University Hospitals Bristol
NHS Foundation Trust

Public Trust Board Meeting Papers

Date: 31 October 2017

Time: 11:00 – 13:00

Venue: Conference Room, Trust Headquarters

University Hospitals Bristol NHS Foundation Trust

PUBLIC TRUST BOARD

Meeting to be held on Tuesday 31 October 2017, 11.00 – 13.00

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.	Minutes of the last meeting • 28 September 2017	Approval	*Chairman*	**3**
4.	Patient Story	Assurance	*Chief Executive*	**16**
5.	Matters arising and action log	Approval	*Chairman*	**20**
6.	Chief Executive's Report	Information	*Chief Executive*	**22**
7.	Board Assurance Framework – Q2	Information	*Chief Executive*	**28**
Care and Quality				
8.	Quality and Performance Report	Assurance	*Deputy Chief Operating Officer*	**51**
9.	Quality and Outcomes Committee - Chair's Report	Assurance	*Quality & Outcomes Committee Chair*	**[Included]**
10.	Independent Review of Children's Cardiac Services – Final Report	Assurance	*Chief Nurse*	**110**
Research and Innovation				
11.	Research and Innovation Quarterly Report	Assurance	*Acting Medical Director*	**154**
Financial Performance				
12.	Finance Report	Assurance	*Director of Finance & Information*	**162**
13.	Review of Finance Committee Terms of Reference	Assurance	*Director of Finance*	**182**
14.	Finance Committee Chair's Report	Assurance	*Chair of the Finance Committee*	**To be tabled**

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Governance				
15.	Audit Committee Chair's Report	Assurance	*Chair of the Audit Committee*	**To be tabled**
16.	Register of Seals	Assurance	*Chief Executive*	**200**
Items for Information				
17.	Governors' Log of Communications	Information	*Chairman*	**204**
Concluding Business				
18.	Any Other Urgent Business	Information	*Chairman*	**Verbal**
19.	Date and time of next meeting **29 November 2017, 11.00 – 13.00, Conference Room, Trust Headquarters**	Information	*Chairman*	**Verbal**

Minutes of the Public Trust Board Meeting

Held on Thursday 28 September 2017, 11:00-13:00, Conference Room, Trust Headquarters

Present

Board Members

Member Name	Job Title/Position
John Savage	Chairman
David Armstrong	Non-Executive Director
Julian Dennis	Non-Executive Director
Lisa Gardner	Non-Executive Director
Guy Orpen	Non-Executive Director
Emma Woollett	Non-Executive Director
Jill Youds	Non-Executive Director
Martin Sykes	Non-Executive Director
Steve West	Non-Executive Director(Designate)
Robert Woolley	Chief Executive
Paula Clarke	Director of Strategy and Transformation
Paul Mapson	Director of Finance and IM&T
Carolyn Mills	Chief Nurse
Matthew Joint	Director of People
Alex Nestor	Acting Director of Workforce and Organisational Development
Mark Smith	Chief Operating Officer/Deputy Chief Executive

In Attendance

Name	Job Title/Position
Pam Wenger	Trust Secretary
Sophie Melton Bradley	Deputy Trust Secretary
Sara Kirby	Corporate Governance Administrator

Minutes:

Sophie Melton Bradley	Deputy Trust Secretary

The Chair opened the Meeting at 11.00

Minute Ref	Item Number	Action
Preliminary Business		
144/09/17	**1. Welcome and Introductions**	
	The Chairman welcomed everyone to the meeting, in particular new Non-Executive director Martin Sykes. The Board also welcomed Tariq, a Trust patient who attended to present his patient story (see **Item 6**). Apologies for absence were noted from Non-Executive Director John Moore, and Non-Executive Director (Designate) Madhu Bhabuta.	
145/09/17	**2. Declarations of Interest**	
	There were no declarations of interest.	
147/09/17	**4. Minutes of the last meeting**	
	The minutes of the meeting held on the 28 July 2017 were agreed as a true and accurate record, there were no amendments made. **Members RESOLVED to:** • **Approve** the minutes as a true and accurate record from the meeting held on 28 July 2017.	
148/09/17	**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.	
149/09/17	**6. Chief Executive's Report**	
	The Chief Executive discussed key highlights from the Chief Executive's report and updated the Board on several further matters which were not covered in the report, including the following: • Key messages had been published nationally from NHS Improvement (NHSI) and NHS England (NHSE) regarding preparations for winter. Providers had been asked them to prepare and to focus on the 4 hour A&E target, the 62 day cancer target and the other major priorities. *Single Oversight Framework* Changes to the regulators' framework: NHSI had reviewed its single oversight framework, trying to create greater alignment with care quality	

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	regulation and to better reflect the principle of earned autonomy. • It was noted that NHSI is proposing to revise and add several aspects of the performance metrics. Some of the changes relate to agency spending and these metrics would be effective immediately. It was noted that the revised Single Oversight Framework contains an explanation how NHSI will use the Use of Resources report and rating, along with the finance score to inform the consideration of provider support and/or intervention that would be required. The changes also indicated that the regulator would be expanding its value for money approach, e.g. using income and expenditure rather than EBITDA in accounting processes. This reflected a tightening approach to managing national financial recovery in the NHS. **Action:** Deputy Trust Secretary to circulate the NHS Providers briefing on the regulator changes to the Board. • The proposal for the Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCG) to merge was put to members and had been overwhelmingly approved. Plans would go to NHSI shortly, and this would bring the three CCGs into a single entity from April 2018. • The Sustainability and Transformation Partnership (STP) continued to reset its priorities, in particular proposals around models of healthcare across all sectors in North Somerset. • The CCG have developed outlined proposals "Healthy Weston: joining up services for better care in the Weston area" which would be considered at the Governing Body in common meeting on 3 October 2017. Members noted that there would be a period of public dialogue about the future of health services in North Somerset. The proposals were ambitious, in line with STP vision last year, but applied in the North Somerset area. As part of the strong partnership arrangements already in place, the Trust would need to ensure it continues to work closely with Weston to ensure we could deliver the highest quality acute services in the future. • With regards to the overnight closure of the Weston Emergency Department, the CCG and Weston Area Health NHS Trust were in agreement that the impact had been managed well in the local community. This had been well managed by North Bristol, Taunton and UH Bristol Trusts, and mechanisms for repatriating patients had been working well.	

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	• There were significant pressures on the Trust's finances. The Trust had begun briefing staff on the need to control spending during winter, but the Trust recognised the risks to the spending plan. The Trust had asked for staff's support on savings measures, but had also been focusing on how staff wellbeing could be supported (this was reported on at the staff meeting in September 2017). • The Trust's emergency department checklist had been recognised via the Academic Health Science Network (AHSN). NHSI had recommended the Emergency Department Checklist as good practice and Emergency Departments across the country are now encouraged to use it. • Three wards in the Bristol Royal Infirmary (BRI) and Heart Institute contributed to the *"PJ paralysis"* initiative, helping to support the message that keeping patients in their own clothes was part of supporting recovery, maintained good routine and prevented institutionalisation. **Members RESOLVED to:** • **Receive** the Chief Executive report for information.	
150/09/28	**7. Patient Story**	
	The meeting began with a patient story, introduced by the Chief Nurse, Carolyn Mills. The patient's story was that of Tariq, a resident of south Bristol. Tariq has a range of complex health needs and is a patient at UH Bristol where he accesses cardiac services. He is also a patient with North Bristol NHS Trust (NBT) where he travels on public transport to attend a vascular clinic. He is an active member of the Bristol Jamia Mosque, Dhek Bhal Elderly Men's Group for the over 50 and has recently joined Bristol Community Health (BCH) as a volunteer with their new community navigator service. He is married to Rawshan, who receives care at the Bristol Eye Hospital, and has two daughters both of whom are on track to develop careers in health care. Tariq talked about how his health conditions had impacted on his life and the experiences that he had had during his care from both UH Bristol and NBT. • The Board were advised that Tariq had used a range of services, beginning with the Cardiology Ward in 2001, where he received	

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	excellent treatment and his family were made to feel welcome and supported. Tariq was later diagnosed with Vasculitis, which had affected his kidneys so his care was transferred to Southmead Hospital. • From Tariq's experience on a surgical assessment unit at the BRI, he felt that staff were overstressed and the unit was understaffed: Tariq felt management policies needed to be improved. For example, Tariq explained that he was discharged wearing his own in his pyjamas, whilst still medicated and without any money. Tariq managed to get home due to assistance from a member of the public who stopped to help. • During a second visit to the BRI for an upper hernia and mal-rotation, Tariq was given no known diagnosis, he was not kept informed and was discharged from the hospital. • Tariq noted that he had been receiving treatment recently at St. Michael's Hospital for fibromyalgia and that the care he had received had been excellent. • The Trust was thanked for providing such good services and Tariq was satisfied with the bulk of his care. Tariq extended a personal thank you to Tony Watkin for his support in getting him involved and engaged with the hospital, including on behalf of his community. The Board discussion highlighted the following: • The Board were concerned by Tariq's negative experiences, and would want assurance that no patient would be discharged in their pyjamas now - it was noted that this incident occurred in 2003. • Tariq confirmed that throughout his current care the Trust and North Bristol had been able to 'sync up' well and each hospital knew about what was happening with his care. They were able to access his records electronically and communicated well. • The Board were advised that there was a positive relationship with South Asian community. For example, food was very important to Muslim, Hindu and Sikh populations and the Trust provided a menu which catered appropriately to religious and cultural sensitivities. Communication was good for patients and visitors whose first language was not English, and there was provision of services to	

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	support prayer. **Members RESOLVED to:** • **Receive** the patient story.	
Care and Quality		
151/09/17	**8. Quality and Performance Report**	
	Mark Smith, Chief Operating Officer and Deputy Chief Executive presented this report. It was noted that: • There were no significant changes noted this month. A&E performance had continued to improve and sustained the Sustainability and Transformation Fund (STF) trajectory. The Trust was slightly behind on the Referral To Treatment (RTT) trajectory and the Cancer 62 day score remained below STF trajectory. • The A&E target remained under significant pressure. The Country as a whole was expected to be 90% compliant but was currently at 85%. UH Bristol was doing well in this context. The Emergency Department (ED) saw an unprecedented number of patients on Sunday and Monday (24/25 September 2017) but recovered quickly. This indicated that the Trust systems were more robust than in previous years. However, it would have been challenging to withstand numbers like this throughout winter. • The Trust had done significant analysis to identify the number of patients in ED above which performance would drop. There was good evidence to indicate that performance dropped when there were more than 35 patients waiting in ED. When there were 35 or more patients in the department, the department decompensated very quickly and admitted patients unnecessarily. The Trust needed to be able to plan and act before this number is reached. • RTT target deteriorated partly due to the Trust implementing a new reporting system: RTT4. The reporting architecture previously used to pull data from the Medway system was no longer fit for purpose. This had been a massive and technically complex piece of work. The Intensive Support Team (IST) investigated the new system and gave the Trust a clean bill of health with few queries. • However, following the success of the new system it was identified that the Trust had been over-reporting RTT by 1-2% for some time due to insufficiencies in the old system and methodology. The move to new architecture and reporting would help the Trust manage waiting lists and patients more appropriately. • It was noted that the Trust is under trajectory for the 62 day cancer target for several historical reasons. In Q2 2013 we lost two big	

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	services which affected numbers. Members received assurance that the Trust are working with two specialities to improve their performance. It was hoped that the Trust will meet the trajectory figure by the end of financial year. • The demand for the Sleep study service was not abating. The Trust referral protocols had been re-written and GPs were asked to check that the patients that were on the lists were correct. • The Chief Nurse confirmed that performance around quality continued to be strong. A review of dissatisfied complainants showed that for 50% of the complaints the Trust could have done little to improve or it was out of the Trust's control to address the issues. However, there was an overall discussion happening around improving the tone of the Trusts responses. • The Acting Director of Workforce and Organisational Development noted that workforce report indicators continued to be red or amber but there were improvements within these. The Board discussion highlighted the following: • Members received assurance in relation to the significant amount of work that had been actioned to improve performance against the A&E target. Further assurance was provided in relation to the actions to address the cancer waiting times including how the processes could be improved. Non-executive Directors were reassured by the substantial amount of work the Trust was doing to address target performance (as this was discussed at length at the Quality and Outcomes Committee). • The Board asked for clarity as to why the RTT was historically 1-2% over reported given the qualified opinion by PricewaterhouseCoopers (PwC) on the RTT indicator in the Quality Report. The Chief Executive confirmed that the Trust had been aware of the data quality issues and recognised the data was accurate (a) within the limits of the systems and (b) within the requirements of the regulators. However, the system had now improved and the requirements had changed. It was now possible to identify the (still relatively minor) discrepancy and address it. Assurance was provided that PwC had confirmed that the Trust was in line with other trusts in relation to the RTT reporting position. • The Trust confirmed it had been monitoring the Weston A&E situation since the overnight closure. It was noted that additional numbers were higher than expected and were affecting the Trust when it was already stretched; the pressures were likely to increase with winter. It was noted that winter planning was in a better position compared to this time last year. A discussion was held in relation to the Australian outbreak of flu, which was likely to reach the UK in 4-6 weeks.	

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	Therefore the Chief Executive Officer had asked the Emergency Planner to re-look at the flu pandemic preparedness plan. • As winter arrived the Trust anticipated more requests for ambulance diverts. However, there was no evidence of South West Ambulance Service Trust (SWAST) moving patients to UH Bristol inappropriately at the moment. • The Board questioned the reasons for the unusually high A&E numbers on 24 and 25 September 2017. The Chief Operating Officer stated that there was no evidence as to why this was and the Trust had asked the CCG to look at this too, they had not identified any specific reasons either. Patient Governor Garry Williams enquired whether the identified pressures on ED were also affecting the Eye and Dental hospitals. The Trust confirmed there was a slight increase, but the impact was mainly on general acute hospitals. **Members RESOLVED to:** • **Receive** the Quality and Performance Report for assurance.	
152/09/17	**9. Quality and Outcomes Committee Chair's Reports**	
	Members received written reports following the meetings of the Quality and Outcomes Committee held on: • 29 August 2017 • 26 September 2017 Members also received a verbal account of both meetings from Non-Executive Director, Julian Dennis (Chair of the Committee). Key issues raised included the following: • The Root Cause Analysis reports had flagged that in a couple of instances processes were not being followed appropriately. The Committee had sought assurance that reflective learning was being taken forward and was being shown to be effective. • The WHO checklist was now in active use across the Trust. However, there were some areas where it was not yet as fully embedded as it should be. • The Committee had reviewed the Quality and Performance Report. In particular, the Committee sought assurance in relation to the actions to restore performance against the 62-day GP cancer waiting times standard to the national 85% standard by quarter 1 18/19 and achieve the recovery trajectory during 2017/18.	

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	• The Committee received an assurance report which outlined the new methodology by which the adult mortality review process will be undertaken, in line with the National Learning from Deaths Guidance. Assurance was provided that the new process had been established which had indicated that, already, themes are emerging and appropriate action was taken to ensure that the Trust is learning from deaths. • The Committee had reviewed the National Cancer Patient Survey: there was only one Trust score below the national average, which was around patient communication. **Members RESOLVED to**: • **Receive** both Quality and Outcomes Committee Chair's Reports for assurance.	
153/09/17	**10. Quality and Patient Experience**	
	a) <u>Quarterly Complaints Report – Q1</u> Members received for assurance the quarter 1 complaints report and Carolyn Mills, Chief Nurse confirmed that this report had been considered in detail at the Quality and Outcomes Committee. Members noted that further detail into the issues relating to Dental Complaints had been requested. Assurance was provided that all dissatisfied cases are now being formally reviewed on a monthly basis with learning shared with Divisions and the Patient Experience Group. The Board discussion highlighted the following: • The Board welcomed the significant reduction in complaints regarding staff attitude; and • The Board requested that the report include an executive summary in future. **Action:** Chief Nurse to investigate whether report could be amended to include an executive summary in future. b) <u>Quarterly Patient Experience Report – Q1</u> The Chief Nurse, Carolyn Mills, presented this report noting that the Quality and Outcomes Committee had discussed in detail. Members received assurance that the Trust continued to get sustained excellent	

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	feedback from patients. Members noted that there has been a consistent trend of the Trust receiving *relatively* lower inpatient survey scores for wards which have a high proportion of older patients. The Chief Nurse clarified that the Trust were trying to understand some of the poorer scores in relation to elderly patients, though it was noted that UH Bristol was consistent with other peer trusts in this area. Assurance was provided that the Trust was not an outlier compared to other Trusts. Patient Governor Garry Williams enquired whether the report reflected the outpatient experience. It was confirmed that for the first time outpatient and inpatient experience had been reported separately within the report. **Members RESOLVED to:** • **Receive** the Quarterly Complaints Report and Quarterly Patient Experience Report for the quarter for assurance.	
154/09/17	**11. Six-monthly Staffing Report**	
	The Chief Nurse, Carolyn Mills, presented this report and provided assurance to the Board that this report had been discussed in detail at the Quality and Outcomes Committee. Members noted that there had been no significant changes in the UH Bristol funded nursing establishment over the last six months. It was also noted that there had been no requests for staffing information from the Care Quality Commission in the last six months. Members received assurance that the Trust has had safe staffing levels in the last six months. The Board discussion highlighted the following: It was noted that the report did not include details on the use of agency versus in-house staff on night shifts. However, the Trust felt it was very unlikely patients would be seen by agency staff at night given current vacancy rates. The Chair noted that people did notice use of agency staff, particularly if it negatively impacted continuity of care. The Trust was mindful that lack of knowledge of relevant areas and Trust processes among some agency staff, and disruptions to continuity of care, could impact negatively on care quality. However there were systems in place to help mitigate this. Patient Governor Garry Williams asked whether the planned restriction on the use of agency staff was likely to kick on before the potential flu	

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	outbreak forecast. The Trust noted the restrictions were focused not just on volume of agency staff but on the rates agencies were charging. However, the Board was clear its priority was to put the needs of the service first.	
Financial Performance		
155/09/17	**12. Finance Report**	
15/09/17	The Director of Finance and IM&T, Paul Mapson, presented the Finance Report to the Board. It was noted that: • The most important report would be next month's half-yearly report. • The month five position showed a significant deterioration: divisions were £5m down against operating plans. The Trust was looking to bring down overspending. • The Trust was taking actions to address this, both at divisional and Executive level. • A major issue was in trying to bring pay under control. • The Trust had identified issues which could affect the year end position, and would report to the Board on those in due course. • The Trust had advised the regulator it would hit plan for this year, and was taking actions to ensure this, but wanted to make clear to the Board that the plan was high risk. The Trust remained optimistic however and would monitor position carefully. • The capital programme had already been reduced to £35m. The Trust would be reviewing capital programme spend in the next few months. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	
156/09/17	**13. Finance Committee Chair's Report**	
	Members received a report from the meeting of the Finance Committee held on 25 September 2017. Members also received a verbal account of the meeting held on 25 September 2017 from Lisa Gardner, Non-executive Director covering the following key areas: • The Committee had sought assurance on the actions the Executive Team were taking with regards to the financial position against the operating plan. There were concerns particularly around three	

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	divisions: Medicine, Women's and Children's Services, and Surgery. • The Trust was slightly below target for the year against the cost improvement savings plans, as most targets were phased for the second half of the year (the Committee had been assured they would be back on track for second half). • The Committee received a presentation on recruitment strategy from the Workforce and OD team, which demonstrated there had been good implementation of the recruitment strategy: 'Love Life, Love Bristol'. Vacancies were also at a good level. There were issues such as Bristol cost of living affecting decisions to come to the city/work for the Trust. There had been a significant reduction in hiring times, which the Committee were pleased about (down to an average of 34 days (external recruitment); and 4.5 days (internal recruitment)). • Capital spending was under plan, which helped cash flow. The Trust was in a strong financial position, with net current assets higher than operational plans. With regard to recruitment issues, Non-Executive Director Steve West stated that nursing students would be graduating with student loan debt in a few years: this might also have an impact on recruitment. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's report for assurance.	
Items for Information		
157/09/17	**14. Governors' Log of Communications**	
	The report provided the Board with an update on governors' questions and responses from Executive Directors. **Members RESOLVED to:** • **Note** the Governors' Log of Communications.	
Governance		
158/09/17	**15. Transforming Care Report**	
	Members received the report, which was to update Trust Board on progress over the last quarter with the programmes of work within the Transforming Care programme. The Chief Executive drew members' attention to the Admin Teams Transformation programme which had focussed on addressing some of the underlying causes of staff turnover in the teams supporting clinical admin. The group has developed a competency framework and common job descriptions for the core clinical admin roles and used these to	

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	establish values based recruitment. Members noted the launch during August 2017 of the expected Leadership Behaviours at UH Bristol, which were based on the work carried out with groups of leaders from across our Trust. Significant progress has been made in relation to the QI Academy and in particular the launch of the Silver level course. Aimed at teams with an agreed project to deliver, this course would provide training and support over a 6 month period. The Board discussed the progress of the Transforming Care Programme and agreed that it would be helpful to consider as a discussion topic for a future Board Development Seminar. **Action:** Trust Secretariat to add the Transforming Care Report to the Board Seminar Business Cycle**.** **Members RESOLVED to:** • **Receive** the Transforming Care Report for information.	
Concluding Business		
159/09/17	**16. Any Other Business**	
	The Chair noted this would be Alex Nestor's last meeting. The Board thanked Alex Nestor, Acting Director of Workforce Development for all her hard work and support during the last year.	
160/09/17	**17. Date of Next Meeting**	
	31 October September 2017, 11:00am-1:00pm, Conference Room, Trust Headquarters	

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

Cover report to the Public Trust Board. Meeting to be held on 31 October 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	4
Meeting Title	Public Trust Board	**Meeting Date**	Tuesday, 31 October 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

In this story NM will share her experiences of taking an active role as a parent representative in the Independent Review of Children's Cardiac Services Steering Group. NM will explain how, through her involvement in “Cardiac Listening” events at the Bristol Royal Hospital for Children, she became involved in the Steering Group and what she feels her parent voice has brought to the process in terms of actions. NM will share her personal reflections on what the process says about the organisation, the changes she has seen and her aspirations for how a continued parent voice can add value to the service in the future.

By way of context, NM is mum to C who, as part of their continuing care at the Bristol Royal Hospital for Children, has had four open heart surgery operations since birth.

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

Public Trust Board of Directors meeting
31 October 2017
Action tracker

Outstanding actions from the meeting held on 28 September 2017					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	153/09/17	**Quality and Patient Experience Report** Chief Nurse to investigate whether the report could be amended to include an executive summary in future.	Chief Nurse	December 2017	**Work in Progress** To be included in the next quarterly report to the Board.
Closed actions from the meeting held on 28 September 2017					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
2.	149/09/17	**Chief Executive's Report** Deputy Trust Secretary to circulate the NHS Providers briefing on the regulator changes to the Board.	Deputy Trust Secretary	October 2017	**Completed** Circulated with papers for October Board meeting.
3.	158/09/17	**Transforming Care Report** Trust Secretariat to add the Transforming Care Programme to the Board Seminar Business Cycle	Trust Secretary	October 2017	**Completed** Transforming Care Programme added to Board Seminar Business Cycle.
4.	91/05/17	**Independent Review of Children's Cardiac Services progress report** **Receive** the closure report in September 2017 and invite the Divisional Director and the families to the meeting.	Chief Nurse	October 2017	**Completed** Agenda Item
5.	115/06/17	**Finance Chairs Report** Schedule a session on CQUINS at a Board Seminar.	Trust Secretary	September 2017	**Completed** To be added to the Board Seminar business cycle.

Cover report to the Public Trust Board. Meeting to be held on 31 October 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	6
Meeting Title	Public Trust Board	**Meeting Date**	Tuesday, 31 October 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 choose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

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

Executive Summary
<u>Purpose</u> To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team. <u>Key issues to note</u> 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 October 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 recruit, train and sustain an engaged and effective workforce.	☒	Failure to comply with targets, statutory duties and functions.	☐
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.	☐		

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	**Finance**	**Quality and**	**Remuneration**	**Other (specify)**

Committee	Committee	Outcomes Committee	& Nomination Committee	

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – OCTOBER 2017

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in October 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 **received** an update on plans for preparation for winter 2017/2018 and **supported** a number of actions to take forward. The group **approved** the adult inpatient services escalation plan for dissemination, noting that the escalation capacity part of the plan should be presented for sign-off at the next meeting.

The group **approved** the proposed implementation approach for the use of Clinical Utilisation Review in 13 identified priority wards by the end of December 2017.

The group **approved** a business case for emergency department consultant expansion to improve the resilience of the department and increase the availability of senior clinical decision-making on a seven day a week basis.

The group **approved** proposals and next steps for a Trust-wide staff recognition framework.

The group **approved** a number of recommendations to improve compliance within the Trust with Essential Training requirements.

The group **supported** a recommendation in principle to respond to the Avon and Somerset Sexual Assault Referral services tender and delegated the final decision to bid to the designated Executive Director.

4. RISK, FINANCE AND GOVERNANCE

The group **received and approved** the quarterly report from the Guardian of Safe Working around the 2016 Junior Doctors contract for onward submission to the Quality and Outcomes Committee.

The group **received** an update on progress towards completion of the action plans in response to the Care Quality Commission 'must do' requirements, following the Trust's inspection in November 2016.

The group **received** an update on risk assessment and assurance work being undertaken around electrical system safety and resilience in critical areas.

The group **received** the Quarter 2 Corporate Quality Objectives update report, prior to submission to the Quality and Outcomes Committee.

The group **received** the Quarter 2 Themed Serious Incident Quarterly update report, prior to submission to the Quality and Outcomes Committee.

The group **approved** the Quarter 2 Board Assurance Framework for onward submission to the Trust Board.

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

The group **received** three satisfactory Internal Audit Reports in relation to Infection Control, National Institute of Clinical Excellence (NICE) Guidance Process and Non-EROS Purchasing Process.

The group **received** an update on the continuing development of the Congenital Heart Disease Network, hosted by UH Bristol.

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

The group **received** an update on the Register of Interests, Gifts and Hospitality.

Reports from subsidiary management groups were **noted,** including updates on the current position following the transfer of Cellular Pathology to North Bristol NHS 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
October 2017

Cover report to the Public Trust Board meeting to be held on Tuesday, 31 October 2017 at 11.00 -13.00 in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	7
Meeting Title	Public Trust Board	**Meeting Date**	31 October 2017
Report Title	**Board Assurance Framework 2017-18 (Quarter 2)**		
Author	Sarah Wright, Head of Risk Management		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

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

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

Key Changes

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

- No material changes.
- Second line of assurance robust forms of assurance, some gaps in controls remain around business continuity arrangements, however re-audit is imminent.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- 10 associated Corporate Risks

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

- Review has aligned key controls to SP6 in relation to the work being undertaken to achieve the delivery of the 2017/18 operational plan.
- The principal risk has increased in relation to the ability to invest in future development of the estate, in the event of an ongoing deterioration in the underlying run rate.
- The re-assessment is based on 25% chance of this occurring (= likely - 4) and that more that >1% loss of budget is at risk (= Catastrophic - 5).
- The Estates Strategy and medium term capital programme are now approved.
- Second line level of assurance in relation to committee reports, third line in respect of Internal Audit work programme provides evidence of good estate maintenance.
- Previous Risk Rating 8, Current Risk Rating 20, increasing trajectory due to the financial challenges.
- 1 associated Corporate Risk.

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

- Additional controls now in place relating to E-appraisal and implementation of staff experience plans.
- Draft Dignity at Work policy has been approved with a roll out plan in place to support staff understanding the Trusts commitment to decreasing bullying and harassment.
- Action agreed to Refresh Workplace Wellbeing Strategy with focus on psychological wellbeing at work
- First & second line assurance around reporting arrangements and agency action plan remain in place.
- Previous Risk Rating 12, Current Risk Rating 12, static trajectory.
- 5 associated Corporate Risks.

STRATEGIC PRIORITY 4:
We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.
Principal Risk 4 - 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.

- Additional action added in relation to the appointment of new research lead in Surgery.
- Second line assurances in place but gaps remain around supporting innovation and improvement, to be addressed by implementation of Innovation Strategy.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- No associated Corporate Risks.

STRATEGIC PRIORITY 5:
We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.
Principal Risk 5 - Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.

- No material changes
- Previous Risk Rating 6, Current Risk Rating 6, static trajectory.
- 3 associated Corporate Risks.

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

- Additional gaps in controls identified around the ability of divisions to deliver the agreed operating plans nor formulate the actions necessary to mitigate extra expenditure.
- Additional actions underway with Executive Directors recently agreeing a suite of actions summarised in the "Review of 2017/18 Financial Position"
- Second line assurance in place via internal reporting and divisional reporting arrangements, weak controls and gaps in assurance identified.
- Previous Risk Rating 9, Current Risk Rating 25 significant increase in trajectory.
- 4 associated Corporate Risks

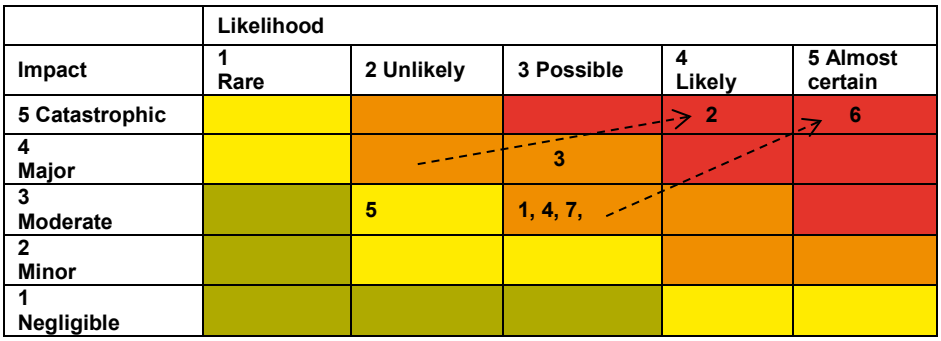
STRATEGIC PRIORITY 7:
We will ensure we are soundly governed and are compliant with the requirements of our regulators
Principal Risk 7 - Failure to comply with targets, statutory duties and functions

- No significant gaps identified in controls
- Limited assurance around the of effectiveness of controls, in light of on-going failure of some standards, however, no specific action identified as necessary.
- Robust second level assurance in place and third level in respect of NHS Improvement returns and CQC inspections.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- 5 associated corporate risks.

