across the headline survey measures. It has been a consistent feature of the survey data that care of the elderly areas tend to attract lower patient experience scores. This has led to additional analysis and exploration of the data, which suggests that the scores are a realistic reflection of the challenges of caring for patients (and being a patient / carer) in this setting - rather than a reflection of the quality of care being provided. To further test this theory, in Quarter 1 the Patient Experience and Involvement Team are carrying out a range of patient / family feedback activities on care of the elderly wards. • Ward A602 (trauma and orthopaedics) had relatively low scores on two key survey measures. This was an unusual result for this ward, further analysis did not identify any specific improvement issues, and the number of complaints actually fell over this period. The most likely explanation at present is that this was a statistical "blip", but the ward Sister has been alerted to the result and the score will continue to be monitored to look for any consistent trend.

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

2.1 Overview

A range of activities are carried out at UH Bristol 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 carried out by the Trust's Patient Experience and Involvement Team (principally the Involvement Network, *Face2Face* patient interviews, Patient Experience at Heart staff workshops, and the "15 steps challenge" – see Appendix B for a summary)
- Engagement with partner organisations, principally through the Patient Experience and Involvement Team (e.g. Healthwatch, Patient's Association, local health and social providers)
- Service-level PPI activity

This section of the Quarterly Report provides examples of some of the PPI developments/activity that have recently been carried out.

2.2 Update on current corporate Patient and Public Involvement activity

2.2.1 Quarter 1 focus on care of the elderly wards

A plan of quarterly patient and public involvement themes for 2017/18 was agreed by the Patient Experience Group in December 2016:

- Quarter 1 (April-June 2017): Patient experience in care of the elderly services
- Quarter 2 (July-September 2017): exploring the theme of "customer service"
- Quarter 3 (October-December 2017): providing a positive patient experience to patients with a learning disability
- Quarter 4: "Quality Counts" – informing the Trust's corporate quality objectives for 2018/19

The Quarter 1 focus care of the elderly is well underway. Over 50 patient / family / carer interviews have been carried out by the *Face2Face* interview team. An initial review of feedback from the interviews suggests that experiences of care are positive. A "patient experience at heart" staff workshop has also been carried out to explore the consistent delivery of a positive patient experience in this context. The next stage is to utilise the Trust's Involvement Network for a discussion on this topic. The results of this activity will be analysed in June 2017. A summary of outcomes and resulting actions will be provided in the next Quarterly Patient Experience and Involvement Report.

2.2.2 Customer service

Delivering a consistently positive customer service at UH Bristol is a key theme in the Trust's Quality Strategy (2016-20). In January 2017, the Trust's "Quality Counts" event brought together a range of stakeholders (including the Involvement Network, Healthwatch, and Trust Governors) to discuss customer service in an acute hospital setting. In April 2017 a similar workshop was carried out for UH Bristol staff and was also attended by a customer service expert from the private sector. The outcomes from this work are currently being analysed and will be the subject of a Trust quality improvement objective during 2017/18. In Quarter 2, the Patient Experience and Involvement Team will further explore this topic with patients as part of the focus on customer service (see above).

2.3 Engaging with partner organisations

2.3.1 Translating and interpreting services at UH Bristol

Representatives from the Trust's Patient Experience and Involvement Team attended a stakeholder meeting in March to discuss the provision of British Sign Language interpreting services in hospital. The meeting also included representatives from the Bristol City Council Sensory Impairment team, patient advocates, interpreters, Healthwatch Bristol, North Bristol NHS Trust and Sign Solutions Ltd (who provide British Sign Language interpreters to UH Bristol and North Bristol Trust). A range of issues were discussed that relate to developments being taken forward by the Trust in 2017/18, including:

- Ensuring that patients who require access translating and interpreting services have a flag on their Medway patient record to reflect this need
- Establishing new feedback systems for patients who access language interpreting services
- Exploring the use of video British Sign Language interpreting for use via ward / department iPads

2.3.2 Bristol Clinical Commissioning Group – Respiratory pathway interviews

At the request of the Bristol Clinical Commissioning Group, during May 2017 a member of UH Bristol's *Face2face* volunteer interview team talked to patients in the Trust's respiratory clinics about their experiences of NHS respiritory care. This insight will be used by the Clinical Commissioning Group to inform a new model of respiritory care across Bristol, North Somerset, and South Gloucestershire.

2.3.3 Bristol City Council Overview and Scrutiny Committee visits

Members of the Bristol City Council People's Scrutiny Committee were invited by the Trust to visit the paediatric cardiac service (in February 2017) and the Bristol Eye Hospital (April 2017). These visits offer committee members a further understanding of how UH Bristol functions, in order to support their scrutiny role over local health and social care services. The Trust was thanked by the visiting members for being proactive in providing these opportunities and the insight that they provide.

2.4 Service-level Patient and Public Involvement activity

2.4.1 Hospital food / food service staff workshop

In March, 38 staff from a range of roles attended a Nutrition and Hydration Study day at the Trust. The morning of the workshop explored how patient experience during mealtimes could be improved, including around breakfast provision and ensuring protected mealtimes are adhered to. The afternoon session focused on learning about different special dietary needs patients may have. This included a visit from the Trust Iman, Rafiqul Alam, who talked to the group about the religious basis for the Halal diet and heard about how the Trust ensures that patients can follow a Halal diet in hospital.

2.4.2 Spiritual and Pastoral Care Strategy

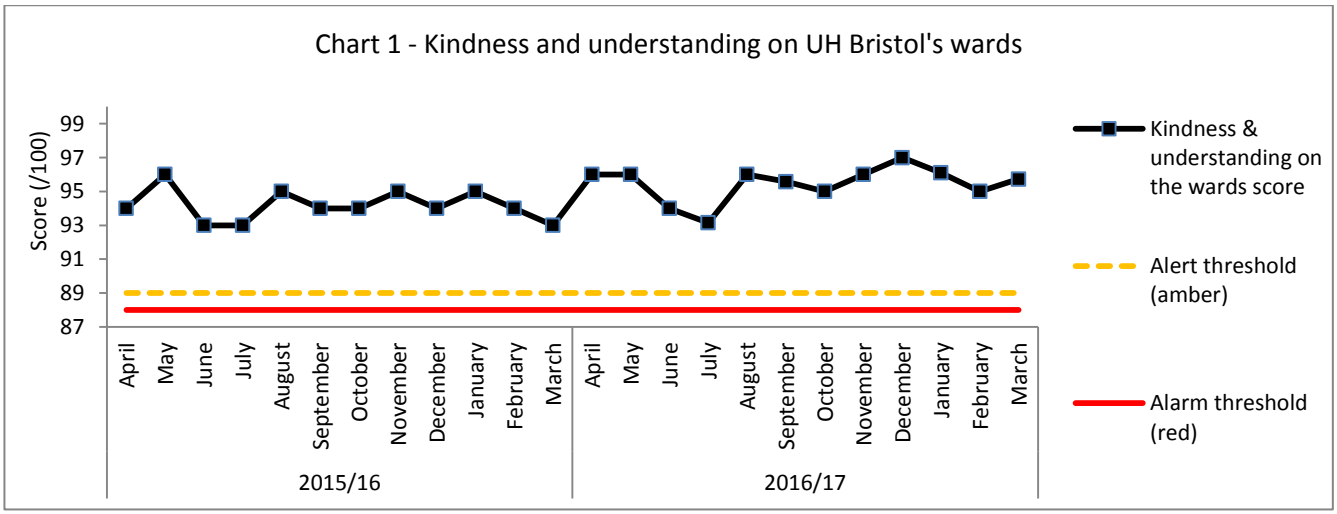
The Spiritual and Pastoral Care Team ("Chaplaincy") play a key role in the delivery of a positive patient, visitor and staff experience at UH Bristol. In April 2017, the Trust's Patient and Public Involvement Lead facilitated focus groups with Chaplains and Volunteer Chaplains across UH Bristol and North Bristol NHS Trust, to explore their aspirations for spiritual and pastoral care and inform the development of a new strategy. Further discussions are planned with matrons and sisters to explore the role of spiritual care within our hospitals.

3. Patient survey data to Quarter 4

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[2]. The key messages from Quarter 4 are:

- All of the UH Bristol's Trust-level patient survey measures remained above target - demonstrating the continued provision of a high quality patient experience (Charts 1-6).
- UH Bristol has a contractual obligation with the Bristol Clinical Commissioning Group to meet specified Friends and Family Test response rate targets. In Quarter 4 the Trust continued to meet these targets (Charts 7-9). There was an improvement in the response rate for the inpatient and day case element of this survey during Quarter 4 (Chart 7), having only just been meeting the 30% target in Quarter 3.
- As noted in previous Quarterly Reports, it has not been possible to set a target FFT score for the Emergency Department Friends and Family Test so far in 2016/17 (Chart 5). This is because of the trialling of different approaches to collecting feedback in this setting, including cards, touchscreen and more recently SMS (text message). These methods have varying effects on the score, which made it difficult to set an appropriate minimum target score. However, from Quarter 1, a target threshold will be put in place and this will be reported from the next Quarterly Patient Experience and Involvement Report.



[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.

[2] In light of these increases in the scores, a review of the target thresholds has taken place and the minimum target thresholds will be increased from 2017/18. It is important to note that in survey terms these effects are marginal: even discounting the inflationary effect of these changes, at a Trust level we would not be scoring below our target levels. The effects at Divisional and site level will be more marked and we will need to evaluate the application of the thresholds below Trust level.

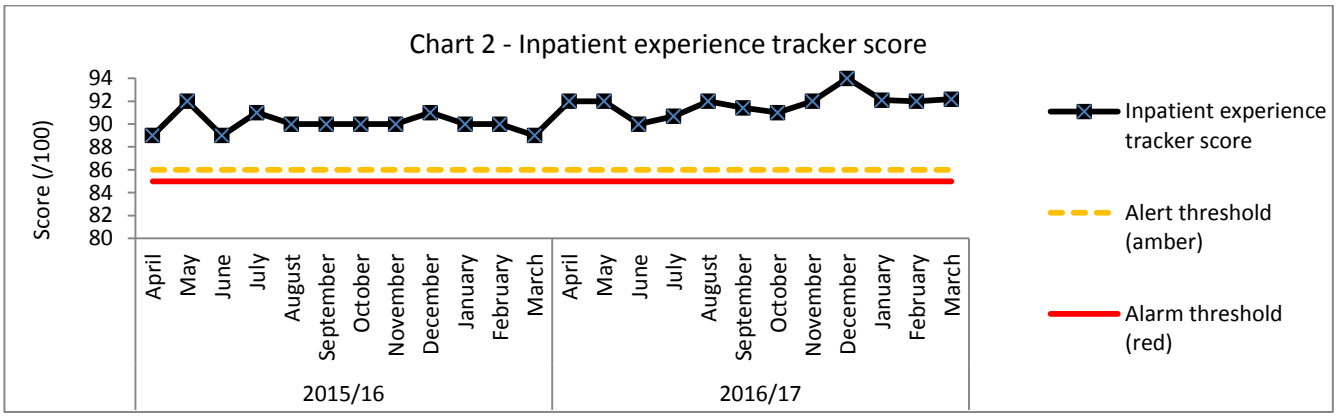


Chart 2 - Inpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April
May
June
July
August
September
October
November
December
January
February
March
2015/16
2016/17
Inpatient experience tracker score
Alert threshold (amber)
Alarm threshold (red)

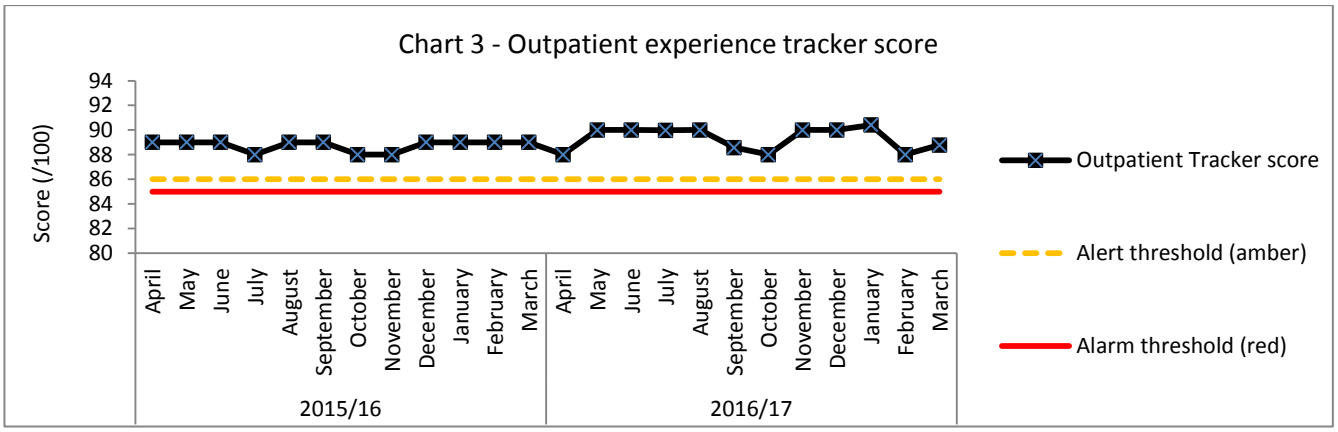


Chart 3 - Outpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April
May
June
July
August
September
October
November
December
January
February
March
2015/16
2016/17
Outpatient Tracker score
Alert threshold (amber)
Alarm threshold (red)

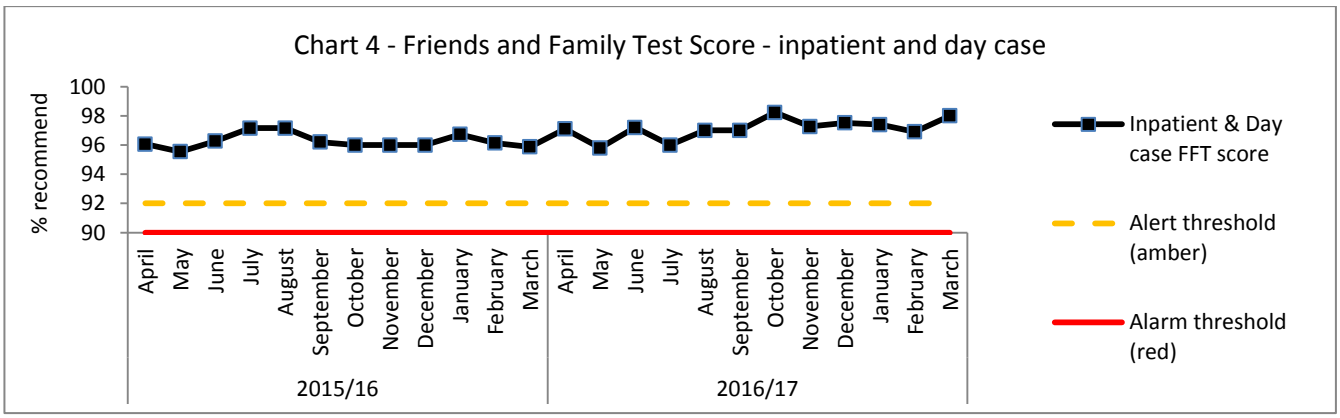


Chart 4 - Friends and Family Test Score - inpatient and day case
% recommend
100
98
96
94
92
90
April
May
June
July
August
September
October
November
December
January
February
March
2015/16
2016/17
Inpatient & Day case FFT score
Alert threshold (amber)
Alarm threshold (red)

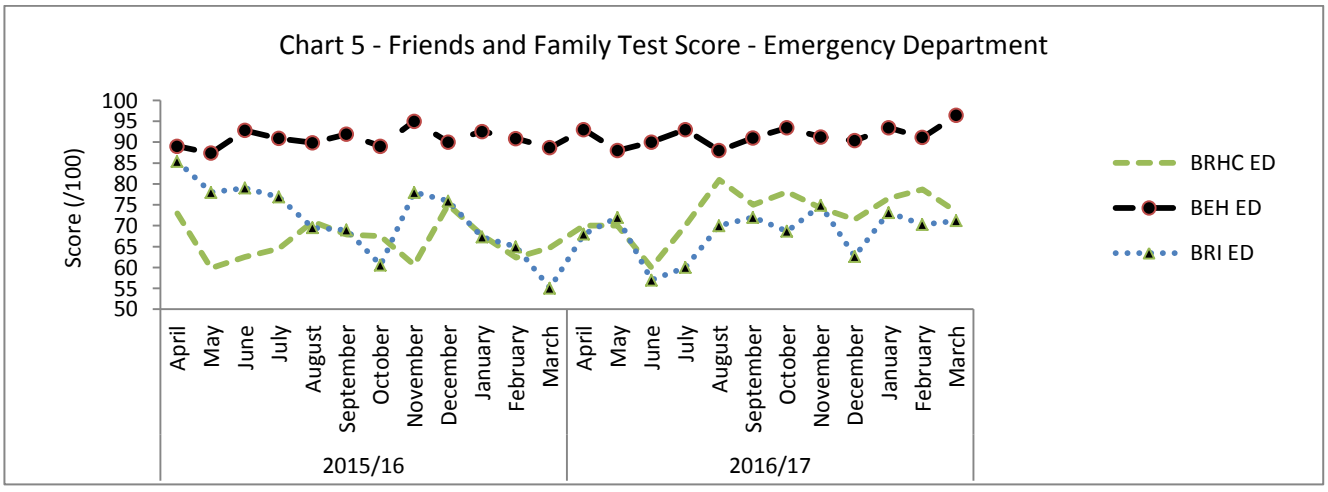


Chart 5 - Friends and Family Test Score - Emergency Department
Score (/100)
100
95
90
85
80
75
70
65
60
55
50
April
May
June
July
August
September
October
November
December
January
February
March
2015/16
2016/17
BRHC ED
BEH ED
BRI ED

Chart 6 - Friends and Family Test Score - maternity (hospital and community)

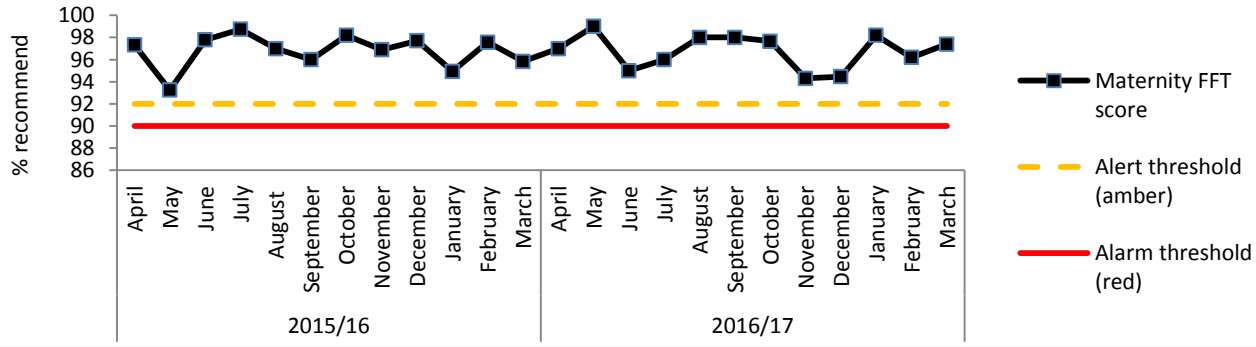


Chart 7: Friends and Family Test Response Rates (inpatient and day case) 2015/16

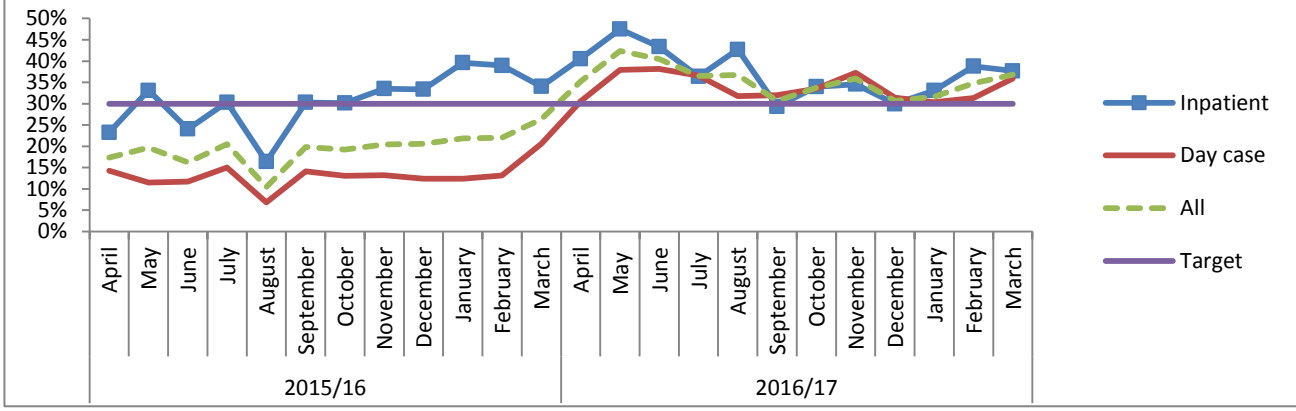


Chart 8: 2015 /16 Friends and Family Test Response Rates (maternity combined)