Summary

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

- The risk that the Trust will be unable to develop and maintain the Trust estate (SP2)has increased from 8 to 20 and
- The risk of being unable to deliver the 2017/18 financial plan (SP6) has increased from 9 to 25



Recommendations

Members are asked to:

- **Receive** the Board Assurance Report as at end September 2017.

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 comply with targets, statutory duties and functions.	☒	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.			☒

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

Impact Upon Corporate Risk
As detailed in the report.

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

Date papers were previously submitted to other committees				
Executive Director Meeting	**Risk Management Group**	**Senior Leadership Team**	**Quality and Outcomes Committee**	**Audit Committee**
27/09/2017	03/10/2017	18/10/2017	27/10/2017	30/10/2017

University Hospitals Bristol
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

Q2 2017-18

1. Board Assurance Framework (BAF) for the delivery of the Trusts Strategic Objectives.

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process.

The Board achieves this, primarily through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.

2. The Trust Strategic Plan

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

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

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

Our strategy outlines nine key clinical service areas:

1. Children's services;
2. Accident and Emergency (and urgent care);
3. Older people's care;
4. Cancer services;
5. Cardiac services;
6. Maternity services;
7. Planned care and long term conditions;
8. Diagnostics and therapies; and
9. Critical Care.

3. Our 2014-19 five year Strategic Plan

The 5 year plan outlines seven strategic priorities, structured according to the characteristic of our Trust Vision outlined above. Our strategic priorities are:

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

4. The Trusts Operational Plan 2017-19

The focus of strategic and operational plans over the next two year period will be the following from section three of the Operational Plan:

3. Care and Quality and Health and Wellbeing

3.1.1 Delivery of our quality objectives as agreed in our new quality strategy *(SP1)*
Including delivery against requirements outlined in the nine 'must dos' and NHS mandate to close our identified gaps in care and quality. For our organisation; this will include a specific focus on;

- *ensuring timely access to services*
- *delivering safe and reliable care*
- *improving patient and staff experience*
- *improving outcomes and reducing mortality*

3.1.2 Independent Children's Cardiac Review *(SP1)*

- *full delivery of the recommendations*

3.1.3 Staff strategic engagement and retention strategy *(SP3)*

- *focus on staff engagement and wellbeing,*
- *supported by real-time feedback, using innovative approaches such as the 'Happy App' (2016 HSJ winner) and;*
- *the on-going development of leadership capacity and capability.*

3.1.4 Access standards *(SP7)*

- *Improving performance and delivery of our performance trajectories in the four core standards.*

3.2 Finance and Efficiency

3.2.1 Operational and financial sustainability *(SP6)*

- *with a specific focus on internal specialty level productivity and the efficient delivery of activity aligned to our capacity modelling,*
- *along with the implementation of Carter recommendations,*
- *including a system view of corporate overheads, estates and pathology.*

3.2.2 Maximising the impact from partnership system working *(SP5)*

- *service redesign and strategic partnerships within region*
- *development of shared leadership and associated opportunities to improve system and service level productivity.*

3.2.3 Estates and capital strategy for 2017-19 *(SP2)*

- *continue to align the modernisation and development of our estate to our evolving clinical strategy and*
- *support delivery of the emerging strategic planning new model of care.*

3.2.4 Maximising workforce productivity *(SP3)*

- *including controlling agency and locum costs.*

3.3 Strategy, Transformation, Innovation and Technology

***3.3.1 Refresh our existing Trust Strategy** (SP1)*

- *to reflect the need to respond to local and national changes to our operating environment and*
- *with a specific focus on developing our clinical strategy*

***3.3.2 Exploring options to continue to develop our specialist portfolio** (SP4)*

- *in the context of potential changes to Specialised Commissioning approaches across the south*

***3.3.3 Maximise our opportunity to continue to develop our research capacity and capability** (SP4)*

- *associated with the significant grant secured from the National Institute for Health Research to fund a Biomedical Research Centre undertaking cutting edge studies that will improve care and treatment in the future.*

***3.3.4 Development of an Innovation and Improvement Strategy for the organisation** (SP4)*

- *including maximising the opportunities for innovation and transformational change associated with our successful appointment as a National Digital Exemplar site,*
- *with clear alignment to organisational and STP digital priorities / local digital roadmap.*

***3.3.5 Continued development and delivery of our Transforming Care Programme** (SP5)*

- *focussing on transforming the way in which we deliver care through service and workforce redesign,*
- *with a focus over the next two years on real time internal processes to support patient flow alongside engaging in and supporting STP processes to develop effective system care pathways and patient flow.*

5. Principal Risks

- **Risks to SP 1**: Risk that the Trust will be unable to maintain the quality of patient services**.**
- **Risks to SP 2**: Risk that the Trust will be unable to develop and maintain the Trust estate.
- **Risks to SP 3:** Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.
- **Risks to SP 4:** Risk that the Trust will not be able to support transformation and innovation and that the Trust will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.
- **Risks to SP 5:** Risk of failing 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.
- **Risks to SP 6:** Risk of being unable to deliver the 2017/18 financial plan.
- **Risks to SP 7:** Risk of failing to comply with targets, statutory duties and functions.

6. Approach to Risk Assessment - Risk scoring = consequence x likelihood

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

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

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

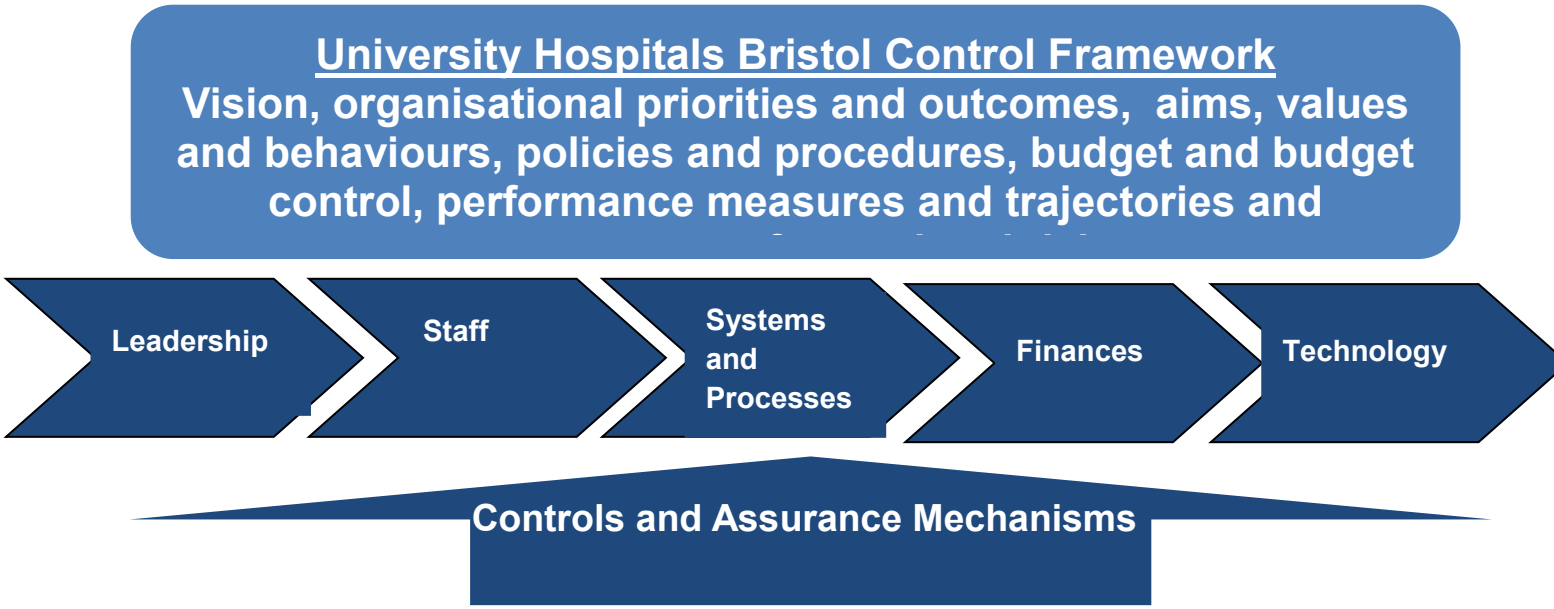
The current scores for principal risks are summarised in the following heat map.

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

The progress summary of the principal risks are as follows.

Principal Risk	**April 17**	**July 17**	**October 17**	**December 17**
1. Risk that the Trust will be unable to maintain the quality of patient services.	Possible x Moderate **= 9**	Possible x Moderate **= 9**	Possible x Moderate **= 9**	
2. Risk that the Trust will be unable to develop and maintain the Trust estate	Unlikely x Major **= 8**	Unlikely x Major **= 8**	Unlikely x Catastrophic = **20**	
3. Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.	Possible x Major **= 12**	Possible x Major **= 12**	Possible x Major **= 12**	
4. Risk that the Trust will not be able to support transformation and innovation and that the Trust will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	Possible x Moderate **= 9**	Possible x Moderate **= 9**	Possible x Moderate **= 9**	
5. Risk of failing 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.	Unlikely x Moderate **= 6**	Unlikely x Moderate **= 6**	Unlikely x Moderate **= 6**	
6. Risk of being unable to deliver the 2017/18 financial plan	Possible x Moderate **= 9**	Possible x Moderate **= 9**	Almost Certain x Catastrophic = **25**	
7. Risk of failing to comply with targets, statutory duties and functions	Possible x Moderate **= 9**	Possible x Moderate **= 9**	Possible x Moderate **= 9**	

7. Controls Framework



High Quality Care

Controls: **evidenced within**

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

Assurance: gained via

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

Performance Management

Controls:

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

Assurance: gained via

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

Risk Management

Controls:

- Risk management strategy and Policy
- Board Assurance Framework
- Corporate Risk Register
- Divisional Risk Register
- Reports to the Board, Senior Leadership Team and sub committees
- Policies and Procedures
- Scheme of Delegation

Assurance: gained via

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

8. Risk Assurance

Levels of Assurance

VISION AND CORPORATE PRIORITIES

First Line
Operational

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

Second Line
Risk and Compliance

Reports to Assurance and Oversight Committees

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

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

Third Line
Independent

- Internal Audit Plan
- External Audits (eg. Annual Accounts and Annual Report)
- CQC Inspections
- NHS Improvement Inspections
- Visits by Royal Colleges
- External visits and accreditations
- Independent Reviews
- Well Led Governance Review

REGULATORS

EXTERNAL AUDIT

9. Risk Appetite

Risk Domain	Definition	Risk Appetite	Risk Rating
Safety	Impact on the safety of patients, staff or public	Low	
Quality	Impact on the quality of our services. Includes complaints and audits.	Moderate	
Workforce	Impact upon our human resources (not safety), organisational development, staffing levels and competence and training.	Moderate	
Statutory	Impact upon on our statutory obligations, regulatory compliance, assessments and inspections.	Low	
Reputation	Impact upon our reputation through adverse publicity.	High	
Business	Impact upon our business and project objectives. Service and business interruption.	Moderate	
Finance	Impact upon our finances.	Moderate	
Environmental	Impact upon our environment, including chemical spills, building on green field sites, our carbon footprint.	Moderate	

10. Key

The Assurance Framework has the following headings:

Principal Risk	What could prevent the objective from being achieved?
Key Controls	The systems/processes/strategies that we have in place to assist secure delivery of the objective
Gaps in Controls	Gaps in the effectiveness of controls in place
Form of Assurance	Evidence of how the controls are monitored e.g. reporting mechanism
Gaps in assurance	Gaps in the evidence required to provide assurance or failure of the monitoring/reporting process
Level of Assurance	Robustness of the assurance which is being relied on - 1st line, 2nd line, 3rd line.
Actions Agreed for any gaps in controls or assurance	Plans to address the gaps in control and / or assurance and reference to any related risks.
Current Risk Rating	Assessment of the principal risk taking into account the strength of the controls currently in place to manage the risk
Direction of travel	Are the controls and assurances improving? ↑ ↓ ↔

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

Operational Plan 2017/19 Focus	**3.1.1 - Delivery of our quality objectives as agreed in our new quality strategy**, including delivery against requirements outlined in the nine 'must dos' and NHS mandate to close our identified gaps in care and quality. For our organisation; this will include a specific focus on; ➢ Ensuring timely access to services ➢ Delivering safe and reliable care ➢ Improving patient and staff experience ➢ Improving outcomes and reducing mortality	**3.1.2 -** Full delivery of the recommendations from the **Independent Children's Cardiac Review**. **3.3.1** - **Refresh our existing Trust Strategy** to reflect the need to respond to local and national changes to our operating environment and with a specific focus on developing our clinical strategy.

Executive Lead - Chief Nurse & Chief Operating Officer **Assuring Committee -** Quality and Outcomes Committee & Service Delivery Group

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk that the Trust will be unable to maintain the quality of patient services.	Trust wide Risk Management arrangements including incident reporting and investigation processes to identify areas of failure and implement corrective actions. Patient Safety Strategy and delivery of Patient Safety Improvement Programmes, including Sign Up to Safety initiative Implementation and monitoring of Quality Strategy objectives and metrics. And implementation of updated Volunteers Strategy UH Bristol survey programme to measure and monitor the quality of service-user reported experience. This programme will be further developed in 2017/18 with the procurement of a real-time patient feedback system. Clinical Audit Programme, including process for the self -assessment against NICE guidance Productive theatre initiative to reduce the number of cancelled Operations. Whole system approach being delivered through the Urgent Care Network and development of an internal Urgent Care Plan which will be overseen by the newly created Urgent Care Steering Group Professional Standards and Code of Practice/Clinical Supervision. Quality Impact Assessment (QIA) process for savings schemes meeting specific criteria. Monitoring of RTT Performance via: • Emergency Access Performance • Divisional Access performance scorecards • Divisional Monthly Reviews with Executive Team Business Continuity and Emergency planning arrangements Roll out of Evolve to provide ready availability of electronic patient records	Annual Governance Statement providing assurance on the strength of internal control regarding risk management processes, review and effectiveness Corporate reporting structure to Trust Board and Quality and Outcomes Committee via Clinical Quality Group. Quality metrics demonstrate that despite operational pressures, our patients are receiving good quality care despite delays in their discharge. Reports to SLT & Audit Committee/ via Clinical Quality Group/Clinical Audit Group/ Clinical Effectiveness Group, Patient Experience Group. Reporting functions in place to SDG, SLT Trust Board, via: • RTT Operations Group • RTT Steering Group • Cancer PTL Meetings • Cancer Performance Improvement Group • Cancer Steering Group • Urgent Care Steering Group External - EPRR assessment (NHSE) and Internal - self assessment. Performance reports in relation to the implementation of recommendations in relation to the paediatric cardiac review.	Internal performance reports form first line assurance. Reports to: • Trust Board, • Senior Leadership Team • Audit Committee • Quality & Outcomes Committee • Risk Management Group • Service Delivery Group • Clinical Quality Group • Patient Experience Group Form second line assurance External audit/review forms third line assurance.	Although some of the patient feedback collected corporately is made available directly to inpatient wards (e.g. via posters and circulation of spread sheets), there is an opportunity to make this more rapidly available and more accessible to ward staff. QIA Process requires development.	Emergency Preparedness, Resilience and Response *(*EPRR*)* externally assessed as partially compliant	Procurement of a real-time patient feedback system. Further development of the QIA process to cover /support changes to service provision/stopping of services There is a work programme in place to achieve full EPRR compliance. This will next be assessed in September 2017 by the CCG and NHS England where we expect to reach full compliance.	**Moderate x Possible = 9**	↔

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

Operational Plan 2017/19 Focus	**3.2.3** - **Estates and capital strategy for 2017-19** • continue to align the modernisation and development of our estate to our evolving clinical strategy and • Support delivery of the emerging strategic planning new model of care.

Executive Lead - Chief Operating Officer **& Director of Finance** **Assuring Committee -** Finance Committee & Trust Board

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk that the Trust will be unable to <u>develop</u> and <u>maintain</u> the Trust estate	<u>Maintenance of the estate:</u> Approved Estates Strategy. Internal Capital Project Team in place with adequate training. Ability to employ external support as required Appropriate selection of procurement options Internal Audit work programme. <u>Development of the estate (investment):</u> Trust Capital Group Chaired by COO, receives monthly status reports on Capital Projects from Divisions and Director of Estates. Financial Control Procedures, including the scheme of delegation and Standing Financial Instructions in place. Approved Five year Medium Term Capital Programme. Delivery of the 2017/18 capital programme, including the prioritisation and allocation of strategic capital. Delivery of the 2017/18 Operational plan without significant deterioration in the underlying run rate to ensure availability of strategic capital is available for future investment.	Internal audit reports Reports from Trust Capital Group to Capital Programme Steering Group. Chairs reports from Capital Programme Steering Group to Finance Committee. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Regular Reporting to the Finance Committee and Trust Board.	Reports to: • Trust Board • Audit Committee • Finance Committee • Capital Programme Steering Group • Trust Capital Group • Divisional Boards Form second line assurance Outcome of internal audit reports form third line assurance.	Evidence that the delivery of capital investment plans are weak in terms of programming and financial profiling. Evidence that the delivery of the operational plan without significant deficit in underlying run is at risk of being achieved.	Lack of assurance that capital expenditure controls for delegated Divisional and Operational Capital are fully effective.	The Trust Capital Group has been established to scrutinise delivery of capital plans and has met since November 2016.	**Catastrophic x Likely = 20**	↑

STRATEGIC PRIORITY 3: We will strive to employ the best staff and help all our staff fulfil their individual potential

Operational Plan 2017/19 Focus	**3.1.3 Staff strategic engagement and retention strategy**, • Focus on staff engagement and wellbeing, • Supported by real-time feedback, using innovative approaches such as the 'Happy App' (2016 HSJ winner) and; • The on-going development of leadership capacity and capability.	**3.2.4 Maximising workforce productivity** • Including controlling agency and locum costs.

Executive Lead - Director of Workforce and Organisational Development **Assuring Committee -** Trust Board

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.	Delivery of the Workforce and Organisational Development Strategy Corporate and Local Induction Quality objective on staff engagement HR Policies and Procedures support a framework for clear accountability at Divisional level for staff engagement. Monthly compliance reports on Essential Training are sent to Divisions and include trajectories to achieve compliance and divisional Reviews include performance against workforce plans and HR KPI's to improve staff experience Appraisal Process/Personal Development Plan moving towards E-Appraisal in May 2017 in order to measure quality and support comprehensive development plans at Divisional and trust wide level. E-Appraisal launched in May 2017. Phase 2 now focuses on the quality of the experience and the introduction of a 360 degree feedback mechanism in 2018. Workplace Health and Wellbeing Framework delivery plan to include the NHS Staff Health and Wellbeing CQUIN National Staff Survey Robust improving staff experience plans are in place which target hotspot areas with bespoke interventions to improve staff engagement. This includes training and focus groups. The Staff Friends and Family Test. Other, local or more specific surveys/focus groups also take place sickness and turnover). The FTT has been targeted in hotspot areas for Q2 in order to be able to use the data from the questionnaire to improve staff experience. Happy App available in clinical areas Leadership Behaviours launched 14th August by Executive Directors. Local launches and training is in place until mid-November.	Metrics in relation to key controls are reviewed by the Senior Leadership Team, QOC and Trust Board: Annual learning and development report. Weekly returns agency staffing. Agency action plan. Reports from new E-Appraisal system in place August 2017 Dashboard reports will be developed in the future to support managers completing appraisals in a timely way Reports to Agency Controls Group. Health & Safety Reports to Trust Health, Safety and Fire Committee and Risk Management Group. Externally accredited Health & Safety audit and Workplace Wellbeing Charter. Reporting of results on achievement of staff wellbeing CQUIN Reporting of Occupational Health KPI's Reporting on results of Staff survey/ friends and family tests. This will now be in a targeted department approach in response to the heat map data Divisional improving staff experience plans in place focusing on hotspot areas in response to the divisional heat maps Leadership behaviours Developed by Trust leaders and approved at SLT for roll out in August 2017 Draft Dignity at Work policy has been approved with a roll out plan in place to support staff understanding the Trusts	Regular internal reports form first line assurance. Reports to: • Trust Board, • Senior Leadership Team • Quality Outcome Committee • Risk Management Group • Workforce and OD • Health, Safety & Fire Safety Committee Form second line assurance External audit/review forms third line assurance.	Workplace Wellbeing Framework requires a shared strategic vision with a view to establishing a Board Wellbeing Champion Workplace Wellbeing and Health & Safety to be more explicitly determined within the Workforce and Organisational Development Strategy. Happy App not available in all areas.	Limited assurance primarily around achieving compliance with essential training rates. Limited assurance around levels of staff retention.	Identification of a Board Wellbeing Champion Refresh Workplace Wellbeing Strategy with focus on psychological wellbeing at work Refresh of the Workforce and OD Strategy. Mid-year review of workforce KPIs to understand forecast out turn. Staff Recognition Awards and rewards framework being developed Roll out Happy App across whole organisation.	**Major x Possible = 12**	↔

STRATEGIC PRIORITY 4:	**We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.**	
Operational Plan 2017/19 Focus	**3.3.2 Exploring options to continue to develop our specialist portfolio** • in the context of potential changes to Specialised Commissioning approaches across the south **3.3.3 Maximise our opportunity to continue to develop our research capacity and capability** associated with the significant grant secured from the National Institute for Health Research to fund a Biomedical Research Centre undertaking cutting edge studies that will improve care and treatment in the future.	**3.3.4 Development of an Innovation and Improvement Strategy for the organisation** • including maximising the opportunities for innovation and transformational change associated with our successful appointment as a National Digital Exemplar site, • with clear alignment to organisational and STP digital priorities / local digital roadmap.

Executive Lead - Medical Director & Director of Strategic Development & Transformation **Assuring Committee -** Trust Board

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk that the Trust will not be able to support transformation and innovation. and that the Trust will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	Memorandum of agreement with University of Bristol. Joint Posts and Clinical Networks. Research Standing Operating Procedures. Process in place for corrective and preventative actions where breaches of GCP/protocol are identified to support learning by PI/CI and research team. Regular review of research recruitment on a trust-wide level. Key Performance Indicators at divisional level (bed holding only) finalised for regular divisional review. Staff engagement embedded in planning service improvement and transformation work. Transformation and other service improvement leads networked across the divisions – role includes identifying and supporting local innovation. Partnership with the Academic Health Science Network to train a cohort of improvement coaches to add capacity to this support network. During 16/17 review of approach to supporting innovation across the Trust completed and Innovation & Improvement strategy developed Quality Improvement Academy established 2017 Research grants, Research Capability Funding, commercial and delivery income maintained. SPAs recognised in consultant job plans NIHR award £21m over 5 years for Biomedical Research Centre to Trust and UoB partnership. Trust chosen as Global Digital Exemplar, securing the opportunity to progress our Digital Transformation plans at pace	Reporting structures for divisional research committees/groups to Trust Research Group. Regular reports to the Board on KPI reviews (trust wide & divisional) Education and Training Annual Report Project steering groups /reporting to Transformation Board & Senior Leadership Team. Regular reports to the Trust Board. Evidence of wide range of innovation and improvement programmes completed/underway including good response to programmes such as Bright Ideas, Trust Recognising Success awards etc. Audit and inspections. Digital Strategy presented to Trust Board, Including updated objectives and additional functional scope. Clinical Systems Board (incorporating GDE programme components) providing overall governance on digital delivery projects reporting to Trust Board and Senior Leadership Team Routine departmental assurance by programme management office for all digital and IM&T projects and activities reported to IM&T Management Group.	Regular reviews and departmental programme management forms first line assurance. Reports to: • Trust Board, • Transformation Board • Senior Leadership Team • IT Management Group • Divisional Groups • Transformation Board • NHS Digital for GDE and Tech-funded project boards Form second line assurance Internal/External Audit/inspections forms third line assurance.	No significant gaps.	Clear mechanism for protecting time for non-medical PIs who do not hold funded research role recruiting to National Institute of Health Research portfolio trials not in place. Evidence that Improvement & Innovation Strategy approach further promotes and encourages innovation and improvement, in order that staff with good ideas can bring them to life for the benefit of patients, staff, the Trust and the wider NHS There is currently lack of evidence that the use of digital technology renders direct benefits. The proposed direct reporting of benefits realization will address this gap.	Very low numbers of non-medical PIs not supported by research funding. Address on a case by case basis. Work in progress to address the divisional research committee's gaps - Appointment of new research lead in Surgery under way. Implementation of plan for supporting Innovation & Improvement in line with action plan agreed by Transformation Board and supported by SLT with focus on three aims: • To support and connect people with our structured programmes • To provide support to staff with good ideas outside these programmes • To build capability to support staff to lead improvement independently of these programmes Full implementation of Digital Transformation, including Global Digital initiatives and embedding as an integral part of the Trust's business	**Moderate x Possible = 9**	↔

STRATEGIC PRIORITY 5:	**We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.**	
Operational Plan 2017/19 Focus	**1.2.2 Maximising the impact from partnership system working** • service redesign and system wide re-configuration, with • Development of shared leadership and associated opportunities to improve system and service level productivity.	**3.3.5 Continued development and delivery of our Transforming Care Programme** • focussing on transforming the way in which we deliver care through service and workforce redesign, • with a focus over the next two years on real time internal processes to support patient flow alongside engaging in and supporting STP processes to develop effective system care pathways and patient flow.

Executive Lead - Director of Strategic Development & Transformation **Assuring Committee -** Trust Board

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk of failing 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.	Formal Partnership Agreement with Weston Area Health NHS Trust (WAHT) to increase joint working between the two Trusts. Formal Partnership Agreement with North Bristol NHS Trust (NBT) to increase joint working between the two Trusts. Programme Partnership Boards in place and regular reporting through to the Trust Board. 4 way Partnership meeting with NBT, UoB, UWE Chief Executive agreed as local system leader for regional joint working/collaboration planning with other Executives playing lead roles Range of senior staff involvement in NS Sustainability Board programme Staff involved in wide range of external activities e.g. Bristol Health Partners, Better Care Bristol, CLAHRC West, BNSSG System Leadership Group. Implementation of new Strategic Planning Governance Process Development of new internal STP Leads meeting to improve visibility of staff engagement in external activities, reporting into Strategy Steering Group	Reports to the Trust Board following each of the Partnership Board Meetings. Tender Framework and business case templates in place from April 2016 explicitly addressing partnership opportunities. Evidence in recent tenders that Trust is a sought after partner - Children's Community Services; Sexual Health No indication in current self-assessment within STP of adverse perceptions. National feedback on Sustainability and Transformation Plan processes and leadership. Bristol NIHR Biomedical Research Centre successful partnership bid for funding 2016.	Internal reviews and monitoring form first line assurance. Reports to: • Trust Board, Form second line assurance	Complete visibility of scope of staff engagement in external activities challenging and not necessarily always required.	Ability to harness soft information. Ensuring forums are established to co-ordinate Trust approach into, and secure communication output from key system groups	Co-ordinated approach to key system processes overseen by Executive Directors – to include new internal urgent care steering group and action to target input into CEP/savings control centres.	**Moderate x Unlikely = 6**	↔

STRATEGIC PRIORITY 6 : We will ensure we are financially sustainable to safeguard the quality of our services for the future

Operational Plan 2017/19 Focus	**3.2.1 Operational and financial sustainability** • with a specific focus on internal specialty level productivity and the efficient delivery of activity aligned to our capacity modelling, • along with the implementation of Carter recommendations, • Including a system view of corporate overheads, estates and pathology.
Executive Lead - Director of Finance	**Assuring Committee -** Finance Committee

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Current Risk Rating	Direction of travel
Risk of being unable to deliver the 2017/18 financial plan.	Measurement of financial performance against planned performance covering revenue income and expenditure performance, capital expenditure, the statement of financial position and cash flow statement. Monthly Finance & Operational Divisional Performance reviews involving Executives and Divisional Boards. Monthly review by Savings Board. Monthly Divisional Board scrutiny of operational and financial performance. Monthly Divisional CIP reviews. Monthly Divisional contract income and activity reviews, savings reviews. Monthly savings work stream reviews. Divisional control of vacancies and procurement monitored at monthly performance meetings. Agreed budget holders and budgetary control systems in place. Monthly review of financial performance with Divisional budget holders. Financial Control Procedures, including the scheme of delegation and Standing Financial Instructions in place. Approved Five year Medium Term Capital Programme Monthly Capital Programme Steering Group.	Detailed monthly submission of financial performance submitted to the Regulator, NHS Improvement. Strong statement of financial position. Liquidity metric of 1 (highest) and Use of Resources Rating of 1 (highest rating) for 2017/18 year to date. Regular Reporting to the Finance Committee and Trust Board. Monthly Pay Controls Group, Non Pay Controls Group and Nursing Controls Group scrutiny of Divisions performance. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Delivery of the 2017/18 capital programme, including the prioritisation and allocation of strategic capital.	Regular Executive and Divisional Board scrutiny and reviews form first line assurance. Reports to: • Trust Board, • Audit Committee • Finance Committee • Senior Leadership Team • Savings Board • Capital Programme Steering Group Form second line assurance Annual External audit and monthly NHS Improvement submissions of financial position forms third line assurance.	Evidence that staffing controls are weak in some areas, particularly nursing and medical staffing. Evidence that divisions are not able to deliver their agreed Operating Plans nor formulate the actions necessary to mitigate expenditure in order to deliver their agreed Operating Plan trajectories. Evidence that income and activity performance controls are weak e.g. inpatient activity planning and delivery performance. Evidence that the delivery of capital investment plans are weak.	Lack of assurance that pay expenditure controls are fully effective in light of continued spend above plan in some areas e.g. nursing and medical staffing spend. Weak assurance in Divisions given adverse positions to Operating Plans largely due to elective income underperformance and high levels of nursing and medical expenditure. Lack of assurance that activity capacity planning and income performance controls are fully effective. Lack of assurance that capital expenditure controls for operational capital and major medical equipment are fully effective.	Prioritised Executive review at Divisional Reviews. Executive Directors recently agreed a suite of actions summarised in the "Review of 2017/18 Financial Position" paper are which necessary to deliver expenditure reductions, for example: • Nursing staff; • Medical staff; • Non pay Transformation Board and productivity review process via Savings Board to identify further savings. The Trust Capital Group has been established to scrutinise delivery of capital plans and has met since November 2016.	**Catastrophic x Almost Certain = 25**	↑