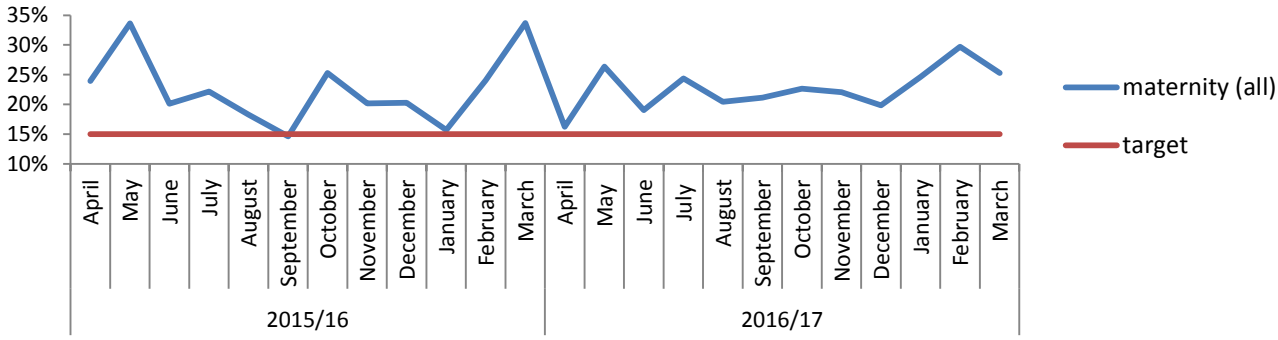
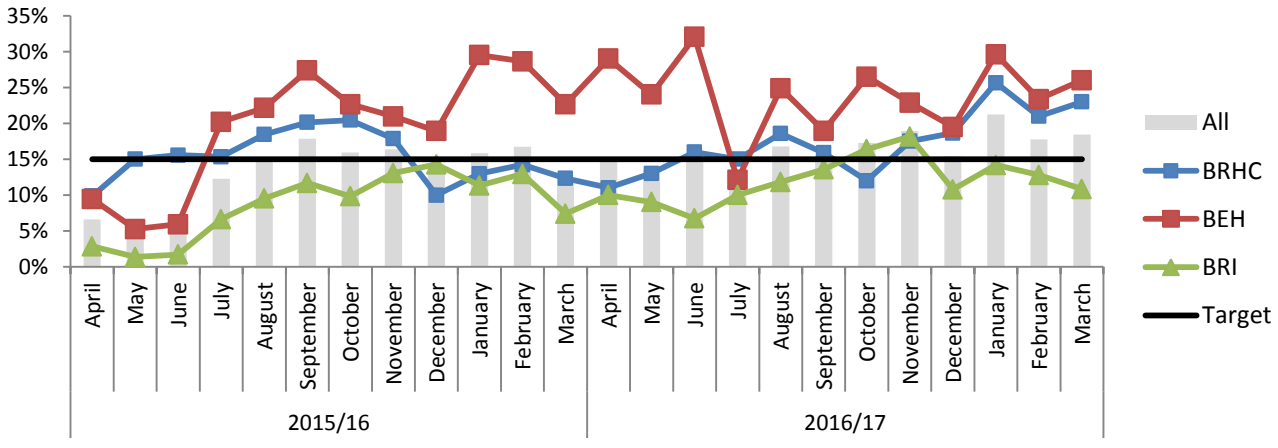


Chart 9: 2015/16 Friends and Family Test Response Rates (Emergency Departments)



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3.2 Survey scores at Division, hospital and ward level

Charts 10-20 provide a view of patient-reported experience at UH Bristol, from a Division to ward-level. The margin of error gets larger as the data is broken down and so the Trust alert / alarm threshold shown on the charts is only a guide at this level (at a ward level in particular it becomes important to look for consistent trends across more than one of the survey measures). The full Divisional-level inpatient and outpatient survey question data is provided in Tables 1 and 2 (pages 12-14).

None of the Divisional or hospital level scores were below the minimum target level in Quarter 4. At a ward-level (Charts 18-20), there are two negative outliers across the headline measures:

- Ward C808 (care of the elderly, Division of Medicine): in Quarter 4, ward C808 had the lowest score across all of our headline measures. Whilst the ward-level scores can fluctuate considerably between quarters, it has been a consistent feature of the survey data that care of the elderly areas tend to attract lower patient experience scores. This has led to additional analysis and exploration of the data, which suggests that the scores are a realistic reflection of the challenges of caring for patients (and being a patient / carer) in this setting - rather than a reflection of the quality of care being provided. To further test this idea, in Quarter 1 the Patient Experience and Involvement Team are focusing on care of the elderly wards (see Section 2 above). Initial analysis of this feedback is very positive, but a more detailed review of this data will be carried out in June 2017. An update will be provided in the next Quarterly Report.
- Ward A602 (trauma and orthopaedics) had a relatively low survey score on two key measures (the inpatient tracker and kindness and understanding). This was an unusual result for this ward and further analysis did not identify any specific improvement issues. The Division of Surgery, Head and Neck have reviewed this result / analysis, but it did not correlate it with other quality data for Quarter 4. The most likely explanation at present is that this was as statistical “blip”, but the ward Sister has been alerted to the scores and they will continue to be monitored to look for any consistent trend (in Quarter 1 to date, the April and May 2017 scores have reverted to being within the expected range).

The Division of Medicine has two relatively low scores around inpatient communication themes in Table 1 (explaining operations / procedures and being told who to contact after leaving hospital). As noted in previous Quarterly Reports, this result has been difficult to account for, besides the possibly of it being related to the trend for relatively lower “involvement” and “communication” scores seen for this Division (see above re: ward C808). For this reason, communication is a key theme in the Trust’s focus on patient experience in the care of the elderly wards being carried out in Quarter 1. Learning from this will be shared with the wards and Division.

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 Trust recognises these issues and ensuring that patients are kept informed of delays was a corporate quality objective for 2016/17. There have been demonstrable actions to improve this score, for example standardised clinic information boards have now been implemented in a large number of outpatient departments. But it has proved very difficult to move the score and in effect it stayed static over the year. This quality objective will therefore be carried over to 2017/18. 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.

The Bristol Royal Hospital for Children has a relatively low score on whether parents / patients are offered a choice of outpatient appointment time (Table 2). Many appointments are currently sent straight out in the post without a choice being given, but a new “partial booking” system will shortly commence at the hospital in a number of areas, which should have a positive impact on this score.

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

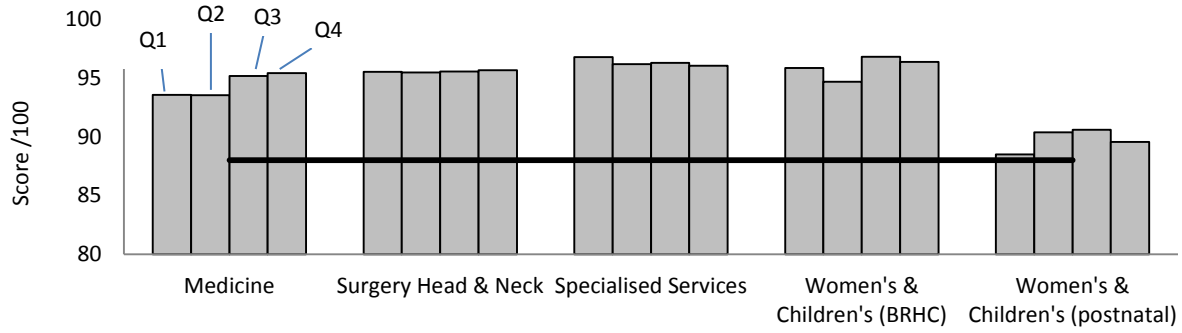


Chart 11 - Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)

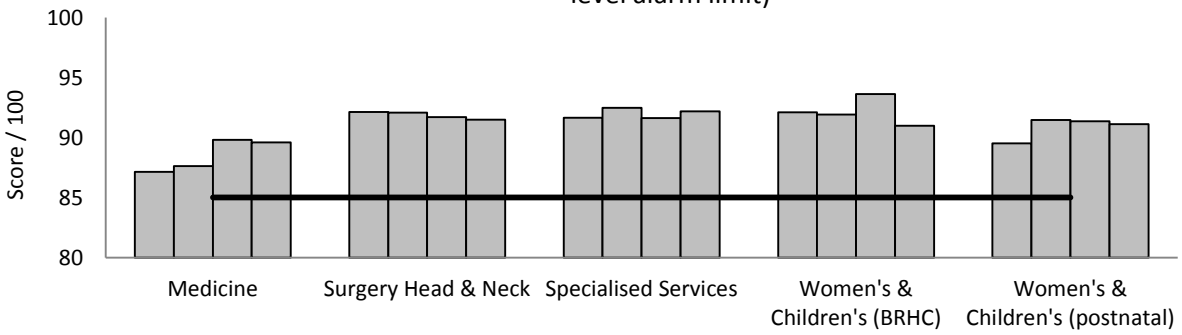


Chart 12 - Inpatient Friends and Day Case Family Test score - last four quarters by Division (with Trust-level alarm limit)

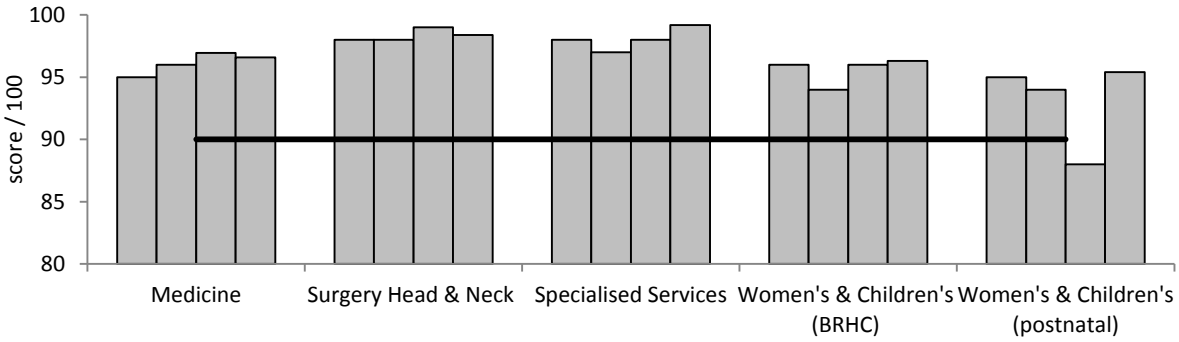
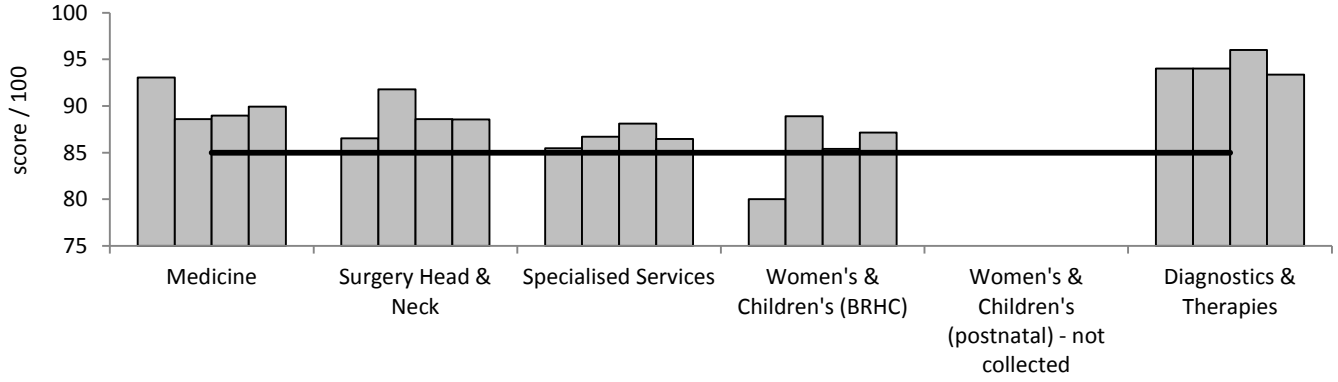
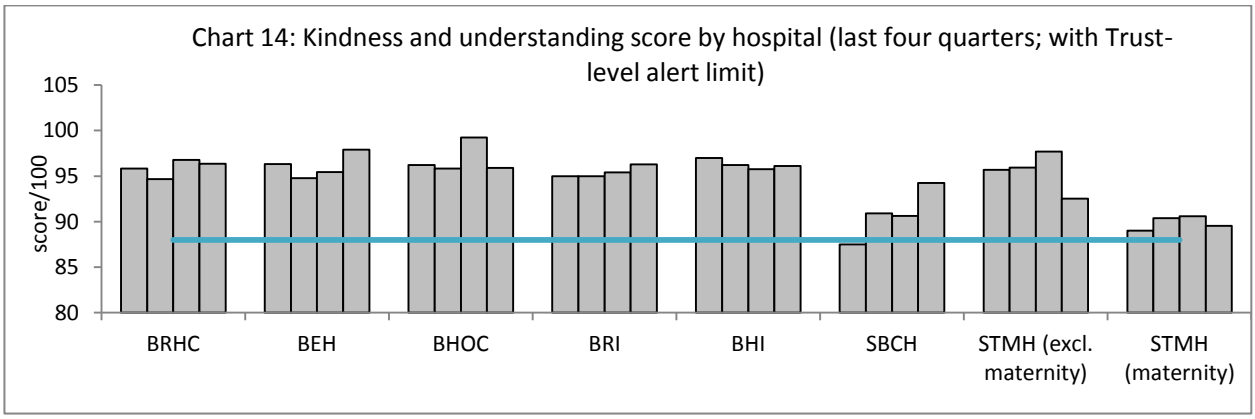
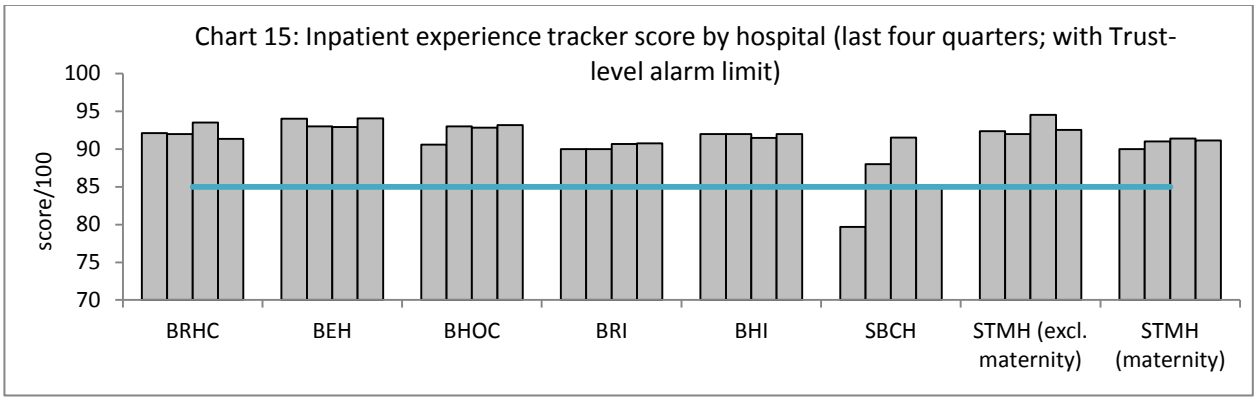
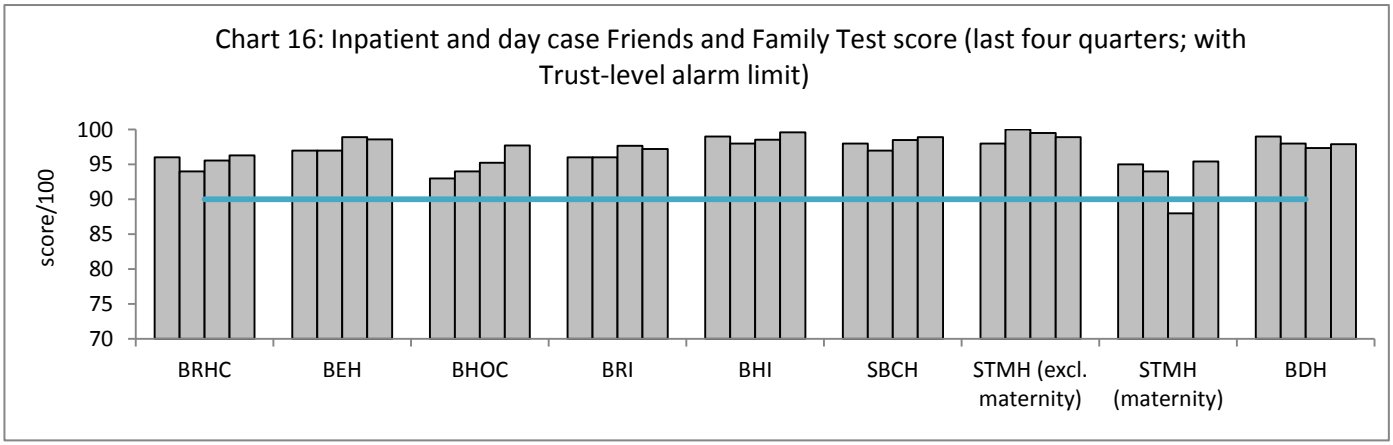


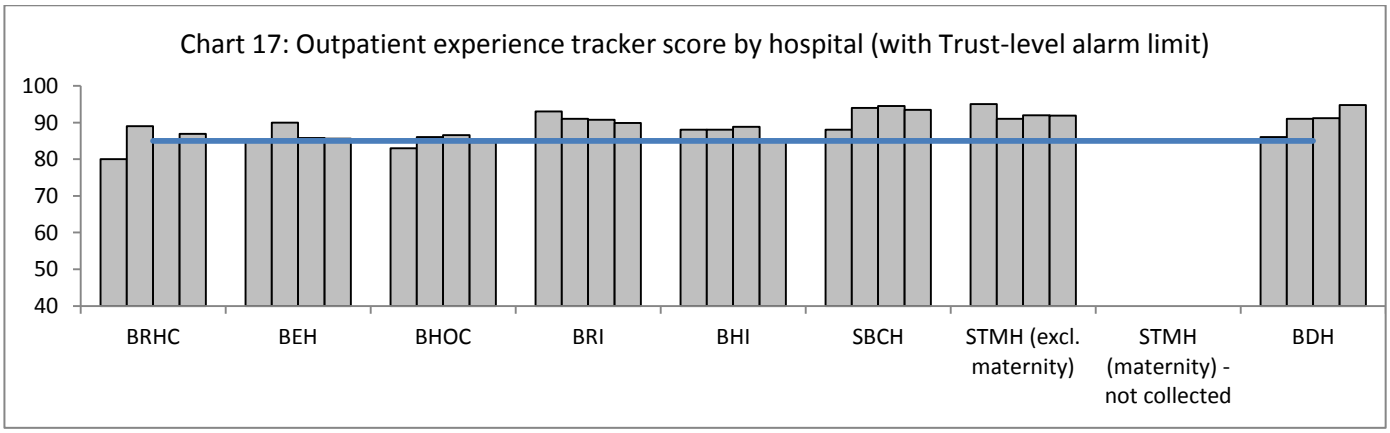
Chart 13 - Outpatient experience tracker score by Division - with Trust-level alarm limit