STRATEGIC PRIORITY 7 : We will ensure we are soundly governed and are compliant with the requirements of our regulators								
Operational Plan 2017/19 Focus	**3.1.4 Access standards** • Improving performance and delivery of our performance trajectories in the four core standards.							
Executive Lead - Chief Executive	**Assuring Committee - Trust Board**							
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Current Risk Rating**	**Direction of travel**
Risk of failing to comply with targets, statutory duties and functions	Trust Board and all committees have an annual forward plan aligned to their terms of reference, Trust's Standing Orders and Standing Financial Instructions to ensure appropriate annual reporting against plans is in place. Monitoring of CQC inspection action plans via Clinical Quality Group, Senior Leadership Team, QOC.	Annual Report, Annual Governance Statement, and Annual Quality Report, Annual Account submitted to Trust Board. Regular reporting to NHS Improvement following Board approval. NHS Improvement returns signed off by the Trust Board. Internal Audit Reports on Governance, risk management and financial accounts reported to Audit Committee. Self-assessment. Monthly Board Reports. Performance and Finance Reports at each Board Meeting. Committee Reports at each Board Meeting. Independent reports from CQC on Inspection Visits.	Regular reviews form first line assurance. Reports to: • Trust Board, • Quality & Outcomes Committee • Audit Committee • Risk Management Group Form second line assurance CQC Inspection Report provides third level assurance into areas inspected.	No significant gaps	Partial assurance of effectiveness of controls, in light of on-going failure of some standards.	None.	**Moderate x Possible = 9**	↔

Appendix 2: Links to the Corporate Risk Register

Strategic Objective	Principal Risk	Corporate Risk Register	Risk Rating
STRATEGIC PRIORITY 1: We will consistently deliver high quality individual care, delivered with compassion.	**Risk that the Trust will be unable to maintain the quality of patient services.**	**423 -** Risk that length of stay does not reduce in line with planning assumptions resulting in an increase in bed occupancy. **856 -** Risk that the emotional & Mental Health needs of children and young people are not being fully met. **888** - Risk of failure to deliver the agreed recovery trajectories for all RTT standards **919 -** Risk that the Trust does not meet the national standard for cancelled operations. **932 -** Risk of failure to deliver care that meets National Cancer Waiting Time Standards. **949 -** Risk that perinatal mental health services are not adequate to the needs of those requiring to access the service. **1595 -** Risk that patients detained under s136 may be brought to ED due to lack of capacity in community provision **1598 -** Risk of Patients Falls Resulting in Harm. **2037** - Risk of delayed care and decision making to patients due to difficulty accessing external images **2198** - Risk that patients may fail to receive timely test results and treatment due to new clauses within National Hospital Contract	**9**
STRATEGIC PRIORITY 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	**Risk that the Trust will be unable to develop and maintain the Trust estate**	**1843** -Risk of failing to achieve the Trust's 2017/18 Operational Plan Control Total surplus	**20**
STRATEGIC PRIORITY 3: We will strive to employ the best staff and help all our staff fulfil their individual potential**.**	**Risk that the Trust will be unable to recruit, train and sustain an engaged and effective workforce.**	**674-** Risk of increased agency spend due to significant non-compliance with national agency caps. **793 -** Risk of work related stress affecting staff across the organisation. **920** - Risk of Non-compliance with both the New Deal and junior doctors contract requirements **921 -** Risk of not achieving 90% compliance for Essential Training for all Trust staff. **737** - Risk that continuity of service due to inability to recruit sufficient numbers of substantive staff	**12**
STRATEGIC PRIORITY 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	**Risk that the Trust will not be able to support transformation and innovation and that the Trust will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.**	No corporate risks identified	**9**
STRATEGIC PRIORITY 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	**Risk of failing 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.**	**1497 -** Risk of Delays in transfer of North Somerset patients due to temporary closure of Clevedon Hospital. **1640 -** Risk of poorer quality service for patients due to delays with reporting of histology samples following service transfer. **2063** - Risk of closure of Weston ED for a sustained period leading to additional demand on UHB services	**6**
STRATEGIC PRIORITY 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	**Risk of being unable to deliver the 2017/18 financial plan.**	**416 -** Risk that the Trust's Financial Strategy may not be deliverable **951** - Risk of the loss of Sustainability and Transformation Funding (STF) **959 -** Risk that Trust does not Deliver the operational plan due to Divisions not achieving their current year savings target **1843** -Risk of failing to achieve the Trust's 2017/18 Operational Plan Control Total surplus	**25**
STRATEGIC PRIORITY 7: We will ensure we are soundly governed and are compliant with the requirements of our regulators.	**Risk of failing to comply with targets, statutory duties and functions**	**801 -** Risk that the Trust does not maintain a GREEN single oversight framework Rating **869 -** Risk of Reputational Damage Arising From Adverse Media Coverage of Trust Activities **970 -** Potential risk of non-compliance with some of Monitor's core 4-hour Wait Clinical Indicator **2242** - Risk that the Trust will be non-compliant with statutory requirements in relation to water safety (HTM 04-01 & ACoP L8) **2273** - Risk that the inability to cover nursing shifts has a negative impact on the delivery of safe and quality care to patients	**9**

Cover report to the Public Trust Board meeting to be held on Tuesday, 31 October 2017 at 11.00 am -13.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	8
Meeting Title	Trust Board	**Meeting Date**	31 October 2017
Report Title	**Quality and Performance Report**		
Author	• James Rabbitts, Head of Performance Reporting • Anne Reader, Head of Quality (Patient Safety) • Alex Nestor, Interim Director of Workforce & Organisational Development		
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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☒
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.	☐		

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)**
		26th September 2017		

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

October 2017

Executive Summary

Single Oversight Framework

One of the four measures was achieved.

- The 62 Day Cancer standard for GP referrals achieved 85.1% for August (target 85%) but the standard is not being met for Quarter 2. Commissioners have agreed the Trust's remedial action plan and recovery trajectory which aims to reach 85% in March 2018.
- The measure for percentage of A&E patients seen in less than 4 hours did achieve the Sustainability and Transformation Fund (STF) target of 90% for each month in Quarter 2 but not the national 95% standard. The Children's Hospital has sustained consistently good performance and there have been marked improvements in the Bristol Royal Infirmary with a renewed focus on patient flow and the ambulatory care assessment units. Winter planning work is underway now and also the Emergency Care Improvement Programme (ECIP) is supporting the Trust to try and sustain this performance during winter.
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks did not achieve the national 92% standard or the recovery trajectory for end of September. Total numbers waiting and numbers waiting over 18 weeks remain above last year's levels. There is a continuing weekly review of management of longest waiting patients through RTT Operations Group and a focus on chronological booking.
- The percentage of Diagnostic patients waiting under 6 weeks at month end did not achieve the national 99% standard. The recovery trajectory has been revised and accepted by commissioners, to show a delivery of the 99% standard by December. The revised trajectory was achieved at end of September but challenges remain for future months, especially in Sleep Studies.

Headline Indicators

Performance against CDiff Cases, Medication Errors, Early Warning Scores and Patient Experience remain consistently above target. The Safety Thermometer measure of New Harms and Heart Reperfusion measure (90 minute "Door To Balloon Time) have been achieved in September, after both measures were not achieved in August. There has been a significant improvement in sepsis screening (92.9%) and antibiotics administered within an hour (100%) in the emergency department. However In September, falls per 1,000 beddays exceeded the red threshold of 5.0 for the first time since April 2015. A focussed work plan continues to be implemented including launch of an updated Enhanced Care Observations Policy.

Last Minute Cancelled (LMC) Operations remain slightly above the required threshold of 0.8% of admissions. However for the last four months, number of LMCs has been sustained below 62 per month which is the lowest level since December 2016. Also the 28 day readmission standard was achieved in September for a fourth month.

In relation to Flow metrics, the level of patients outlying also remains below planned levels. There is also a continued drop in Bed Occupancy levels, driven by changes in configuration of Acute Medical Unit (AMU) resulting in more zero length of stay emergency activity. However, the total number of Green to Go (delayed discharge) patients in hospital is over double the jointly agreed planning assumption of 30 patients.

Workforce measures remain Red or Amber rated this month. Sickness levels reduced again in September to 3.8% and Vacancy Rate to 5.1%. Bank and Agency usage also fell in September (5.8% and 1.2% respectively).

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	4 stars	OK	OK	✓ 96.5%
BDH	3 stars	OK	OK	Not available
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.

NHS Improvement Single Oversight Framework

For the latest month reported (i.e. September for A&E, RTT and 6-weeks, and August for 62-day GP) the Trust failed to achieve the national standard in three of the four Single Oversight Framework (SOF) measures. The Cancer 62 day standard of 85% was achieved in August, but the standard is still below 85% for the quarter.

However, the Sustainability & Transformation Funds (STF) trajectory of 90% was achieved for the A&E 4 hour standard for all three months in Quarter 2. For the 6-week diagnostic standard, the Trust has an agreed improvement trajectory with commissioners which aims to achieve the 99% standard by the end of December 2017. The recovery trajectory for end of September was to have less than 206 patients waiting 6+ weeks, which the Trust achieved (192 waiting 6+ weeks).

The Referral to Treatment (RTT) performance remains below the national standard and the recovery trajectory.

Access Key Performance Indicator		Quarter 4 2016/17			Quarter 1 2017/18			Quarter 2 2017/18		
		Feb 17	Mar 17	Dec 16	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17
A&E 4-hours	Actual	80.4%	80.7%	83.3%	82.3%	84.2%	87.9%	90.5%	91.3%	90.8%
	STF trajectory	88.5%	87.4%	91.0%	82.5%	83.5%	85.0%	90.0%	90.0%	90.0%
62-day GP cancer	Actual	84.3%	78.8%	81.2%	76.5%	77.8%	81.7%	74.7%	85.1%	
	STF trajectory	83.6%	85.7%	85.9%	81.0%	81.0%	81.0%	83.6%	83.6%	83.6%
Referral to Treatment Time (RTT)	Actual	92.2%	92.0%	91.1%	91.1%	91.1%	91.0%	90.2%	89.9%	89.4%
	STF trajectory*	92.8%	92.8%	93.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
6-week wait diagnostic	Actual	98.4%	98.7%	98.7%	98.6%	98.8%	98.6%	98.5%	97.6%	97.7%
	STF trajectory*	99.2%	99.2%	99.2%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

*minimum requirement for securing Sustainability & Transformation Funds (STF) is achievement of the national standard

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory and/or recovery trajectory (where agreed) achieved
RED rating = national standard not achieved, the STF trajectory not achieved, and the recovery trajectory (where agreed) not achieved

Summary Scorecard

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

Key changes in indicators in the period:

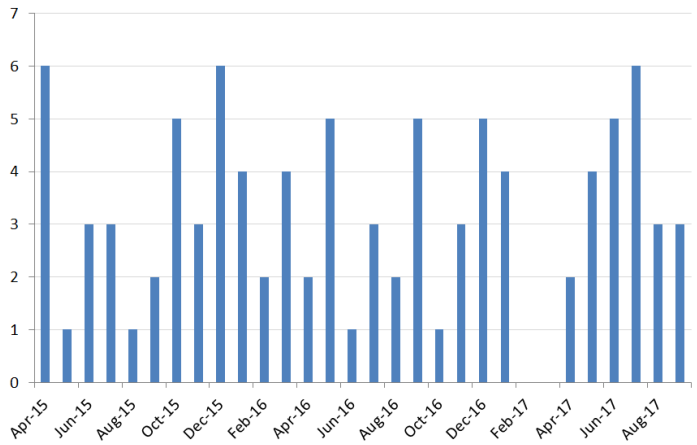
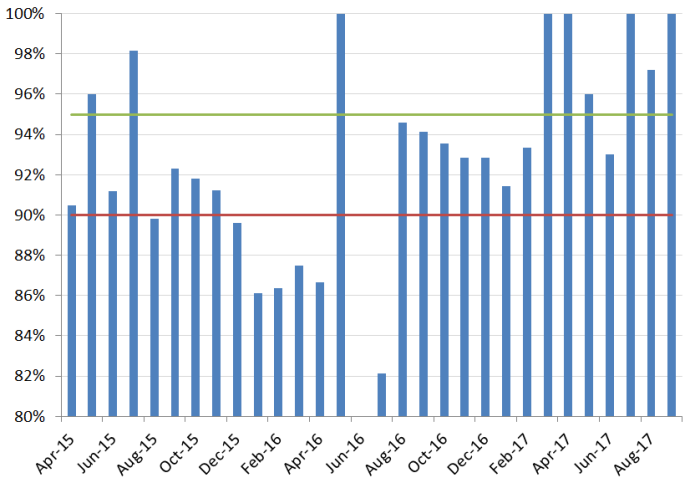
RED to GREEN
Safety Thermometer (No New Harms)
Heart Reperfusion Times

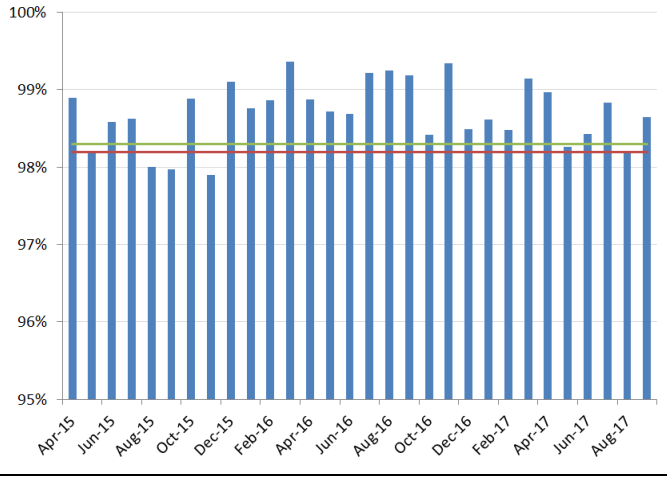
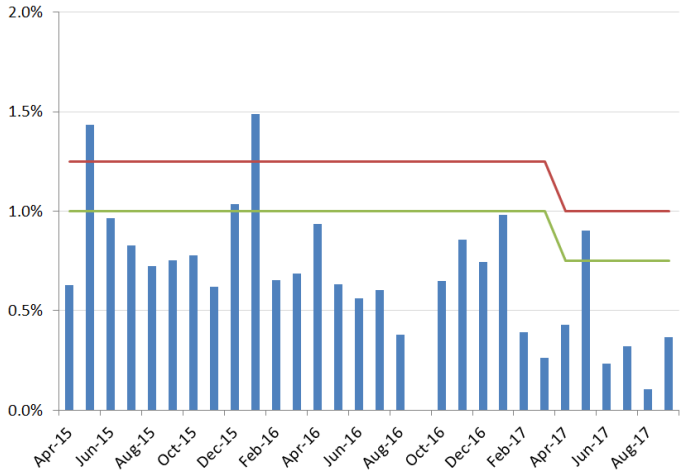
RED to AMBER
Dissatisfied Complaints
Cancer Wait Times

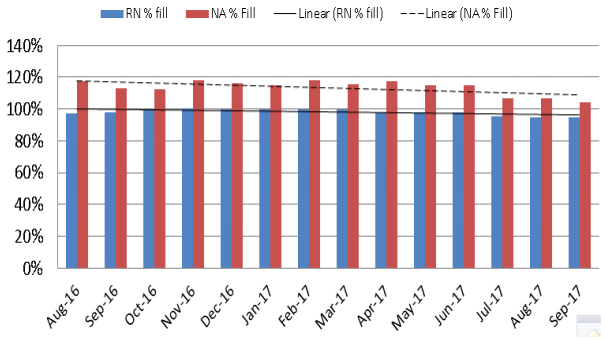
Overview

The following summarises the key successes in September 2017, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 2 2017/18.

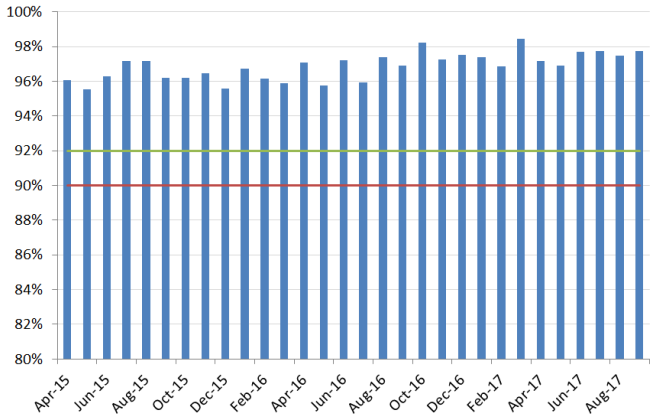
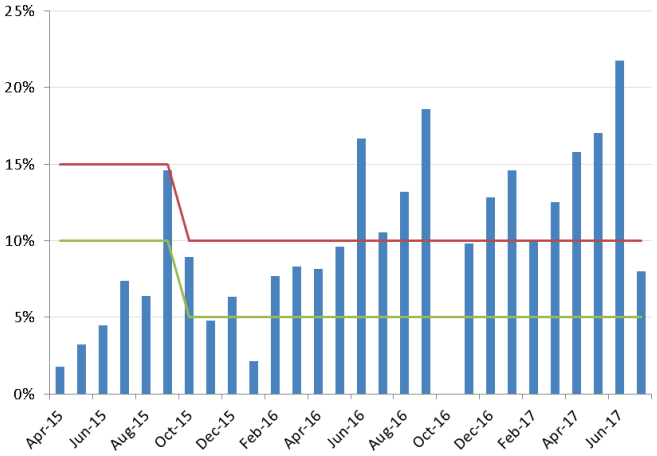
Successes	Priorities
• The Trust achieved the A&E 4 Hours Sustainability and Transformation Fund (STF) target of 90% for each month in Quarter 2. • Bristol Eating Better Award Scheme – Gold Level awarded to BHI and STMH internal kiosks to offer food that is healthier and more environmentally friendly. • In September, World Health Organisation (WHO) Surgical Checklist Compliance was 99.9% against a green target of 100%. This is the best reported figure since September 2016 (100%). • Significant improvement in sepsis screening (92.9%) and antibiotics administered within an hour (100%) in the emergency department. • National standard of 85% for Cancer 62 Day GP Referrals was achieved in August • Impact of Musculoskeletal (MSK) ultrasound activity from MATS service has been mitigated in October. Follow up meeting with commissioners planned in November	• Further improvements in A&E 4-hour performance against trajectory, recent pressures seen in minors presentations have challenged performance particularly in the evening periods. • Implementation of revised Diagnostics 6 week trajectory for CCG Activity and Performance Sub Group: recovery of performance against the 6-week diagnostic waiting times standard by the end of December • Joined Neutral Vendor contract (agreed across the BNSSG) which introduces tighter controls to reduce agency spend. • Restore performance against the 62-day GP cancer waiting times standard to the national 85% standard by quarter 1 18/19 and achieve the recovery trajectory during 2017/18. • Work with other providers to reduce late referrals for patients on Caner pathways
Opportunities	**Risks & Threats**
• Continue to drive flu programme with flexible approach to ensure front line staff have access to flu clinics. • Sustaining improvements seen in the A&E 4hr target as we move into the winter period. • Pilot in Cardiac CT to increase throughput on lists is proceeding well and increasing to 10 slots per session at the end of October • Recovery plan being developed for Sleep Studies to support delivery of Diagnostic 6 Week Wait • Avoiding cancellation is the single most important high impact action for the Trust to improve and sustain performance against the cancer standards.	• Understand and manage the impact of going live with the Neutral vendor model, from the 7th November. • Late referrals from other providers continue to impact on achievement of the 62-day GP cancer waiting times standard • Surgical cancellations are a high risk to achievement of several cancer standards as well as to patient experience and quality • In September 2017, falls per 1,000 beddays was 5.04. This is the first time since April 2015 that this indicator has reached the red threshold of 5.0. A focussed work plan continues to be implemented including launch of an updated Enhanced Care Observations Policy. • The number of over 6-week waiters for Cardiac CT scans and Sleep Studies is expected to remain high and above current capacity, exacerbated by short and medium term capacity issues in respiratory (for sleep studies) • PET scanning delays are a new risk for Cancer standards delivery in quarters 3 and 4, following a nationally determined provider change.

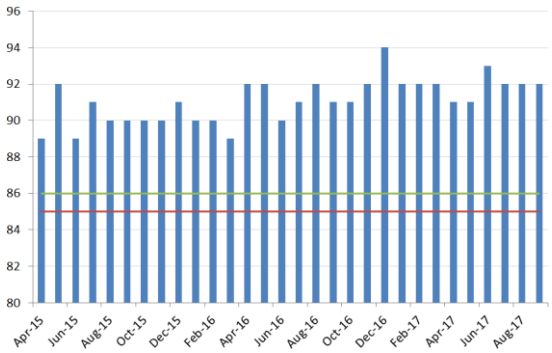
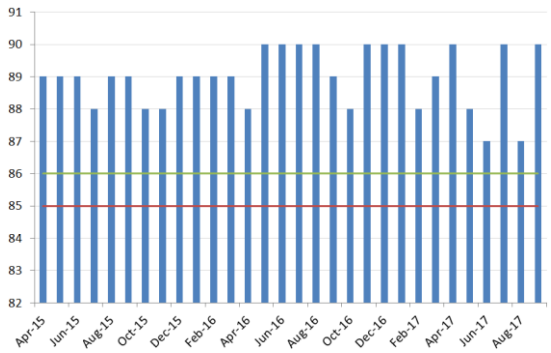
Description	Current Performance	Trend	Comments
Infection control The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16).	Performance in Trust acquired *Clostridium difficile* (C. diff) shows low numbers of cases in relation to the limits set. There were three cases of C. diff attributed to the Trust in September 2017. However, these three cases are awaiting review by the CCG therefore this figure may be lower. To date, this year, we have three hospital apportioned avoidable cases of clostridium difficile however there are further cases awaiting a decision by the CCG. Note that only April and May have had all their cases reviewed.	**Total number of C. diff cases**  .	Monthly meetings between the infection control team and Clinical Commissioning Group (CCG) aim to review all cases of clostridium difficile and apportion these appropriately. There is a time delay for these meetings and therefore Trust attributed cases may not be agreed for some time after the infection was identified. There are higher rates of clostridium difficile within three ward areas. A business case is currently under review to trial screening on admission within these three wards to identify the appropriate source of the infection.
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 September 2017 was 100% against a three-year improvement goal of 95%. This is a slight improvement from August's position of 97 % (one breach).	**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 (Actions 1A and 1B. Previous ongoing actions reported to the Board continue).

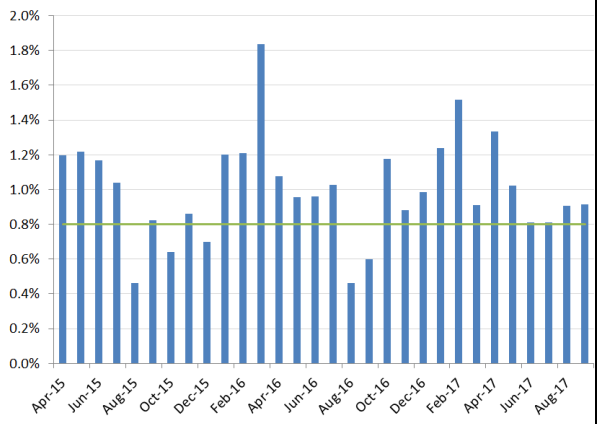
Description	Current Performance	Trend	Comments
Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.	In September 2017, the percentage of patients with no new harms was 98.7% (10 patients had new harms), against an upper quartile target of 98.3% (GREEN threshold) of the NHS Improvement patient safety peer group of Trust. This was a slight improvement on August 2017 figure of 98.2%.	**The percentage of patients surveyed showing No New Harm each month** 	The September 2017 Safety Thermometer point prevalence audit showed two new catheter associated urinary tract infections, four falls with harm, one new pressure ulcer and three new venous thrombo-emboli.
Non-purposeful omitted doses of listed critical medicines Monthly audits by pharmacy incorporate a review of administration of critical medicines: insulin, anti-coagulants, Parkinson's medicines, injected anti—infectives, anti-convulsants, short acting bronchodilators and 'stat' doses.	In September 2017, 0.37% of patients reviewed (3 out of 816) had one or more omitted critical medications in the past three days. The target for omitted doses is no more than 0.75%. The 0.37% for September 2017 is a slight deterioration from the August 2017 figure of 0.11%.	**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).

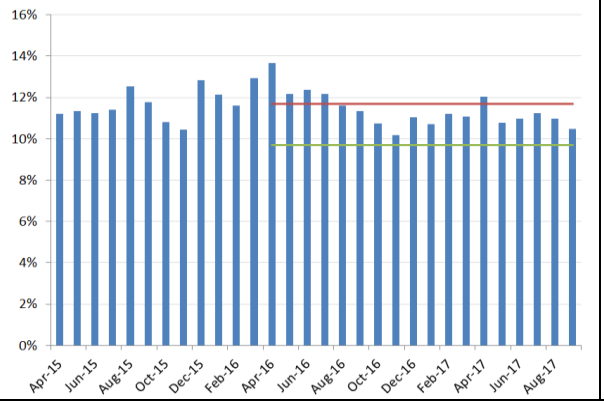
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Overall compliance is 89% (excluding Child Protection Level 3). Compliance with each of the reporting categories is provided below.
<table>
<tr><th>September 2017</th><th>UH Bristol</th></tr>
<tr><td>Total</td><td>89%</td></tr>
<tr><td>Three Yearly (14 topics)</td><td>87%</td></tr>
<tr><td>Annual (Fire)</td><td>87%</td></tr>
<tr><td>Annual (IG)</td><td>82%</td></tr>
<tr><td>Induction & Orientation</td><td>98%</td></tr>
<tr><td>Doctors induction</td><td>89%</td></tr>
<tr><td>Resuscitation</td><td>81%</td></tr>
<tr><td>Safeguarding</td><td>87%</td></tr>
</table>
</td>
<td>Overall the compliance for the Trust has risen 1% from last month.</td>
<td>See Actions in 3A of the Improvement Plan section.</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 September 2017 the Trust had rostered 229,166 expected nursing hours, with the number of actual hours worked of 222,557. This gave a fill rate of 97%.
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>63,822</td><td>60,201</td><td>+3621</td></tr>
<tr><td>Specialised Services</td><td>38,958</td><td>39,466</td><td>-509</td></tr>
<tr><td>Surgery</td><td>42,753</td><td>43,012,</td><td>-259</td></tr>
<tr><td>Women’s & Children’s</td><td>77,024</td><td>86,487</td><td>-9462</td></tr>
<tr><td>Trust</td><td>222,557</td><td>229,166</td><td>-6609</td></tr>
</table>
</td>
<td>The percentage overall staffing fill rate by month


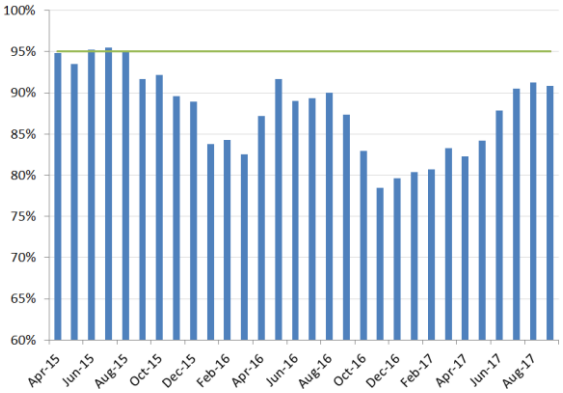
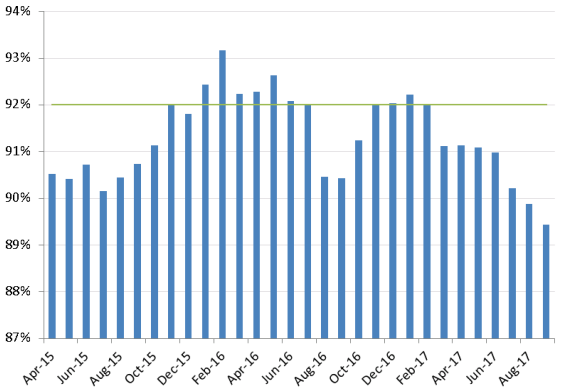
</td>
<td>Overall for the month of September 2017, the Trust had 94% cover for Registered Nurses (RN) on days and 96% RN cover for nights. The unregistered level of 101% for days and 109% for nights reflects the activity seen in September 2017. This was due primarily to Nurse Assistant specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night. Close monitoring continues.
See Action 4A in Improvement Plans section.</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 September 2017 was 97.7%. 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 score** 	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. Our goal is for less than 5% of complainants to report that they are dissatisfied with our response to their formal complaint. Note there is an Amber threshold between 5% and 10%	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 July 2017. As of 12th October 2017, 4 of the 50 responses sent out in July had resulted in dissatisfied replies (8% against a target of 5%).	**Percentage of compliantaints dissatisfied with the complaint response each month** 	In relation to formal complaints responded to in 2016/17 as a whole, 65 complainants expressed dissatisfaction with one or more aspects of our response to their concerns; this represented a small increase on 59 cases relating to 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).

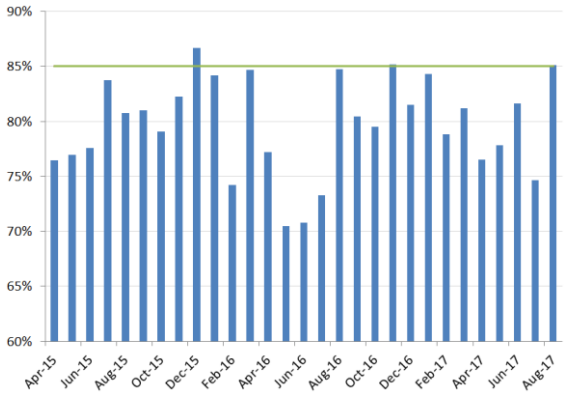
Description	Current Performance	Trend	Comments
Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as "key drivers" of patient satisfaction via analysis and focus groups.	For the month of September 2017, the score was 92 out of a possible score of 100, and 92 for Q2 as a whole. Divisional level scores are provided on a quarterly basis to ensure sample sizes are sufficiently reliable. Trust: Q1 2017/18: 91; Q2 2017/18: 92 Medicine: 87; 89 Surgery: 93; 91 Specialised Services: 92; 92 Women's & Children's (Bristol Children's Hospital): 92; 94 Women's & Children's Division (Postnatal wards): 92; 94	**Inpatient patient experience scores (maximum score 100) each month** 	UH Bristol performs in line with national norms in terms of patient-reported experience. This metric would turn red if patient experience at the Trust began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the score remains green. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report.
Outpatient experience tracker comprises four scores from the Trust's monthly survey of outpatients (or parents of 0-11 year olds): 1) Cleanliness 2) Being seen within 15 minutes of appointment time 3) Being treated with respect and dignity 4) Receiving understandable answers to questions.	The score for the Trust as whole was 90 in September 2017 (out of score of 100). Divisional scores for quarter 2 are provided as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful. Trust: Q1 2017/18: 88; Q2 2017/18: 89 Medicine: 89; 88 Specialised Services: 87; 88 Surgery: 88; 88 Women's & Children's (Bristol Children's Hospital): 84; 86 Diagnostics & Therapies: 92; 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 turns red if outpatient experience begins to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action is 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. The score for Bristol Royal Hospital for Children was red-rated in July, but recovered to 86 in August (green-rated and BRHC's best score since April).