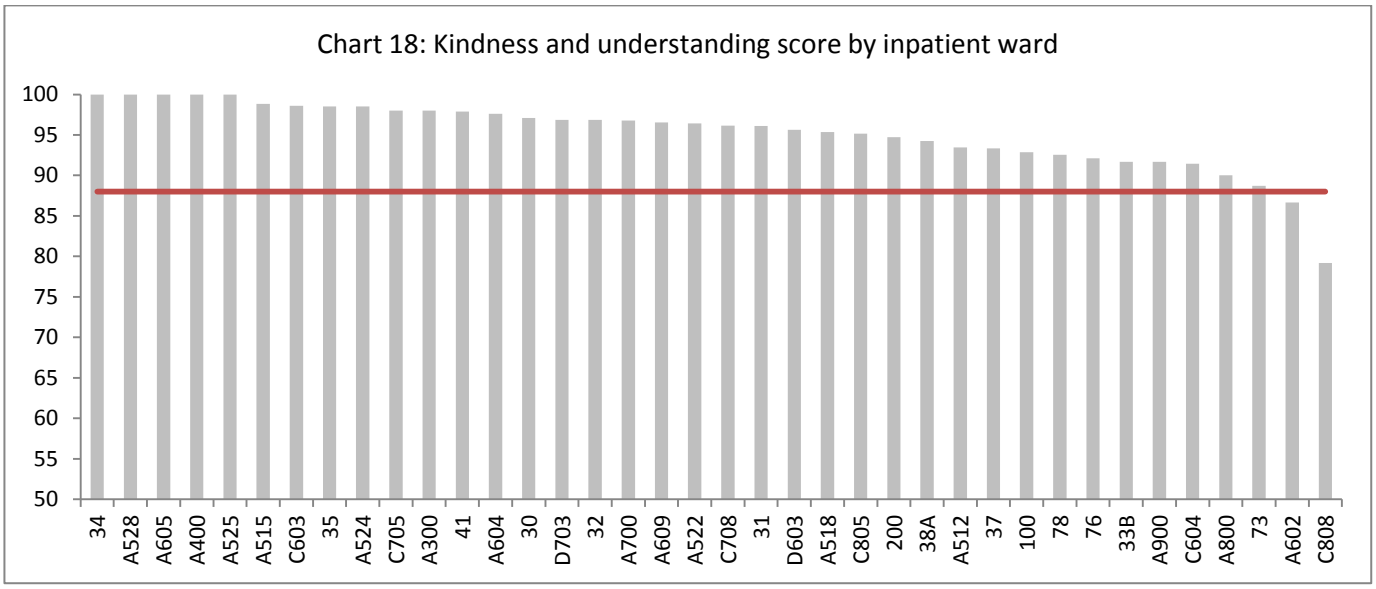


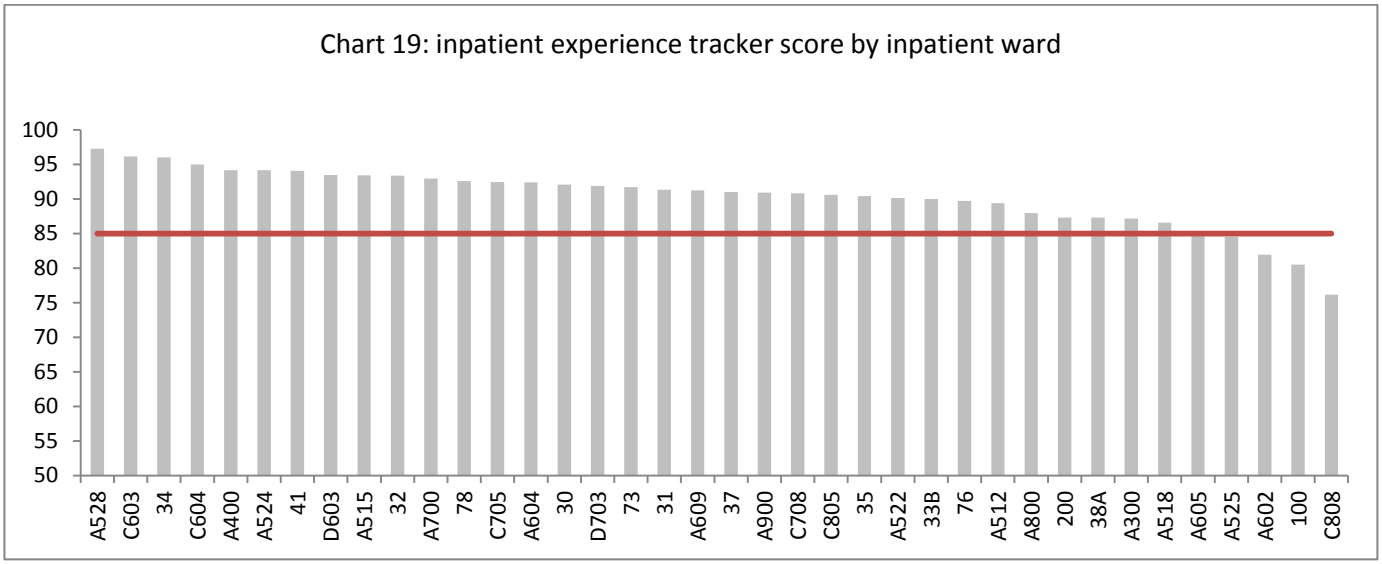


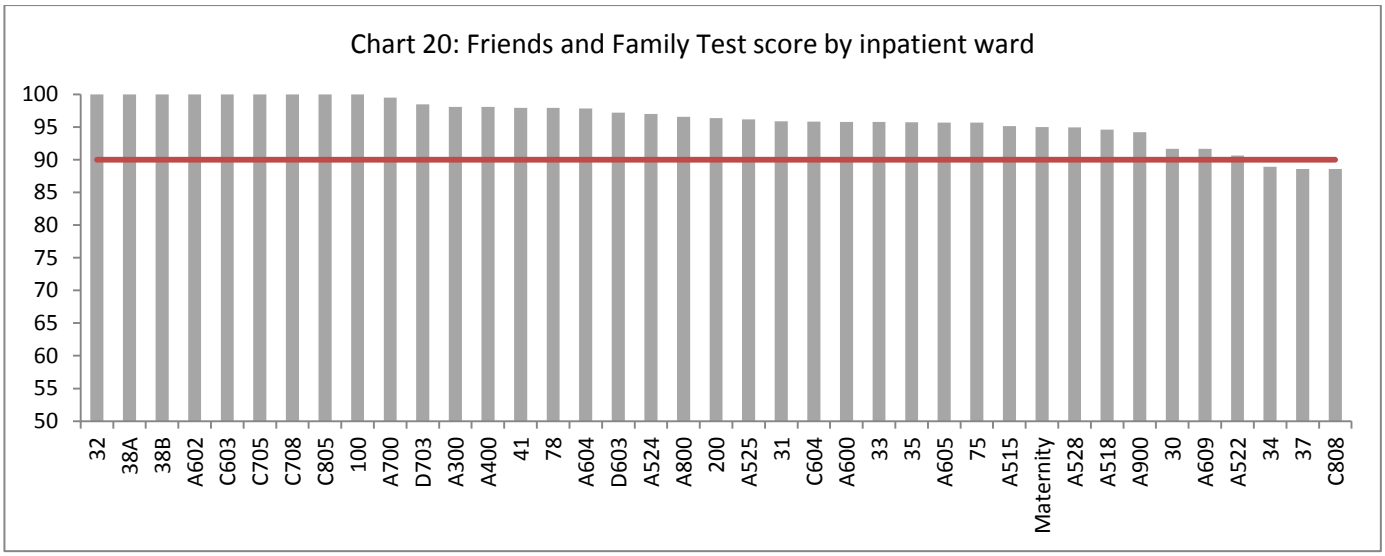




Key: BRHC (Bristol Royal Hospital for Children), BEH (Bristol Eye Hospital), BHOC (Bristol Haematology and Oncology Centre), BRI (Bristol Royal Infirmary), BHI (Bristol Heart Institute), SBCH (South Bristol Community Hospital), STMH (St Michael's Hospital), BDH (Bristol Dental Hospital)







(Please note tha,t as per NHS England national-level reporting protocol, the maternity Friends and Family Test data is reported at "postnatal ward" level).

Table 1: Full Quarter 4 Divisional scores from UH Bristol's monthly **inpatient** postal survey (cells are highlighted if they are more than 10 points below the Trust score). Scores are out of 100 unless otherwise stated – see appendices for an explanation of the scoring mechanism. Note: not all inpatient questions are included in the maternity survey.

	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Maternity	Trust
Were you given enough privacy when discussing your condition or treatment?	92	94	92	95		93
How would you rate the hospital food?	69	62	61	65	60	63
Did you get enough help from staff to eat your meals?	77	90	83	84		84
In your opinion, how clean was the hospital room or ward that you were in?	95	96	96	94	93	96
How clean were the toilets and bathrooms that you used on the ward?	92	93	93	92	83	93
Were you ever bothered by noise at night from hospital staff?	80	82	87	84		83
Do you feel you were treated with respect and dignity by the staff on the ward?	96	98	96	96	93	97
Were you treated with kindness and understanding on the ward?	95	96	96	96	90	96
Overall, how would you rate the care you received on the ward?	88	92	91	92	85	91
When you had important questions to ask a doctor, did you get answers that you could understand?	86	90	88	89	90	88
When you had important questions to ask a nurse, did you get answers that you could understand?	87	90	91	90	91	90
If your family, or somebody close to you wanted to talk to a doctor, did they have enough opportunity to do so?	72	75	79	79		76
If your family, or somebody close to you wanted to talk to a nurse, did they have enough opportunity to do so?	81	88	88	91		88
Were you involved as much as you wanted to be in decisions about your care and treatment?	84	87	86	90	89	87
Do you feel that the medical staff had all of the information that they needed in order to care for you?	90	91	91	88		90
Did you find someone on the hospital staff to talk to about your worries or fears?	67	79	78	82	85	77
Did a member of staff explain why you needed these test(s) in a way you could understand?	82	88	89	89		87

	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Maternity	Trust
Did hospital staff keep you informed about what would happen next in your care during your stay?	81	86	85	87		85
Were you told when this would happen?	78	83	83	84		82
Beforehand, did a member of staff explain the risks/benefits in a way you could understand?	74	91	94	95		92
Beforehand, did a member of staff explain how you could expect to feel afterwards?	69	78	78	81		78
Were staff respectful of any decisions you made about your care and treatment?	90	95	93	94		93
During your hospital stay, were you ever asked to give your views on the quality of your care?	26	24	28	31	30	27
Do you feel you were kept well informed about your expected date of discharge from hospital?	80	84	86	84		84
On the day you left hospital, was your discharge delayed for any reason?	65	53	67	69	70	63
Did a member of staff tell you about medication side effects to watch for when you went home?	54	63	65	64		62
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	62	84	79	89		80
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	88	94	91	92	90	91

Table 2: Full six-monthly Divisional-level scores (October 2016 – March 2017) from UH Bristol's monthly **outpatient** postal survey (cells are highlighted if they are more than 10 points below the Trust score). Scores are out of 100 unless otherwise stated – please see appendices for an explanation of this scoring mechanism.

	Diagnostic & Therapy	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	**TOTAL**
When you first booked the appointment, were you given a choice of appointment date and time?	86	68	78	69	59	**74**
Was the appointment cancelled and re-arranged by the hospital?	96	94	95	95	97	**95**
When you contacted the hospital, was it easy to get through to a member of staff who could help you?	76	63	70	67	71	**69**
How would you rate the courtesy of the receptionist?	87	86	87	85	84	**86**
Were you and your child able to find a place to sit in the waiting area?	100	100	98	99	96	**99**
In your opinion, how clean was the outpatient department?	95	94	95	94	89	**94**
How long after the stated appointment time did the appointment start? (% on time or within 15 minutes)	92	71	65	73	64	**73**
Were you told how long you would have to wait?	48	39	35	22	33	**35**
Were you told why you had to wait?	63	56	58	55	64	**59**
Did you see a display board in the clinic with waiting time information on it?	30	60	50	36	45	**45**
Did the medical professional have all of the information needed to care for you?	88	89	93	92	92	**91**
Did he / she listen to what you had to say?	96	97	95	97	95	**96**
If you had important questions, did you get answers that you could understand?	92	94	91	90	92	**92**
Did you have enough time to discuss your health or medical problem?	91	94	91	92	94	**92**
Were you treated with respect and dignity during the outpatient appointment?	99	99	97	98	99	**98**
Overall, how would you rate the care you received?	92	92	91	92	91	**91**
If you had any treatment, did a member of staff explain any risks and/or benefits in a way you could understand?	88	90	81	91	89	**88**
If you had any tests, did a member of staff explain the results in a way you could understand?	80	86	74	78	86	**80**
Did a member of staff tell you about medication side effects to watch for when you went home?	60	73	63	66	76	**68**
How likely are you to recommend the outpatient department to friends and family if they needed similar care or treatment?	92	90	92	91	91	**91**

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

3.3.1 Themes arising from free-text comments

At the end of the Trust's postal survey questionnaires, respondents are invited to comment on any aspect of their stay. The themes from these comments are provided in Table 3. By far the most frequent type of feedback is praise for staff. Key improvement themes focus on 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 and themes seen in the complaints data (see accompanying Quarterly Complaints Report).

Table 3: Quarter 4 themes arising from free-text comments in the patient surveys (the comments are taken from the Trust's postal survey programme, unless otherwise stated)[3]

	Theme	*Sentiment*	*Percentage of comments containing this theme*
Trust (excluding maternity[4])	Staff	Positive	72%
	Staff	Negative	12%
	Communication/information	Negative	9%
Division of Medicine	Staff	Positive	70%
	Information/communication	Negative	8%
	Waiting / delays	Negative	8%
Division of Specialised Services	Staff	Positive	69%
	Staff	Negative	12%
	Information/communication	Negative	10%
Division of Surgery, Head and Neck	Staff	Positive	74%
	Staff	Negative	14%
	Communication/information	Negative	10%
Women's and Children's Division (excluding Maternity)	Staff	Positive	75%
	Staff	Negative	12%
	Noise	Negative	9%
Maternity	Staff	Positive	67%
	Care during labour and birth	Positive	23%
	Staff	Negative	12%
Outpatient Services	Staff	Positive	59%
	Waiting/delays	Negative	12%
	Communication/information	Negative	10%

[3] The percentages shown refer to the number of times a particular theme appears in the free-text comments. As each comment often contains several themes, the percentages in Table 1 add up to more than 100%. "Sentiment" refers to whether a comment theme relates to praise ("positive") or an improvement opportunity ("negative).

[4] 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.

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

The feedback received via the Trust's Friends and Family Test is generally very positive. Table 4 provides an overview of activity that has arisen from the relatively small number of negative ratings, where that rating was accompanied by a specific, actionable, comment from the respondent.

Table 4: Divisional response to specific issues raised via the Friends and Family Test in Quarter 4, where respondents stated that they would not recommend UH Bristol and a specific / actionable reason was given

Division	Area	Comment	Response from ward / department
Medicine	Rheumatology outpatient department	Appointments keep getting cancelled or changed, then not informed so you turn up anyway. Bookings they are rude - saying it's hard for them that appointments are changed. The consultant is nice. The admin side spoils the whole process.	We are sorry the patient didn't have a positive experience with us. This feedback has been shared with the clinic admin staff and will be discussed further at a departmental meeting to determine changes that can be implemented to address these concerns. Additional customer care skills training will be implemented where necessary.
	A515	All nurses and doctors repeatedly slam bin lid, 20 times a day, with no consideration for patients. Occasionally machines left beeping, no consideration for patients. Men's toilet often left in a dirty state	The ward Sister has carried out checks and confirmed that all bins in patient areas are "quiet closing", making it difficult to corroborate this aspect of the comment and identify specific improvements. Patients in the high care end of the ward may be on monitors and, whilst the sound may be on low, unfortunately it cannot be turned off altogether as staff need to be able to hear them. We are sorry that the patient found the toilet in a dirty state. We can confirm that all the toilets are checked several times each day, but we are also reliant on being informed by staff / patients if extra cleaning is required.
	Emergency Department (Bristol Royal Infirmary)	Somewhat unsanitary (toilets were occasionally covered in urine etc)	The Emergency Department takes cleanliness standards extremely seriously and we are disappointed to hear this comment. Our staff inspect the various areas of the ED throughout the day, formally and informally. We will continue to respond quickly if any concerns are raised about cleanliness in the toilets.
	A300	Given no food… left out when asked they said they'd ran out. Didn't even get a sandwich.	The ward sister has discussed this with the nursing, housekeeper and catering team on the ward. Food is always available and the team ward work hard to be flexible in this respect, as patients often miss formal meal times due to transfers from other departments / wards. This patient should have been offered food and we are very sorry that this did not occur.

Division	Area	Comment	Response from ward / department
Surgery, Head and Neck	Ward 43 (Bristol Eye Hospital day case)	I was told I would be woken just around 7.00 am but was woken at 5.45 and there did not seem any justification for disturbing me. Only two people had been in the ward overnight.	We are sorry that the patient was given this incorrect information. Sometimes patients have to stay in the day surgery unit overnight. Unfortunately they need to be woken up early, as day surgery patients arrive at 07:30 and the area needs to be prepared for their admission. We will remind staff to ensure that if a patient has to stay overnight then they are told about the early start.
	Ward 41 (Bristol Eye Hospital inpatient ward)	Had to change in toilets. No lock on door. Toilet roll on floor - not nice. However, no bed available so all pre-op discussions, getting changed, putting on socks in Day Ward, in front of many other people. No privacy.	Unfortunately, if there is no bed available at the time of admission, a patient may have to be prepared for theatre in the day surgery unit. Privacy and dignity is challenging in these circumstances, but remains a priority and the charge nurse will share these comments with staff as a point of learning. The toilets are checked regularly throughout the day to ensure levels of cleanliness remain high. It is not possible to check after every patient and unfortunately in this case toilet roll may have been left on the floor by someone using the room previously.
	Ward A609	Arriving with my wheelchair using wife, we were faced with a desk so high staff didn't realise she was there.	We are sorry that this situation arose. We are reviewing whether it is possible to change the reception desk, to make it more accessible to all patients. In the meantime, we will share this feedback with our staff as a reminder to be alert to this issue, and to come around to the front of the desk to talk to people if necessary. Despite this feedback, we are pleased to say that the patient did go on to say the reception staff were “fantastic” and made every effort to communicate with them.
Women’s and Children’s - maternity	Postnatal wards	Every day at reception my mum who was my birthing partner was asked several questions and numerous times told she is not my partner so she cannot come in the times partners could. There are numerous reasons women do not have a male partner visiting and they should not be interrogated in this way if that is the case.	We are very sorry that this situation arose, as we recognise that a birthing partner may not necessarily be a spouse. The Head of Midwifery has asked the ward Sisters to put in place a process where, once it is identified that a patient is having their mother or someone else as their birth partner, this is communicated to everyone including the reception team.

Division	Area	Comment	Response from ward / department
Women's and Children's – Bristol Royal Hospital for Children	Emergency Department	On bay 6 in the children's A&E the machines had stickers on them showing the calibration of the machines had expired and needed doing. Also, we used the bed as a cot with the sides up. And we couldn't work out how to lower the cot sides.	The Matron has checked the only fixed patient monitor in the bay and it is in date (expires 2019). The Matron has emailed MEMO to check that all equipment is up to date. The nursing staff will be reminded to show parents who need the cot how to use this.
	Emergency Department	My daughter was referred to the children's hospital with a severe PNS she could not walk, sit, stand. And was in terrible pain. After waiting to be seen by a doctor for hours we were told due to the fact she is 16. No one in the children's hospital was willing to see her. We spent a total of 5 hours only to be sent home.	We are very sorry to hear this feedback. It is our standard practice to inform someone at the point of booking in (usually at the time of arrival) that they need to go to the adult Emergency Department if they are over 16 years old and not under speciality care. We cannot determine why this did not happen in this case, but will share this feedback with the reception team as a point of learning.
	Ward 31	Would have liked to have had the linen changed. My daughter's bed had blood, sweat and antibiotic liquid on it which distressed her.	This patient should have had clean bed linen and we are very sorry that this was not the case. This comment will be used as a reminder to all staff to ensure basic care needs are addressed in a timely manner and levels of cleanliness are maintained.

5. Update on key issues identified in the previous Quarterly report

Table 5 provides a summary and update on issues identified in the previous Quarterly Patient Experience report.

Table 5: update on key issues identified in the previous Quarterly Patient Experience report

Issue / area	*Main action(s) cited*	*Outcome*
Outpatient Friends and Family Test response rate	To explore funding for an SMS based solution to increasing the outpatient Friends and Family Test response rate, in line with 2017/18 commissioning contractual requirements	The funding bid was approved and an SMS survey is now in place.
Patient Experience at Heart workshops in care of the elderly wards	To carry out these patient-focussed workshops with members of staff in the service during Quarter 3 2016/17.	Staffing pressures delayed this action, but a workshop has now taken place with ward A515 (stroke) and ward 100 (rehabilitation). The Patient Experience and Involvement Team will pursue a workshop with ward C808 in response to low survey scores (see main body of the current report).

Issue / area	*Main action(s) cited*	*Outcome*
Low Friends and Family Test score for postnatal wards	This appeared to be a response to temporarily lower (but safe) staffing levels on the wards, due a high sickness level in Quarter 3.	As anticipated, the score has reverted to its previous (higher) levels in Quarter 4. It will continue to be monitored.
Ward C808 – relatively low survey score	Lowest inpatient tracker score in Quarter 3.	As discussed in the current report, the survey results for care of the elderly services are consistently lower than the "Trust average". This will be the focus of Patient and Public Involvement activity in Quarter 1
Ward 38A at the Bristol Royal Hospital for Children had a relatively low Friends and Family Test score	This was an unusual result for this ward and further analysis suggested that it was primarily an artefact of the FFT scoring methodology	The scores are within the normal range in Quarter 4 and it therefore does appear to have been a statistical blip
Ward A605 - low score in the inpatient experience tracker	Ward A605 is the Division of Medicine "delayed discharge ward". It was acknowledged that delivering a positive patient experience is difficult on this ward, but that a number of improvement actions were being carried out	The scores for Quarter 4 are now within the normal range. We will continue to monitor the scores but are hopeful that this reflects a consistent improvement as a result of the service improvement activity.
The Division of Medicine consistently achieves relatively low survey scores around telling patients information about operations / procedures and who to contact if they had concerns after leaving hospital.	It has been difficult to explain this result as relatively few patients have operations / procedures in the Division of Medicine and comprehensive information is given at discharge.	The theme of "communication" is currently being explored in Quarter 1 as part of the Patient Experience and Involvement Team's collaboration with care of the elderly wards in the Division of Medicine
A cluster of low survey scores are present in the outpatient survey data (Table 3), relating to ensuring patients are kept informed about delays in clinic, either via a member of staff or an information board (ideally both).	Although a number of improvement actions were described in the report, the scores have essentially remained static since 2015/16.	This continues to be a challenge for and will remain the focus of a Trust quality improvement objective for 2017/18.

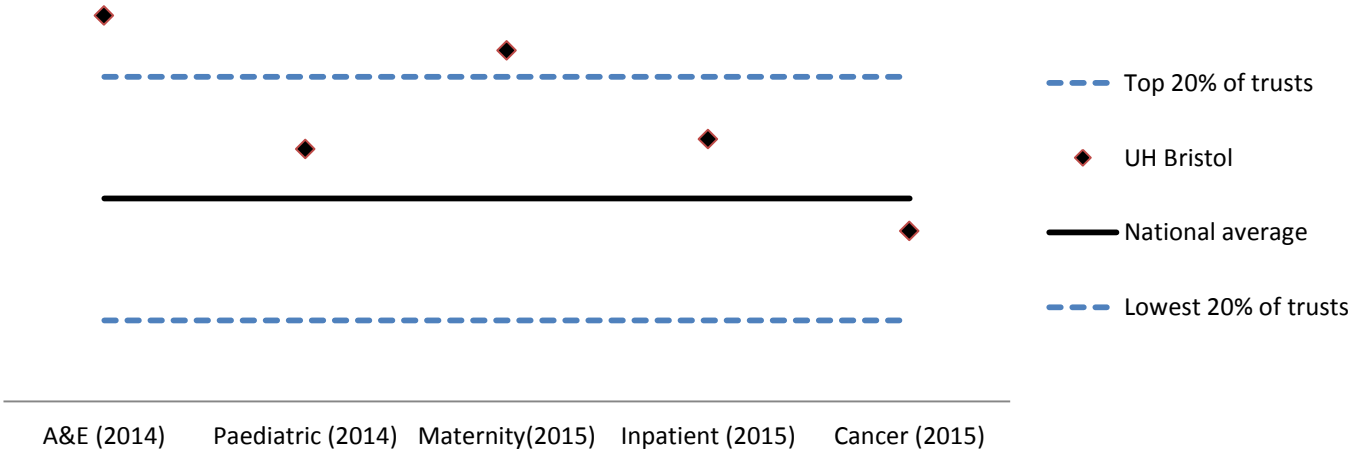
6. National Patient Surveys

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[5]. 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 Patient Experience and Involvement Report was published and therefore Chart 21 is provided for information only.

Please note that since this report was reviewed by the Patient Experience Group in May 2017, the 2016 national inpatient survey results have been released. These were very positive with UH Bristol receiving scores that were among the very best trusts nationally. A separate analysis of these national inpatient survey results is being provided to the Senior Leadership Team and Trust Board committees in June 2017. Chart 21 will be updated to reflect this latest data in the next Quarterly Patient Experience and Involvement Report.

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



[5] 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	June 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 / outpatient surveys)	These surveys, which each month are sent to a random sample of approximately 2500 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.
	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. Whilst the 15 steps challenge and Face2Face interviews remain stand-alone methodologies, in 2017 they were merged – so that volunteers now carry out the 15 steps challenge whilst in a ward / department to interview patients.
	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 Public Trust Board meeting to be held on Thursday, 29 June 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**	29 June 2017
Report Title	Volunteering Strategy		
Authors	Judith Reed, Voluntary Services Manager Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)		
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

The purpose of this strategy is to set out the Trust's ambitions for developing and growing the contribution of volunteering to the organisation over the next three years.

Key issues to note

- Our ambitions for 2017-2020 can be summarised as:
  - Consolidating existing core volunteer roles and developing a defined number of new core roles which will deliver the greatest benefit for patient experience
  - Making our volunteer 'offer' attractive and opening it up to a diverse range of people
  - Maintaining a continuous focus on best practice in volunteer management
- New plans include lowering the minimum age for volunteering to 16, as part of a two year

initiative funded by the Pears Foundation via Above and Beyond to significantly increase in-hospital volunteering opportunities for people aged 16-25 (pending final confirmation of funding support at the time of writing)
- Governance arrangements for volunteering at UH Bristol are already strong and robust and must continue to be so
- We are committed to listening to our volunteers and constantly improving the volunteer experience
- Our numbers of volunteers are significantly less that many of our peer trusts – a potentially missed opportunity which we want to address through this strategy.

These key themes have previously been discussed and supported by our governors and the Quality and Outcomes Committee of the Board.

Recommendations

Members are asked to:
- **Approve** the strategy

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)**
		23/5/17		Voluntary Services Steering Group, Senior Leadership Team

University Hospitals Bristol
NHS Foundation Trust

Volunteering Strategy 2017 - 2020

1. Introduction

Volunteers make a unique and valuable contribution to patients, carers, visitors and staff at University Hospitals Bristol (UH Bristol). Volunteering is 'unpaid work that benefits others to whom one owes no obligation' (Gottlieb and Gillespie 2008), and we are grateful to the many volunteers who contribute their time, skills and compassion so freely.

There are many reasons why people choose to volunteer with us including giving something back to the hospital for care they or a loved one have received, developing new skills, gaining new experiences and serving the community.

The Trust has an established volunteering programme, but we want more people to have the opportunity to volunteer and we want volunteers to make a difference in more areas of our hospitals.

This strategy builds on an earlier volunteering strategy covering the years 2012-2015, written at the time in response to the challenges set out in the Government paper Social Action for Health & Wellbeing: Building Cooperative Communities (2011). As a result of implementing that strategy, we have strengthened our governance and support arrangements for volunteering and made significant improvements to the training and support that volunteers receive. This has created a strong foundation from which we now want to expand the reach and impact of volunteering across our hospitals.

2. Our mission and vision

The Trust's mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. The Trust's vision is for Bristol, and our hospitals, to be among the best and safest places in the country to receive healthcare. Research published by the King's Fund has highlighted "a positive association between exposure volunteer services and various dimensions of patients' experience", in particular volunteers' contribution to a culture of compassion.

Our vision for volunteering is that by 2020, volunteers will be recognised by staff as integral and valued assets to their teams, making a measurable difference to patient experience across our hospitals. We also want to provide a supportive volunteering offer and experience that earns us a reputation as a go-to organisation when people are considering giving their time freely.

3. The current position of volunteering in University Hospitals Bristol

At the start of the 2017/18 financial year, the Trust had fewer volunteers than the national average for NHS acute trusts: 225 active volunteers compared to an average of 471[1], although the number of UH Bristol volunteers varies considerably throughout the year due to students starting and leaving. In addition, the Trust is supported by around 70 volunteers from our external partners.

There are, however, no shortages of willing volunteers. NatCen Social Research's 2015 British Social Attitudes (BSA) survey revealed that an estimated 24 million British adults would consider volunteering in a health context, and it is also recognised that young people represent a huge untapped resource for the health and care volunteering community[2].

4. What do our volunteers do at the moment?

At present, the majority of the volunteering roles within the Trust are direct patient-facing ones, including:

- Mealtimes volunteers – helping with the meal service, encouraging patients to eat and feeding patients
- Ward befrienders – providing companionship to patients and family and carers
- Meet and greet /reception volunteers – welcoming patients and visitors to our hospitals and helping people find their way around
- Bristol Haematology & Oncology Centre volunteers offering a listening ear and sign-posting to information available on cancer
- Maternity unit tours – leading tours of the unit for parents-to-be.
- Play centre volunteers offering distractional play to patients and their siblings in the children's hospital
- Chaplaincy volunteers

5. What do volunteers say about volunteering at UH Bristol?

The Trust carries out a detailed survey of volunteers' experience every two years. The most recent survey in 2015 showed that 9 out of 10 volunteers enjoyed volunteering at the Trust. Comments made by volunteers about their experiences with the Trust included:

"[Volunteering is] a way to help people and make a difference to your life and others"

"What I didn't appreciate when I started volunteering is that you get back much more than you put in"

"I feel I am giving something back in recognition for the way my late husband was looked after"

"I have been a volunteer here for many years and feel that volunteers today are appreciated by management and staff"

Most of our volunteers enjoy their time in the hospital and gain a personal sense of worth and satisfaction from volunteering. However, in the same survey, only 78% of volunteers said that they would recommend the Trust as a place to volunteer to a friend or relative thinking of becoming a hospital volunteer. This means that, at that time, more than a fifth of volunteers who responded to the survey would not have

[1] Volunteering in Acute Hospital Trusts, Kings Fund, November 2013
[2] NCVO Almanac, 2016, Department of Health/ Livity, 2015, Ipsos Mori, 2015

recommended us as a place to volunteer, which is something we have been striving to improve and will continue to do so under the auspices of this new strategy.

6. The need to develop volunteering – external drivers for change

As well as supporting our Trust's mission and vision, there are also a number of key external drivers which place an onus and expectation on hospital trusts to develop and promote volunteering opportunities. The Department of Health Strategic Vision for Volunteering (2011) describes the contribution of volunteering to enhancing quality of services, reducing inequalities and improving outcomes in health, public health and social care. The Social Value Act 2012 requires those who commission public services to think about how they can also secure wider social, economic and environmental benefits; a robust volunteering programme will support the Trust when applying for commissioned services.

Various publications from the King's Fund have highlighted the value and contribution of volunteering. In *Volunteering in Health and Care – Securing a sustainable future* (2013), the King's Fund suggested that "it may not always be possible to sustain high-quality services without involving volunteers and other sources of informal care." In its *Evaluation of King's College Hospital Volunteering Service* the following year, the King's Fund described "a positive association between exposure to the volunteer service and various dimensions of patients' experience" including contributing to a culture of compassion.

7. The aims and objectives of this strategy

Continuing the direction of travel set in our earlier strategy, our overall aims for volunteering are:

- To make University Hospitals Bristol a place where volunteering opportunities are exciting and diverse
- To enable more people to make a positive difference to our patients through volunteering
- To support volunteers through training, mentoring and appreciation of their contribution
- To demonstrate in measurable terms the added value that volunteering brings to our hospitals

In support of these aims, over the course of the next three years we will, for example:

- Develop a 'brand' for volunteering within the Trust, which will resonate with volunteers, staff and patients, helping to create fresh interest in our volunteering 'offer'.
- Offer high quality volunteering opportunities which, to quote Nesta, "are designed to channel volunteer time where it can deliver the greatest difference to patients and carers, and that matter the most to staff".
- Significantly increase the number of volunteers in the Trust. A net increase of 75 volunteers per year will be needed to bring us up to the national average of around 470 for an organisation of our size. We will achieve this through targeted recruitment, community engagement and by providing bespoke volunteering placements.
- Review the accessibility of volunteering roles so that we do more to meet the needs of volunteers who have physical or learning disabilities, or are socially excluded, and work with relevant local organisations such as Remploy and Jobcentre Plus to raise awareness of volunteering opportunities within the Trust.
- Continue to tailor our volunteer induction programme to make this as accessible as possible to volunteers whilst meeting the Trust's governance requirements.
- Introduce routine mentoring support for volunteers, particularly for those volunteering on wards and for young people. We will also work with staff to introduce the role of Volunteer Champion in each area where volunteering takes place, to support volunteers and continuously raise the awareness of volunteering.

- Continue to work in partnership with our external volunteering partners, including the Above and Beyond Appeal.
- Evaluate volunteering so it can be recognised and celebrated.
- By 2020, have achieved the Investing in Volunteers standard, a national quality standard for good practice in volunteer management.

Further details of our plans are set out in the appendix to this strategy.

8. Our core volunteering roles

Over the next three years we will consolidate our ward volunteer role and develop new roles in cancer services, outpatients, children's services and discharge support. We also hope to be able work in partnership with the Pears Foundation to develop new opportunities for young people to volunteer in our hospitals.

Ward volunteering (mealtimes volunteers, befrienders, providing activities)

- Our goal is to have at least one volunteer helping at the lunch and evening meal service on seven specific wards every day of the week. The wards we have identified are a trauma and orthopaedics ward, a stroke ward and wards for older people. Currently there are 60 mealtimes on these wards with no mealtime volunteer support. The eventual goal is to have two volunteers helping at each of these mealtimes. We will also extend the role further into therapies at mealtimes.
- We also want to have one befriender volunteer on these seven wards every day of the week. Currently there are 23 sessions per week without a volunteer befriender, although some sessions at present have two volunteers[3].
- We will establish volunteer-led activity and engagement programmes on wards, which patients, carers and family members can attend. Focussing initially on the seven wards described above, we envisage that the programmes will include visits from external voluntary groups such as PAT dogs (Pets as Therapy) and complementary therapists/pamper sessions.

Cancer Services

- Following disappointing results in a previous National Cancer Patient Experience Survey, the Trust was linked with South Tees NHS Foundation Trust as part of the NHS IQ Cancer Patient Experience Buddying Improvement Programme. South Tees sees a similar number of patients with cancer compared with UH Bristol, and has 50 volunteers supporting patients; UH Bristol currently has only 12. Our learning from South Tees has included the difference to patient experience that volunteers can make by providing written information about cancer, side effects and financial support, and by providing opportunities for patients and carers to discuss their worries and fears. In 2017/18, Voluntary Services will begin by working with the management team at the Bristol Haematology and Oncology Centre to develop volunteering within the hospital that enhances the role of the existing Cancer Information and Support Centre and provides support for patients, their families and friends, and staff within the Chemotherapy Day Unit and Radiotherapy Department.

Outpatient departments

- In 2016, our Speech and Language Therapy volunteers buddied with patients to practice speech and language exercises between clinic appointments. This community-based volunteer role was well received by patients and volunteers, so as part of our new strategy we will be exploring whether volunteers can fulfil similar community-based roles in other outpatient departments.
- Hospital-based roles within outpatient departments will include more volunteers who can befriend patients and offer peer support, including a follow up 'in touch' telephone call, a listening ear and signposting to other services and support.

[3] Figures exclude visits by chaplaincy volunteers to the wards

Bristol Royal Hospital for Children

- Volunteering in the children's hospital has previously been limited to the playroom and to a small number of volunteers (Friends for Parents and chaplaincy volunteers) supporting families on wards. We have significantly fewer volunteers than our peers such as Great Ormond Street and Birmingham Children's Hospital. At the end of 2016, two new roles were identified with the head of nursing and the matrons in the children's hospital: a dedicated ward volunteer befriending families and patients, and providing general administration support for staff; and a meet and greet role based at two of the entrances to the hospital. A recruitment plan and tailored training and induction will be introduced during 2017.

Supporting discharge

- Based on learning from Kingston Hospital, we will explore the potential to create a role for hospital-based discharge volunteers who could complete a checklist with patients to see what help and advice they need and then provide a telephone in-touch service.
- We will also continue to work in partnership with the RVS and Red Cross and their respective home-from-hospital support services, aimed at reducing preventable readmission to hospital.

Young People volunteering

- Supported by the Trust's charity, Above and Beyond, and funding from the Pears Foundation, we hope to be able to develop more volunteering opportunities for those aged 17 years and over, and will to introduce volunteering for 16 year olds. Currently, there are no 16 year olds in the Trust volunteering, and opportunities for those aged 17 are limited to reception desks / meet and greet roles. Subject to confirmation of funding, this project will involve developing a volunteering programme for young people from local schools, colleges and the two Bristol universities.

9. Working together with our volunteering partners

The Trust is fortunate to be supported by a number of external organisations who place volunteers in specific roles within our hospitals. For example:

- Bristol Hospital Broadcasting Service (BHBS) provides in-hospital radio programmes to wards.
- Radio Lollipop is based in the Playroom in the Bristol Royal Hospital for Children during the evening and on Saturdays, providing activities and a radio station for patients and their siblings.
- Royal Voluntary Service runs cafes, in-patient trolleys and a Home from Hospital service.
- Scouts run a group based in the children's hospital.
- Pets as Therapy (PAT) dogs regularly visit wards across three of our hospital sites.
- Bliss volunteers support families of babies in our Neonatal Intensive Care.
- National Osteoporosis Society providing a listening ear and signposting for patients and their carers.