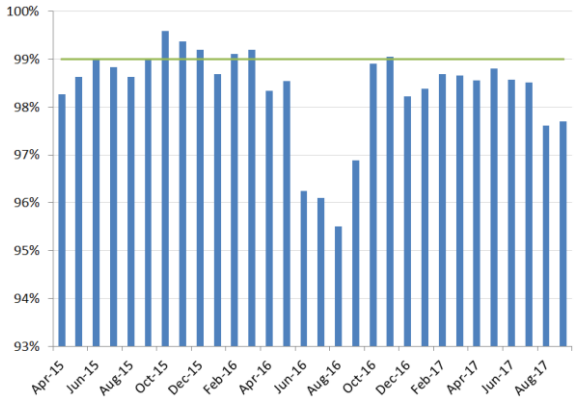
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In September the Trust cancelled 58 (0.91% of) operations at last-minute for non-clinical reasons. The top reasons for the cancellations are shown below:
<table>
<tr><th>Cancellation reason</th><th>Number</th></tr>
<tr><td>No HDU beds</td><td>16</td></tr>
<tr><td>Other patient prioritised</td><td>11</td></tr>
<tr><td>No CICU beds</td><td>5</td></tr>
<tr><td>No beds available</td><td>5</td></tr>
</table>
Of the 61 patients cancelled in August, 3 were not readmitted within 28 days. Meaning 95.1% were re-admitted within 28 days. This means the Trust achieved the former national standard of 95%.</td>
<td>Percentage of operations cancelled at last-minute
 
</td>
<td>Sustained good performance through August, and only narrowly missed the target for the second month running. Concern continues to be around the availability of HDU capacity to support complex surgery.
See Actions 6A-6B for further details.</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 September 10.5% of outpatient appointments were cancelled by the hospital, which is below the revised Red threshold of 11.7%. This is a similar level of performance to 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>Cancellation rates are monitored monthly at Outpatient Steering Group. This includes detailed discussion around what further actions could be taken to reduce cancellations (Actions 7A-7G).</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 September. However, Trust-level performance was 90.84%, and was above the in-month trajectory (90%). Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Jul 2017</th><th>Aug 2017</th><th>Sep 2017</th></tr>
<tr><td>Attendances</td><td>5930</td><td>5684</td><td>5688</td></tr>
<tr><td>Patients managed < 4 hours</td><td>5,047
85.1%</td><td>4935
86.8%</td><td>4922
86.5%</td></tr>
<tr><th>BCH</th><th>Jul 2017</th><th>Aug 2017</th><th>Sep 2017</th></tr>
<tr><td>Attendances</td><td>3,373</td><td>2687</td><td>3316</td></tr>
<tr><td>Patients managed < 4 hours</td><td>3,259
96.6%</td><td>2589
96.4%</td><td>3150
94.99%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments
 
</td>
<td>A significant improvement has been seen and sustained in the performance against the A&E 4hr target leading to achievement of the STF trajectory in Quarter 2. The Children's Hospital has sustained its consistently good performance and there has been marked improvement in the BRI with a renewed focus on patient flow out of ED, and through the ambulatory care assessment units. Some risk remains around sustaining this performance based on a recent pattern of increase in minors</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 September, with performance reported at 89.4%. We are managing to decrease the number of patients waiting over 52 weeks RTT against the recovery targets set against a contract performance notice received from the commissioners'.
<table>
<tr><th></th><th>July</th><th>Aug</th><th>Sept</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>193</td><td>240</td><td>182</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>45*</td><td>32</td><td>19</td></tr>
</table>
*originally reported as 30</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 

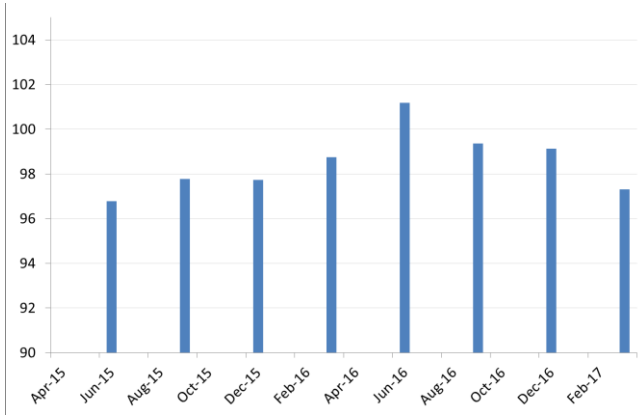
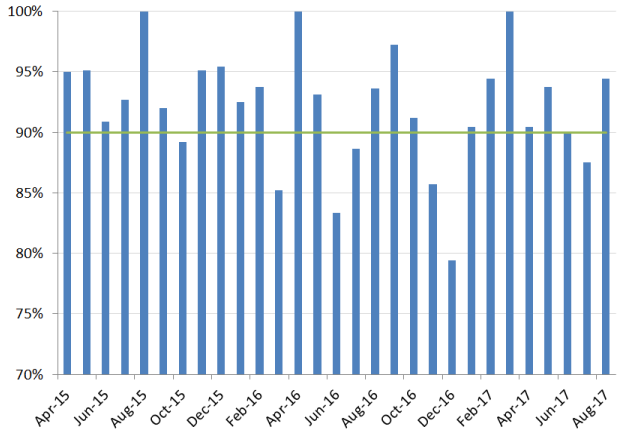
Forecast for September will continue to be below the 92% standard, due to rising demand.</td>
<td>Performance against the RTT standard has worsened in September due to rising demand. The total number of patients on an incomplete RTT pathway and those patients waiting over 18 weeks continues to be higher than 16/17. The size of the elective waiting list remains high, which in combination with the now rising outpatient waiting list, poses risks to recovery of the 92% standard. See the actions which continue to be taken to restore performance (Action 9A to 9G).</td>
</tr>
</table>

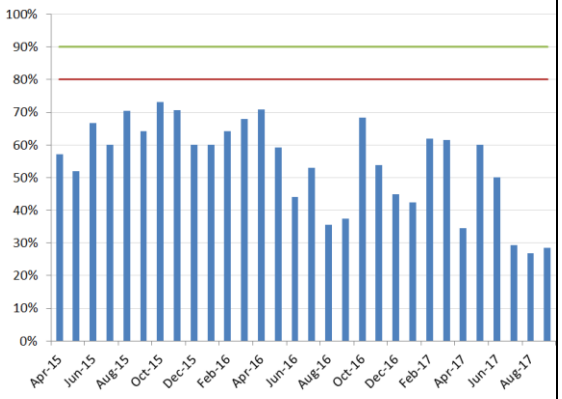
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.</td>
<td>August’s performance was 85.1% against the 85% 62-day GP standard, a Sustainability and Transformation trajectory of 83.6% and a recovery trajectory of 81%. August’s 62-day GP breach reasons were:
<table>
<tr><th>Breach reason</th><th>Aug 17</th></tr>
<tr><td>Medical deferral/clinical complexity</td><td>2.0</td></tr>
<tr><td>Late referral by/delays at other provider</td><td>7.0</td></tr>
<tr><td>Other causes (seven reasons)</td><td>6.5</td></tr>
<tr><td>TOTAL</td><td>27.5</td></tr>
</table>
There were no breaches of the 62 day GP screening standard in August.</td>
<td>Percentage of patients treated within 62 days of GP Referral
 

Forecast for October will continue to be below the 92% standard, due to rising demand.</td>
<td>August performance against the 62 day GP standard achieved the 85% standard, which is a significant achievement. 85% performance will not be sustained due to cancellations in September and other ongoing challenges. Commissioners have agreed the Trust’s remedial action plan and recovery trajectory which aims to reach 85% in March 2018. Avoiding cancellation is the single most important high impact action for the Trust to improve and sustain performance against the cancer standards. It should be noted that the majority of ‘breaches’ are due to unavoidable factors such as late referral and medical deferral. PET scanning delays are a new risk for quarters 3 and 4, following a nationally determined provider change. See Actions 10A-J in Improvement Plans section for more details.</td>
</tr>
<tr>
<td>Diagnostic waits – diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end.</td>
<td>Performance was 97.7% in September, which is below the 99% national standard, but was on the recovery trajectory for the month. The number of over 6-week waiters at month-end, is below:
<table>
<tr><th>Diagnostic test</th><th>Aug</th><th>Sep</th></tr>
<tr><td>MRI</td><td>19</td><td>30</td></tr>
<tr><td>Sleep</td><td>67</td><td>73</td></tr>
<tr><td>Endoscopies</td><td>26</td><td>29</td></tr>
<tr><td>CT</td><td>76</td><td>55</td></tr>
<tr><td>Echo</td><td>3</td><td>5</td></tr>
<tr><td>Other</td><td>10</td><td>0</td></tr>
<tr><td>TOTAL</td><td>201</td><td>192</td></tr>
<tr><td>Percentage</td><td>97.6%</td><td>97.7%</td></tr>
</table></td>
<td>Percentage of patients waiting under 6 weeks at month-end
 
</td>
<td>Trajectory is in the process of being reviewed, in light of recovery plans being developed to improve the Sleep Studies position. There are 2 main causes:

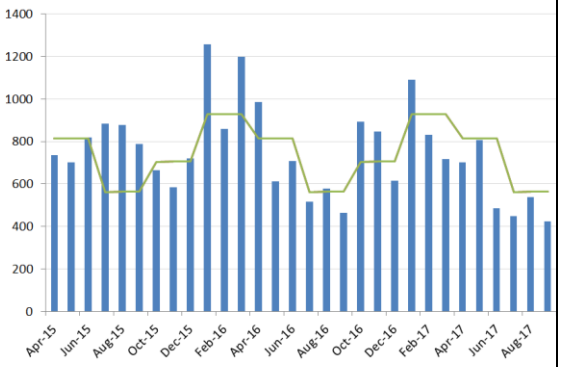
Demand for Cardiac CT remains high. Pilot for increasing capacity commenced in July. By the end of October, capacity will have increased from 6 slots per session to 10, with a further plan to move to 12 in November
High demand for Sleep Studies tests, and ongoing shortfall in recurrent capacity, exacerbated by unexpected short and medium non-recurring capacity issues

See Actions 11A-C in Improvement Plans section</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator is the ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors. This is nationally published quarterly, six months in arrears.	Summary Hospital Mortality Indicator (SHMI) for March 2017 was 97.3. This covers the 12 month period April 2016 to March 2017 This statistical approach estimates that there were 47 fewer actual deaths than expected deaths in the 12-month period. Actual number of deaths was 1737. Note this national data is updated quarterly, so no change from last month.	**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 September, 34 out of 36 patients (94.4%) 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%. Performance for 2017/18 is currently at 91.2%	**Percentage of patients with a Door to Balloon Time < 90 minutes by month** 	There was a slight dip in performance in August but year to date remains above the 90% target and performance recovered to above 90% in September.

<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 September 2017 we achieved 28.6% (6/ 21 patients) overall performance in Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 85.7% (18/21 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number of patients</th></tr>
<tr><td>Patents required medical optimisation before they could undergo surgery.</td><td>2</td></tr>
<tr><td>Procedure postponed until following day due to a complex case causing the Theatre list to overrun.</td><td>1</td></tr>
</table>
</td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards


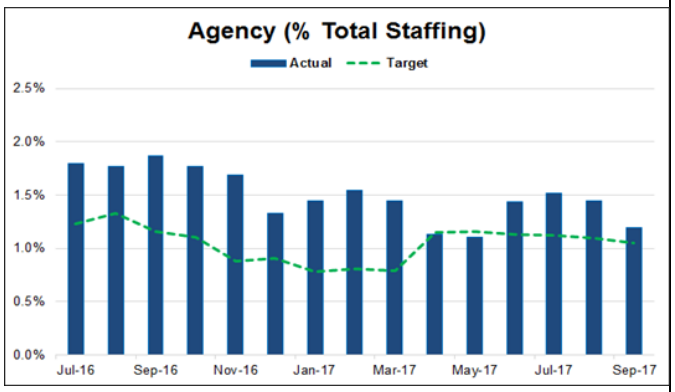
</td>
<td>Fourteen patients did not receive any ortho-geriatrician review due to annual leave, and clinician having to cover the Older Person Assessment Unit.

Actions are being taken to establish a future service model across Trauma & Orthopaedics, and ensure that consistent, sustainable cover is provided (Actions 12A to 12D).</td>
</tr>
<tr>
<td>Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.</td>
<td>In September 2017 there were 424 outlier bed-days against a target of 562 outlier bed-days.
<table>
<tr><th>Outlier bed-days</th><th>September 2017</th></tr>
<tr><td>Medicine</td><td>182</td></tr>
<tr><td>Surgery</td><td>152</td></tr>
<tr><td>Specialised Services</td><td>77</td></tr>
<tr><td>Women's & Children's Division</td><td>10</td></tr>
<tr><td>Diagnostics and Therapies</td><td>3</td></tr>
<tr><td>Total</td><td>424</td></tr>
</table>
</td>
<td>Number of days patients spent outlying from their specialty wards


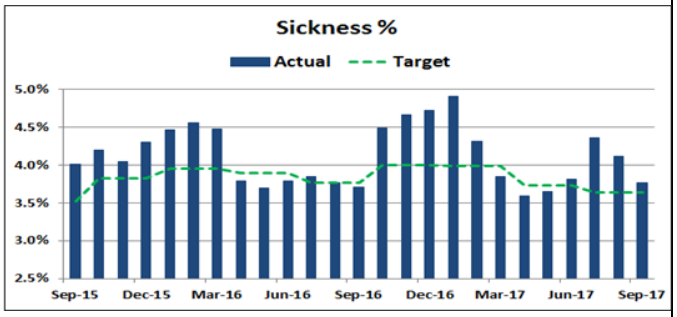
</td>
<td>The quarter two target has been set at 562 bed days per month and this was achieved in September 2017 by 138 bed days.
Ongoing actions are shown in the action plan section of this report. (Action 13A).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Agency usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2015/16. The red threshold is 10% over the monthly target.	Agency usage reduced by 22.4 FTE, with reductions across all staff groups and divisions. Nursing & Midwifery usage reduced by 10.1 FTE in month, but bookings to cover vacancies increased by 12.3 FTE.	**Agency usage as a percentage of total staffing by month**	A summary of compliance with agency caps is attached in Appendix 2. See actions 14A-C for a summary of key actions to target agency use.
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2015/16. The red threshold is 0.5% over the monthly target.	Sickness absence reduced from 4.1% to 3.8%, with reductions in all Divisions except Trust Services. Stress/Anxiety continues to be the biggest reason for absence, but this month has seen a reduction (10.7%).	**Sickness absence as a percentage of full time equivalents by month**	See action 15A-15E in the Improvement Plan section for the sickness action plan.

September 2017	FTE	Actual %	KPI
UH Bristol	**102.9**	**1.2%**	**1.0%**
Diagnostics & Therapies	11.9	1.2%	0.6%
Medicine	26.7	2.1%	1.1%
Specialised Services	10.8	1.1%	1.5%
Surgery	12.0	0.7%	1.1%
Women's & Children's	26.8	1.4%	0.5%
Trust Services	11.2	1.4%	2.1%
Facilities & Estates	3.5	0.5%	1.0%



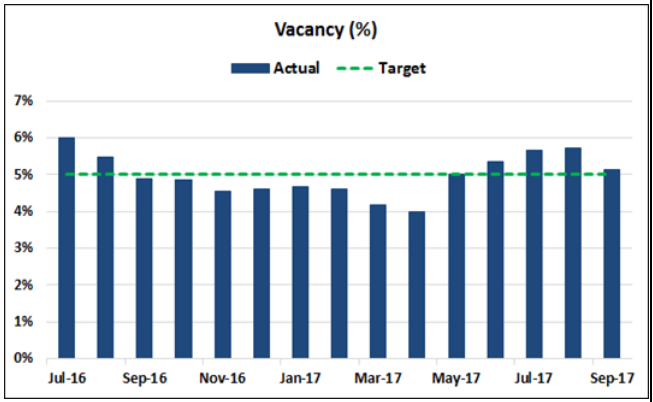
September 2017	Actual	KPI
UH Bristol	**3.8%**	**3.6%**
Diagnostics & Therapies	3.0%	2.7%
Medicine	4.3%	4.4%
Specialised Services	3.0%	3.6%
Surgery	3.2%	3.6%
Women's & Children's	3.6%	3.4%
Trust Services	3.3%	2.8%
Facilities & Estates	7.1%	5.2%



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.

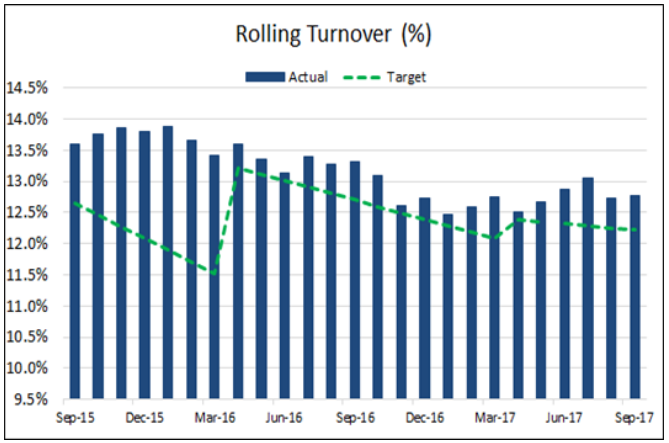
Description	Current Performance	Trend	Comments
Vacancies - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.	Overall vacancies reduced to 5.1%, compared with 5.7% last month, still slightly higher than the Trust target of 5%. Reductions are seen across all staff groups except ancillary, which has increased to 10.9% (9.6% last month). Nursing vacancies reduced by 43.3 FTE in month to 192.3 (6.0%), with reductions in all clinical divisions.	**Vacancies rate by month**	See Actions 16A-16B for further details of the plans that continue to be implemented to reduce the vacancy rate.

September 2017	Actual	KPI
UH Bristol	**5.1%**	**5.0%**
Diagnostics & Therapies	5.1%	5.0%
Medicine	6.1%	5.0%
Specialised Services	5.3%	5.0%
Surgery	4.9%	5.0%
Women's & Children's	1.9%	5.0%
Trust Services	5.8%	5.0%
Facilities & Estates	11.1%	5.0%

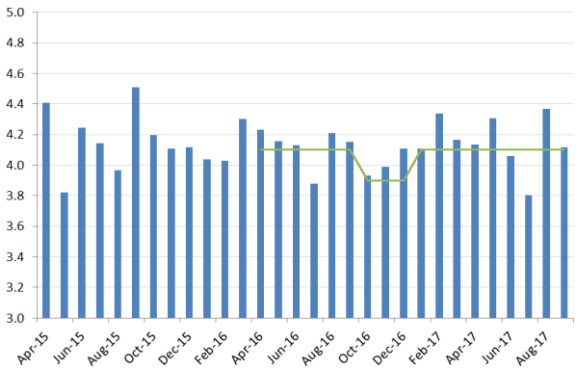


Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.1% by the end of 2016/17. The red threshold is 10% above monthly trajectory**.**	Turnover increased slightly to 12.8%, compared with 12.7% last month. In month increases were seen in the divisions of Surgery and Facilities and Estates. Nursing and Midwifery Unregistered continues to be the staff group with the highest level of turnover, but there has been a reduction compared with last month.	**Staff turnover rate by month**	See Action 17A-17C for further details of the plans that continue to be implemented to reduce turn-over.

September 2017	Actual	KPI
UH Bristol	**12.8%**	**12.2%**
Diagnostics & Therapies	11.4%	11.9%
Medicine	13.5%	14.5%
Specialised Services	14.3%	12.0%
Surgery	12.6%	11.7%
Women's & Children's	10.7%	10.8%
Trust Services	13.3%	12.3%
Facilities & Estates	16.3%	14.1%



<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>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.</td>
<td>In September the average length of stay for inpatients was 4.12 days, which is just above the RED threshold of 4.1 days.

Number of patients in hospital at month-end with a “long” Length of Stay is below:
<table>
<tr><th></th><th>Jul-17</th><th>Aug 17</th><th>Sep 17</th></tr>
<tr><td>7+ Days</td><td>392</td><td>399</td><td>364</td></tr>
<tr><td>14+ Days</td><td>250</td><td>256</td><td>237</td></tr>
<tr><td>21+ Days</td><td>166</td><td>188</td><td>162</td></tr>
</table>
</td>
<td>Average length of stay (days)
 
</td>
<td>The total number of Green to Go (delayed discharge) patients in hospital is 58 as at end of September (almost double the jointly agreed planning assumption of 30 patients).</td>
</tr>
</table>

Improvement Plans

Number	Action	Timescale	Assurance	Improvement trajectory
SAFE – Deteriorating Patient, Early Warning Scores Acted Upon				
1A	Procurement of e observations system to enable automatic calculation of NEWS and notification of elevated NEWS to responder.	Pilot of e observations commencing on two wards in Medicine in November 2017. Implementation in majority of adult wards planned by April 2018. Electronic escalation tool will follow. Timescale TBC	Monthly progress reviewed in the deteriorating patient work stream and quarterly by the Patient Safety Improvement Programme Board, Clinical Quality Group and Quality and Outcomes Committee	Sustained improvement to 95% by 2018.
1B	Testing new SBAR communication sticker in Trauma and Orthopaedic Ward	November 2017	As above	Sustained improvement to 95% by 2018.
SAFE – Non-purposeful omitted doses of critical medication				
2A	The implementation of electronic prescribing will allow continuous data monitoring from exact dose administration prescription and administration times. Reasons for omission have to be recorded.	Full rollout anticipated by autumn 2018	Improvement under development	All omitted medication to be recorded and reported on, with reasons for omission and if fully omitted with no reason entered
2B	Pilot stage to be used to develop reporting suite. Data to be reviewed for ease of reporting, ability to amalgamate data and for conciseness. 'Critical' medication to be looked at as well as all medication.	Pilot Stage October 2017 to February 2018	Improvement under development	All omitted medication to be recorded and reported on, with reasons for omission and if fully omitted with no reason entered

Number	Action	Timescale	Assurance	Improvement trajectory
SAFE – Essential Training				
3A	The Education Board will consider reducing the monthly compliance report from the 35 current topics to 11 Core Skills of the UK Core Skills Framework. Continue to drive 90% compliance in all subjects via the developed recovery plans. Increase in the provision of additional training sessions as required.	31/09/2017 (Completed) 30/11/2017 (Completed)	Oversight of training compliance by the Education Board. Monthly and quarterly Divisional Performance Review meetings.	Overall the compliance for the Trust has risen 1% from last month. The update requirement for Medical Devices is now 'Essential Specific to Role' resulting in a rise in compliance from 79% in August to 97% in September. VTE and Medicines Management update requirements are also now 'Essential Specific to Role' for M&D staff (the Consultant Portfolio Group). Induction (M&D) is up +22%, due to increased number of completions. The Education Team and Information Governance (IG) Lead are developing a new IG presentation, which will allow far more staff to achieve compliance at induction. This will be effective in November. Compliance increased form from 72% in June to 87% in July as a result of this action
SAFE – Nursing Staffing Levels				
4A	Continue to validate temporary staffing assignments against agreed criteria.	Ongoing	Monitored through agency controls action plan	Action plan available on request.

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 Clinical Effectiveness) and Acting Patient Support and Complaints Manager undertook a detailed review of all dissatisfied cases from August and September 2016.	Ongoing.	From June 2017 (reviewing March cases), all dissatisfied cases are now retrospectively reviewed on a monthly basis for learning by the Head of Quality (Patient Experience and Clinical Effectiveness) and Patient Support and Complaints Manager. Findings are reported to the Patient Experience Group and Divisional Management Teams.	Achieve and maintain a green RAG rating for this indicator
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

Number	Action	Timescale	Assurance	Improvement trajectory
CARING – 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 End August	Monthly Divisional Review Meetings; Senior Leadership Team sign-off	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.
CARING – Hospital Cancelled Outpatient Appointments				
7A	Explore option of increasing required notice of annual leave from six to eight weeks to reduce the number of cancelled clinics	Agreed in principle but process of how to communicate this out and enact it being worked through	Senior Leadership Team	Review of progress requested
7B	Full service-level review of the electronic Referral Service (eRS) Directory of Services, to limit the number of required re-bookings.	Complete - full improvement plan in place around ERS to comply with the CQUIN and NHSE Paper Less initiative; Milestones across each quarter	Outpatient Steering Group	Ongoing delivery of plan continues in line with CQUIN milestones
7C	Implement changes to the way capacity is managed to support eRS appointment bookings and limit cancellations.	Working through as part of the ERS plan. NHS Digital to undertake one capacity review on one service for us by September	Outpatient Steering Group	Linked in to ERS plan. Outpatients Operating Model being developed which clearly identifies levels of responsibility and action between divisions, corporate team and IM&T
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 outpatients	Complete.	Outpatient Steering Group	In place as per 6b above

Number	Action	Timescale	Assurance	Improvement trajectory
7E	Deep dive reviews of follow-ups in 5 specialities planned: Gastroenterology, Haematology, ENT, Gynaecology and Paediatric T&O. This is aimed at reducing the number of follow-up appointments made in each service. This should free up capacity to see patients in a timely manner, reducing the need to move patients to accommodate urgent patients.	Project plan to be reviewed and signed off at OSG in September 17	Outpatient Steering Group	Ongoing work with divisions to identify specialities to support the reduction in follow-up work at CCG level.
7F	Re-build clinics in Medway to ensure they correctly reflect appointment slots available and are clearly named. This should prevent cancellations due to incorrect booking.	It was agreed at OSG in August to bid for a band 5 to be part of the central outpatients team to support the divisions to do re-build work.	Outpatient Steering Group	Recruitment underway
7G	On the 14th August clinic cancellation codes have been updated in Medway to remove 'hospital cancellation' as a reason and add 'short notice leave' as a reason. 3 months following the change a report will be produced to look at how often clinics are cancelled as a result of leave booked with less than 6 weeks' notice.	Report to be tabled at December OSG	Outpatient Steering Group	
RESPONSIVE – A&E 4 Hour Wait				
8A	Urgent Care Steering Group Improvement plan (BRI) has been refreshed to focus on the high impact schemes initially. Pilot underway in AMU to increase ambulatory capacity Model agreed with team for adult ED streaming – going to UCSG in August Specialty pathway work ongoing with other divisions	Ongoing	Oversight through Urgent Care Steering Group monthly, plus with partners through UHB Hospital Flow group and Access Performance Group	Aiming to sustain 90% target for September
8B	One day a week support from ECIP has commenced – focussing on support IDS work and implementing trusted assessor	Ongoing	Progress tracked through Urgent Care Steering Group	

Number	Action	Timescale	Assurance	Improvement trajectory
8C	Progress and recommendations presented to SLT. Further update to be presented to November SLT	November	Service Delivery Group and A&E Delivery Board	
RESPONSIVE – Referral to Treatment Times				
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. Additional request from the CCGs has resulted in reporting all of our 46 to 52 week waiters on a weekly and monthly basis	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review meetings. The request from the Clinical Commissioning Groups (CCGs) will need to be taken to the relevant groups for sign off against the 18 weeks best practice guides that have been issued.	Achievement of 92% standard from the end of October/November. Achievement of 92% standard from end of July has not been met and continues to be challenging.
9B	Contract performance notice received against our level of 52 week breaches	End of December	A RAP will be issued to the CCGs to give assurance that our level of 52 week waiters will reach 'zero' by the end of December 2017	Achieve '0' 52 week waiters by End of December 2017
9C	Implementation of RTT Sustainability Plan for the first half of 2017/18, which focuses on areas of recent growth and those specialties whose backlogs are still above sustainable levels	Ongoing	Fortnightly meetings between Divisions and Associate Director of Performance, and Access Improvement Manager	
9D	Refresh of IMAS Capacity and Demand modelling for key specialties (including Clinical Genetics, Paediatric Cardiology and Sleep Studies).	Complete	Modelling to be reviewed by Associate Director of Performance Review completed for Clinical Genetics on 27/7/17 The outcome of the review is that the position is Improving and the service is confident from the findings from a capacity point of view. The service feel that that they have enough recurrent capacity in place based on current backlog position.	

Number	Action	Timescale	Assurance	Improvement trajectory
9E	Chronological booking report to be developed to challenge inefficient booking practices for outpatients and elective procedures.	End July	Sign-off of report by Chief Operating Officer completed	
9F	Implementation of chronological booking report.	End August	Divisional PTL meetings making use of this report This could be monitored at the Weekly RTT OPS Group meeting chaired by Access Improvement Manager once sign off has been agreed by the Chief Operating Officer of the content. (see item 9D)	
9G	Dental administrative management improvement plan to be developed.	Complete	Sign-off of plan by Associate Director of Performance	
RESPONSIVE – Cancer Wait Times				
10A	Ensure there is sufficient thoracic surgery outpatient capacity to meet demand in a timely way	End November 17	Oversight of implementation by Cancer Performance Improvement Group, with review at Cancer Steering Group.	Achievement of 85% standard by the end of 2017/18
10B	Ensure thoracic surgery operating capacity is adequate for the longer term, in face of rising demand	End November 17	As above	As above
10C	Ensure adequate elective bed capacity to reduce cancellations and capacity issues for cancer resections (to keep cancellations at the level seen in Q2 2016/7)	End March 2018	As above	As above
10D	Undertake necessary work for Trust to become lead provider for adult dermatology in Taunton	End March 2018	As above	As above
10E	Resolve the short term capacity issues for chemotherapy treatment delivery	End October 17 (resolved)	As above (resolved and for ongoing monitoring)	As above (achieved as planned)
10F	Put in place more formal processes and guidance for managing the impact of MDT/planning meeting cancellations, for instance due to bank holiday	End January 2017	As above	As above

Number	Action	Timescale	Assurance	Improvement trajectory
10G	Reduce delays in the colorectal pathway due to capacity and pathway management issues	End February 2018	As above	As above
10H	Reduce delays for radiological diagnostics, in particular CT colonography, head and neck ultrasound, and PET	End November 2017	As above	As above
10I	Work with partners to reduce late referrals	Ongoing	As above	As above
10J	Resolve capacity shortfall in gynaecology following staff sickness	End October 2017 (resolved)	As above (resolved)	As above (achieved as planned)
RESPONSIVE – Diagnostic Waits				
11A	Additional Sleep Studies waiting list sessions to be established to minimise residual backlog of long waiters. Revised trajectory being developed with introduction of short term measures to resolve the recent non-recurrent capacity shortfall	TBC	Weekly monitoring by corporate team, with escalation to monthly Divisional Review meetings as required.	Additional capacity to commence end October with plans to increase in November and December
11B	Changes made to Cardiac CT scanning sessions to improve utilisation. Pilot commenced in July, slots increased/session to 10 by end of September, and to 12 by the end of October	End January	Weekly monitoring by corporate team, with escalation to monthly Divisional Review meetings as required.	Achievement of 99% standard again for this diagnostic modality by the end of January. On track to deliver
11C	AQN (Activity Query Notice) called with CCG regarding unplanned transfer of MSK ultrasound from MATS service. Actions agreed include CCG investigating additional short term capacity; establishment of diagnostic control centre to reduce demand; UHBristol to audit suitability of referrals.	Actions to be completed in September with progress review meeting in November	Weekly monitoring by corporate team, with escalation to monthly Divisional Review meetings as required. Involvement of Trust Commissioning and Planning team in discussions with commissioners	Achievement of 99% predicted in October, ahead of trajectory

Number	Action	Timescale	Assurance	Improvement trajectory
EFFECTIVE – Fracture Neck of Femur				
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.	Business case submitted on the 21st April. Funding confirmed with the executive team on 16th August. The Division of Medicine is progressing to advertisement with interviews in October / November.	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 capacity – there are currently vacancies within the COTE service that is impacting on the capacity of the orthogeriatric service.	Anticipated some improvement in orthogeriatric capacity from November.	The Division of Medicine has two COTE consultant vacancies. One of these vacancies is being covered by two clinical fellows. It is not anticipated that this will provide any additional capacity for the orthogeriatric service. However, the second vacancy has been appointed to and a new consultant will be starting in November. This appointment will release the two orthogeriatric consultants from undertaking sessions in OPAU and other COTE ward work. However, the service will still only be staffed by 2 rather than 3 orthogeriatric consultants and will, therefore, continue to struggle at times with cross-cover. The Divisions of Medicine and Surgery have discussed the COTE job plans.	Improvements in time to review by an orthogeriatrician.

Number	Action	Timescale	Assurance	Improvement trajectory
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.	Business case submitted on the 21st April. Pending approval by executive team. This is contingent upon amending care pathways and admission protocols.	There also needs to be sufficient capacity to maintain ring fenced admission beds (A602 and A604 are not currently ring-fenced) and medical ward capacity to accommodate step down patients. This will be very challenging during periods of an increased demand for inpatient beds. The Division of Surgery will coordinate a round table discussion with the site team and other clinical divisions in October to plan for the establishment of this ward. The proposed ward staffing enhancements at the weekend will be incorporated in the annual staffing levels review.	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	An options appraisal was received on the 4th August from the D&T Division presenting different staffing models to satisfy this standard. An on-call model for #NOF patients is the most cost effective, however, this will mean that other types of elderly fracture patients will not receive a physiotherapy review on a Sunday. Investment proposal pending approval by executive team.	There are potential benefits associated with reduction in patient length of stay with earlier mobilisation. The D&T Division have indicated a four month lead time to consult and give notice to their staff members. Therefore, the on-call physiotherapy cover will not be in place until the new calendar year.	Improvements against the new quality standard measure of therapy review the day after surgery.

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.	The Division of Surgery is trialling ways to increase theatre productivity including scheduling an additional theatre porter to reduce downtime on the trauma lists.	The throughput of trauma surgery is being tracked to demonstrate an improvement. New SOPs have been introduced to ensure that there is a clear process for escalating any delays for surgery. The measure for hours to surgery on the NHFD website indicates that the Trust is tracking national average performance.	Improvements against time to theatre standard
EFFECTIVE - Outliers				
13A	Ward processes to increase early utilisation of discharge lounge to facilitate patients from Acute Medical Unit getting into the correct speciality at point of first transfer.	Ongoing	Oversight in Ward Processes Project Group	Linked to increased and timely use of discharge lounge
EFFICIENT – Agency Usage				
14A	**Effective rostering**: • "Healthroster" – implemented and KPIs agreed in place. The new Safe Staffing module is now being rolled out across the Trust which will make it easier to move staff across the organisation in a timely manner to minimise agency usage.	• Ongoing	KPI Performance monitored through Nursing Controls Group.	A KPI has been agreed for 2017/18 of 1% through the Divisional Operating Planning. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings. Marketing activity now being actively deployed.
14B	**Controls and efficiency**: • Revised agency rules in place for Nursing from 1st October 2017 • Neutral Vendor contract now signed off and going live across the BNSSGE area 7th November 2017 which will help achieve cap compliance from agencies. • Operating plan agency trajectories monitored by divisional reviews.	• Ongoing • Ongoing • Monthly/ quarterly reviews	Nursing agency: oversight by Savings Board and Nursing Agency Controls Group. Medical agency: oversight through the Medical Efficiencies Group	

Number	Action	Timescale	Assurance	Improvement trajectory
14C	**Enhancing bank provision:** • Recruitment and marketing plan for all staff groups in place for 2017/18. • Bank-only RNs, Nursing Assistants, Domestics Employee On Line to be implemented through a phased approach.	• Ongoing • From end of October 2017	Oversight by WFOD Group	
EFFICIENT – Staff Sickness				
15A	**Supporting Attendance Policy:** Revised Supporting Attendance Policy; returning to JUC at start of November following further negotiation. Implementation plan and training programme in place for when policy is agreed. Supporting attendance surgeries ongoing; to expedite individual cases. Range of HW&B interventions to support staff; • Care First workshop on tackling stress (W&C) • Annual staff flu vaccination programme commenced with the first week achieving a higher rate of vaccination in comparison with 2016/17. • 3 new cohorts of the Step into Health programme (physical activity, nutrition & weight management and stress management modules) and Over 40's NHS health checks	December 2017	Oversight by Workforce and Organisational Development (OD) Board via the Staff Health and Well Being Sub Group Workplace Wellbeing Steering Group (quarterly) /CQUIN Delivery Group	Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings. Where divisions are above target an extensive deep dive into the data with a recovery plan. Manual Handling: • Continue to build on 'targeted' and in-loco compliance training (to give training with greater relevance to environment and role). • Responded request for increase in available MH training places by releasing another 190 patient handling training places
15B	**Supporting Attendance Surgeries:** To expedite cases where possible.	Ongoing		
15C	**Musculo-skeletal:** Interventions by Occupational Health, Physio Direct, and Manual Handling Team.	Ongoing		
15D	**Mental health:** Development of Workplace Wellbeing Strategy and Policy (to incorporate Work-Related Stress).	Senior Leadership December 2017		

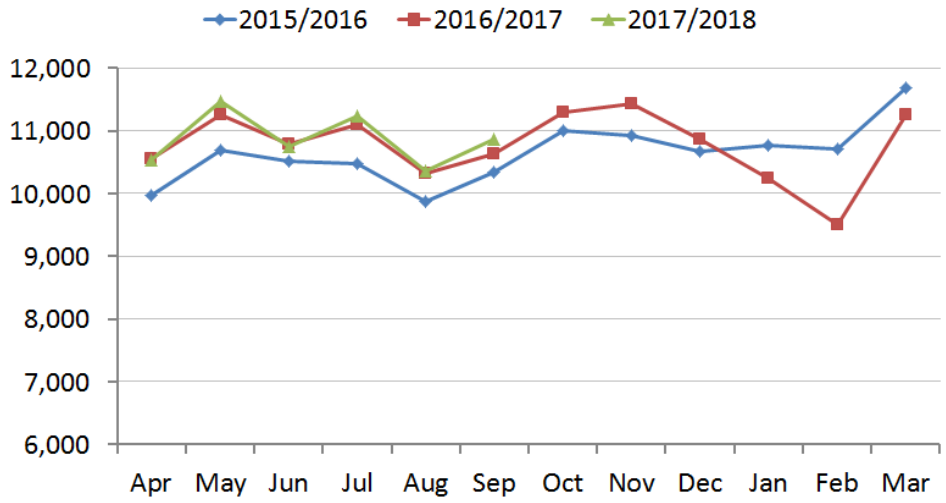
Number	Action	Timescale	Assurance	Improvement trajectory
15E	**Staff Health and Well Being:** Improve workplace wellbeing initiatives in support of Staff Health & Wellbeing CQUIN 2017/18	April 2017 to March 2019		
EFFICIENT – Vacancy				
16A	**Recruitment Performance:** Divisional Performance and Operational 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. Success seen in targeted areas including Sonography and Radiology.
16B	**Marketing and advertising:** • Recruitment and marketing plan for nursing in place for 2017/18. • Marketing for Radiology in place 2017/18 maximising new recruitment website. • Marketing plan for Domestic Assistants now live and producing results. • Divisional Nurse Recruitment Leads in bed-holding divisions supported by the Nurse Recruitment Manager. • Head-hunter" agency approach has been extended to hard to fill areas e.g. Sonography, Trauma & Orthopaedics and Care of the Elderly nursing. • Active attendance at careers events including 4 during the month of October.	Ongoing Ongoing Rolling programme starting September 2017 April 2017-18 From April 2017 Ongoing	Divisional Performance and Operational Review Meetings.	
EFFICIENT - Turnover				
17A	Scoping of Phase 2 of the E-Appraisal programme was completed in August and a project on a page detailing timescales for 360 feedback to support the embedding of the leadership behaviours in the future will be presented at Transformation Board in November	May 2018	Transformation Board	

Number	Action	Timescale	Assurance	Improvement trajectory
17B	Following on from the Leadership Behaviors Executive Launch in August. Local Divisional cascade continues and is further supported by corporate briefing sessions	Continuing	Senior Leadership Team/Divisional Board	
17C	Engagement (Staff Survey): HR BPs Improving Staff Experience Plans for 2017/2018 are complete and interventions are underway to support 'hot spot' areas	2017/18	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.

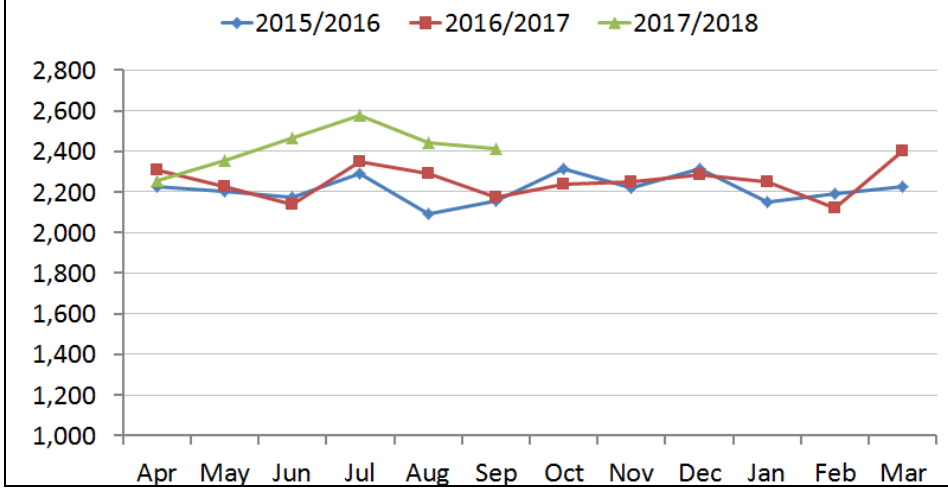
Emergency Department (ED) attendances



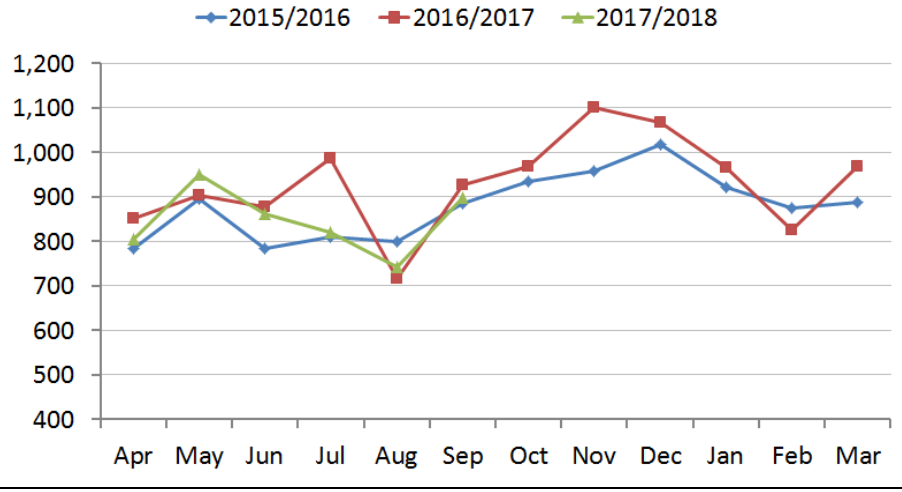
Summary points:

- Emergency Department attendances remain similar to last year's levels
- Total number of emergency admissions into the BRI is above the seasonal norm but has reduced from last month. This is being driven by a rise in short stay (0 or 1 day) Medical admissions in Ambulatory Care and Acute Medicine Unit (AMU). See next section where there is a corresponding reduction in overnight bed occupancy on AMU.
- The number of new outpatient attendances has remained above previous year's level.
- The number of elective admissions has returned to seasonal norm levels for August and September.

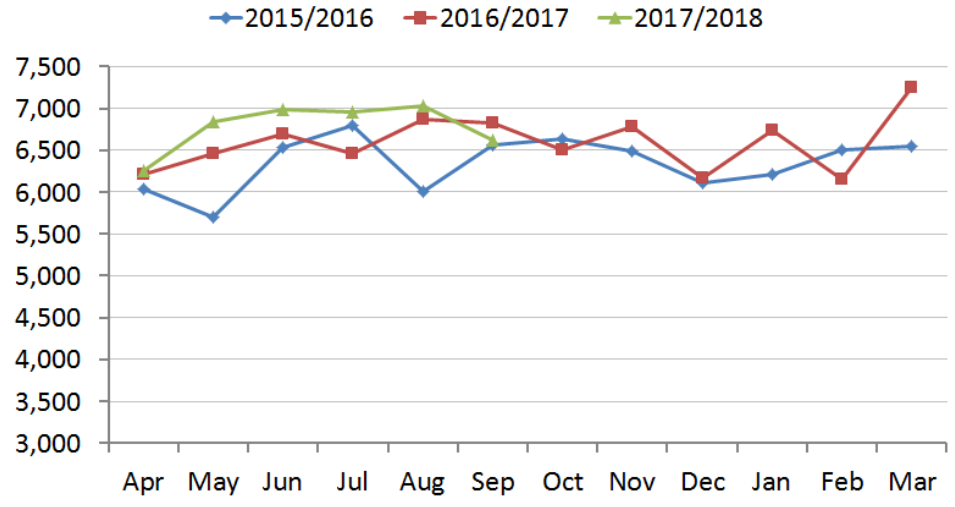
Emergency Inpatient Activity (BRI Discharges)



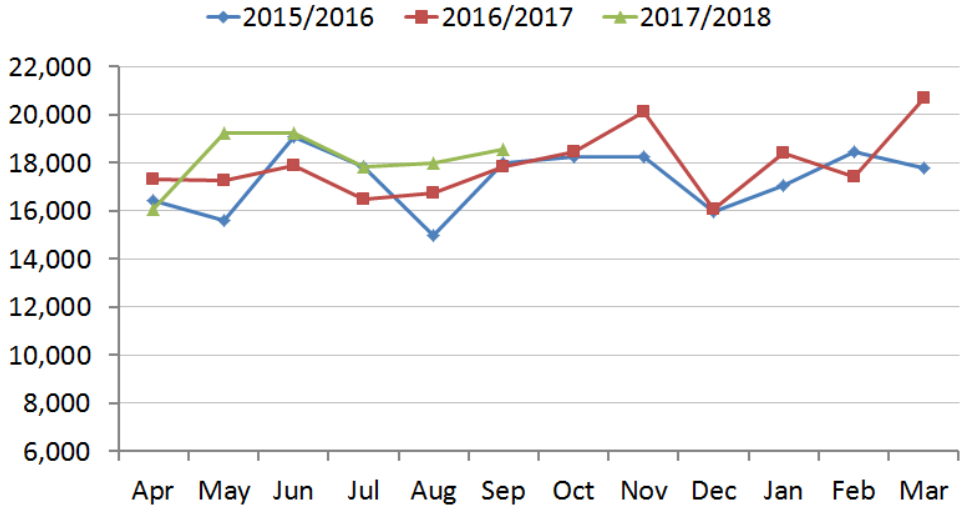
Emergency Inpatient Activity (BCH Discharges)



Elective Inpatient/Day Cases (number of Discharges)



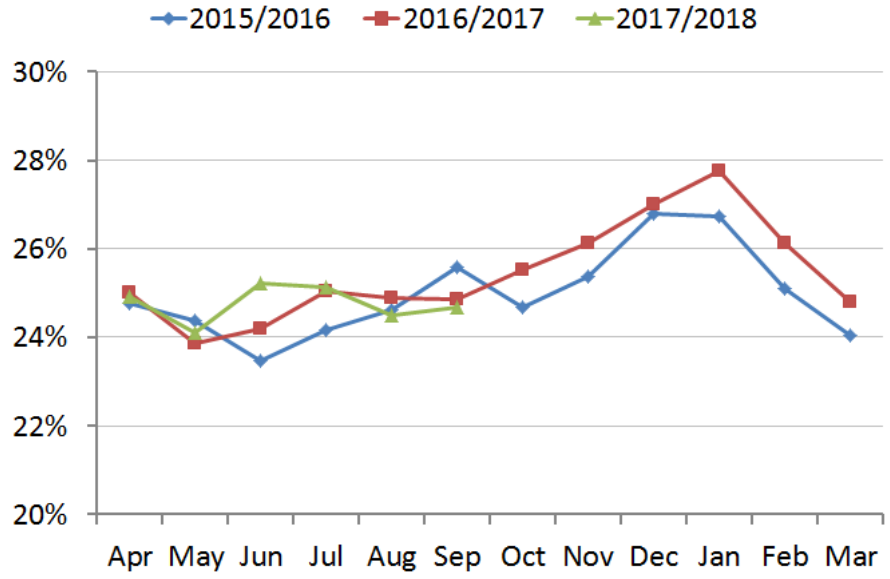
New outpatient attendances



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.

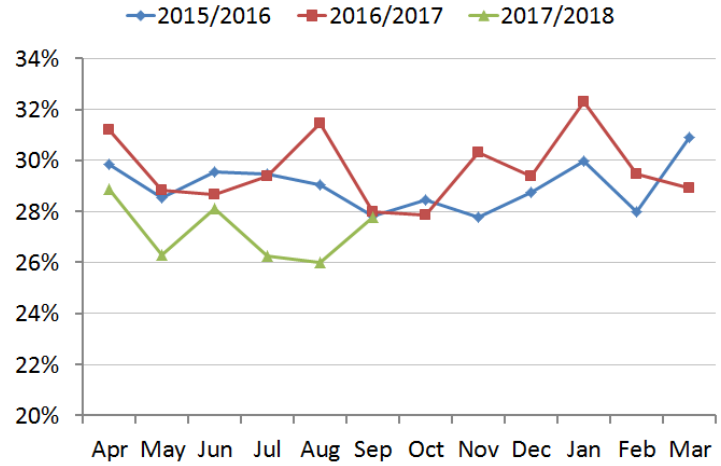
Percentage ED attendances resulting in admission



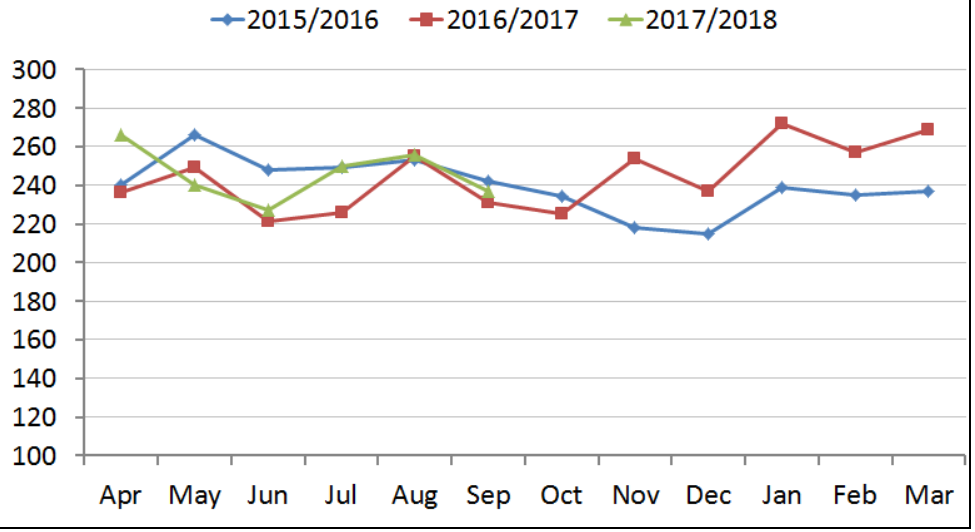
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission remains around the 25% level
- The number of over 14 days stays remains is in-line with last year's level.
- The BRI bed occupancy level continues to fall, and is now below 2016/17 levels. The drop is almost all in overnight occupancy on the Acute Medical Unit (AMU, A300). This tie-in with rise in short stay emergency medical patients as noted in the previous section. Changes in pathways for short-stay emergency medical patients are triggering changes in these measures.
- The rise in the number of patients on the outpatient waiting list has levelled-out this month, but remains below previous year levels.
- Number of RTT patients waiting over 18 weeks continues to rise
- The number of patients referred by their GP with a suspected cancer (2-week waits) continues to rise and remain significantly above previous year's levels.
- Elective waiting list has stopped in reducing in size this month.

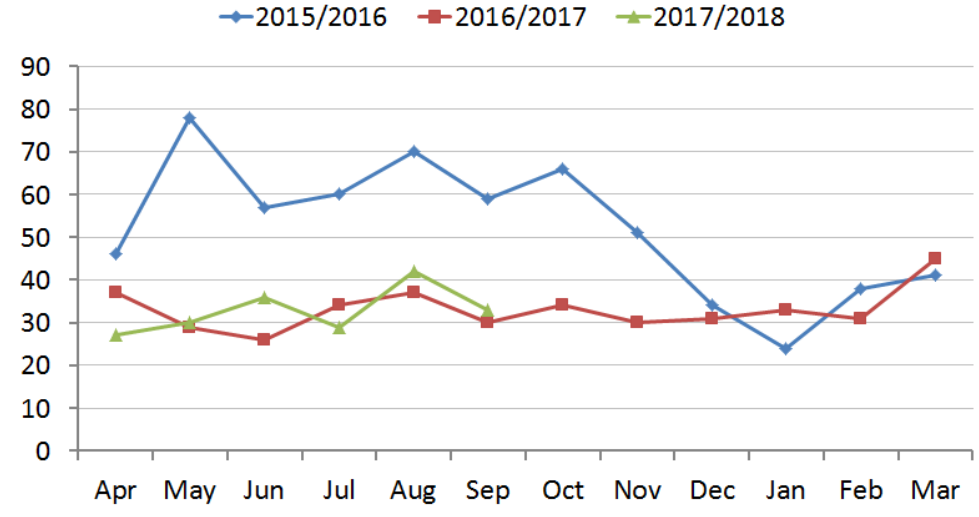
Percentage of Emergency BRI spells patients aged 75 years and over



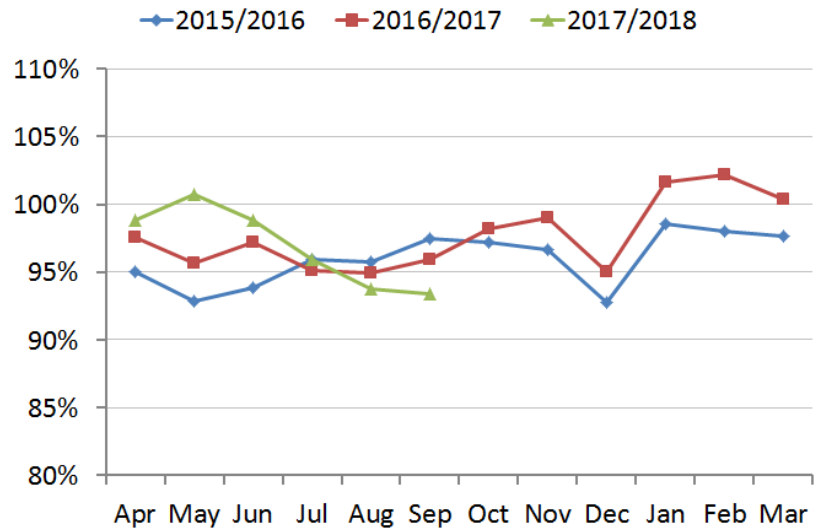
Over 14 day stays , at month-end



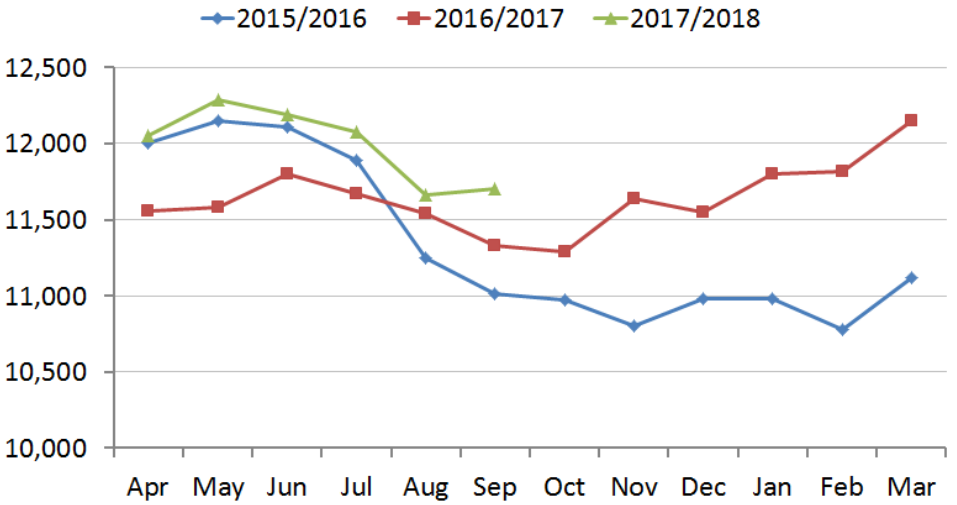
Delayed Transfers of Care (Number of patients at month-end)



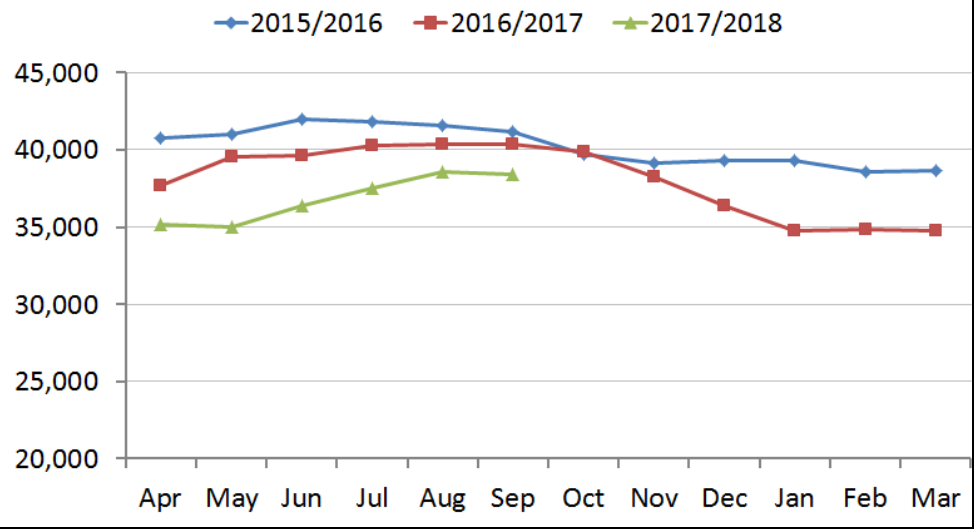
BRI Bed Occupancy (Overnight)