Supporting one of our Trust's core values, 'working together', these organisations complement our own volunteers, providing specialist support as well as valuable points of connection with our wider communities. Over the next three year we will seek to strengthen these relationships. This will, for example, include further working with BHBS to provide bespoke audio material for older patients, particularly those with dementia.

10. A continuous focus on delivering best practice in voluntary services management

Our planned growth in volunteering will be underpinned by robust governance. Throughout the lifetime of this strategy we will be striving to continually improve how we recruit, induct, train, mentor, support and monitor our volunteers. As well as tailoring our volunteer induction programme so that it better reflects the needs of different volunteer groups, we will explore the potential for wider use of training workbooks and e-learning to maximise flexibility.

We will also be exploring ways of ensuring that volunteer records are complete, current and insightful; this includes the possibility of using the Trust's recruitment system, TRAC, and the Trust Membership database, to provide improved electronic support for the recruitment and management of volunteers (the latter would replace our current Excel-based volunteer records).

11. Accountability and monitoring

The Trust's Voluntary Services Steering Group was established in early 2015 and oversees all volunteering activity within the Trust. The group, which is chaired by the chief nurse, will oversee implementation of this strategy.

Step progress towards achieving our aims will be set out in an annual voluntary services work plan. Progress reports will be shared with the Trust's Patient Experience Group, and an annual report submitted to the Trust Board.

Key measures of progress will include:

- A year-on-year increase in absolute numbers of volunteers, with evidence of growth in numbers of volunteers in each of the core roles described in this strategy
- Over the course of the three years, evidence of increasing diversity amongst our volunteer workforce
- Improvements in volunteer experience measured through our volunteer survey, which will now be undertaken annually
- Improvements in the quantity and quality of feedback received from staff in volunteer-active areas of the Trust about the contribution of volunteers
- The introduction of a new survey of the experience of people who volunteer at UH Bristol through our partner organisations
- The introduction and monitoring of new measures of the impact of volunteering, based on learning from partnership working with the University of the West of England and our anticipated collaboration with the Pears Foundation
- Evidence of application of learning from exit interviews with volunteers
- Evidence of case studies being used within the Trust to highlight the contribution and positive impact of volunteering

Appendix - Further information about how we will seek to achieve the aims of our strategy

Aim: To make University Hospitals Bristol a place where volunteering opportunities are exciting and diverse
We will: • Develop a volunteering 'brand' with relevant marketing material and enhanced website profile. • Continue to explore potential for volunteering in areas of the Trust which are not currently volunteer-active • Support volunteers to become more actively involved in the development and management of the volunteering service. • Actively support Voscur, a charity supporting voluntary organisations across Bristol. • Engage local external partners and organisations supporting people to develop skills such as Jobcentre Plus and Remploy. • Develop volunteering for young people over the next two years to ensure it becomes a core volunteering activity.

Aim: To enable more people to make a positive difference to our patients through volunteering
We will: • Focus resources on volunteering roles which have the greatest potential for positive impact on patient experience, and patient outcomes (as described in this strategy) • Review our recruitment process to ensure both robustness and simplicity, whilst demonstrating Trust values throughout. • Develop partnership working to support hard to reach groups of potential volunteers, and those groups which can meet specific needs of patients or family/carers. • Engage staff in areas with volunteers to fully utilise and involve volunteers.

Aim: To support volunteers through training, mentoring and appreciation of their contribution
We will: • Establish a new plan for communicating with volunteers which appreciates that volunteers have different levels of engagement with the Trust. • Support volunteers to become more actively involved in the development and management of the volunteering service. • Promote the role and contribution of volunteers to all staff, including a role of Volunteer Champion in each volunteering area. • Continue the development of volunteers' induction and update training. • Increase the delivery of role specific training. • Actively encourage volunteers to develop their skills and progress in their volunteering. • Utilise volunteers more in the delivery of training. • Identify new ways of celebrating the impact volunteers have, recognising the diversity of the volunteers.

Aim: To demonstrate in measurable terms the added value that volunteering brings to our hospitals
We will: • Improve volunteers' data management, identifying active volunteers, those with specific skills and their availability. • Routinely record and report time spent on volunteering activities in order to demonstrate the contribution to the Trust. • Use regular evaluation to drive the quality of volunteering experiences. • Unlock the potential of patient experience data to demonstrate the impact of volunteering. • Communicate the contribution of volunteers both internally and externally. • Share evaluation with our stakeholders.

Cover report to the Trust Board meeting to be held on 29th June 2017, 11:00-1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	14
Meeting Title	Quality and Outcomes Committee	**Meeting Date**	Thursday, 29 June 2017
Report Title	Guardian of Safe Working Hours Annual Report		
Author	Alistair Johnstone, Guardian of Safe Working Hours		
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

<u>Purpose</u>

The Guardian of Safe Working is a new post mandated by the introduction of the 2016 Junior Doctors Contract. Part of the responsibility of this post is to produce regular reports for the Trust Board to ensure that issues around junior doctor staffing are visible at a high level across the organisation.

These reports are intended to be publicly available and the annual report (or a link to it) will form part of the Trust Annual Quality report. The CQC have indicated that these reports will form part of their assessment of organisations in future. This report follows the national format suggested by NHS employers. The annual report is intended to focus on "rota gaps" and provide a commentary on the steps taken by the Trust to address any issues that they have identified.

Key issues to note

The 2016 junior doctors contract is gradually being introduced at University Hospitals Bristol NHS Trust. The new contract introduces stricter safe working limits and reduces the maximum number of sequential shifts that a junior doctor can work necessitating significant rota redesign in some areas. Whilst there is a national implementation timetable the Trust has chosen to depart from this where divisions have been unable to provide assurance that safe levels of medical cover can be provided under the new terms and conditions.

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

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**	**Other (specify)**
		27/06/2017		

GUARDIAN OF SAFE WORKING HOURS
ANNUAL REPORT 2016/17 ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

Executive summary

The 2016 junior doctors contract is gradually being introduced at University Hospitals Bristol NHS Trust. The new contract introduces stricter safe working limits and reduces the maximum number of sequential shifts that a junior doctor can work necessitating significant rota redesign in some areas. Whilst there is a national implementation timetable the Trust has chosen to depart from this where divisions have been unable to provide assurance that safe levels of medical cover can be provided under the new terms and conditions.

Our first group - 42 Foundation Year 1 doctors – started on the contract at the beginning of December 2016 a further 23 doctors of more senior grades started on the contract in April 2017. The majority of the remainder of doctors will transition to the new contract between August and October 2017. Work is ongoing to identify the number of additional medical staff that the Trust will require to appoint to deliver the new contract safely with a view to these post being advertised and appointed to in time for the August transition.

Introduction

The 2016 junior doctors contract introduces a new role - the Guardian of Safe Working- who is responsible for monitoring the new junior doctors contract and providing the Trust Board with assurance that departments and divisions are observing the safe working limits. Part of this responsibility includes this report – which is specifically designed to address rota gaps and vacancies within junior doctors working arrangements. As the Trust has chosen to have a local implementation timetable data in this report will only cover information from the 65 doctors currently on the new contract. Future reports will cover posts once they have transitioned onto the new contract.

High level data

Number of doctors / dentists in training (total):	385 (headcount)
Number of doctors / dentists in training on 2016 TCS (total):	65
Annual vacancy rate among this staff group:	None

Annual data summary

The table below shows the rota gaps per specialty for posts on the 2016 Contract. Further information on posts still on the 2002 Contract can be found in appendix 1

Specialty	Grade	No of doctors (WTE)	Quarter 4 2016	Quarter 1 2017
General Medicine	F1	21	0	0
General Surgery	F1	17	1*	1*
Psychiatry	F1	3	0	0
HDU	F2	5	n/a	
General Surgery	F2 / CT1	8	n/a	0**
O&G tier 1	F2 / GPVTS / CT 1&2	10	n/a	0
Total		**65**	**1***	**1***

- * Vacancy for F1 doctor identified on this rota but has been addressed by appointment of clinical fellow covering daytime shifts
- ** Rotating gap from the deanery every 6 months on this rota. May affect future quarters reporting.

Issues arising

Introduction of the new contract has revealed several areas of the Trust with gaps in existing rotas which have been compounded by the new terms and conditions. The reason for these gaps is complex and the exact nature and extent of them is not fully understood but most seem to stem from:

- Variations in numbers of trainees sent to the Trust by the deanery
- Difficulty recruiting into Trust grade posts
- Long term structural rota problems not addressed under the old contract
- Reliance on internal locums to cover short and long term gaps

There seems to be a particularly heavy workload for F1 cardiology doctors which has resulted in a large number of exception reports under the new contract. Although this is not due to a “rota gap” in the current workforce it is likely that additional staffing may be required in this area.

There are significant challenges in the Childrens Hospital, especially for the Paediatric Medicine ST4+ rota. Under the 2002 T&C rota rules they have 5 vacancies on this 27 person rota. In March 2017 they had to implement an emergency 24 person rota which increased the frequency of on call work for the trainees. This rota still has 2 rota gaps. This emergency rota has had a significant, negative, impact on the training provided for these doctors and on many occasions the level of staffing falls below that required to provide teaching and training. Moving this rota onto the new contract risks worsening these gaps further.

There is a significant reliance on internal locums to cover both short and long term gaps in junior medical staff rotas across the Trust. This is a major challenge for the Trust as the flexibility to employ juniors in this way is reduced under the new contract and the rates of pay for these shifts is significantly reduced meaning that shifts may be harder to cover.

Month 16/17	Locum spend £ (approx)	No. of claim forms processed
September	70,000	129
October	52,000	127
November	94,000	404
December	104,000	351
January	72,000	319

The no of claim forms processed reflects the number of additional shifts carried out. The length of these shifts ranges from 5 – 12 hours.

Actions taken to resolve issues

Significant work is being undertaken across the Trust with high levels of engagement in identifying problematic rotas and developing action plans to address the issues prior to implementation of the contract. Appendix 1 shows the state of readiness for each of the rotas (as at May 2017) yet to be transitioned onto the new contract – this should be read with some caution as much of the data is provisional.

The Trust has approved recruitment into several new Trust Grade posts from August 2017 to address some of the problems revealed by the new contract. This is a very positive step but success will rely on being able to recruit to these posts quickly to ensure doctors are in post by August 2017.

Division	No of posts approved
Specialised Services (SpS)	4
Surgery, Head and Neck (SH&N)	6
Medicine (Med)	4
Womens and Childrens (W&C)	7

The Trust has provided details of the various attempts made within cardiology to improve the workforce problems over the past few years. The new contract has again brought these long standing issues into sharp focus and a plan to recruit to new educational fellow and trust doctor posts has been developed. It is hoped that this will help ease the workload for junior doctors in this area.

Work to address the use of locum staff and the arrangements for employing internal locums is being carried out by the Medical HR department but it seems inevitable that a centralised staff locum bank and investment in electronic rota software will be required to meet the terms of the new contract.

There are fortnightly meetings of the Junior Doctors Contract Implementation Group which are well attended by divisional clinical and HR representatives, Medical HR and the Medical Directors team. This group has been instrumental in understanding the challenges posed by the new contract and in developing action plans to allow implementation in a way which ensures safe staffing levels.

Summary

It is clear that the new contract is challenging for the Trust and is highlighting several rotas where additional support / staffing may be required. Future reports – both this annual report and quarterly reports to the Trust Board - will provide updates on the progress being made.

Questions for consideration

The Board is asked to note the significant challenges posed by the introduction of the 2016 Junior Doctors contract and the work being undertaken across the organisation to ensure safe levels of medical staffing.

Appendix 1 Readiness of other rotas for transition to 2016 Terms and Conditions as at May 2017

Division	Rota	Date of transfer	Compliance with 2016	Risk	Comments	No. of Trust posts needed for compliance
Med	General Medicine F1	07/12/2016	Compliant	Low	Rota is live	0
Med	Emergency Medicine ST3+	02/08/2017	Non compliant	Low	One shift needs reallocating to achieve compliance	0
Med	Emergency Medicine ST1-2	02/08/2017	Non compliant	High	Rota will need additional Doctors to maintain current staffing levels	3
Med	Dermatology ST3+	02/08/2017	Compliant	Low	Rota agreed, ready to go live	0
Med	General Medicine ST1-2	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
Med	General Medicine ST3+	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
Med	Academic F2	02/08/2017	Compliance achievable	Medium	Rota analysis with Division, F2s support AMU but are an additional resource to the rota	0
SH&N	F2 HDU	05/04/2017	Compliant	Low	Rota is live	0
SH&N	General Surgery F1	07/12/2016	Compliant	Low	Rota is live	0
SH&N	General Surgery CT1-2 & F2	05/04/2017	Compliant	Low	Rota is live	0
SH&N	General Surgery ST3+	04/10/2017	Non compliant	High	Rota analysis with department for consideration, exceeds average hours and maximum weekly hours	To be confirmed
SH&N	General Anaesthesia 1st on-call	02/08/2017	Compliance achievable	Medium	Compliant options produced, more complex than other rotas due to module system	0
SH&N	General Anaesthesia 2nd on-call	02/08/2017	Compliance achievable	Medium	Compliant options produced, more complex than other rotas due to module system	0
SH&N	Obstetric Anaesthesia ST3+	02/08/2017	Compliance achievable	Medium	Compliant options produced, more complex than other rotas due to module system	0

Division	Rota	Date of transfer	Compliance with 2016	Risk	Comments	No. of Trust posts needed for compliance
SH&N	Cardiac Anaesthesia ST3+	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
SH&N	Paediatric Anaesthesia ST3+	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
SH&N	ITU ST3+	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
SH&N	Ophthalmology 1st on-call	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
SH&N	Ophthalmology 2nd on-call	02/08/2017	Compliance achievable	Medium	Compliant options produced, work is continuing to finalise the rota	0
SH&N	Trauma & Orthopaedics ST1-2	02/08/2017	Non compliant	High	Needs additional resource to achieve compliance	2
SH&N	Trauma & Orthopaedics ST3+ (incl. Paeds T&O)	02/08/2017	Compliance achievable	Medium	Compliant options produced, service impact being assessed	0
SH&N	ENT ST1-2	02/08/2017	Compliance achievable	Medium	Compliant options produced, service impact being assessed and may require additional resource	To be confirmed
SH&N	ENT ST3+	02/08/2017	Compliance achievable	Medium	Compliant options produced, service impact being assessed and may require additional resource	To be confirmed
SH&N	Oral Max Fax ST1-2 & Dental Core Trainees	02/08/2017	Compliance achievable	Medium	Compliant options produced, service impact being assessed and may require additional resource	To be confirmed
SH&N	Oral Max Fax ST3+	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0

SpS	Oncology ST3+	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
SpS	Haematology ST3+	02/08/2017	Non compliant	High	Needs additional resource to achieve compliance	2
SpS	Oncology & Haematology CT1-2 / F2	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
SpS	Cardiology ST3+	02/08/2017	Non compliant	High	Needs additional resource to achieve compliance	3
SpS	Cardiothoracic ST1+	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
SpS	Palliative Care ST3+	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
SpS	Clinical Genetics ST3+	02/08/2017	Compliant rota option(s) produced	Low	Shift pattern is normal working day, no action needed	0
W&C	O&G ST1-2/ F2	05/04/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
W&C	O&G ST3-5 1st on-call	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
W&C	O&G ST6+ 2nd on-call	02/08/2017	Compliance achievable	Medium	Compliant rota options produced, the risk is that not all posts will be recruited to which will exacerbate existing difficulties for training	0
W&C	Paediatric Surgery ST1-2	02/08/2017	Non compliant	High	Needs additional resource to achieve compliance	2
W&C	Paediatric Surgery ST4+	02/08/2017	Non compliant	High	Needs additional resource to achieve compliance	2
W&C	Paediatric Medicine F2 & GPVTS	02/08/2017	Non compliant	High	Needs additional resource to achieve compliance	2

W&C	Paediatric Medicine ST1-3	06/09/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accomodated, rota to be finalised	0
W&C	Paediatric Medicine ST4+	06/09/2017	Compliance achievable	Medium	Compliant options produced, work is continuing to finalise the rota	0
W&C	PICU	02/08/2017	Compliance achievable	Medium	Compliant options produced, service impact being assessed and may require additional resource	To be confirmed
W&C	NICU ST1-3	06/09/2017	Compliance achievable	Medium	Compliant options produced, work is continuing to finalise the rota	0
W&C	NICU ST4+	06/09/2017	Non compliant	High	Needs additional resource to achieve compliance	1
W&C	Paediatric Emergency Department	02/08/2017	Compliant	Low	No change to rota needed, existing pattern compliant	0
W&C	Paediatric Cardiology	06/09/2017	Compliant rota option(s) produced	Medium	Compliant options produced, work is continuing to finalise the rota	0
W&C	Paediatric Oncology / BMT	06/09/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
W&C	Paediatric Cardiac Surgery	06/09/2017	Non compliant	High	Needs additional resource to achieve compliance	1
W&C	Paediatric Neurosurgery	02/08/2017	Non compliant	High	Needs additional resource to achieve compliance	1
W&C	Plastics & Burns ST3+	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0

D&T	Radiology ST1+	02/08/2017	Compliant	Low	Changes needed to facilitate compliance are able to be accommodated, rota to be finalised	0
D&T	Microbiology	02/08/2017	Non compliant	High	Rota covers various Trusts, meeting with Lead Consultant is arranged	To be confirmed
D&T	Chemical Pathology ST3+	2/8/147	Compliant rota option(s) produced	Medium	Due to low work intensity on-call the rota may be able to retain current working pattern with Divisional approval, awaiting further information	0
Trust	Occupational Health	02/08/2017	Compliant	Low	Shift pattern is normal working day, no action needed	0

Low	Rota is compliant and low risk in terms of safety and training
Medium	Compliant options have been produced but work is ongoing to assess the impact of implementation and the extent to which safety and training is impacted. There is a medium risk that additional resource is needed or there will be difficulty recruiting to existing posts
High	Rota is high risk and implementation is not possible without adversely impacting safety and training, highly likely that additional resource is needed to achieve compliance

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Thursday, 29 June 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**	29 June 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

To inform the Finance Committee of the financial position of the Trust for May.

<u>Key issues to note</u>

The Trust is reporting a deficit of £1.400m (before technical items) at the end of May. The Operational Plan is a deficit of £1.028m and therefore the Trust is £0.373m below plan. This position includes £0.932m sustainability and transformation (S&T) funding but is £0.399m behind the planned receipt of £1.331m. Therefore the Trust is reporting a surplus of £0.027m excluding S&T funding. However the divisional position is an overspend of £1.230m after only two months which is of serious concern and risks delivery of the 2017/18 Control Total.

Recommendations

Members are asked to:

- **Note** the contents of this 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)**
	26 June 2017			

University Hospitals Bristol
NHS Foundation Trust

REPORT OF THE FINANCE DIRECTOR

1. Summary

The summary income and expenditure statement (appendix 1) shows a deficit (before technical items) of £1.400m. After technical items the deficit is £1.391m. This reported deficit position is in the context of the Trust's Operational plan for May being a deficit of £1.028m before technical items.

The £13.313m Sustainability and Transformation (S&T) funding for the year is dependent on achieving the control total excluding S&T funding (70%) and achieving the A&E target (30%).

Excluding Sustainability and Transformation Funding (S&TF) the Trust is reporting a deficit of £2.332m against a planned (phased) deficit of £2.359m. Therefore the control total excluding S&TF has just been met, and receipt of £0.466m S&T core funding included for May. However A&E performance was not met for a second month in a row with performance of 84.2% against the joint NHS England / NHS Improvement nationally required trajectory of 90.0%. Therefore S&T performance funding of a further £0.200m has not been earned for May.

Budgets are managed and profiled within Divisions at cost centre level. A profiling adjustment of £0.844m is required to reflect the May Operational Plan.