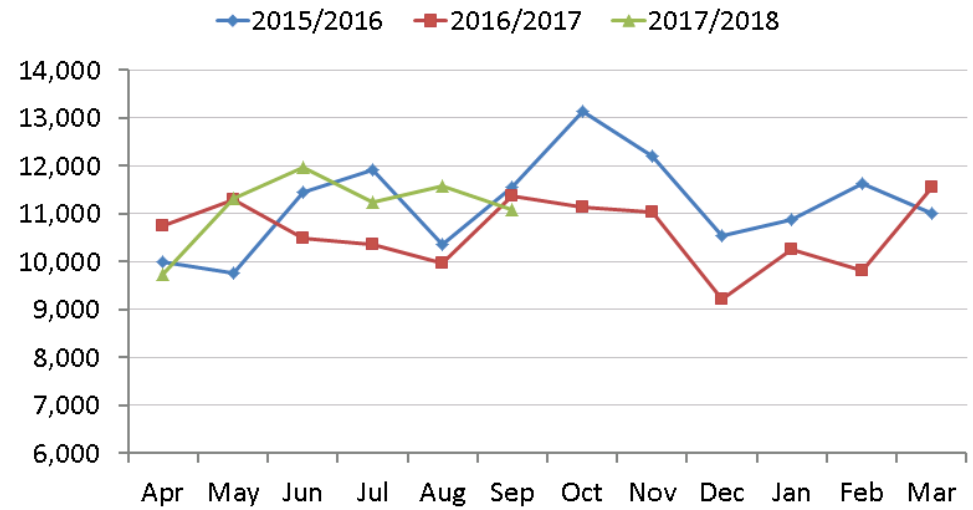
Elective waiting list size



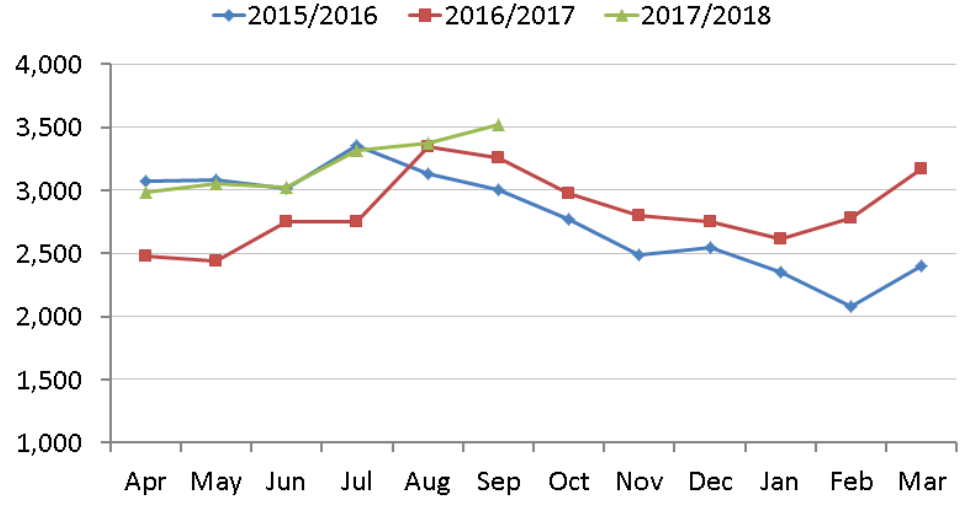
Outpatient waiting list size



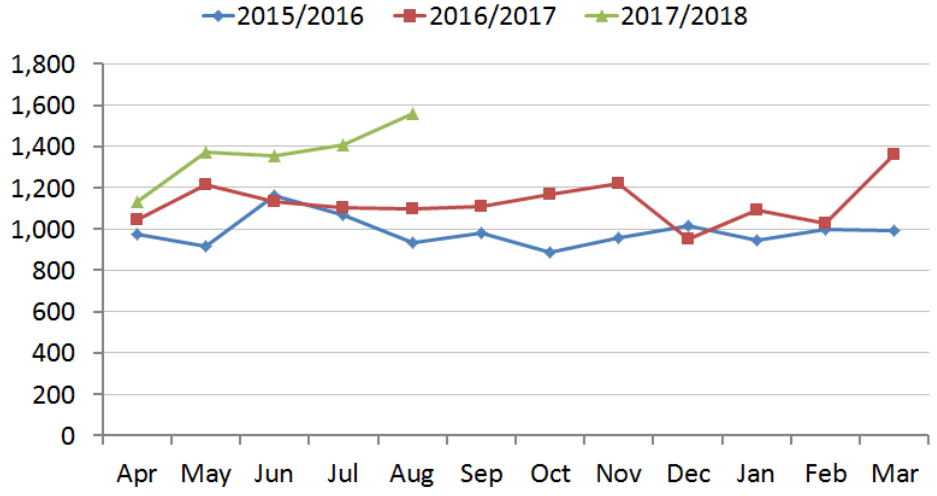
Number of RTT pathways stopped (i.e. treatments)



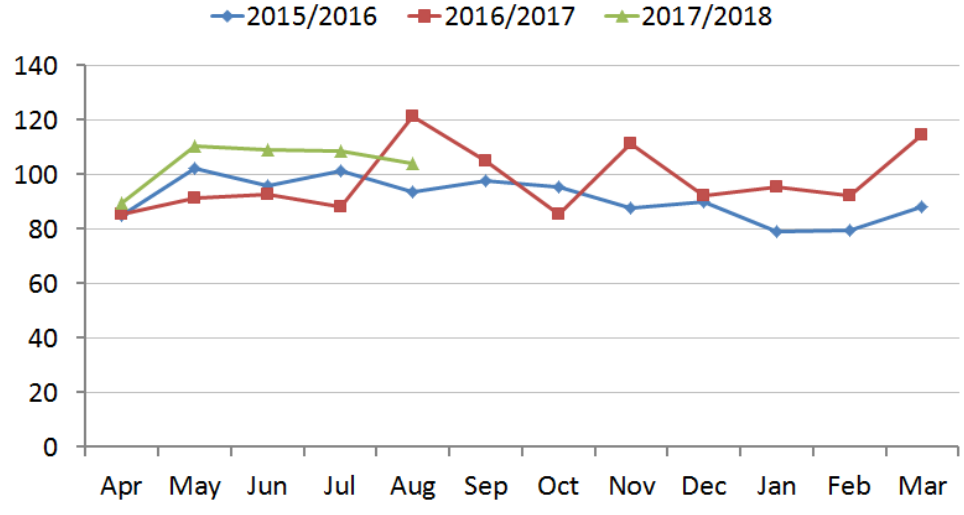
Number of RTT pathways over 18 weeks



Cancer 2-week wait – urgent GP – referrals seen



Cancer 62-day GP referred treatments



Trust Scorecards

SAFE, CARING & EFFECTIVE

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			16/17	17/18 YTD	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	0	1	1	1	1	1	-	0	1	1	2	3	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	1	3	0	1	0	0	0	0	0	0	1	0	1	1	1	0	1	2
	DA03	C.Diff Cases - Monthly Totals	31	23	1	3	5	4	0	0	2	4	5	6	3	3	9	4	11	12
	DA02	MSSA Cases - Monthly Totals	37	7	0	6	2	3	3	2	0	1	3	0	3	0	8	8	4	3
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	5	8	9	10	10	10	0	2	-	-	-	-	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	96.6%	97.7%	97%	96.5%	95.7%	95.5%	95.4%	97%	98.4%	98.1%	98.4%	97.2%	97.7%	96.2%	96.4%	96%	98.3%	97%
	DB02	Antibiotic Compliance	88.3%	86.2%	90.9%	90.3%	91.2%	91.7%	92%	88.1%	87.7%	89.6%	87.4%	87.8%	81.3%	84.4%	90.8%	90.8%	88.3%	84.3%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	95%	96%	96%	96%	94%	95%	96%	96%	96%	96%	97%	97%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	97%	97%	97%	98%	97%	97%	98%	98%	98%	98%	98%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	96%	96%	97%	96%	96%	95%	96%	96%	97%	97%	97%	97%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	52	32	4	5	3	5	2	5	2	7	6	5	3	9	12	12	15	17
	S02a	Number of Confirmed Serious Incidents	49	13	4	5	3	5	2	5	2	5	6	-	-	-	12	12	13	-
	S02b	Number of Serious Incidents Still Open	-	18	-	-	-	-	-	-	-	1	0	5	3	9	-	-	1	17
	S03	Serious Incidents Reported Within 48 Hours	94.2%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	90.4%	96.9%	75%	80%	66.7%	100%	100%	100%	100%	100%	83.3%	100%	100%	100%	75%	100%	93.3%	100%
	S04	Serious Incident Investigations Completed Within Timescale	98%	95.8%	100%	100%	75%	100%	100%	100%	100%	75%	100%	100%	100%	100%	93.3%	100%	91.7%	100%
	S04a	Overdue Exec Commissioned Non-SI Investigations	-	9	-	-	-	-	-	-	1	2	2	1	1	2	-	-	5	4
Never Events	S01	Total Never Events	2	5	1	0	0	0	0	0	0	1	2	2	0	0	1	0	3	2
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	14866	6385	1220	1389	1185	1335	1211	1332	1203	1315	1330	1288	1249	-	3794	3878	3848	2537
	S06b	Patient Safety Incidents Per 1000 Beddays	47.82	49.73	45.61	52.93	46.21	48.94	48.67	48.47	47.02	49.94	53.99	49.49	48.38	-	48.25	48.69	50.27	48.94
	S07	Number of Patient Safety Incidents - Severe Harm	95	39	10	12	10	10	7	5	7	11	8	6	7	-	32	22	26	13
Patient Falls	AB01	Falls Per 1,000 Beddays	4.23	4.65	4.86	4.04	3.74	3.74	4.9	3.89	4.85	3.91	4.91	4.5	4.76	5.04	4.22	4.16	4.55	4.76
	AB06a	Total Number of Patient Falls Resulting in Harm	36	12	2	2	4	3	3	5	2	3	4	0	0	3	8	11	9	3
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.148	0.144	0.075	0.114	0.195	0.11	0.201	0.182	0.078	0.076	0.203	0.154	0.155	0.203	0.127	0.163	0.118	0.17
	DE02	Pressure Ulcers - Grade 2	40	17	1	3	5	3	3	3	1	1	5	2	4	4	9	9	7	10
	DE04A	Pressure Ulcers - Grade 3 or 4	6	5	1	0	0	0	2	2	1	1	0	2	0	1	1	4	2	3
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	99.1%	98.5%	99%	99.4%	99%	99.1%	98.9%	99.1%	98.9%	98.9%	98.7%	98.8%	97.4%	98.3%	99.1%	99%	98.8%	98.2%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	96.4%	95.5%	97%	96.5%	97%	97.8%	98%	96.6%	94.5%	97.6%	97%	97.4%	94.9%	92.3%	96.8%	97.4%	96.3%	94.7%
	N04	Number of Hospital Associated VTEs	63	20	2	9	7	11	3	2	5	3	6	4	2	-	18	16	14	6
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	7	1	1	0	1	2	0	0	0	0	1	0	0	-	2	2	1	0
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	13	5	0	4	2	3	1	0	0	3	0	2	0	-	6	4	3	2
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	89.6%	92.1%	86.5%	87.1%	94.3%	92.7%	89.1%	90.2%	89.9%	87.7%	91.5%	96.2%	94.6%	92.6%	89.4%	90.6%	89.7%	94.5%
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	86.9%	92.2%	-	-	91.2%	-	-	87.9%	-	-	92.2%	-	-	-	91.2%	87.9%	92.2%	-
Safety	Y01	WHO Surgical Checklist Compliance	99.1%	99.8%	99.6%	-	97.7%	98.4%	98%	97.8%	99.5%	99.7%	99.8%	99.8%	99.8%	99.9%	98.7%	98.1%	99.7%	99.8%

SAFE, CARING & EFFECTIVE (continued)

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	16/17	17/18 YTD	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
Medicines	WA01	Medication Incidents Resulting in Harm	0.37%	0.65%	0.55%	1.19%	0%	0%	0.53%	0%	0.98%	0.44%	0%	1.35%	0.51%	-	0.64%	0.16%	0.46%	0.96%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.59%	0.4%	0.65%	0.86%	0.74%	0.98%	0.39%	0.26%	0.43%	0.9%	0.24%	0.32%	0.11%	0.37%	0.75%	0.52%	0.53%	0.25%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.9%	97.6%	97.6%	97.5%	97.4%	98%	97.3%	98.3%	97.9%	97.3%	97.9%	97.7%	96.9%	97.7%	97.5%	97.9%	97.7%	97.4%
	AK04	Safety Thermometer - No New Harms	98.9%	98.6%	98.4%	99.3%	98.5%	98.6%	98.5%	99.1%	99%	98.3%	98.4%	98.8%	98.2%	98.7%	98.7%	98.7%	98.6%	98.6%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	92%	97%	94%	93%	93%	91%	93%	100%	100%	96%	93%	100%	97%	100%	93%	95%	96%	99%
Out of Hours	TD05	Out of Hours Departures (8pm-7am)	7.7%	9.3%	7.2%	7.6%	7.9%	8.3%	9%	6.3%	8.2%	7.7%	7.5%	9.3%	12.2%	10.8%	7.6%	7.8%	7.8%	10.8%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	22.3%	22.8%	22.1%	22.5%	22.3%	21.7%	21.5%	21.2%	22.2%	22.6%	23.3%	22.9%	21.9%	24%	22.3%	21.5%	22.7%	22.9%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	11063	5615	956	951	916	887	799	914	867	950	944	962	909	983	2823	2600	2761	2854
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.7%	100.6%	102.6%	105.3%	104.2%	103.6%	104.5%	104.1%	107.1%	102.6%	102.4%	98.6%	98%	97.1%	104%	104%	103.7%	97.9%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	99.2	-	-	-	99.1	-	-	97.3	-	-	-	-	-	-	99.1	97.3	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	91.4	85.5	91.3	110.4	92.2	87.2	90.9	92.1	88.8	80.6	93.3	79.3	-	-	97.9	89.9	87.5	79.3
Mortality Review	tbc	Number of Deaths											229						229	
	tbc	Number of Deaths Subject to Casenote Review											55						55	
	tbc	Number of Casenote Reviews Awaiting Completion											14						14	
	tbc	Number of Deaths With More Than 50:50 Chance of Being Avoidable											1						1	
Readmissions	C01	Emergency Readmissions Percentage	2.66%	2.45%	2.54%	2.64%	2.92%	2.73%	2.89%	2.45%	2.98%	2.44%	2.39%	2.18%	2.32%	-	2.7%	2.68%	2.59%	2.25%
Sepsis (Inpatients)	AG02a	Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	21.6%	34.2%	20%	21.7%	27.3%	27.8%	28.6%	41.7%	38.5%	37.5%	38.1%	21.1%	50%	16.7%	22%	31.8%	38.1%	29.7%
	AG03a	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatient	65.7%	78.3%	66.7%	85.7%	71.4%	100%	50%	42.9%	100%	50%	62.5%	66.7%	100%	100%	73.9%	68%	71.4%	88.9%
	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%	100%	100%
Sepsis (Emergency Department)	AG02b	Percentage of Patients Meeting Criteria Screened for Sepsis (ED)	74.4%	87%	60%	80%	80%	90%	80%	100%	85.7%	76.9%	78.3%	93.8%	95%	92.9%	73.3%	90%	80%	94%
	AG03b	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (ED)	56.3%	83.1%	40%	50%	60%	77.8%	70%	25%	85.7%	63.6%	77.8%	84.6%	88.2%	100%	50%	59.3%	76.7%	90%
	AG04b	Sepsis Patients Percentage with a 72 Hour Review (ED)	94.3%	100%	100%	100%	70%	100%	100%	100%	100%	100%	100%	100%	100%	100%	84.2%	100%	100%	100%
Maternity	G01	Percentage of Low Weight Babies	2.7%	2.4%	3.1%	3.3%	2.3%	2.4%	3.9%	3.3%	2.3%	3.5%	0.5%	1.5%	3.3%	3.4%	2.9%	3.2%	2.2%	2.7%
	G01A	Number of Low Weight Babies	137	58	14	13	9	10	14	14	9	15	2	6	13	13	36	38	26	32
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	70.5%	77.1%	73.7%	69.2%	51.7%	69.2%	81%	80.8%	57.7%	86.7%	85%	67.6%	84.6%	85.7%	63.5%	76.7%	76.3%	77.8%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	74%	54.1%	89.5%	69.2%	86.2%	61.5%	71.4%	73.1%	73.1%	73.3%	60%	47.1%	34.6%	33.3%	81.1%	68.5%	69.7%	39.5%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	51.9%	38.2%	68.4%	53.8%	44.8%	42.3%	61.9%	61.5%	34.6%	60%	50%	29.4%	26.9%	28.6%	54.1%	54.8%	48.7%	28.4%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	49.4	51.7	53.2	48.8	43.3	37.3	67.4	38	37.1	45.9	43.8	37.1	-	-	-	-

SAFE, CARING & EFFECTIVE (continued)

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	16/17	17/18 YTD	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	58.6%	63.6%	56.8%	61.8%	35.3%	52.4%	50%	64.3%	61.5%	51.4%	66.7%	72.9%	61.9%	-	51.4%	55.5%	59.6%	67.8%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90.2%	83.3%	97.3%	88.2%	94.1%	90.5%	84.1%	88.6%	90.9%	80.6%	81.8%	83.3%	81%	-	93.3%	87.7%	84.3%	82.2%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.8%	60%	60%	65.2%	81.8%	51.7%	72.2%	61.5%	56.3%	50%	77.3%	27.3%	66.7%	75%	68.2%	60%	62.5%	55.9%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	90.4%	89.8%	93.1%	88.9%	89.1%	80.8%	80.1%	84%	87.2%	88.3%	89.4%	91.1%	89.9%	93.5%	90.2%	81.6%	88.3%	91.5%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	97.2%	98.4%	96.8%	94.1%	97.6%	97.6%	88.9%	100%	97.3%	97.6%	100%	100%	97.7%	97.9%	96.3%	96.2%	98.3%	98.6%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	94.7%	94.1%	100%	100%	71.4%	100%	100%	100%	100%	66.7%	100%	100%	100%	100%	88.2%	100%	88.9%	100%
	AC04	Percentage of Dementia Carers Feeling Supported	75%	100%	-	-	-	-	-	-	-	-	100%	-	-	-	-	-	100%	-
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	8854	3403	892	847	614	1089	830	717	702	807	485	448	537	424	2353	2636	1994	1409
		Patient Experience																		
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	91	92	94	92	92	92	91	91	93	92	92	92	92	91	91	92
	P01g	Patient Survey - Kindness and Understanding	-	-	95	96	97	96	95	96	96	95	97	96	94	96	95	95	96	95
	P01h	Patient Survey - Outpatient Tracker Score	-	-	88	90	90	90	88	89	90	88	87	90	87	90	90	89	88	89
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35.5%	36.1%	33.7%	35.9%	30.6%	31.7%	34.8%	36.8%	34.6%	38.3%	37.4%	35.8%	35.1%	35.3%	33.5%	34.5%	36.8%	35.4%
	P03b	Friends and Family Test ED Coverage	16.4%	17.8%	17.3%	18.9%	15.4%	21.2%	17.7%	18.4%	15.9%	16.1%	20.9%	17.2%	18.5%	18.3%	17.2%	19.1%	17.6%	18%
	P03c	Friends and Family Test MAT Coverage	22.5%	19.6%	22.6%	22.1%	19.8%	24.6%	29.7%	25.3%	23.6%	17.1%	21.8%	20%	17.3%	18.3%	21.6%	26.4%	20.7%	18.6%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	97.2%	97.5%	98.2%	97.3%	97.5%	97.4%	96.9%	98.5%	97.2%	96.9%	97.7%	97.7%	97.5%	97.7%	97.7%	97.6%	97.3%	97.6%
	P04b	Friends and Family Test Score - ED	78.2%	81.3%	79.3%	78.9%	74.1%	80.8%	79.6%	80.2%	83.2%	77%	84.4%	77.4%	81.9%	83.5%	77.6%	80.2%	81.7%	81%
	P04c	Friends and Family Test Score - Maternity	96.8%	96.7%	97.7%	94.3%	94.5%	98.2%	96.2%	97.4%	96.9%	95.8%	96.9%	94.9%	96.5%	99.2%	95.6%	97.3%	96.6%	96.8%
Patient Complaints	T01	Number of Patient Complaints	1875	985	140	139	118	129	144	168	247	158	150	146	146	138	397	441	555	430
	T01a	Patient Complaints as a Proportion of Activity	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	T03a	Complaints Responded To Within Trust Timeframe	86.1%	81.8%	92.3%	93.4%	97.4%	87.5%	87.5%	83.3%	76.3%	83%	80.4%	82%	87.3%	78.7%	94.2%	86%	80.2%	83%
	T03b	Complaints Responded To Within Divisional Timeframe	86.6%	82.4%	92.3%	85.2%	76.9%	85.4%	85%	72.9%	76.3%	83%	78.3%	90%	80.3%	85.2%	84.9%	80.9%	79.4%	84.6%
	T04c	Percentage of Responses where Complainant is Dissatisfied	11.41%	7.53%	0%	9.84%	12.82%	14.58%	10%	12.5%	15.79%	17.02%	21.74%	8%	-	-	7.91%	12.5%	18.32%	1.66%
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	0.98%	0.96%	1.18%	0.88%	0.99%	1.24%	1.52%	0.91%	1.34%	1.02%	0.81%	0.81%	0.91%	0.91%	1.01%	1.2%	1.05%	0.88%
	F01a	Number of Last Minute Cancelled Operations	734	374	73	57	58	79	89	63	80	67	54	54	61	58	188	231	201	173

RESPONSIVE

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 16/17	Annual 17/18 YTD	Monthly Totals Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Quarterly Totals 16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.7%	90.5%	91.2%	92%	92%	92.2%	92%	91.1%	91.1%	91.1%	91%	90.2%	89.9%	89.4%	91.8%	91.8%	91.1%	89.8%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	2978	2805	2751	2619	2777	3171	2985	3056	3023	3317	3372	3524	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	11	143	0	1	1	3	3	2	5	11	46	30	32	19	2	8	62	81
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	696	1131	53	78	93	86	106	133	153	165	193	198	240	182	224	325	511	620
New Outpatient Wait List	L02L	New Outpatient List (RTT Specialties) - Numbers Waiting 12+ Weeks	-	-	-	-	9295	7986	8521	7372	7068	6307	6723	7105	7586	7453	9537	11273	-	-	-	-
	L02M	New Outpatient List (RTT Specialties) - Percentage Waiting 12+ Weeks	-	-	-	-	33.7%	29.8%	32.3%	28.5%	28.9%	27.5%	27.6%	28.7%	28.3%	25.6%	30.4%	34.7%	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	94.8%	94.3%	94.3%	96.2%	96%	95.9%	95.5%	96.3%	95.1%	95.6%	94.3%	93.4%	93.2%	-	95.5%	95.9%	95%	93.3%
	E01c	Cancer - Urgent Referrals Stretch Target	80%	80%	68.4%	59.3%	55.1%	71%	60.8%	75.3%	76%	79.7%	52.5%	55.4%	62.1%	63.6%	62.4%	-	62.4%	77.2%	56.8%	62.9%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	96.7%	95.7%	97.8%	98.3%	96.1%	96.5%	96.8%	97.4%	91.3%	96.6%	95.1%	97.1%	97.9%	-	97.4%	96.9%	94.5%	97.5%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.7%	98.5%	97.5%	100%	99.1%	100%	100%	98.4%	99.2%	97.5%	98.7%	98.6%	98.6%	-	98.9%	99.5%	98.4%	98.6%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.4%	91.1%	96.4%	98%	95.9%	93.8%	92.3%	96.5%	83.3%	92.2%	93.2%	90.7%	96%	-	96.8%	94.3%	89.5%	93.5%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	96.6%	96.6%	95.4%	98.1%	98.2%	96.9%	97.6%	96.7%	98.1%	96.6%	95.9%	95.4%	97.3%	-	97.3%	97%	96.7%	96.3%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	79.3%	79.2%	79.5%	85.2%	81.5%	84.3%	78.8%	81.2%	76.5%	77.8%	81.7%	74.7%	85.1%	-	82.4%	81.5%	78.8%	79.8%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	69.4%	81.8%	100%	83.3%	100%	57.1%	100%	83.3%	71.4%	44.4%	100%	87.5%	100%	-	94.3%	77.8%	65%	95.8%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	87.9%	84.1%	88%	90.1%	82.1%	93.2%	77.8%	88.4%	93%	77.7%	87%	78.6%	85.5%	-	86.5%	86.8%	85.5%	81.7%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	-	-	62	27	4	6.5	4	5.5	4.5	7.5	4	5	5	8	5	-	14.5	17.5	14	13
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	0.98%	0.96%	1.18%	0.88%	0.99%	1.24%	1.52%	0.91%	1.34%	1.02%	0.81%	0.81%	0.91%	0.91%	1.01%	1.2%	1.05%	0.88%
	F01a	Number of Last Minute Cancelled Operations	-	-	734	374	73	57	58	79	89	63	80	67	54	54	61	58	188	231	201	173
	F02c	Number of LMCs Not Re-admitted Within 28 Days	19	19	72	16	3	6	4	4	6	15	4	6	2	0	1	3	13	25	12	4
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.36%	1.43%	2.11%	1.61%	1.38%	0.67%	1.16%	1.13%	1.05%	1.86%	1.82%	1.2%	0.88%	1.73%	1.7%	0.99%	1.59%	1.26%
	F07a	Number of Admissions Cancelled Day Before	-	-	1021	555	131	104	81	43	68	78	63	122	121	80	59	110	316	189	306	249
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	72.4%	79.1%	73.5%	57.1%	64.7%	69%	86.1%	83.3%	83.3%	78.1%	77.5%	75%	80.6%	-	65%	79.2%	79.8%	77.9%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	91.7%	91.2%	91.2%	85.7%	79.4%	90.5%	94.4%	100%	90.5%	93.8%	90%	87.5%	94.4%	-	85.4%	95%	91.2%	91.2%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	97.79%	98.3%	98.91%	99.05%	98.23%	98.38%	98.69%	98.65%	98.56%	98.8%	98.58%	98.52%	97.61%	97.7%	98.74%	98.58%	98.65%	97.94%
Outpatients	R03	Outpatient Hospital Cancellation Rate	9.7%	11.7%	11.5%	11.1%	10.7%	10.2%	11%	10.7%	11.2%	11.1%	12%	10.8%	11%	11.2%	11%	10.5%	10.6%	11%	11.2%	10.9%
	R05	Outpatient DNA Rate	5%	10%	7.3%	7.3%	7.7%	6.9%	7.8%	7.3%	6.9%	6.9%	7.1%	7.2%	7.5%	7.4%	7.2%	7.4%	7.4%	7%	7.3%	7.4%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.03	2.03	2.24	2.23	2.17	2.17	2.2	2.29	2.3	2.27	2.2	2.25	2.23	2.25	2.26	2.16	2.18	2.28	2.23	2.22
ERS	BC01	ERS - Available Slot Issues Percentage	-	-	31%	20.2%	21.6%	25.3%	34.3%	26.1%	25.2%	26.4%	24.4%	24%	21.7%	18.8%	16.8%	15.8%	26.2%	25.9%	23.4%	17.1%

RESPONSIVE (continued)

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 16/17	Annual 17/18 YTD	Monthly Totals Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Quarterly Totals 16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	30	28	28	29	29	29	19	24	30	18	31	22	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	4	2	3	4	2	16	8	6	6	11	11	11	-	-	-	-
	Q01B	Acute Delayed Transfers of Care - Beddays	-	-	10232	3985	927	802	834	891	750	809	655	604	577	745	647	757	2563	2450	1836	2149
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	-	-	2167	1605	233	138	131	106	183	252	306	145	259	278	374	243	502	541	710	895
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	-	-	55	54	51	59	52	47	43	42	43	46	51	36	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	-	-	6	8	8	6	9	22	14	13	11	15	17	22	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	-	-	1706	1864	1691	1937	1575	1716	1400	1371	1403	1430	1580	1502	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	-	-	372	249	270	189	334	450	503	383	419	401	572	515	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.11	4.13	3.93	3.99	4.11	4.11	4.34	4.17	4.14	4.31	4.06	3.8	4.37	4.12	4.01	4.2	4.17	4.09
	J04D	Percentage Length of Stay 14+ Days	-	-	6.9%	6.9%	6.1%	6.4%	7.1%	6.6%	7.6%	7.1%	7%	7.8%	6.7%	6.2%	7%	6.8%	6.5%	7.1%	7.2%	6.7%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	-	-	225	254	237	272	257	269	266	240	227	250	256	237	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	3.9%	4.8%	5.6%	2.8%	2.9%	2.2%	4.1%	1.4%	3.9%	5.2%	4.2%	4.3%	4.2%	4.4%	3.2%	3.5%	4.2%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	39.2%	44.6%	30.3%	52.6%	33.3%	57.1%	57.1%	44.1%	63.6%	61.3%	37.2%	39.5%	50%	32.4%	40.2%	50.7%	49.4%	40.9%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	85.01%	87.83%	82.94%	78.45%	79.64%	80.37%	80.73%	83.25%	82.31%	84.21%	87.89%	90.53%	91.26%	90.84%	80.35%	81.53%	84.81%	90.87%
		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%	87.83%	82.94%	78.45%	79.64%	80.37%	80.73%	83.25%	82.31%	84.21%	87.89%	90.53%	91.26%	90.84%	80.35%	81.53%	84.81%	90.87%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	77.42%	80.14%	73.39%	71.69%	73.47%	68.86%	68.15%	73.89%	69.16%	73.76%	79.01%	85.11%	86.82%	86.53%	72.85%	70.4%	73.99%	86.14%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	89.89%	95.95%	90.65%	78.6%	79.38%	90.19%	92.11%	88.92%	96.83%	94.05%	97.14%	96.62%	96.35%	94.99%	82.63%	90.28%	95.93%	95.97%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	98.97%	96.87%	98.06%	99.06%	99.15%	98.56%	99%	99.18%	96.52%	96.57%	97.9%	96.58%	97.04%	96.58%	98.74%	98.93%	97%	96.74%
		This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets																				
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	40	0	2	1	11	19	5	0	0	0	0	0	0	0	14	24	0	0
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	97.6%	98.2%	98.3%	97.9%	97.9%	98%	98.5%	98.8%	98.9%	96.3%	98.3%	98.5%	99.3%	97.8%	98%	98.4%	97.8%	98.5%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	92.8%	91.9%	91.8%	92.7%	93.7%	93.6%	94.1%	93.9%	92.1%	91.6%	92.8%	91.8%	92.6%	90.7%	92.7%	93.8%	92.1%	91.7%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.6%	53.2%	52.8%	48.2%	50.5%	53.3%	54.3%	51%	50.8%	52.3%	52.8%	54%	55.4%	54.1%	50.5%	52.8%	52%	54.5%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.5%	97.4%	98%	98.5%	98.3%	98.7%	98.1%	98.1%	97.8%	97.2%	97.1%	97.4%	97.3%	97.5%	98.3%	98.3%	97.4%	97.4%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.6%	2.5%	2.4%	2.5%	3.3%	2.5%	3.1%	2.5%	2.6%	2.6%	2.7%	2.7%	1.9%	2.3%	2.7%	2.7%	2.6%	2.3%
	B05	ED Left Without Being Seen Rate	5%	5%	2.2%	2.6%	2.6%	2.2%	2.4%	1.4%	1.8%	2%	2.8%	2.6%	2.5%	2%	2.1%	3.7%	2.4%	1.8%	2.6%	2.6%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1216	421	161	119	114	138	83	11	111	82	84	46	54	44	394	232	277	144
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	3.9%	4.8%	5.6%	2.8%	2.9%	2.2%	4.1%	1.4%	3.9%	5.2%	4.2%	4.3%	4.2%	4.4%	3.2%	3.5%	4.2%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	39.2%	44.6%	30.3%	52.6%	33.3%	57.1%	57.1%	44.1%	63.6%	61.3%	37.2%	39.5%	50%	32.4%	40.2%	50.7%	49.4%	40.9%

EFFICIENT

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			16/17	17/18 YTD	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2
Sickness	AF02	Sickness Rate	3.9%	3.9%	4.5%	4.7%	4.7%	4.9%	4.3%	3.8%	3.7%	3.8%	3.9%	4.4%	4.1%	3.8%	4.7%	3.8%	3.9%	3.8%
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	8557.9	8393.1	8402.2	8407.6	8434.2	8436	8446.1	8367.1	8479.3	8491.6	8499.7	8547.6	8557.9	8407.6	8446.1	8491.6	8557.9
	AF09A	Actual Staff FTE (Including Bank & Agency)	8566.5	8642	8427.7	8468.8	8412.7	8458.1	8496.4	8566.5	8510.5	8546.3	8584.7	8602.5	8641.4	8642	8412.7	8566.5	8584.7	8642
	AF13	Percentage Over Funded Establishment	1.4%	1%	0.4%	0.8%	0.1%	0.3%	0.7%	1.4%	1.7%	0.8%	1.1%	1.2%	1.1%	1%	0.1%	1.4%	1.1%	1%
Green is below 0.5%. Amber is 0.5% to below 1% and Red is 1% or above																				
Bank Usage	AF04	Workforce Bank Usage	427.9	503.4	376.3	387	358.5	378.3	398.9	427.9	446.7	476.6	501.8	531	536.4	503.4	358.5	427.9	501.8	503.4
	AF11A	Percentage Bank Usage	5%	5.8%	4.5%	4.6%	4.3%	4.5%	4.7%	5%	5.2%	5.6%	5.8%	6.2%	6.2%	5.8%	4.3%	5%	5.8%	5.8%
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	102.9	149.1	142.7	111.5	122.5	131	123.7	96.7	94.1	123.4	130.6	125.3	102.9	111.5	123.7	123.4	102.9
	AF11B	Percentage Agency Usage	1.4%	1.2%	1.8%	1.7%	1.3%	1.4%	1.5%	1.4%	1.1%	1.1%	1.4%	1.5%	1.5%	1.2%	1.3%	1.4%	1.4%	1.2%
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	434.4	404.5	379.6	383.7	389.4	384	349.8	331.4	420.4	451	477.3	483.8	434.4	383.7	349.8	451	434.4
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.2%	5.1%	4.9%	4.6%	4.6%	4.7%	4.6%	4.2%	4%	5%	5.4%	5.7%	5.7%	5.1%	4.6%	4.2%	5.4%	5.1%
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	219	128	109	133	165	111	146	173	172	147	187	365	219	133	146	147	219
	AF10	Workforce Turnover Rate	12.8%	12.8%	13.1%	12.6%	12.7%	12.5%	12.6%	12.8%	12.5%	12.7%	12.9%	13%	12.7%	12.8%	12.7%	12.8%	12.9%	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%	87%	88%	88%	89%	89%	89%	85%	85%	89%	89%	88%	86%	87%	89%	85%	89%	87%
	AF21b	Essential Training Compliance - Annual Training (Fire & IG)	-	-	75%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	AF21f	Essential Training Compliance - Fire Safety	83%	87%	-	80%	81%	82%	82%	83%	82%	84%	84%	86%	87%	87%	81%	83%	84%	87%
	AF21g	Essential Training Compliance - Information Governance	76%	82%	-	76%	76%	76%	77%	76%	75%	75%	75%	80%	82%	82%	76%	76%	75%	82%
	AF21c	Essential Training Compliance - Induction	97%	98%	96%	96%	96%	96%	97%	97%	98%	98%	98%	98%	98%	98%	96%	97%	98%	98%
	AF21d	Essential Training Compliance - Resuscitation Training	75%	81%	81%	81%	83%	85%	85%	75%	75%	71%	71%	77%	80%	81%	83%	75%	71%	81%
	AF21e	Essential Training Compliance - Safeguarding Training	91%	87%	89%	90%	90%	90%	90%	91%	90%	90%	90%	89%	87%	87%	90%	91%	90%	87%
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 SEPTEMBER 2017:

All Essential Training

	UH Bristol	Diagnostic & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's & Children's
Three Yearly	87%	88%	89%	89%	88%	88%	89%	85%
Annual Fire	87%	88%	88%	86%	88%	88%	90%	84%
Annual IG	82%	86%	83%	80%	84%	85%	86%	78%
Induction & Orientation	98%	99%	99%	97%	98%	98%	98%	98%
Medical & Dental Induction	89%	44%	N/A	87%	90%	93%	50%	98%
Resuscitation	81%	75%	100%	88%	85%	84%	77%	77%
Safeguarding	87%	89%	87%	89%	85%	86%	90%	86%

Timeline of Trust Essential Training Compliance:

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

Safeguarding Adults and Children

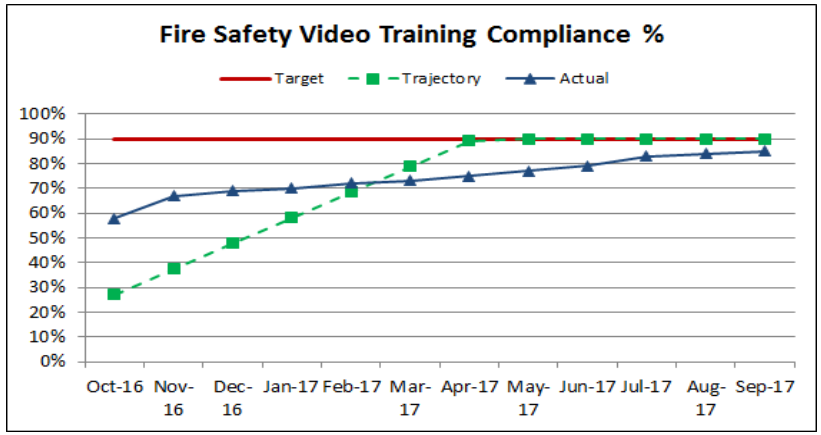
	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's & Children's
Safeguarding Adults L1	88%	87%	88%	83%	86%	87%	90%	91%
Safeguarding Adults L2	87%	91%	84%	91%	87%	87%	88%	84%
Safeguarding Adults L3	85%	75%	N/A	88%	100%	82%	93%	55%
Safeguarding Children L1	89%	90%	83%	88%	92%	90%	93%	N/A
Safeguarding Children L2	86%	87%	95%	89%	82%	84%	79%	92%

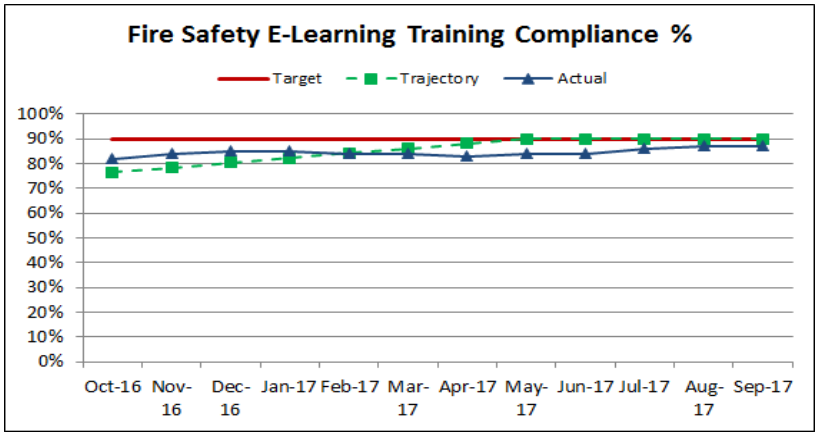
Child Protection Level 3

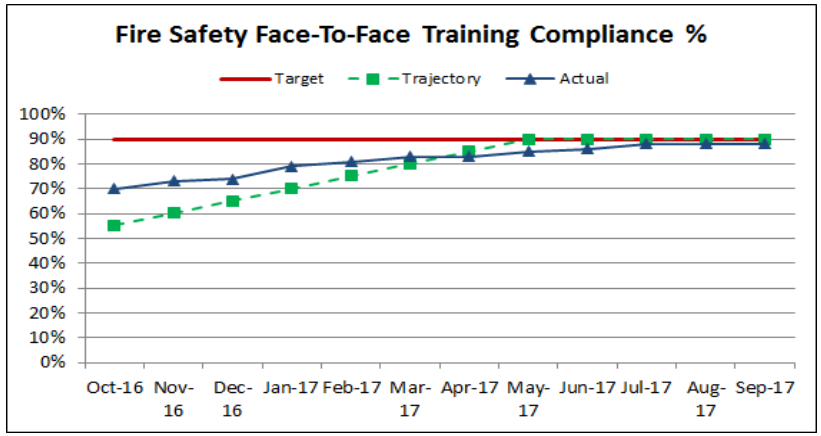
	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery	Trust Services	Women`s & Children`s
Core	78%	76%	61%	90%	80%	100%	80%
Specialist	73%	N/A	N/A	N/A	N/A	100%	72%

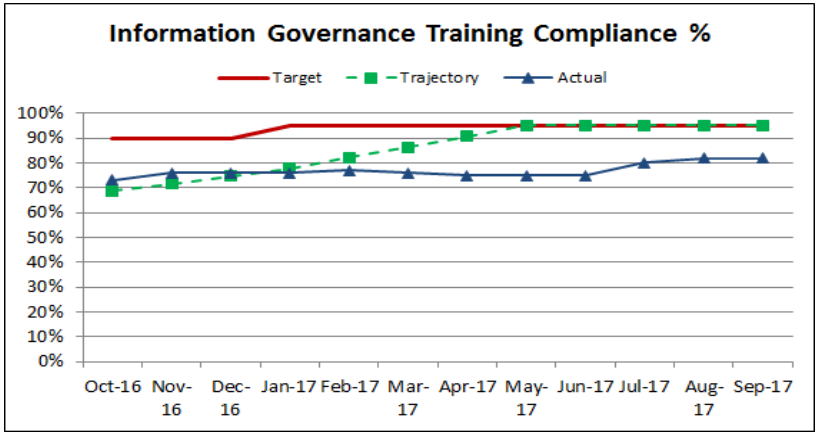
Appendix 2 (continued)

PERFORMANCE AGAINST TARGET 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 (21/08/17 – 17/09/17)

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

Staff Group	Within framework and price cap	Exceeds price cap	Exceeds wage cap	Non framework and above both price and wage cap	Exceeds price and wage cap	Total
Nursing and Midwifery	0	214	0	200	649	1063
Health Care Assistant & other Support	10	8	8	2	0	28
Medical & Dental	0	0	0	0	37	37
Scientific, Therapeutic/ Technical Allied Health Professional (AHP) & Healthcare Science		2			0	2
Administrative & Clerical and Estates	1263					1263

Appendix 3

Access standards – further breakdown of figures

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

Tumour Site	UH Bristol	Internal operational target	National
Brain*†	-	-	-
Breast†	100%	-	94.1%
Gynaecology	83.3%	85%	79.1%
Haematology (excluding acute leukaemia)	85.7%	85%	78.2%
Head and Neck	87.0%	79%	65.3%
Lower Gastrointestinal	70.6%	79%	73.2%
Lung	67.9%	79%	72.2%
Other*	85.7%	-	71.5%
Sarcoma*†	-	-	-
Skin	97.8%	96%	95.2%
Upper Gastrointestinal	40.0%	79%	73.5%
Urology*†	0%	-	78.8%
Total (all tumour sites)	**85.1%**	**85.0%**	**82.5%**
Improvement trajectory (Sustainability and Transformation)	**83.6%**		
Improvement trajectory (recovery trajectory)	**81.0%**		
Performance for internally managed pathways	**94.9%**		
Performance for shared care pathways	**55.8%**		
Performance with breach reallocation applied	**85.1%**		

*3 or fewer patients treated in accountability terms

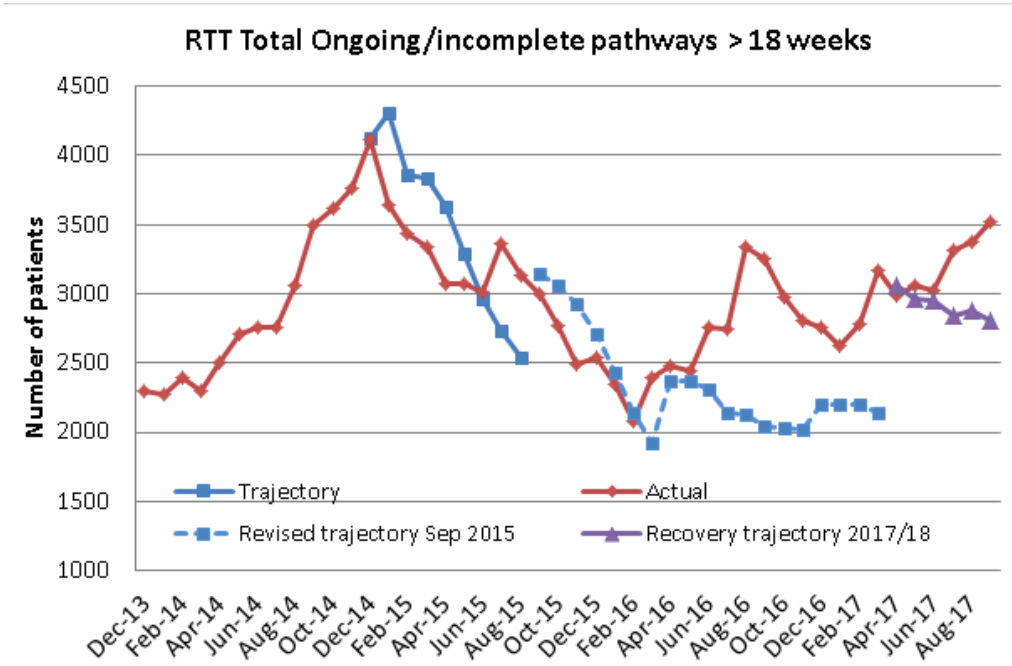
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

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 August 2017

RTT Specialty	Ongoing Over 18 Weeks	Ongoing Pathways	Ongoing Performance
Cardiology	483	2,430	82.2%
Cardiothoracic Surgery	32	396	91.9%
Dermatology	89	2,479	96.4%
E.N.T.	40	2,096	98.1%
Gastroenterology	27	381	92.9%
General Medicine	0	67	100.0%
Geriatric Medicine	5	158	96.8%
Gynaecology	154	1,403	89.0%
Neurology	52	441	88.2%
Ophthalmology	340	4,683	92.7%
Oral Surgery	133	1,832	92.7%
Other	2,110	14,457	95.4%
Rheumatology	5	471	98.9%
Thoracic Medicine	14	1,071	98.7%
Trauma & Orthopaedics	90	996	91.0%
Grand Total	**3,524**	**33,361**	**89.4%**

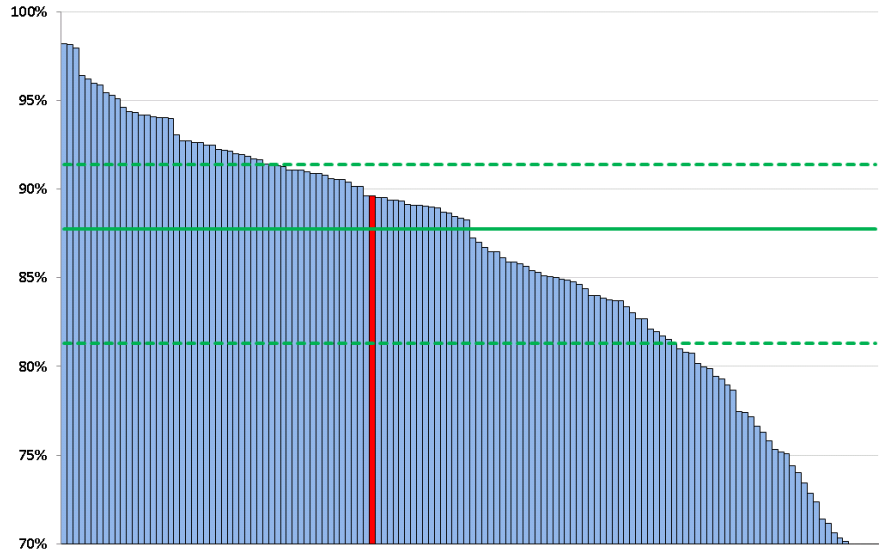


	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17
Non-admitted pathways > 18 weeks	1528	1592	1826	1705	1744	1750	2006	2107	2221
Admitted pathways > 18 weeks	1091	1185	1345	1280	1312	1273	1311	1265	1303
Total pathways > 18 weeks	2619	2777	3171	2895	3056	3023	3317	3372	3524
Actual % incomplete < 18 weeks	92.2%	92.0%	91.1%	91.1%	91.1%	91.0%	90.2%	89.9%	89.4%
Recovery forecast	92.0%	92.0%	92.0%	90.9%	91.4%	91.8%	92.0%	92.0%	92.0%

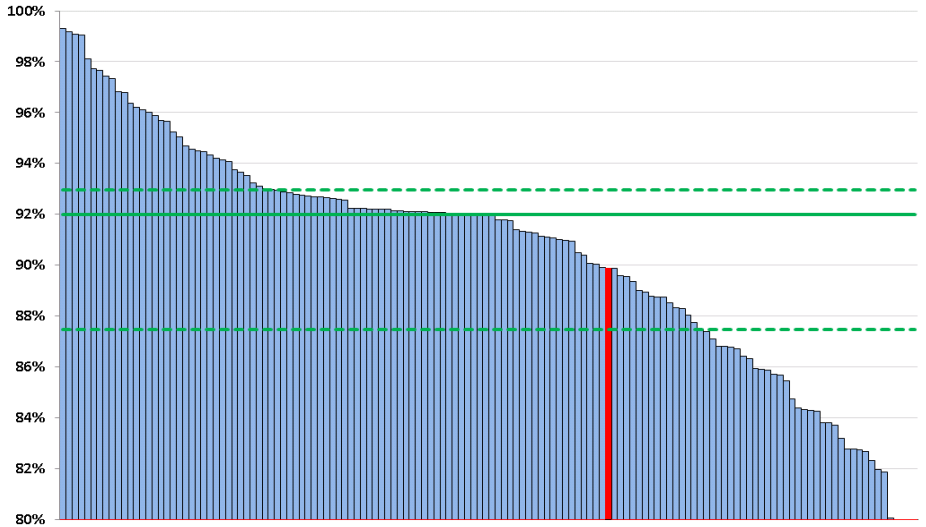
Appendix 4

Benchmarking Reports

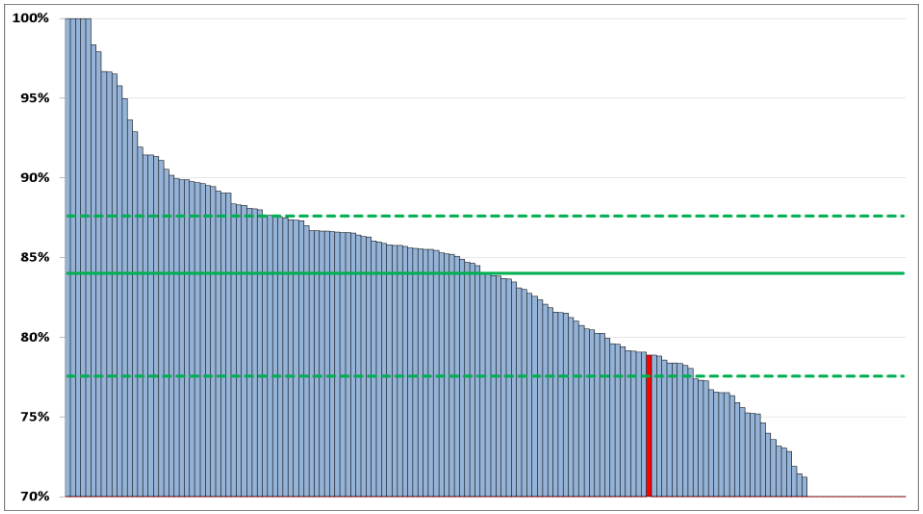
A&E 4-hours (Quarter 2 – July to September 2017)



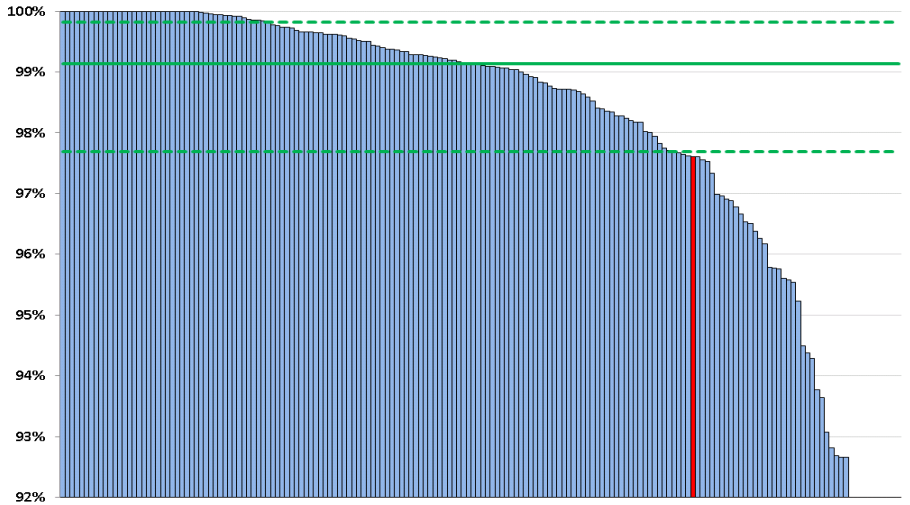
Referral to Treatment Time (August 2017)



62-day GP cancer (Quarter 1 2017/18)



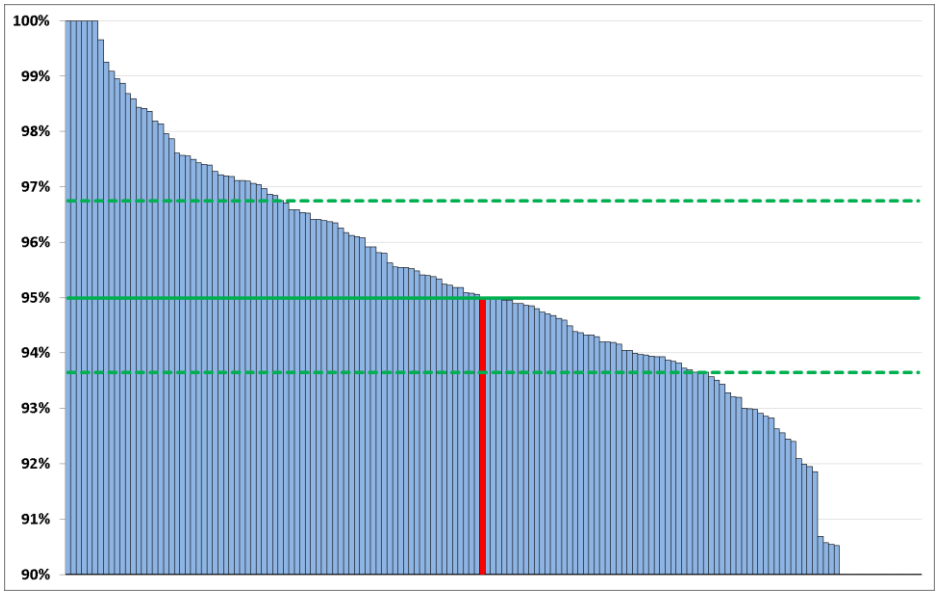
6-week diagnostic (August 2017)



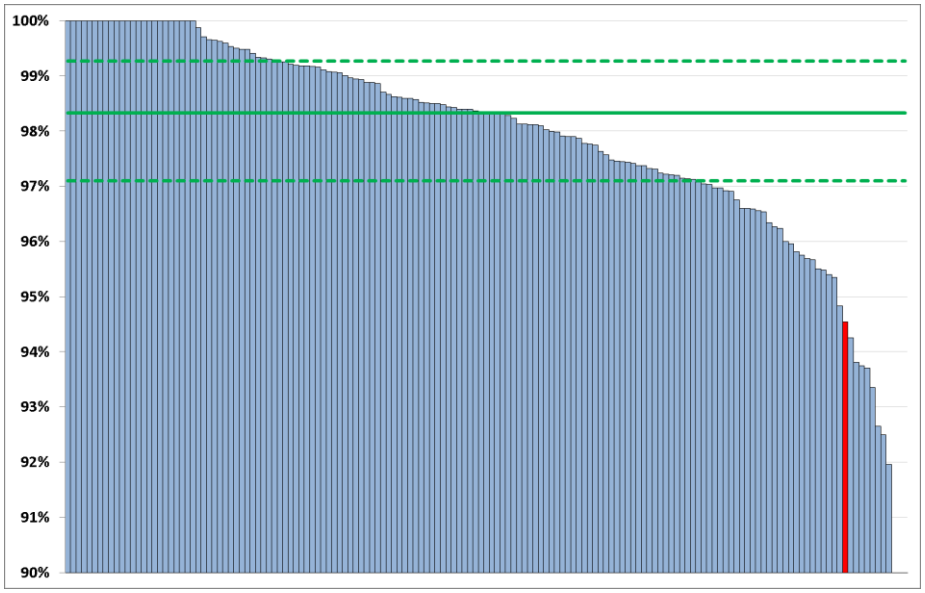
Appendix 4 (continued)

Benchmarking Reports

2-Week wait (Quarter 1 2017/18)



31-day first definitive cancer (Quarter 1 2017/18)



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.

Note:

Cancer data is published quarterly, so next update to these graphs will be at the end of October.

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

		Agenda Item	9
Report Title	Chair's Report Quality and Outcomes Committee		
Author	Julian Dennis, Non- Executive		
Executive Lead(s)	Carolyn Mills, Chief Nurse	Mark Callaway, Acting Medical Director	
Freedom of Information Status		Open	

Reporting Committee	Quality and Outcomes Committee	
Chaired by	Julian Dennis, Non Executive Director	
Lead Executive Director (s)	Carolyn Mills, Chief Nurse	Mark Callaway, Acting Medical Director
Date of last meeting	27 October 2017	

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

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 27 October 2017.

Safe Guardian Working Hours

The Committee received a report from the Safe Working Hours Guardian Alistair Johnston for assurance.

Key points to note included:

- The vast majority of Trust junior doctors (512 in total) are now employed on the new contract. Implementation has been challenging but there is positive engagement across the divisions. The Safe Working Hours Guardian continues to raise awareness of safe working hours compliance with junior doctors.
- The Trust had agreed to fund additional clinical fellow posts where rota gaps were identified.
- Breaches of safe working limits were low and the exception reporting has been an effective way to help identify areas of concern. There have been 400 exception reports since December 2016, reflecting increased engagement/awareness from junior doctors.
- There are still challenges around the use of locums: the use of a paper based system made it very difficult to understand or report on the use of locums in a timely way. The Acting Medical Director is looking into implementing an e-reporting system.
- There were still evident issues with junior doctors' morale – this is a national issue. It is important to ensure junior doctors felt 'heard' and the implementation of an l e-reporting system did not make their work more difficult.

Serious Incident Report

- Serious Incidents were reviewed.

Key points to note included:

- There were nine serious incidents reported in September 2017, within time and all 72 hour reports were also completed on time. The Committee had previously requested information about the number of serious incident investigations still underway. A brief report highlighted that at the end of September 2017 there were 12 serious incident investigations open, 11 within the 60 day timescale and one within an extended timescale agreed with commissioners.

Quality Performance Report

Key points to note included:

- The national standard for the 4 hour A&E target was not meet. However, Trust level performance was sustained at 90.84% and was above the in-month trajectory of 90%.
- The 62 day cancer referral national standard was achieved in August 2017.
- RTT patients waiting under 18 weeks worsened (80.4%) due to rising demand. It was noted that there was better understanding of RTT in terms of urgent versus elective care.
- It was noted that on 26 October UH Bristol had received 16 patients overnight from Weston (compared to a usual figure of 3-4). There was no evidence yet that this is a trend, however, it was raised in the context of upcoming winter pressures.
- The Patient Safety Checklist has developed in UHB has now been nationally mandated across every A&E department across the country. This generated positive press interest. **Progress Against Quality Objectives Report for Q2**In May 2017 the Board approved the Trust's Quality Report for 2016/17 which included a number of objectives for 2017/18: the Progress Report against these quality objectives for quarter two was tabled.

Key points to note included:

- At the end of quarter 2, six of the eight objectives were rated as 'on plan' (blue), completed by end of 2017.
- Two objectives were at 'risk of slippage' (amber) –reduction in the number of last minute cancelled operations and the implementation of a better system for gathering patient feedback at point of care.
- The Committee noted that the Trust is in a much stronger position to deliver the quality objectives than in previous years.

Monthly Nurse Staffing Report

Key points to note included:

- The Committee were satisfied that the revised report format gave clearer evidence that the Trust had been safely staffed during this period.
- Significant differences were noted between actual staff working hours and forecast hours in the Women's and Children's Division. It was agreed that a report will be presented by the Division at the next committee.

Assurance Reports

Members received the following reports for assurance:

- Infection Control Quarterly Report
- Care Quality Commission 'Must Do' Actions Update
- Clinical Quality Group Meeting Report

• The Board Assurance Framework – Q2	
Key risks and issues/matters of concern and any mitigating actions	
None.	
Matters requiring Committee level consideration and/or approval	
None.	
Matters referred to other Committees	
None	
Date of next meeting	27 November 2017

Cover report to the Public Trust Board. Meeting to be held on 31 October 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	10
Meeting Title	Public Trust Board	**Meeting Date**	Tuesday, 31 October 2017
Report Title	**Independent Review of Children's Cardiac Services – Final Report**		
Author			
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please choose 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 paper is to provide Board members with assurance and a high level overview of the actions taken to deliver practical changes and service developments at University Hospitals Bristol NHS Foundation Trust in response to the publication of Independent Review of children's cardiac services in Bristol in 2014, to support formal closure of the improvement action plan by the Board.

Key issues to note

The assurance document (Appendix 1) details the original recommendation, the responsible delivery group, the key actions taken to meet the requirements of the recommendation, details of the evidence to support actions completion, the timescales that the actions were completed in, any future developmental actions and the governance group for assuring delivery of these.

Recommendations
Members are asked to • Approve formal closure of the improvement action plan developed to deliver practical changes and service developments at University Hospitals Bristol NHS Foundation Trust in response to the publication of Independent Review of children's cardiac services in Bristol in 2014.

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

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

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

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

1.0 Introduction

The purpose of this paper is to provide board members with assurance and a high level overview of the actions taken to deliver practical changes and service developments at University Hospitals Bristol NHS Foundation Trust in response to the publication of Independent Review of children's cardiac services in Bristol in 2014, to support formal closure of the improvement action plan by the Board.