Divisions and Corporate Services are £1.230m adverse to plan. Whilst this is a slow down in the rate of overspending from last month, the position remains extremely concerning given the £13.0m corporate support funding provided to remove underlying deficits to facilitate balanced Divisional Operating Plans. The Trust requires Divisions to break-even to meet its overall financial plan for the year.

The position is summarised in the table below:

(excluding technical items)	Plan to date	Actual to date	Variance
	Income/(expenditure)		Favourable/(adverse)
	£m	£m	£m
Corporate Income	97.410	97.305	(0.105)
Divisions & Corporate Services	(91.786)	(93.015)	(1.230)
Financing	(5.808)	(5.690)	0.118
Operating Plan Profile Adjustment	(0.844)		0.844
Surplus/(deficit) including S&TF	(1.028)	(1.400)	(0.373)
Less S&T Core Funding	(0.932)	(0.932)	-
Less S&T Performance Funding	(0.399)	-	(0.399)
Surplus/(deficit) excluding S&TF	(2.359)	(2.332)	0.027

The Divisional overspend of £1.230m after two months risks delivery of the Trust's control total. Divisions must take action to mitigate the current key areas of overspending and deliver their operating plans. There are four areas of concern in May:

- Nursing costs in Medicine.
- Cardiac Surgery activity performance.
- Medical staff costs particularly in Surgery and Women's and Children's.
- Unmet savings delivery particularly within Surgery and Medicine

The Divisional performance is described in the following section.

2. Division and Corporate Services Performance

Clinical Divisions and Corporate Services overspend against budget increased by £0.369m in May to a cumulative position of £1.230m adverse. This compares with the combined Operating Plan trajectory to May of £0.254m. This is summarised in the table below:

	Variance to Budget favourable/(adverse)			Operating Plan trajectory favourable/(adverse)	
	To 30 April £m	May £m	To 31 May £m	Trajectory To May £m	Variance £m
Diagnostic & Therapies	0.016	0.073	0.089	0.015	0.074
Medicine	(0.429)	(0.173)	(0.602)	(0.257)	(0.345)
Specialised Services	(0.113)	(0.138)	(0.251)	0.044	(0.295)
Surgery	(0.189)	(0.142)	(0.331)	(0.032)	(0.299)
Women's & Children's	(0.169)	0.069	(0.100)	(0.004)	(0.096)
Estates & Facilities	(0.012)	(0.008)	(0.020)	(0.020)	(0.000)
Trust Services	(0.001)	(0.001)	(0.002)	-	(0.002)
Other corporate services	0.036	(0.049)	(0.013)	-	(0.013)
Totals	**(0.861)**	**(0.369)**	**(1.230)**	**(0.254)**	**(0.976)**

The key drivers are:

Medicine

The Division is adverse by £0.6m (50% of the total Divisional position) – their Operating Plan has not been signed off, being a £0.6m planned deficit for the year. Executives have requested a revised Operating Plan submission.
Even against the draft plan which assumed a £0.257m deficit to May (due to expected delays in delivering nursing savings), the actual deficit is a further £0.345m. This is primarily due to additional nursing costs and a failure to deliver 53% of the planned CIP savings to date. The Division is targeting recruitment to establish A518 using permanent staff and to reduce the vacancy level as well as using benchmarking and reviewing service delivery to drive down nursing costs.

Specialised Services

Non delivery of cardiac surgery activity is the key driver for the £0.295m adverse variance to the Operating Plan trajectory. In May, the acuity of patients in CICU caused 17 cancellations. The Division has taken a number of actions to improve the position,

including greater involvement of clinicians in discharge reviews, internal surgical referrals, scheduling and flow, escalating proposed cancellations to a more senior level, focussing on inter-hospital transfers and making individual activity data available across the team.

Surgery

The main components include a share of the Cardiac Surgery activity shortfall (£0.158m), additional nursing costs in ITU in April (due to exceptional case mix pressures - £0.095m), ophthalmology drugs (£0.038m), blood practice changes (£0.045m) and residual medical staffing overspends to cover long term sickness. All of these require a full understanding and urgent action to prevent continuation through the year.

Women's and Children's

The Division's strong activity performance would have generated a balanced position but control issues within BCH Theatres (old year agency costs) have generated the net adverse position. Within this there are still significant costs which need addressing once the activity performance drops to normal levels.

Further details on Divisional and Corporate Services financial performance is provided under agenda item 2.3.

3. Subjective Analysis

The adverse variances of £0.369m in May and £1.230m to date are analysed subjectively in the table below:

Favourable/(Adverse)	May £m	April £m	Year to date £m	2016/17 Outturn £m
Nursing & midwifery pay	(0.061)	(0.468)	(0.529)	(4.606)
Medical & dental staff pay	(0.269)	(0.208)	(0.477)	(1.442)
Other pay	(0.018)	(0.022)	(0.040)	2.107
Non-pay	(0.270)	0.265	(0.005)	(9.492)
Income from operations	(0.366)	(0.181)	(0.547)	0.513
Income from activities	0.615	(0.247)	0.368	(1.429)
Total	**(0.369)**	**(0.861)**	**(1.230)**	**(14.349)**

Movements between April and May include the allocation of contract transfer funding held within non- pay in April.

Further information is provided below.

Nursing & Midwifery Pay

The nursing and midwifery pay variance for May is £0.061m adverse. The table below shows analysis between substantive, bank and agency:

Favourable/(Adverse)	May £m	April £m	2017/18 to date £m		March £m	Feb £m	Jan £m	2016/17 out turn £m
Substantive	0.895	0.599	1.494		0.806	0.813	0.581	9.130
Bank	(0.520)	(0.630)	(1.150)		(0.654)	(0.543)	(0.553)	(6.340)
Agency	(0.436)	(0.437)	(0.873)		(0.657)	(0.560)	(0.569)	(7.397)
Total	**(0.061)**	**(0.468)**	**(0.529)**		**(0.505)**	**(0.290)**	**(0.541)**	**(4.606)**

The increased favourable variance on substantive staff reflects the increased vacancies particularly within Medicine (9.4% compared with 5% target) and Surgery (8.4% compared with a target of 5%).

Surgery spend on agency is considerably higher than their Operating Plan reflecting the use of agency to cover the vacancies as well as backfilling supervisory staff. The Division has a number of new starters requiring supervision.

Sickness across all Divisions is higher than target, most markedly in Specialised Services and Women's and Children's.

Nursing controls are auditing compliance with the recently introduced SOP for supervisory staff during June and July to ensure that the additional 'double running' costs are minimised in line with agreed process. Work on the implementation of a neutral vendor contract across the region continues. The contract has been awarded and the focus is now on ensuring all organisations work consistently.

The nursing control dashboard is attached at appendix 3.

Medical & Dental Pay

The adverse variance of £0.269m for May and £0.477m year to date is analysed below:

Favourable/(Adverse)	May £m	April £m	Year to date £m	2016/17 Outturn £m
Consultant				
- Substantive costs	0.135	0.131	0.266	0.277
- Additional hours payments	(0.149)	(0.157)	(0.306)	
- Locum	0.013	(0.023)	(0.010)	(0.143)
- Agency	(0.028)	(0.020)	(0.048)	(0.741)
Other medical				
- Substantive costs	(0.027)	0.095	0.068	(0.369)
- Additional hours payments	(0.197)	(0.192)	(0.389)	
- Exception reporting payments	-	-	-	
- Locum	(0.058)	(0.045)	(0.103)	(0.469)
- Agency	0.042	0.003	0.045	0.003
Total	**(0.269)**	**(0.208)**	**(0.477)**	**(1.442)**

(note – analysis of additional hours payments was not available throughout 2016/17)

The high level of additional hours payments reflects the cost of covering vacancies, sickness and additional work to deliver activity. The coding of these payments within the payroll system has been redesigned to facilitate greater management information on additional hours payments but this remains limited in the absence of a time and attendance system for medical staff.

In particular Surgery medical and dental staffing budgets are reporting an overspend to date of £0.248m and Women's and Children's £0.1547m. This reflects the cost of covering long term sickness and maternity leave as well as additional hours payments to deliver activity.

Non Pay

There were significant budget virements in May to allocate contract transfer funding held in non-pay, therefore the focus is on year to date variances rather than movement in month. An analysis is shown below:

Favourable/(Adverse)	May £m	April £m	Year to date £m
Blood	(0.027)	0.008	(0.019)
Clinical supplies & services	(0.210)	0.025	(0.185)
Drugs	0.092	(0.111)	(0.019)
Establishment	(0.004)	0.054	0.050
General supplies & services	0.011	0.023	0.034
Outsourcing	(0.176)	(0.098)	(0.274)
Premises	0.032	0.003	0.035
Services from other bodies	0.141	(0.209)	(0.068)
Research	0.067	0.245	0.312
Other non-pay expenditure	(0.196)	0.325	0.129
Totals	**(0.270)**	**0.265**	**(0.005)**

Whilst non-pay to date is broadly break-even this includes a favourable variance of £0.312m relating to research (offset by an adverse variance in operating income).

The Trust continues to outsource work to private sector providers and has cumulative adverse variances of £0.037m relating to South West Eye Surgeons, £0.032m to Glanso, and £0.025m to dermatology. The remaining balance relates to the virtual ward provided by Orla, which has now closed.

The £0.185m cumulative adverse variance against Clinical Supplies and Services reflects increased clinical activity.

Income from Operations:

As described above, there is an adverse variance of £0.301m in relation to Research and Innovation, offset by an underspend on non pay. The nature of the grants funding is driving this and the budgets will be re-profiled as appropriate. Of the other net variance of £0.246m, £0.105m is within technical items corporately with other smaller variances across all Divisions.

4. Clinical Activity and Contract Income

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

	May 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	0.069	2.892	3.012	0.120
Emergency Inpatients	0.839	14.458	15.156	0.698
Day Cases	(0.087)	6.070	6.254	0.184
Elective Inpatients	(0.158)	8.759	8.746	(0.013)
Non-Elective Inpatients	0.202	5.349	5.139	(0.210)
Excess Beddays	0.042	0.892	1.041	0.149
Outpatients	0.270	12.068	12.403	0.335
Bone Marrow Transplants	(0.317)	1.292	1.240	(0.052)
Critical Care Beddays	0.047	7.339	7.122	(0.217)
Other	(0.147)	15.464	15.088	(0.376)
Commissioner Assumed Savings	-	-	-	-
Total Activity Based	**0.760**	**74.583**	**75.201**	**0.618**
Contract Penalties	(0.194)	(0.165)	(0.373)	(0.208)
Contract Rewards	0.010	1.528	1.531	0.003
Pass through payments	0.339	14.232	14.592	0.360
Sustainability and Transformation Funding	(0.200)	1.331	0.932	(0.399)
2017/18 Total	**0.715**	**91.509**	**91.884**	**0.375**
Prior year income	0.217	-	0.217	0.217
Overall Total	**0.933**	**91.509**	**92.100**	**0.591**

Activity based income was £0.760m favourable to plan in May, giving a cumulative over performance to date of £0.618m.

Emergency activity was £1.041m above plan in month, and is £0.488m above plan to date. Whilst Women's and Children's and Surgery are above plan by £0.730m and £0.235m respectively, Specialised Services is £0.538m below plan, predominantly cardiac surgery.

Elective inpatients is broadly in line with plan, although Surgery is £0.137m above plan and Specialised Services is £0.156m below plan, within which cardiac surgery is £0.228m below plan.

Outpatients are £0.335m higher than plan to date, notably in dermatology (£0.062m), BHOC (£0.10m) and across a number of specialties in Women's and Children's (£0.11m..

Critical care bed days were low in April, particularly within Women's and Children's which was £0.20m below plan, un-coded data is being validated. Maternity pathways were £0.28m below plan but this is considered to be due to incomplete data that will be available in May.

The plan assumes 82% achievement of CQUINs, which is £9.43m. An early assessment indicates achievement of 68%. It is vital to the achievement of the Trust's Operating Plan that the full CQUIN value is earned, therefore targeted action will be required.

Given the Trust has accepted the control total, national core penalties and local penalties will not apply. Other national penalties will apply and the Trust has received penalties of £0.373m to date, £0.208m worse than plan. Two thirds of penalties, £0.234m, relate to the emergency marginal tariff with emergency readmissions of £0.070m and cancelled operations of £0.040m.

Pass through payments for excluded drugs are £0.96m higher than plan, particularly due to increased dermatology activity. This is offset by blood products (£0.37m) and excluded devices (£0.33m) which are below plan.

Month 12 activity for 2016/17 has been finalised and there is £1.3m additional income due from Commissioners, of which £0.217m is recognised in the May position.

5. Savings Programme

The savings requirement for 2017/18 is £11.878m. In May, achievement of savings is reported as £1.491m against a plan of £1.947m. Divisional performance is summarised in appendix 4. A summary of progress of the key work streams is summarised in the following table. A more detailed report is given under item 2.4 on this month's agenda.

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

	2017/18 Plan £m	Year to Date			Forecast outturn £m
		Plan £m	Actual £m	Variance fav / (adv) £m	
Pay	1.653	0.262	0.211	(0.051)	(0.117)
Drugs	0.400	0.064	0.114	0.050	0.275
Clinical Supplies	2.229	0.366	0.302	(0.064)	0.266
Non Clinical Supplies	3.178	0.510	0.325	(0.185)	(0.425)
Other Non-Pay	0.217	0.032	0.029	(0.003)	(0.005)
Income	2.582	0.443	0.343	(0.100)	0.196
Capital Charges	1.000	0.167	0.167	-	-
Unidentified	0.619	0.103	-	(0.103)	(0.619)
Totals	**11.878**	**1.947**	**1.491**	**(0.456)**	**(0.429)**

Whilst clinical supplies and income are behind plan to date, it is expected that this position will improve and the planned savings will be achieved. Of greatest concern are pay, non-clinical supplies and unidentified savings.

With the exception of Medicine and Surgery, Divisions are expecting to achieve their required savings. Medicine have significant unidentified savings of £0.674m and are only forecasting to achieve 70% of their £2.429m target. Surgery are forecasting a current shortfall of £0.408m and are establishing savings targets against service lines. Savings performance by Division is shown in the table below, with further information provided at agenda item 2.4.

	2017/18 Requirement £m	Year to Date			Forecast outturn £m
		Plan £m	Actual £m	Variance fav / (adv) £m	
Diagnostics and Therapies	1.386	0.218	0.196	(0.022)	0.101
Medicine	2.429	0.380	0.179	(0.201)	(0.730)
Specialised Services	1.192	0.190	0.205	0.014	0.364
Surgery	2.393	0.440	0.236	(0.204)	(0.408)
Women's and Children's	2.036	0.331	0.295	(0.036)	0.115
Facilities and Estates	0.817	0.117	0.108	(0.009)	0.025
Trust Services	0.546	0.092	0.078	(0.013)	0.017
Corporate	1.080	0.180	0.195	0.015	0.088
Totals	**11.878**	**1.947**	**1.491**	**(0.456)**	**(0.429)**

6. Use of Resources Rating

The Use of Resources Rating (URR) for the Trust to date is 3, against the plan of 2. NHS Improvement applies an over-ride such that should any one metric score a 4, the URR is capped at a 3. The income and expenditure margin scores a metric rating of 4 reflecting the net deficit to date of £1.400m, £0.373m adverse to plan. The following table summarises the position.

		31 May 2017	
	Weighting	Plan	Actual
Liquidity			
Metric Result – days		13.39	15.14
Metric Rating	20%	1	1
Capital Servicing Capacity			
Metric Result – times		2.19	2.03
Metric Rating	20%	2	2
Income & expenditure margin			
Metric Result		-1.00%	-1.30%
Metric Rating	20%	3	4
Variance in I&E margin			
Metric Result		0.00%	-0.30%
Metric Rating	20%	1	2
Variance from agency ceiling			
Metric Result		40.7%	35.0%
Metric Rating	20%	1	1
Overall URR		**1.6**	**2.0**
Overall URR (rounded)		**2**	**2**
Overall URR (subject to override)		**2**	**3**

7. Capital Programme

The capital programme for the year submitted in the Operational Plan is £47.885m. It includes £16.040m slippage from the previous year and £37.379m of new schemes in 2017/18. Delivery of the programme is challenging and slippage of £5.534m is forecast.

Expenditure in the month totalled £1.918m and at the end of May capital expenditure totalled £2.478m. The Trust is developing the spend profiles of the schemes to inform its internal plan against which performance will be measured. Profiles have been included in the table below. The profiles for Information Technology were finalised after the month end reporting so plan was set to spend and will be adjusted next month. The Strategic Scheme profile relates to the remaining phase 4 schemes with phase 5 funding held towards the end of the year pending prioritisation of schemes and agreed profiles. The table below shows spend against the internal plan to date

The current forecast out-turn is £47.885m but it is recognised that prioritising and profiling the phase 5 schemes will result in slippage and a revised forecast out-turn.

Operational Plan £m	Subjective Heading	Year to date		
		Internal Plan £m	Actual £m	Variance £m
	Sources of Funding			
3.800	PDC	-		
	Donations	-	0.267	0.267
	Cash:			
22.764	Depreciation	3.658	3.662	0.004
21.321	Cash balances	(1.381)	(1.451)	(0.070)
47.885	**Total Funding**	**2.277**	**2.478**	**0.201**
	Expenditure			
(16.035)	Strategic Schemes	(0.316)	(0.201)	0.115
(10.278)	Medical Equipment	(0.503)	(0.752)	(0.249)
(11.370)	Operational Capital	(0.722)	(0.786)	(0.064)
(7.328)	Information Technology	(0.692)	(0.692)	-
(2.874)	Estates Replacement	(0.044)	(0.047)	(0.003)
(47.885)	**Gross Expenditure**	**(2.277)**	**(2.478)**	**(0.201)**
	In-year Slippage			
(47.885)	**Net Expenditure**	**(2.277)**	**(2.478)**	**(0.201)**

Depreciation reflects estimates at October 2017 submitted in the Operational Plan. This will be reassessed following the revaluation of assets in 2016/17, the prioritisation and profiling of the Phase 5 schemes and the spend profiles advised by Divisional Capital Leads.

Further information is provided at agenda item 3.1.

8. Statement of Financial Position and Cashflow

Net current assets at 31 May 2017 were £36.989m against the Operational Plan of £33.698m.

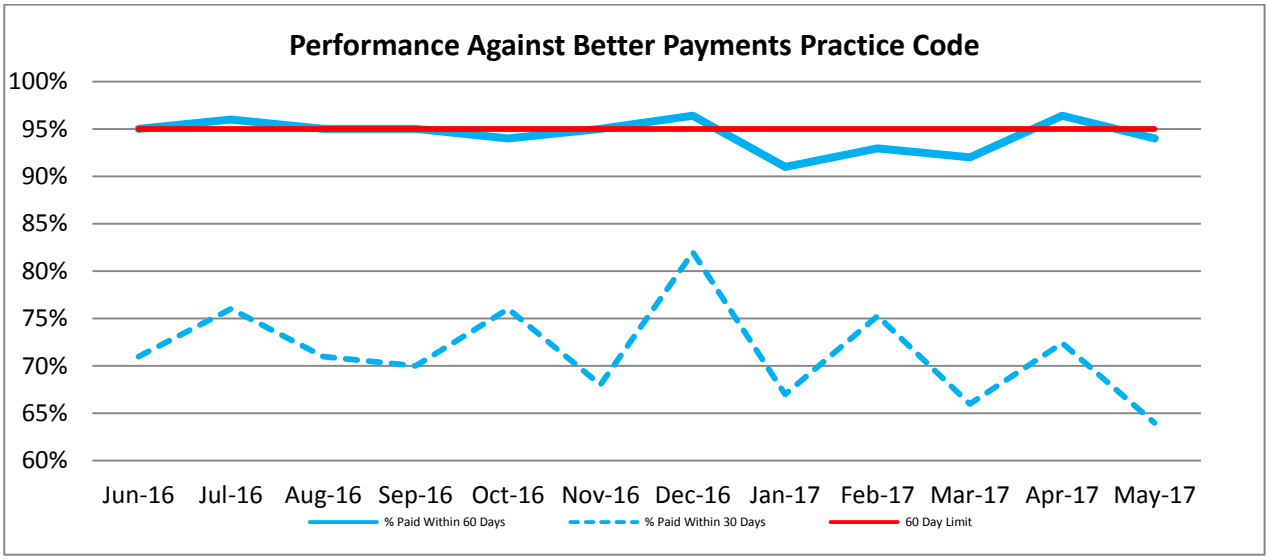
Current assets are £9.215m higher than plan reflecting the outstanding balances relating to the 2016/17 year end estimated activity which have now been finalised.

Current liabilities are £77.307m, £5.924m higher than plan reflecting expenditure accruals in advance of finalising provider to provider arrangements.

The Trust's cash balance at the end of May £65,943, which is £3.588m lower than the planned, reflecting the high level of receivables offset by the slippage in capital spend.

The total value of debtors was £22.579m (£14.548m SLA and £8.031m non-SLA). This represents a decrease in the month of £1.156m (£0.153m SLA increase and £1.310m non-SLA decrease). Debts over 60 days old increased by £6.649m (£6.299m SLA increase and £0.350m non-SLA increase) to £13.544m (£9.538m SLA and £4.006m non-SLA) and represents 60.0% of total debtors. The SLA position includes over £5m of estimated invoices over 60 days relating to March activity which has now been validated.

In May 94% of invoices were paid within the 60 day target set by the Better Payments Practice Code. Performance is shown in the graph below:



Further information is provided at agenda item 4.1.

Attachments *Appendix 1 – Summary Income and Expenditure Statement*
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Nursing KPIs
Appendix 4 – Key Financial Metrics
Appendix 5 - Risks

Appendix 1

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report May 2017– Summary Income & Expenditure Statement

Approved Budget / Plan 2017/18	Heading	Position as at 31st May Plan	Actual	Variance Fav / (Adv)	Actual to 30th April
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
557,265	From Activities	90,931	91,596	665	43,488
101,405	Other Operating Income	15,976	15,028	(948)	7,829
658,670	**Sub totals income**	**106,907**	**106,624**	**(283)**	**51,317**
	Expenditure				
(368,601)	Staffing	(62,860)	(63,906)	(1,046)	(31,382)
(231,219)	Supplies and Services	(38,423)	(38,428)	(5)	(18,801)
(599,820)	**Sub totals expenditure**	**(101,283)**	**(102,334)**	**(1,051)**	**(50,183)**
(10,840)	Reserves	–	–	–	–
–	NHS Improvement Plan Profile	(844)	–	844	–
48,010	**EBITDA**	**4,780**	**4,290**	**(490)**	**1,134**
7.29	**EBITDA Margin – %**		**4.02**		**2.21**
	Financing				
(22,764)	Depreciation & Amortisation – Owned	(3,794)	(3,662)	132	(1,832)
244	Interest Receivable	41	24	(17)	8
(264)	Interest Payable on Leases	(44)	(44)	–	(22)
(3,022)	Interest Payable on Loans	(470)	(467)	3	(230)
(9,247)	PDC Dividend	(1,541)	(1,541)	0	(771)
(35,053)	**Sub totals financing**	**(5,808)**	**(5,690)**	**118**	**(2,847)**
12,957	**NET SURPLUS / (DEFICIT) before Technical Items**	**(1,028)**	**(1,400)**	**(372)**	**(1,713)**
	Technical Items				
–	Profit/(Loss) on Sale of Asset	–	–	–	–
–	Donations & Grants (PPE/Intangible Assets)	–	266	266	5
(1,314)	Impairments	–	–	–	–
–	Reversal of Impairments	–	–	–	–
(1,561)	Depreciation & Amortisation – Donated	(260)	(257)	3	(128)
10,082	**SURPLUS / (DEFICIT) after Technical Items**	**(1,288)**	**(1,391)**	**(103)**	**(1,836)**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report May 2017– Divisional Income & Expenditure Statement

Approved Budget / Plan 2017/18	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	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
	Corporate Income										
35,553	Contract Income	5,901	5,901	–	–	–	–	–			
–	Sustainability and Transformation Funding	–	–	–	–	–	(399)	–	(399)		
–	Penalties	–	–	–	–	–	(169)	–	(169)		
–	Overheads	–	(105)	–	–	–	463	–	463		
567,611	NHSE Income	91,509	91,509	–	–	(402)	402	–	–		
603,164	**Sub Total Corporate Income**	**97,410**	**97,305**	**–**	**–**	**(402)**	**297**	**–**	**(105)**		
	Clinical Divisions										
(51,559)	Diagnostic & Therapies	(8,605)	(8,516)	163	(166)	(16)	143	(35)	89	15	74
(79,538)	Medicine	(13,505)	(14,107)	(403)	(6)	(26)	58	(225)	(602)	(257)	(345)
(111,223)	Specialised Services	(18,527)	(18,778)	(48)	32	11	(252)	6	(251)	44	(295)
(109,259)	Surgery	(18,401)	(18,732)	(433)	(49)	(24)	337	(162)	(331)	(32)	(299)
(124,745)	Women's & Children's	(20,752)	(20,852)	(323)	172	(20)	116	(45)	(100)	(4)	(96)
(476,324)	**Sub Total – Clinical Divisions**	**(79,790)**	**(80,985)**	**(1,044)**	**(17)**	**(75)**	**402**	**(461)**	**(1,195)**	**(234)**	**(961)**
	Corporate Services										
(36,569)	Facilities And Estates	(6,184)	(6,204)	16	(9)	(1)	3	(29)	(20)	(20)	–
(25,543)	Trust Services	(4,545)	(4,546)	58	(26)	(21)	–	(13)	(2)	–	(2)
(5,878)	Other	(1,267)	(1,280)	(12)	383	(408)	10	15	(12)	–	(13)
(67,990)	**Sub Totals – Corporate Services**	**(11,996)**	**(12,030)**	**62**	**348**	**(430)**	**13**	**(27)**	**(34)**	**(20)**	**(15)**
(544,314)	**Sub Total (Clinical Divisions & Corporate Services)**	**(91,786)**	**(93,015)**	**(982)**	**331**	**(505)**	**415**	**(488)**	**(1,229)**	**(254)**	**(976)**
(10,840)	Reserves	–	–	–	–	–	–	–	–		
–	NHS Improvement Plan Profile	(844)	–	–	844	–	–	–	844		
(10,840)	**Sub Total Reserves**	**(844)**	**–**	**–**	**844**	**–**	**–**	**–**	**844**		
48,010	**Trust Totals Unprofiled**	**4,780**	**4,290**	**(982)**	**1,175**	**(907)**	**712**	**(488)**	**(490)**		
	Financing										
(22,764)	Depreciation & Amortisation – Owned	(3,794)	(3,662)	–	132	–	–	–	132		
244	Interest Receivable	41	24	–	(17)	–	–	–	(17)		
(264)	Interest Payable on Leases	(44)	(44)	–	–	–	–	–	–		
(3,022)	Interest Payable on Loans	(470)	(467)	–	3	–	–	–	3		
(9,247)	PDC Dividend	(1,541)	(1,541)	–	–	–	–	–	–		
(35,053)	**Sub Total Financing**	**(5,808)**	**(5,690)**	**–**	**118**	**–**	**–**	**–**	**118**		
12,957	**NET SURPLUS / (DEFICIT) before Technical Items**	**(1,028)**	**(1,400)**	**(982)**	**1,293**	**(907)**	**712**	**(488)**	**(372)**		
	Technical Items										
–	Profit/(Loss) on Sale of Asset	–	–	–	–	–	–	–	–		
–	Donations & Grants (PPE/Intangible Assets)	–	266	–	–	267	–	–	267		
(1,314)	Impairments	–	–	–	–	–	–	–	–		
–	Reversal of Impairments	–	–	–	–	–	–	–	–		
(1,561)	Depreciation & Amortisation – Donated	(260)	(257)	–	3	–	–	–	3		
(2,875)	**Sub Total Technical Items**	**(260)**	**9**	**–**	**3**	**267**	**–**	**–**	**270**		
10,082	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**(1,288)**	**(1,391)**	**(982)**	**1,296**	**(641)**	**712**	**(488)**	**(103)**		

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*	*3.8%*	*3.8%*	*3.8%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*3.9%*	*3.9%*	*3.9%*
Medicine	Actual	3.6%	3.9%										
Specialised Services	*Target*	*3.5%*	*3.5%*	*3.5%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.6%*	*3.6%*	*3.6%*
Specialised Services	Actual	3.7%	4.7%										
Surgery, Head & Neck	*Target*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*
Surgery, Head & Neck	Actual	4.5%	4.4%										
Women's & Children's	*Target*	*3.3%*	*3.3%*	*3.3%*	*3.6%*	*3.6%*	*3.6%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*
Women's & Children's	Actual	4.1%	4.6%										

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	6.9%	9.4%										
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	4.0%	4.5%										
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	8.6%	8.4%										
Women's & Children's	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Women's & Children's	Actual	2.3%	3.6%										

Source: HR

Graph 3 **Turnover**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*
Medicine	Actual	13.5%	12.8%										
Specialised Services	*Target*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*
Specialised Services	Actual	13.6%	14.7%										
Surgery, Head & Neck	*Target*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*
Surgery, Head & Neck	Actual	11.8%	11.9%										
Women's & Children's	*Target*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*
Women's & Children's	Actual	12.9%	12.5%										

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*	*118.8*	*118.8*	*109.8*	*100.8*	*91.8*	*82.9*	*82.9*	*91.8*	*100.8*	*109.8*	*109.8*	*109.8*
Medicine	Actual	207.9	116.5										
Specialised Services	*Target*	*61.5*	*75.0*	*68.5*	*64.2*	*64.2*	*59.8*	*59.8*	*54.4*	*65.3*	*62.5*	*58.8*	*58.8*
Specialised Services	Actual	20.7	49.6										
Surgery, Head & Neck	*Target*	*64.6*	*69.6*	*79.5*	*85.5*	*80.5*	*89.6*	*89.3*	*55.7*	*64.6*	*69.5*	*69.5*	*64.6*
Surgery, Head & Neck	Actual	158.2	147.6										
Women's & Children's	*Target*	*110.0*	*110.0*	*110.0*	*110.0*	*110.0*	*110.0*	*50.0*	*50.0*	*50.0*	*50.0*	*50.0*	*50.0*
Women's & Children's	Actual	85.3	163.8										
Trust Total	*Target*	354.9	373.4	367.9	360.5	346.5	342.3	281.9	251.9	280.6	291.9	288.1	283.2
Trust Total	Actual	472.1	477.5	-	-	-	-	-	-	-	-	-	-

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*	*14.0*	*14.0*	*13.0*	*12.0*	*11.0*	*10.0*	*10.0*	*11.0*	*12.0*	*13.0*	*13.0*	*13.0*
Medicine	Actual	25.3	26.3										
Specialised Services	*Target*	*9.5*	*12.0*	*10.8*	*10.0*	*10.0*	*9.2*	*9.2*	*8.2*	*10.2*	*9.7*	*9.0*	*9.0*
Specialised Services	Actual	2.4	6.1										
Surgery, Head & Neck	*Target*	*13.0*	*14.0*	*16.0*	*17.2*	*16.2*	*18.2*	*18.2*	*11.2*	*13.0*	*14.0*	*14.0*	*13.0*
Surgery, Head & Neck	Actual	17.8	19.2										
Women's & Children's	*Target*	*11.0*	*11.0*	*11.0*	*11.0*	*11.0*	*11.0*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*
Women's & Children's	Actual	10.0	10.1										
Trust Total	*Target*	47.5	51.0	50.8	50.2	48.2	48.4	42.4	35.4	40.2	41.7	41.0	40.0
Trust Total	Actual	55.5	61.7	-	-	-	-	-	-	-	-	-	-

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*	*6.6%*	*6.6%*	*6.2%*	*5.7%*	*5.2%*	*4.7%*	*4.7%*	*5.2%*	*5.7%*	*6.2%*	*6.1%*	*6.1%*
Medicine	Actual	11.1%	6.3%										
Specialised Services	*Target*	*4.4%*	*5.4%*	*4.9%*	*4.6%*	*4.6%*	*4.3%*	*4.3%*	*3.9%*	*4.7%*	*4.5%*	*4.2%*	*4.2%*
Specialised Services	Actual	1.5%	3.5%										
Surgery, Head & Neck	*Target*	*3.7%*	*3.9%*	*4.5%*	*4.8%*	*4.5%*	*5.0%*	*5.0%*	*3.2%*	*3.7%*	*3.9%*	*3.9%*	*3.7%*
Surgery, Head & Neck	Actual	8.5%	8.0%										
Women's & Children's	*Target*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*
Women's & Children's	Actual	2.4%	4.5%										
Trust Total	Actual	5.5%	5.4%										

Source: Finance GL (RNs only)

Graph 7 **Occupied bed days**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	Actual	9,071	9,542										
Specialised Services	Actual	4,392	4,719										
Surgery, Head & Neck	Actual	4,481	4,616										
Women's & Children's	Actual	6,179	6,658										

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	96	88										
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	9	33										
Surgery, Head & Neck	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery, Head & Neck	Actual	33	35										
Women's & Children's	*Target*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
Women's & Children's	Actual	6	9										
Trust Total	*Target*	118.6	118.6	118.6	118.6	118.6	118.6	118.6	118.6	118.6	118.6	118.6	118.6
Trust Total	Actual	143.8	164.6	-	-	-	-	-	-	-	-	-	-

Source: Finance temp staffing graphs (history changes)

Graph 9 **CIP - Nursing & Midwifery Productivity**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Trust Total	*Target*	31	63	94	126	157	189	220	251	283	314	346	377
Trust Total	Actual	22	33										

Source: Service Improvement Team - Amy

Nursing & ODP Variance – May 2017

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	241	(143)	98	
	Other	18	(21)	(3)	
	ED	6	(18)	(12)	
Medicine Total		**264**	**(182)**	**82**	**113%**
Surgery, Head & Neck	Ward	45	(84)	(39)	
	Theatres	(72)	8	(64)	
	Other	17	12	29	
	ED	(0)	(4)	(4)	
Surgery, Head & Neck Total		**(10)**	**(68)**	**(78)**	**127%**
Specialised Services	Ward	25	(54)	(29)	
	Other	50	(38)	12	
Specialised Services Total		**75**	**(91)**	**(16)**	**124%**
Women's & Children's Services	Ward	(9)	(69)	(78)	
	Theatres	(151)	8	(143)	
	Other	82	10	91	
	ED	9	(4)	6	
Women's & Children's Services Total		**(69)**	**(56)**	**(125)**	**132%**
Clinical Division Total	Ward	305	(353)	(48)	
	Theatres	(224)	16	(207)	
	Other	164	(35)	129	
	ED	15	(25)	(10)	
CLINICAL DIVISIONS TOTAL		**260**	**(397)**	**(137)**	**125%**
NON CLINICAL DIVISIONS	Other	12	10	22	
NON CLINICAL DIVISIONS TOTAL		**12**	**10**	**22**	
TRUST TOTAL		**271**	**(386)**	**(115)**	**125%**

Key Financial Metrics -April 2017 **Financial Metrics- May** **Appendix 4**

		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 - Penalties										
	Current Month									
	Plan	0	(17)	(2)	(8)	(4)	0		(53)	(84)
	Actual	0	(43)	(5)	(37)	(7)	0		(185)	(277)
	Variance Fav / (Adv)	-	(26)	(3)	(29)	(3)	-	-	(132)	(193)
	Year to date									
	Budget	0	(33)	(5)	(16)	(8)	0		(103)	(165)
	Actual	0	(48)	(7)	(38)	(7)	0		(272)	(372)
	Variance Fav / (Adv)	-	(15)	(2)	(22)	1	-	-	(169)	(207)
Contract Income - Activity based										
	Current Month									
	Plan	3,480	5,014	5,484	7,096	9,374	336		8,001	38,785
	Actual	3,573	5,218	5,189	7,361	9,671	343		8,191	39,546
	Variance Fav / (Adv)	93	204	(295)	265	297	7	-	190	761
	Year to date									
	Plan	6,664	9,757	10,480	13,524	18,169	650		15,339	74,583
	Actual	6,812	9,967	9,981	13,862	18,359	651		15,570	75,202
	Variance Fav / (Adv)	148	210	(499)	338	190	1	-	231	619

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

Contract Income - Rewards										
	Current Month									
	Plan	79	117	158	162	184	95	-	-	795
	Actual	80	119	160	164	186	96	-	-	805
	Variance Fav / (Adv)	1	2	2	2	2	1	-	-	10
	Year to date									
	Plan	152	225	303	312	353	183	-	-	1,528
	Actual	152	225	304	312	354	183	-	-	1,530
	Variance Fav / (Adv)	0	0	1	0	1	0	-	-	2

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

Cost Improvement Programme										
	Current Month									
	Plan	106	190	78	213	166	59	45	90	947
	Actual	98	105	86	102	149	55	37	98	730
	Variance Fav / (Adv)	(8)	(85)	8	(111)	(17)	(4)	(8)	8	(217)
	Year to date									
	Plan	218	380	190	440	331	117	92	180	1,948
	Actual	196	179	205	236	295	108	78	195	1,492
	Variance Fav / (Adv)	(22)	(201)	15	(204)	(36)	(9)	(14)	15	(456)

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report May 2017 - 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 £12.957m based on the Divisions run rate of overspend to the end of May (month 2).	16 - Very High	£7.2m	Each Division is required to achieve a balanced Operating position which must be delivered.	PM	16 - Very High	£7.2m	4 - Moderate	£0.0m
959	Risk that Trust does not deliver the required savings in year. Only 77% of the required savings have been delivered at 31st May 2017, leaving a savings gap of £0.5m.	16 - Very High	£3.0m	Trust is working to rapidly deliver savings plans to meet 2017/18 target in full of £11.9m and close the current savings gap of £4.2m. Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes.	MS	12 - High	£3.0m	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 that national guidance mandates national core fines and loss of Sustainability & Transformation (S&T) Funding due to under-performance against the A&E 4 hour wait trajectory (all year) and S&T core finance (Q3 and Q4)	20 - Very High	£12.5m	30% of the agreed Sustainability & Transformation Funding is subject to forfeit if the A&E 4 hour wait trajectory is not met. The current risk of loss is very high.	PM	20 - Very High	£12.5m	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	£1.5m	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	-

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Thursday, 29 June 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**	29 June 2017
Report Title	Corporate Governance Statement – Self Certification		
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

This report provides the necessary assurance to the Board of Director of the progress in relation to the agreed actions for 2016/17 to ensure continued compliance with the Corporate Governance Statement.

Key issues to note

Under the governance condition of the Provider Licence regime, the Board is required to submit the following self-certifications to NHS Improvement on 30 June 2017:

The governance statement specifically requires the Board to confirm:

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

This paper provides an update on the progress and provides assurance to the Board of the systems and processes in relation to the Board's self-certification process.

Recommendations
Members are asked to: • **Confirm** self-certification against the requirements of General Condition 4 of the Licence.

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
Failure to appoint External Auditor will result in the Trust in breach of the Foundation Trust Licence. This report sets out the process for approval and appointment in accordance with the constitution.

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)**
18/10/2016	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.	

CORPORATE GOVERNANCE STATEMENT – SELF CERTIFICATION

1. INTRODUCTION

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

NHS Improvement uses the information provided in these documents primarily to assess the risk that an NHS Foundation Trust may breach its licence in relation to finance and governance. NHS Improvement will also assess the quality of the underlying planning processes.

2. SELF CERTIFICATION

The Statements require the Board's consideration and certification are as follows:.

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

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

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

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

3. ASSESSMENT

In order to strengthen the governance and assurance processes in relation to the annual declaration, the Audit Committee received a report setting out the appropriate assurances in relation to the compliance with General Condition 4 in October 2016.

Annex (i) provides a summary of the requirements under the Corporate Governance Statement including the assessment of compliance. Furthermore, the Annual Governance Statement provides a detailed assessment and demonstrates that the Trust has a sound system of corporate governance throughout the organisation.

Progress during 2016/17 has included:

- Review of the Board Assurance Framework which has included the alignment to the Corporate Risk Register;
- Review of the processes including reporting arrangements through to the Board;
- Revision of the board and committee templates;
- Review of the business cycles and agenda planning;
- Completion of the actions following the Deloitte "Well Led Governance Review";
- Review of the Non- Executive Director appraisal process which has included the streamlining of the reporting processes;
- Review of the processes for declaring interests, gifts and hospitality; and
- Implementing Fit and Proper Persons Policy covering all Board Director Positions.

There are no risks identified in relation to the compliance with the Corporate Governance Statement. Any risks that are identified during the year are reported through the Trust's risk management process and the Board Assurance Framework quarterly report to the Board.

4. RECOMMENDATIONS

Members are asked to:

- **Confirm** self-certification against the requirements of General Condition 4 of the Licence.

Annexes

Annex (i) Corporate Governance Statement

Corporate Governance Statement Reference	Suggested Evidence of Self-Certification (*Internal Use only*)	Response
1. The Board is satisfied that University Hospitals Bristol NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• Annual Report outlining Code of Governance compliance • Annual constitutional review • Annual Governance Statement providing assurance on the strength of Internal Control regarding risk management processes, review and effectiveness • ISA 260/External Audit Opinion on Annual Report and Quality Accounts • Head of Internal Audit Opinion and audit of quality indicators • Approved Internal Audit Plan • Internal and external audits with recommendations approved by Executive Leads and follow up process • Trust Board Governance Structure • Board Effectiveness Review • Annual Operating Plan 2016- 19 • Quarterly progress reports against corporate and quality objectives • Compliance with the reporting arrangements under the single oversight framework • Monthly quality and performance reports to relevant committee and Board (including focus on workforce) • Programme of regular quality reports and reporting to committees and Board including: patient safety, workforce; patient experience; serious incidents; complaints; and trust wide learning • Monthly finance reports to the Board • Quarterly review of Board assurance framework and annual assessment of strategic objectives and associated risks • CQC reports and response to CQC inspection/actions • Risk Management Strategy and policy • Corporate and Divisional Risk Registers • IG Toolkit self-certification • Mandatory training compliance • Review of Code of Conduct for both Board and Council of Governors • SFIs, Scheme of Delegation and Standing Orders annual review • Board walk rounds • Staff appraisal performance and compliance • NED appraisal process	Confirmed

Corporate Governance Statement Reference	Suggested Evidence of Self-Certification (*Internal Use only*)	Response
2. The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	• Monitor guidance generally implemented on an ongoing basis, e.g. Risk Assessment Framework/ Code of Governance • Compliance with the guidance on Well Led Governance Reviews • Annual self-assessment on Monitor's guidance on strategic planning undertaken • Annual review of compliance with Monitor's Code of Governance as part of Annual Report submission • PwC technical updates to the Audit Committee advise on forthcoming changes to regulation • Board Development Programme • Well Led Governance Review	Confirmed
3. The Board is satisfied that the Trust implements: (a) effective board and committee structures; (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) clear reporting lines and accountabilities throughout its organisation	• Board committee and governance structure • Reports and minutes from Committees and the Board • Review of the effectiveness of the Board and its committees and Board development/seminar sessions • Terms of reference for Board, committees and working groups • Annual reports from committees and review of terms of reference/ annual forward planners • Internal Audit reports on corporate governance related issues • Annual Governance Statement • Annual self-assessment of compliance with Monitor Code of Governance • Review of the Trust Constitution, Standing Orders, SFIs and Scheme of Delegation • Cross Board Committee NED Membership and reporting lines • Individual board members annual objectives, appraisals and development plans • Board member training records • Performance Management Framework • Risk management strategy outlining flow of information through the organisation regarding risks and the management of corporate and local risks including escalation and de-escalation • Statutory disclosure of Director' responsibilities in Annual Report • Code of Conduct of Board Members and Governors • Organisational Structure	Confirmed

Corporate Governance Statement Reference	Suggested Evidence of Self-Certification (*Internal Use only*)	Response
4. The Board is satisfied that the Trust effectively implements systems and/or processes: (a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively; (b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations; (c) to ensure compliance with healthcare standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions; (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern); (e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	• The Board has access on an ongoing basis to inform its assessment of the risks to compliance with its Licence: - Monthly performance data to the Board and reviewed in respect of targets and standards, in line with Risk Assessment Framework. - Programme of regular quality reports and monitoring information in respect of workforce, patient safety, patient experience, serious incidents, complaints and infection control - Monthly Board finance reporting the overall financial position/performance against efficiency savings and key financial risks - Quarterly consideration of Financial Risk Rating (FRR), Continuity of Service Risk Rating (CoSRR) through self-declaration to Monitor and supporting narrative • Monthly Chief Executive report to the Board • Annual Plan and business planning process/scrutiny/ challenge to KPI Board metrics • Monitoring complaints, survey results, incidents, claims and effective reporting mechanisms that provide intelligence triangulation • Board committee structure providing ongoing review, scrutiny and monitoring of required development actions throughout the year – ensuring the Board has appropriate mechanisms to respond should any concerns develop in year • Annual internal audit programme confirmed by annual accounts audit opinion and ISA 260 report to Audit Committee • Divisional performance review meetings /service line meetings • Quarterly Board report on progress with key elements of the organisation's strategy and corporate objectives • Regular reporting to relevant committees and Board on compliance with CQC Fundamental Standards • Information Governance Toolkit annual submission • Cleanliness audits/PLACE inspections/Clinical Audit & Effectiveness programme /Infection Control standards • Clinical Commissioning Group Contract review meetings • Monthly Board finance reports to Finance Committee and Board, including progress on delivery of efficiency savings programme • Internal audit reports on financial systems and controls • External audit report (ISA 260) on the Annual Report and Accounts	Confirmed

Corporate Governance Statement Reference	Suggested Evidence of Self-Certification (*Internal Use only*)	Response
(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) to ensure compliance with all applicable legal requirements	• Approval of the operational plan and financial plan • Annual cycle of business (forward planner) for Board and committees ensuring appropriate scheduling of reports • Corporate Risk Register and Board Assurance Framework reports key risks for finance and performance • Board assessment of strategic risks • Risks and mitigations identified in Monitor's Operational Plan/ Annual Report and Long Term Financial Model • The Corporate Risk Register and mitigating actions monitored by Risk Management Group, Senior Leadership Team, committees and Board • Trust's going concern review • Cost Improvement plans and budget setting process • Governance arrangements (Constitution, Standing Orders, Standing Financial Instructions, Scheme of Delegation) • Annual Clinical Audit Plans • Board walk rounds • Staff and Patient Surveys • Review of Serious Incidents, Root Cause Analysis link to learning, adherence, improvement	
5. The Board is satisfied: (a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) the collection of accurate, comprehensive, timely and up to date information on quality of care;	• Quarterly and annual self-declarations to Monitor • Appraisal outcomes • Board approved Remuneration Committees Terms of Reference • Details of training undertaken by NEDs and EDs • Board Induction Programme, skills audit and succession planning • Register of interests and standards of business conduct • Pre-employment checks; contractual conditions regarding other employment • Constitution - Board composition and work of Remuneration Committee • Approved Quality Strategy and Quality Accounts • Patient Story to every Board meeting • Board line of sight – walk rounds • Confirm and challenge focussing specifically on complaints process – complaints trends and themes to Board • External assurance on Quality Account	Confirmed

Corporate Governance Statement Reference	Suggested Evidence of Self-Certification (*Internal Use only*)	Response
(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) that the Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) that there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate	• CQC Intelligent Monitoring/ CQC Compliance assessment • Annual Plan • Head of Internal Audit Opinion • Quality Impact Assessments • Clinical Audit plan improvements – time required to understand progress and link to improvements in outcomes of care • IG toolkit compliance reporting • Clinical audit plan • CQUIN performance reports • Committee meeting minutes focusing on quality improvement • Complaints, claims and incidents reporting • SUI reporting to Board via relevant committee, robust RCA process with further work commencing to improve learning loop and dissemination of learning • Board monthly quality dashboard • Survey outcomes to Board with remedial actions • Data quality focus increasing – validation, internal audit focus, business analysts, coding, Buddying arrangements etc • Annual Plan Engagement • Friends and Family Test, patient and staff surveys • CoG Project Focus Groups – independent, influencing agenda CoG and committees • Governor feedback and activity – PLACE audits etc • Quality Strategy driving analysis of Trust's performance on key quality metrics • Direct link to quality improvement through quality accounts and quality strategy • National reporting mechanism to Board (Berwick) • Board approved Committee ToRs – clear responsibilities • Executive job descriptions • Transformation strategy • Risk registers supported by quality issues captured in Divisional registers • Senior Leadership Team escalation protocols re off plan performance/quality	

Corporate Governance Statement Reference	Suggested Evidence of Self-Certification (*Internal Use only*)	Response
6. The Board of University Hospitals Bristol NHS Foundation Trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence	• Formal, rigorous and transparent procedure for the appointment of new directors to the Board • Board approval of constitution review • Board is comprised of appropriately qualified Director of Finance, Medical Director and Chief Nurse • Employment checks • Annual skills and competencies audit and annual appraisal process • Minutes of Remuneration and Nomination Committee (EDs)/Council of Governors' Nomination and Appointments Committee (NEDs) • Nursing staffing review/monitoring of nursing numbers • Revalidation process for doctors • HR policies and procedures • Board development programme in place • Succession planning arrangements in place for new Non Executive Directors	Confirmed

TRAINING FOR GOVERNORS The Board is satisfied that during the financial year, most recently ended the Trust has provided the necessary training to its Governors as required by in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role	• Induction Programme for new Governors • Development Seminars for all Governors • External Training Courses (NHS Providers) • Skills Audit The induction programme was established to provide governors with the necessary core training and development of their skills to perform the statutory duties of governors effectively and to discharge their responsibilities with enhanced levels of insight. The programme reflects Monitor's guidance for governors and was co-created with governors using self-assessment and the Constitutional Focus Group. There is also range of other opportunities for training and development provided to governors in the course of their attendance at various project groups and other meetings and activities throughout the year.	Confirmed
CERTIFICATIONS ON ACADEMIC HEALTH SCIENCE CENTRE (AHSCS) AND GOVERNANCE For NHS Foundation Trusts: • That are part of a major Joint Venture or AHSCS; or • Whose Boards are considering entering into either a major Joint Venture or an AHSC	N/A	N/A

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Thursday, 29 June 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	18
Meeting Title	Quality and Outcomes Committee	Meeting Date	Thursday, 29 June 2017
Report Title	Quality and Outcomes Committee Terms of Reference and Business Cycle		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Pam Wenger, Trust Secretary		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

This paper contains the Terms of Reference for the Quality and Outcomes Committee, in line with the delegated authority from the Trust Board of Directors.

Key Issues:

The terms of reference for the Quality and Outcomes Committee was reviewed at the meeting on 23 May 2017.

One minor amendment to the Terms of Reference is recommended:

- deletion of section 6.3.2 in relation to the risk assessment framework. This has now been replaced by the Single Oversight Framework and does not require a separate

declaration.
Recommendations
Members are asked to: • **Approve** the terms of reference for the Quality and Outcomes Committee.

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**	**Other (specify)**
Click here to enter a date.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.	

University Hospitals Bristol NHS
NHS Foundation Trust

Terms of Reference – Quality and Outcomes Committee

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

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

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1. Constitution of the Committee

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

2. Purpose and function

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

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

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

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

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

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

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

2.2 To achieve this, the Committee shall:

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

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

2.2.3 Support and encourage quality improvement where opportunities are identified.

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

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

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

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

3. Authority

3.1 The Quality and Outcomes Committee will:

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

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

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

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

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

4. Membership and attendance

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

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

4.2.1 Chief Nurse

4.2.2 Medical Director

4.2.3 Chief Operating Officer

4.2.4 Director of Workforce and OD

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

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

4.4.1 Associate Director of Performance

4.4.2 Head of Quality (Patient Experience and Clinical Effectiveness)

4.4.3 Head of Quality (Patient Safety)

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

5. Quorum

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

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

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

6. Duties

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

6.1 Quality Strategy

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

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

6.2 Annual Plan and Quality Report

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

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

6.3 Clinical and Service Quality, Compliance and Performance

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

6.3.1.1 Clinical and service quality;

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

6.3.1.3 Organisational performance measured against specified standards and targets.

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

6.3.3 Review the Board Quality and Performance Report; and

6.3.4 Review the Quarterly Workforce and Organisational Development report.

6.4 Action Plan Monitoring

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

6.5 Benchmarking, Learning and Quality Improvement

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

6.5.2 Review the Annual Clinical Audit report;

6.5.3 Receive quarterly reports on complaints and patient experience;

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

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

6.5.6 Receive and review quarterly reports on Infection Control;

6.5.7 Receive and review the annual report on Safeguarding;

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

6.5.9 Receive and review the Equality and Diversity Annual Report;

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

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

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

6.6 Risk

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

6.7 Quality Governance

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

6.8 Procedural Documents and Corporate Record Keeping

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

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

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

7. Reporting and Accountability

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

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

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

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

8. Administration

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

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

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

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

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

including the names of those present and those in attendance.

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

9. Frequency of Meetings

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

10. Review of Terms of Reference

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

Cover report to the Public Trust Board meeting to be held on Thursday, 29 June 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**	29 June 2017
Report Title	Governors Log of Communication		
Author	Amanda Saunders, 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: • **Receive** the report.

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

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

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

Impact Upon Corporate Risk
N/A

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

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

ID	Governor Name		
187	Clive Hamilton	***Theme:*** Performance	***Source:*** Governor Direct

Query **09/05/2017**

18 week Referral to Treatment target for Neurology - noted on page 81 of the March 2017 Board Report (Appendix 3) the neurology pathway is only achieving a 79.9% response to the 92% target and again on page 115 of the April Board report (Appendix 3).

As this pathway is significantly and consistently below target have action plans been developed to bring the referral time into line?

Division: Medicine ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 10/05/2017

Response **19/05/2017**

Neurology performance has been below the 92% national RTT standard due to difficulties and delays in recruiting to key posts within the service. The number of long waiters had now reduced down from a peak in January of 122 to 84 at the end of April. Waiting List initiatives are being offered to the Clinical Fellow for the service, to attempt to further reduce the number of long waiters. This is a part of the Trust's overall RTT Sustainability Plan for 2017/18.

Status: *Closed*

ID	Governor Name		
186	Florene Jordan	***Theme:*** Incident reporting	***Source:*** Governor Direct

Query **25/04/2017**

Can governors understand what steps are taken by managers in the Trust when investigating incidents to ensure that the correct contributory factors to the incident are identified and correctly documented?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **21/06/2017**

The trust requires timely reporting of all incidents and 'near misses' to improve patient and staff safety and quality of care. The trust has a Policy for the Management of Incidents, which applies to all staff. The purpose of this policy is to ensure there is a systematic trust wide approach to the reporting and investigation of incidents and to ensure that analysis of incidents takes place to capture learning which is used to reduce the risk of a recurrence and to inform service improvements. The trust promotes an open and transparent approach to incident reporting and investigation and to seek to learn lessons and implement risk reduction measures when things have gone wrong. The incident reporting process must therefore be viewed as non-threatening to ensure the involvement of staff.

The policy details the process for responding to a reported incident and when followed this should ensure the contributory factors are assessed and correctly documented or in the event of this not being the case in the initial logging of the incident the correct information added at initial review. Regular review of incidents reported and the incident reporting process is undertaken at a local and trust wide level, and where there is an identified cause for with concern with regards to accuracy of documented information this is addressed with staff/ departments/ divisions as a point of learning improvement to the overall process.

Status: *Awaiting Governor Response*

ID	Governor Name		
185	Rashid Joomun	***Theme:*** Clinical Genetics department	***Source:*** Other

Query **20/04/2017**

On a recent walk around with the Division of Specialised Services we visited the Clinical Genetics department at St Michael's Hospital. The location of a maternity hospital as the site for a clinical genetics team is far from ideal and conditions for staff are cramped. Are there any plans for the department to be relocated to a site more conducive to the type of work they do? And furthermore, when will this team benefit from its patient records being available electronically via Evolve?

Division: Specialised Services ***Executive Lead:*** *Medical Director* ***Response requested:***

Response **26/04/2017**

As part of the Trust's strategic plans we are looking at long term solutions for the accommodation of the Genetics department. While we evaluate the options we have made available additional rooms at South Bristol Community Hospital and the children's hospital to help ease pressures. The genetics department will benefit from Evolve later in the year, once the system has been rolled out through the Bristol Royal Infirmary and Bristol Heart Institute.

Status: *Awaiting Governor Response*

184	Mo Schiller	***Theme:*** Changes to doctors' mess at BRHC	***Source:*** Other

Query **20/04/2017**

Governors are aware of plans to convert the current doctors' mess in the children's hospital into space for another use, and that this has caused concern among doctors working in this hospital. What assurance can governors seek that any proposed changes have been properly assessed and communicated to the doctors involved, and that any proposed alternative space for the doctors mess is fit for purpose?

Division: Women's & Children's Services ***Executive Lead:*** *Medical Director* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

ID	Governor Name		
183	Mo Schiller	***Theme:*** Heygroves Theatres	***Source:*** From Constituency/ Members

Query **23/03/2017**

A Foundation Trust member who had surgery in Heygroves Theatres at the end of last year raised with me a concern that the pre-operative area was so cold that she needed to be warmed by a special heat blanket before staff could insert an IV line. I understand that this has been a common problem and am keen to find out why there is an issue with the heating in this area so that it can be resolved for future patients.

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **24/04/2017**

The heating in the pre-operative area, located in the King Edward Building, is now connected to the constant temperature hot water supply and commissioned to our requirements. The Trust Estates team is not aware of any current issues, however from time to time, breakdowns do occur, especially with the older parts of the estate linked to this area.

The pre-operative area (or SAS Pod) is a new addition to our estate, located on the roof of the King Edward Building, completed in 2015. Adjustments were made in the first winter of 2015/16 in order to optimise the system which was originally commissioned summer 2015.

When the refurbishment of the whole King Edward Building was completed in winter 2016/17, the heating to the pre-operative area was rebalanced as there were additional demands on the supply. The Capital team has confirmed that this was around Christmas 2016 which may in fact coincide with your operation.

Now having three months data, we believe there is a further local balancing optimisation that would benefit the system including the SAS Pod and we are just commissioning this. Please be assured that this system is monitored and we are able to respond swiftly to any issues, however we continue to strive to optimise our energy as part of on-going savings and sustainability work.

Status: *Closed*

ID	Governor Name		
182	Bob Bennett	***Theme:*** Return of NHS equipment	***Source:*** From Constituency/ Members

Query **23/03/2017**

I have been approached by many outpatients regarding the return of NHS equipment such as crutches, walking sticks, commodes etc. as they do not know of any way of returning these items when no longer required. One patient has six walking sticks given to her on many visits to hospital. Can the Trust clarify the process of returning such items for reuse as it is costing the NHS many thousands of pounds in 'lost' equipment.
Follow up question added 10/05/17:
In light of the response received, please can we be advised as to when and how patients are informed of the process for returning items as several patients have informed me that no information was provided, raising the original query.

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **24/04/2017**

Currently there is a process in place via an external contractor for collection and recycling of frames and crutches provided via community services, the Trust is in negotiation to try and expand this collection service for equipment provided by the Trust to inpatients on discharge. The service will have responsibility for collecting items to patients, patients will be advised of this. in addition, patients can choose to, and do bring back equipment once they have finished with it and this, where appropriate, is recycled.

Status: *Closed*