This paper provides the following:

- A summary of the work undertaken;
- For each of the recommendations it provides details of the activities undertaken and milestones achieved through to completion;
- For each of the recommendations it identifies work that will continue as part of business as normal activity and the means by which this will be monitored within University Hospitals Bristol and the Bristol Royal Children's Hospital;
- Identifies where actions and learning have been taken forward throughout the organisation.

Underpinning the delivery of the recommendations has been a commitment to change, and an understanding that when we listen to the views and experiences of our patients and their families we can provide services that people need in the ways that they want. Some of the families involved in the Independent Review have joined us on that journey and continue to contribute in the co-design of children's services for the future. Our strategy is one of continual improvement; we recognise that there is always more work and that to not recognise this would be complacent.

2.0 Background

In February 2014, the Medical Director of NHS England commissioned an independent review of the children's cardiac service at the Bristol Royal Hospital for Children, in response to the continuing concerns expressed by families regarding the care that they had received.

NHS England worked with the families to develop and publish terms of reference for the review and asked Eleanor Grey QC to lead it, with Sir Ian Kennedy acting as an advisor.

At the same time, the Care Quality Commission conducted an independent audit and review of the medical records of a sample of children who were cared for by Bristol children's cardiac services between January 2012 and December 2014.

The reports of the Independent Review of children's cardiac services and the CQC expert review were published on 30 June 2016. The Trust fully accepted the findings of both these reports and welcomed their publication as a way to learn from mistakes. Although the reviews focused on children's cardiac services, the Trust, where possible, has implemented learning and service changes throughout the organisation, as we recognise the benefits this will bring to patients and their families.

3.0 Recommendations

There were 38 recommendations in total for implementation, 32 from the Cardiac Review and 6 from the CQC report. The majority of the recommendations (30) were for the Trust to implement, with the responsibility for delivery of the remaining recommendations being with South West and Wales Congenital Heart Disease Network, Department of Health and NHS England.

A schedule of all the recommendations, along with proposed organisational/individual ownership, proposed governance and details of initial actions and timescales was approved by the Trust Board on 28 July 2016. The recommendations were broadly spread across four categories:

- Women's and children's services;
- Consent for surgery;
- Supporting families and staff through incidents and complaints;
- National and local recommendations for services that the Trust is not directly responsible for but which have an impact on the experience of children and families.

The Trust has fully achieved, and in some cases, exceeded delivery of actions to address the 30 recommendations.

4.0 Governance of programme

The Board of Directors received the outcome of the Independent Review of Children's Cardiac Services in Bristol at the Board Meeting in July 2016. At that meeting, the Board agreed that Carolyn Mills, Chief Nurse, would be the Senior Responsible Officer and Board sponsor of the work programme. A time limited Steering Group which was accountable to the Board of Directors was established to oversee the implementation of the recommendations.

The Board of Directors agreed to receive performance reports against the delivery of the recommendations at each meeting. The Council of Governors also agreed to receive monitoring reports at each meeting of the Council of Governors.

The monthly report to the Board of Directors has provided assurance to the Board that:

- The implementation plan described detailed actions, timescales and responsibilities to ensure the recommendations were fully responded to
- The actions being taken fully addressed the body and spirit of the report
- All actions were completed in a timely and well-coordinated way, and if this was not achievable why.
- There were comprehensive and auditable processes established to enable scrutiny of performance and the delivery of actions
- Stakeholders were involved and engaged as appropriate in the governance and delivery of actions.
- There was a defined process to establish and build a comprehensive portfolio of evidence in support of actions taken and the improvements in place.

To assure the Board that the views of parents and young persons have been heard and that the development of the actions to implement the recommendations reflects what is important to patients and families, the Board have received a monthly update on parents and young person's involvement. Families and young persons have been involved in a number of different ways including:

- Membership of the Steering Group overseeing delivery of the recommendations
- Membership of the Cardiac Parents and Young Persons Reference Group
- Co-designing and involvement with specific work they are interested in
- Showcase of improvement: families have been invited to come and see what has been done to date via open days or 1:1 meetings.

The approach to the governance of the programme has been consistent with the priority given to the programme by the Trust Board and its commitment to transparency in reporting progress. This has provided the Board with a high level of assurance in terms of the delivery of the recommendations from the review.

5.0 Service improvements

For a summary of key actions taken to meet the requirements of the recommendations, evidence to support action completion, additional developmental actions still to be taken, timescales for completion of these and the assurance group for these actions, please see Appendix 1.

A family friendly document summarising the improvements that have taken place following the review has been developed with families which is available via the Trust website.

6.0 Next steps

The Board has recognised the need for improvement and has made a number of service changes/developments. To provide additional assurance to the Board regarding the delivery of the outstanding developmental actions and the sustained delivery of the improvements made, the delivery programme will be subject to internal audit in 2017/18.

Appendix 1: Board Assurance Framework for the delivery of Independent Cardiac Review Recommendations

Recommendation 2: That the Trust should review the adequacy of staffing to support NCHDA's audit and collection of data.	
Reference from original report/CQC review resulting in recommendation: Points 1.19 – 1.21	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Deputy Divisional Director, Women's & Children's**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales	Additional Actions	Assurance group	Completion/ Update timescales
Review of the paediatric cardiac data team staffing in relation to workload to identify any gaps in capacity Results and recommendations of the review reported at Women's and Children's Delivery Group in Sept. '16. Requirement for additional staff fed into Trust business round 2016-17 however additional posts were not funded at that stage. Divisional review of roles and responsibilities as well as additional staff resource agreed.	Staffing review report and terms of reference produced Women's and Children's Delivery Group Agenda and minutes 20.09.16 Expression of interest form and Women's and Children's Operating Plan Mar'17 added to Independent review risk register 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 – recruitment progressing	Planned Completion Date: April 2017 Actual Completion Date: May 2017	To undertake a further review of team establishment and skill mix once the impact of additional fetal reporting requirements is confirmed.	Children's Quality Assurance Committee	September 2017 once additional reporting requirements are confirmed.

Recommendation 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.	
Reference from original report/CQC review resulting in recommendation: Points 1.26 – 1.34	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Specialist Clinical Psychologist, Women's & Children's**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Review of patient information leaflets (discharge, cardiac surgery and cardiac catheterisation) in collaboration with parents and families. Development of website information with visual diagrams displaying pathways of care (Medical, Fetal, Surgical, Cardiac Catheterisation) in collaboration with parents and families. External contractor commissioned, to design pathways that are both interactive and engaging for all ages. Cardiac information pages on hospital website updated to reflect improvements and signpost to virtual patient pathways. Links to signpost patients and families to relevant information added to patient clinic letters copied to families.	Copies of revised patient information leaflets (Links to recommendation 16 and CQC 1) Screenshots of visual pathways of patient journeys (fetal, surgical, medical with others pending) Copy of patient letters demonstrating links present	Planned Completion Date: April 2017 Actual Completion Date: May 2017

Additional Actions	Assurance group	Completion/ Update timescales
Link Congenital Cardiac Network website to BRCH website.	Children's Quality Assurance Committee	November 2017

<u>Recommendation 4:</u> That the Commissioners and providers of fetal cardiology services in Wales should review the availability of support for women, including for any transition to Bristol or other specialist tertiary centres. For example, women whose fetus is diagnosed with a cardiac

anomaly and are delivering their baby in Wales should be offered the opportunity, and be supported to visit the centre in Bristol, if there is an expectation that their baby will be transferred to Bristol at some point following the birth	
Reference from original report/CQC review resulting in recommendation: Points 1.26 – 1.34	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Congenital Heart Disease Network Clinical Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales	Additional Actions	Assurance group	Completion/ Update timescales
English and Welsh commissioning, University of Hospital of Wales (UHW) and University Hospitals Bristol (UHB) developed an agreement to establish: 1. Commissioner oversight of network 2. Commissioner support for independent review recommendations (4,5 &11) 3. Establishment of working groups to address the specific changes in practices required in relation to the network standards and the independent review. Specifics of recommendation defined (e.g. approaches to diagnosis and counselling); options for patient involvement (survey then focus group); Congenital Heart Disease (CHD) standards that relate to this recommendation; examples of practice from other centres Fetal survey to gather patient feedback undertaken between UHB and UHW established a plan to deliver additional fetal working group established to	Meeting minutes confirming discussion Agreed pathway of care in line with new CHD standards and in line with patient feedback. Patient counselling and Clinical nurse specialist cover reviewed and aligned. Offer in place for families to visit Bristol when antenatal diagnosis made. Description of South Wales Fetal Cardiology Service; 3rd fetal session commenced. Fetal survey completed and collated with outcomes shared with all relevant teams for actions. Working group in progress. Network annual plan 2017/18	Planned Completion Date: April 2017 Actual Completion Date: June 2017	In view of vacancies across main sites the final elements of the work planned in this area will move to the Network work plan going forward. Establish fetal patient working group – to be led by new psychologist with responsibility for fetal services	Children's Quality Assurance Committee	Complete July 2017 March 2018

progress work. Implementation of new pathways for families with a baby with fetal abnormality.		

Recommendation 5: The South West and Wales Network should regard it as a priority in its development to achieve better coordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol	
Reference from original report/CQC review resulting in recommendation: Points 1.26 – 1.34	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Congenital Heart Disease Network Clinical Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Meetings between Network Leads, English and Welsh Commissioners, UHW and UHBristol established to discuss terms of working and commitment to the new CHD standard to be driven by the Network Joint working group with Network Team facilitating. UHBristol, UHW and commissioners set up to deliver improvements required for service. The opportunities and actions for improvement in coordination agreed. A patient engagement exercise (e.g. focus group, survey, online reference group) undertaken to test the proposed options for improvement. Actions to improve co-ordination agreed and delivered.	CHD Network terms of reference and governance structure Minutes of meeting and action plan Jointly agreed action plan Proposal sent to virtual parent's reference group, responses received and incorporated into plans. Quarterly network report to the Trust's senior leadership team and the Network annual plan 2017/18	Planned Completion Date: April 2017 Actual Completion Date: June 17

Additional Actions	Assurance group	Completion/ Update timescales
Network to gain commitment to provision of CHD services from each centre in the form of a statement of intent from the hospital, backed by commissioner support, to include: • headlines from baseline self-assessment • current workforce and intentions • service risks & facility issues Develop mechanisms to improve access to members of the specialist team	Children's Quality Assurance Committee	December 2017 December 2017

Recommendation 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	
Reference from original report/CQC review resulting in recommendation: Points 1.26 – 1.34	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Deputy Divisional Director, Women's & Children's**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Conduct 1st annual audit into follow up care for paediatric cardiac patients Report findings of the audit to the Women's and Children's IDR Delivery Group Ensure that paediatric cardiac waiting lists are visible and managed through regular reporting and review at monthly Cardiac Business meeting. Additional steps: - Validation of follow up backlog waiting list; capacity gap analysis; trajectory and action plan for achievement of backlog clearance. - Investigation of alternative plans to address the capacity gaps and space utilisation.	Audit proposal and report Audit presentation and W&C delivery group Agenda and minutes November 2016 meeting Agenda and discussion notes of monthly Cardiac Business meeting Action plan to address follow up backlog with associated actions completed and demonstrable delivery of additional capacity	Planned Completion Date: Jan 2017 Actual Completion Date: September 17

Additional Actions	Assurance group	Completion/ Update timescales
Repeat Annual Audit Include annual audit in BRCH annual audit cycle from November 2017.	Children's Divisional Board	November 2017 From November 2017

Recommendation 8: The Trust should monitor the experience of children and families to ensure that improvements in the organisation of outpatient clinics have been effective	
Reference from original report/CQC review resulting in recommendation: Points 1.26 – 1.34	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Deputy Divisional Director, Women's & Children's**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Baseline assessment (monthly outpatient survey) of current experience of children and families in outpatients reviewed Gap analysis of current monitoring vs monitoring required to understand patients experience of the organisation of outpatients completed Put systems in place for regular and monitoring, review and acting on results of family experience of outpatients.	Outpatients and Clinical Investigations Unit Service Delivery Terms of reference Outpatients and Clinical Investigations Unit Service Delivery Group Agenda (3.10.16) Outpatients and Clinical Investigations Unit Service Delivery minutes of meeting (3.10.16) OPD Patient Experience Report (October 2016) Project on a Page: Outpatient Productivity at BRHC	Planned Completion Date: Oct 16 Actual Completion Date: Jan 17

Additional Actions	Assurance group	Completion/ Update timescales

Recommendation 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. **Recommendation 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)	
Reference from original report/CQC review resulting in recommendation: Points 1.26 – 1.34	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Women's and Children's Divisional Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
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 Identification of actions required to address the gaps Progress to implementing any changes in practice that are deemed necessary	Comparison of specific concerns identified in the IDR against relevant published standards of care to inform benchmarking criteria. Benchmarking data collection analysis completed; Site visit completed May 17 Gaps identified from completion of analysis; actions held by Cardiac business group. Minutes and action log from Cardiac Business Group	Planned Completion Date: Jan 17 Actual Completion Date: April 17

Additional Actions	Assurance group	Completion/ Update timescales
Specific improvement actions identified from benchmarking review to be added to paediatric cardiac benchmarking group action log. Annual benchmarking review to be completed for specific service areas	Children's Quality Assurance Committee	November 2017 Annual

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

Reference from original report/CQC review resulting in recommendation: Points 1.39-1.42	
Responsible Delivery Group: Consent	**Lead Officer: Medical Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Guidance to be developed for medical staff to ensure patients and families are given the option to record conversations when a diagnosis, course of treatment, or prognosis is being discussed. Review of new/existing guidance to reflect the recommendation and include recommendation in updated consent policy, guidance notes and links to e-learning Incorporate new guidance into existing Children's hospital documentation	Copies of guidance produced and published Consent policy (Making clinical decisions in partnership with patients: A Policy for Consent to Examination and Treatment - Section 1.2) Parent/patient information booklets- Preparing for heart surgery and Cardiac Catheterisation	Planned completion date: Dec 16 Actual completion date: April 17

Additional Actions	Assurance group	Completion/ Update timescales
Explore options to improve management and storage of recorded conversations on Medway. Internal audit team to be tasked with finding a method of gauging patient understanding and satisfaction of consent process as part of annual audit.	Clinical Quality Group	November 2017 By April 2018

<u>Recommendations 13:</u> Review of consent policy and the training of staff, to ensure that any questions regarding the capacity of parents or carers to give consent to treatment on behalf of their children are identified and appropriate advice sought.

<u>Recommendation 14:</u> That the Trust reviews its Consent Policy to take account of recent developments in the law in this area, emphasising the

rights of patients to be treated as partners by doctors, and to be properly informed about material risks.	
Reference from original report/CQC review resulting in recommendation: Points 1.39-1.43	
Responsible Delivery Group: Consent	**Lead Officer: Medical Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Set up Trust-wide Consent delivery group to meet monthly for the duration of the programme - final format of meetings, post IDR, to be agreed but likely to be virtual. Review the consent policy and agree a re-write policy or amend existing policy to ensure patients and clinicians are supported to make decisions together Develop training and communication plan Advice from legal team and safeguarding on revised consent policy and e-learning Update e-learning for any changes to consent policy and process	Terms of Reference for Trust Wide Consent Group Minutes and actions from meeting Revised and renamed Consent policy (Consent policy (Making clinical decisions in partnership with patients: A Policy for Consent to Examination and Treatment) ratified by Clinical Quality Group January 2017 Training and communications plan Multi professional Consent workshop 6th April 2017 Legal and safeguarding agreement and comments on consent policy and e-learning Updated E-learning package for consent Use of scenarios in workshops allows staff involved in the consent process to practice their skills	Planned completion date: Jan 17 Actual completion date: April 17

Additional Actions	Assurance group	Completion/ Update timescales
Add links to scenarios/pod casts into online consent training	Clinical Quality Group	April 2018

	and challenge ideas	

Recommendation 16: As an interim measure pending any national guidance, that the paediatric cardiac service in the Trust reviews its practice to ensure that there is consistency of approach in the information provided to parents about the involvement of other operators or team members.	
Reference from original report/CQC review resulting in recommendation: Points 1.39-1.42	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Clinical Lead for Cardiac Services and Consultant Paediatric Cardiac Surgeon**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Enhance existing guidance to describe team working and in particular, the involvement of other operators, team members in patient care and the virtual parent reference group. Review by the Trust-wide consent group and Cardiac Clinical Governance for approval and then implement.	Revised 'Preparing for Surgery' and 'Cardiac Catheter/Intervention' leaflets. In addition - Revision of ward 32's leaflet to replicate changes made to the above leaflets.	Planned completion date: Dec 16 Actual completion date: April 17

Additional Actions	Assurance group	Completion/ Update timescales
Cardiac governance group to collate feedback and comments regarding the leaflets and amend accordingly	Children's Quality Assurance Committee	April 2018

Recommendation 17: That the Trust carry out a review or audit of (I) its policy concerning obtaining consent to anaesthesia, and its implementation; and (ii) the implementation of the changes to its processes and procedures relating to consent	
Reference from original report/CQC review resulting in recommendation: Points 1.39-1.42	
Responsible Delivery Group: Consent	**Lead Officer: Deputy Medical Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Anaesthetic group to be set up to review current practise in pre-op assessment in relation to consent for anaesthesia and how they can implement a consent for anaesthesia process Trust-wide Liaise with Royal College of Anaesthesia and other appropriate professional bodies with regarding national policy Implementation plan for Trust-wide consent process	Minutes and actions from meeting Correspondence with Royal College of Anaesthetists and Associations AAGBNI Guidance on Consent January 2017 Business case for paediatric pre-operative assessment successful, cover provided ad hoc whilst recruitment ongoing to provide permanent solution.	Planned completion date: May 17 Actual completion date: May 17

Additional Actions	Assurance group	Completion/ Update timescales
Audit impact of anaesthetic input into pre-operative assessment at 6 months following implementation	Children's Hospital Quality Assurance Committee	November 2017

Recommendation 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.	
Reference from original report/CQC review resulting in recommendation: Points 1.44-1.51	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Deputy Divisional Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Assessment of current process of risk assessing patients who have been cancelled and the timing of their rescheduled procedure Develop new and improved process for risk assessing cancelled patients ensuring outcomes of this are documented	Current process review report Reviewed meeting agenda and cancelled operations report for the Joint Cardiac Conference (JCC). Standard operating procedure (SOP) for cancelled operations and next steps reviewed and redistributed. Email correspondence confirming team's commitment to the process Records of the JCC discussions of cancelled patients	Planned completion date: Actual completion date: September 2017

Additional Actions	Assurance group	Completion/ Update timescales
Quarterly audit of compliance with the Joint Cardiac Conference Standard Operating Procedure	Children's Hospital Quality Assurance Committee	January 2018

Recommendation 20: That the Trust should set out a timetable for the establishment of appropriate services for end-of-life care and bereavement support.	
Reference from original report/CQC review resulting in recommendation: Points 1.60-1.62	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Deputy Divisional Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
End-of-life care and bereavement support pathway developed Implementation and roll out of new pathway	End of life and bereavement support pathway SOP including input from families who have experienced a bereavement Paediatric palliative care and bereavement support service leaflet Monitoring templates to capture effectiveness of the 'core offer' Minutes of Palliative Care and Bereavement Service Delivery Group Communication and presentations for roll out of bereavement core offer	Planned completion date: Nov'16 Actual completion date: Feb'17

Additional Actions	Assurance group	Completion/ Update timescales
Long term: Review opportunities to improve bereavement pathways in maternity services. The Congenital Cardiac Network team and Trust palliative care lead nurse to work towards a consistent approach to palliative care and bereavement across the network.	Children's Hospital Quality Assurance Committee	April 2018 Quarterly report from the Network

Recommendation 21: Commissioners should give priority to the need to provide adequate funds for the provision of a comprehensive service of psychological support.	
Reference from original report/CQC review resulting in recommendation: Points 1.60-1.62	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Commissioners**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Previous submission to commissioners for psychological support updated. Expression of Interest for increased resource to be submitted as part of business planning	Submission to commissioners Expression of interest completed and supported; Recruitment completed and start dates confirmed	Planned completion date: Nov'16 Actual completion date: April 2017

Additional Actions	Assurance group	Completion/ Update timescales
Annual report from psychology team to demonstrate value added by increase in service provision	Children's Hospital Quality Assurance Committee	April 2018

Recommendation 22: That the Trust review the implementation of the recommendation of the Kennedy Report that a member of the Trust's Executive, sitting on the Board, has responsibility to ensure that the interests of children are preserved and protected, and should routinely report on this matter to the Board.	
Reference from original report/CQC review resulting in recommendation: Points 1.63-1.82	
Responsible Delivery Group: Other	**Lead Officer: Commissioners**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Trust Secretary review of current arrangements and processes to ensure that the needs of the child are a focus of the Trust Board	Executive Lead Role description April 2015 Board annual report BRCH 2015/2016	Planned completion date: March 2017 Actual completion date: March 2017

Additional Actions	Assurance group	Completion/ Update timescales

Recommendation 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.	
Reference from original report/CQC review resulting in recommendation: Points 1.63-1.82	
Responsible Delivery Group: Women's and Children's	**Lead Officer: Deputy Divisional Director**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
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 Targeted approach to all staff groups to be developed with implementation of bespoke training and regular updates to clinical staff	MAPSAF presentation to W&C Divisional Board – Sept 2016 Briefing paper on training plan Training plan and attendance information from June 2016 onwards	Planned completion date: Dec'16 Actual completion date: Feb'17

Additional Actions	Assurance group	Completion/ Update timescales

Recommendation 24: That urgent attention be given to developing more effective mechanisms for maintaining dialogue in the future in situations such as these, at the level of both the provider and commissioning organisations.	
Reference from original report/CQC review resulting in recommendation: Points 1.83-1.88	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Discussion with commissioners about the issues and agreement to mitigate a similar occurrence	Quality Surveillance Group - How to be make your quality surveillance group effective. Mar 14 Document Agenda Clinical Commissioning Group/United Hospitals Bristol Quality Sub Group, Feb 17 Bristol, North Somerset & South Gloucestershire Clinical Commissioning Groups Quality Surveillance Group Report, Feb 17 National guidance on learning from deaths, Mar 17	Planned completion date: Jan 17 Actual completion date: May 17

Additional Actions	Assurance group	Completion/ Update timescales

Recommendation 26: That the Trust should explore urgently the development of an integrated process for the management of complaints and all related investigations following either a death of a child or a serious incident, taking account of the work of the NHS England's Medical Directorate on this matter. Clear guidance should be given to patients or parents about the function and purpose of each element of an investigation, how they may contribute if they so choose, and how their contributions will be reflected in reports. Such guidance should also draw attention to any sources of support which they may draw upon.	
Reference from original report/CQC review resulting in recommendation: Points 1.93-1.99	
Responsible Delivery Group: Incidents and Complaints	**Lead Officer: Chief Nurse**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Develop an appendix to the Serious Incident policy defining "link" between Child Death Review (CDR), complaints and serious incident investigations / reporting, includes adults and children. 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. 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 to the**	Serious incident policy reviewed/updated and appendix document added - Link between serious incidents and other investigatory procedures' Guidance document produced and approved by the Quality Assurance Group. Usage/effectiveness monitored weekly at the Bereavement Group, Audit Apr 17 completed; action plan sits with bereavement group Guidance for Supporting and Working with patients/families after unexpected death of an adult or a serious incident involving an adult – referenced as an	Planned completion date: Jan '17 Actual completion date: May'17

Additional Actions	Assurance group	Completion/ Update timescales
To review the opportunities to improve information/processes for supporting young person's 16-18 year olds involved in a serious incident.	Children's Quality Assurance Group Clinical Quality Group	April 2018 May 2018

requirements of the recommendation. Develop 'guidance' / information for families in children's services how the x3 processes of CDR / Serious Investigation (SI) / Root Cause Analysis (RCA) investigation inquests and complaints are initiated / managed and integrate 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. Develop the above staff guidance for staff in adult services (minus CDR) Develop the above family guidance for adult patients and families (minus CDR). Review options for how patients / families can participate (if they want to) with the SI RCA process implement preferred options (FI). 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	associated document in Evidence 1 SI policy. What review processes might happen when my child dies? Information leaflet –Guide For Patients And Families About Patient Safety Incident Standard operating process - Communication to staff following a clinical event likely to require further investigation (Paediatrics) Standard operating process - Communication to staff following an incident likely to require further investigation (Adults) Staff briefing on investigatory processes following an incident/event involving a patient - referenced as an associated document in Evidence 1 SI policy. Guide for adult patients and their families about investigations of unexpected events and incidents. Information and guidance for patients and families for reviewing an incident investigation (Root Cause Analysis) report/ Letter to accompany item /				

	diagram to describe options for patient / family involvement in SI process, has been incorporated into Draft Minutes of BRHC Quality Assurance Committee, April 2017	

Recommendation 27: That the design of the processes we refer to should take account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue.	
Reference from original report/CQC review resulting in recommendation: Points 1.93-1.99	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Design Guidance for the Preparation and Conduct of Meetings with Parents / Families to discuss concerns and / or adverse event feedback; Completed and signed off at January 2017 I&C meeting Bespoke training opportunities to be considered in light of development of staff guidance by Children's Services – bespoke training programme designed with a plan to utilise in the event of a significant patient safety incident in order to support staff through the process	1) BRHC recorded meeting consent form - internal recording 2) BRHC recorded meeting consent form - external recording 3) PowerPoint presentation showing training on 'Responding to Complaints with Confidence 4) PowerPoint presentation showing training on the 'Link between complaints, incident and mortality investigations' used at Trust-wide induction and root cause analysis training 5) Training records for Trust-wide induction dated February and March 2017	Planned completion date: June 2017 Actual completion date: April 2017

Additional Actions	Assurance group	Completion/ Update timescales
Align patient safety training programmes in paediatric and adult services to ensure consistency.	Clinical Quality Group	April 2018

Recommendation 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.

Reference from original report/CQC review resulting in recommendation: Points 1.93-1.99

Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Review UH Bristol's previous use of independent review / benchmarking from other Trusts to inform • Complaints • RCAs Develop guidance for when to access 'independent advice / review' for • Complaints • SI RCAs Some actions required to complete this recommendation are replicated in recommendation 29	Review of practice re independent complaints investigation document Independent element - serious Incidents benchmarking document Cover sheet and amendments to Serious Incident Policy Email to divisional patient safety managers, divisional directors, clinical chairs and heads of nursing advising of changes to SI policy Extracts from updated Complaints and Concerns policy for CI delivery group Dec 16 Email to all divisional directors, clinical chairs and heads of nursing re. independent investigation, support and mediation	Planned completion date: December 2016 Actual completion date: April 2017

Additional Actions	Assurance group	Completion/ Update timescales
Ongoing audit / review of the extent to which divisions are taking up the options for independent review, as outlined in the Complaints & Concerns Policy. This will be discussed at each division's annual complaints review panel. The Trust is also working in collaboration with the Patients Association to develop a 'toolkit' which will provide staff with guidance about triggers for obtaining an independent/objective view about a complaint and where that input might appropriately come from.	Clinical Quality Group	April 2018

	Email between Trust and Patients Association confirming arrangements for focus group Finalised invitation letter to the focus meeting planned for May 17	

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

Reference from original report/CQC review resulting in recommendation: Points 1.93-1.99

Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Review of options pertaining to dispute resolution. Representatives from the Bristol Royal Hospital for Children (BRHC) and the Trust's Head of Quality met with a representative from the Medical Mediation Foundation (MMF) to gain a better understanding of the services provided. MMF services discussed by the BRHC Quality Assurance Group. Further review required and a funding request to be sought from the Grand Appeal and/or Above and Beyond. **Supplementary to the recommendation** Head of Quality (Patient Experience and Clinical Effectiveness) to undertake further investigation into the market for medical mediation or alternative options; next steps would require executive agreement and a	Summary of the visit to the Trust of Medical Mediation Meeting minutes from BRHC Quality Assurance Committee where the report was considered for next steps on 21/04/2017 High risk complaints SOP Divisional escalation pro-forma Email from Head of Quality (Patient Experience and Clinical Effectiveness) to divisional directors, clinical chairs and HON dated 6th Feb 17, 'Independent investigation support and mediation' Extracts from CC policy	Planned completion date: April 2017 Actual completion date: May 2017

Additional Actions	Assurance group	Completion/ Update timescales
Divisional Governance Group to Evaluate trial of the Medical Mediation Foundation's dispute resolution training.	Clinical Quality Group	April 2018

procurement process to ensure consistency and appropriate Some actions required to complete this recommendation are replicated in recommendation 28		

Recommendation 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.

Reference from original report/CQC review resulting in recommendation: Points 1.93-1.99

Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
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. Serious incident policy updated and information sheets produced for patients / families providing information about feedback to patients/families with regard to serious incident investigations and actions arising from these. 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 The following elements were added to the work of the group to meet this recommendation however they sit outside of the true detail of the recommendation. 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	Revised Serious incident policy – 1 Cover sheet and amendments; 1a full policy Rapid response duty of candour pro-forma Staff Being open policy Proforma of questions used in the formal complaints management process Proforma of questions used in the informal complaints management process Report to I&C group from Head of Quality (Patient Experience and Clinical Effectiveness) summarising changes made for asking patients how they would like to be involved in designing changes in practice in response to the concerns they have raised	Planned completion date: December 2016 Actual completion date: June 2017

Additional Actions	Assurance group	Completion/ Update timescales
Patient Support and Complaints Team work plan to undertake as part of annual audit a question regarding whether complainants are being asked about involvement, what their answers are and whether and how this has led to any involvement opportunities.	Clinical Quality Group	April 2018

raised to be audited at the end of February 2017, including review of survey replies. Regular complainant focus groups to be held, rescheduled to May 2017 to maximise attendance, 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 to the recommendation requirements	Family information sheets advising on processes that may be followed following a death – child Family information sheets advising on processes that may be followed following a death – adult Minutes of the April 2017 BRHC Quality Assurance Committee Minutes of the May 2017 Clinical Quality Group Patient / family involvement in SI process Key associated documents to the Serious Incident Policy updated Draft information and guidance for parents and families for reviewing an incident investigation Letter to accompany parent and family guidance				

Recommendation 31: That the Trust should review the history of recent events and the contents of this report, with a view to acknowledging publically the role which parents have played in bringing about significant changes in practice and in improving the provision of care.	
Reference from original report/CQC review resulting in recommendation: Points 1.93-1.99	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Paper submitted to Trust Board to acknowledge parental roles in change Assurance visits by local councillors Trust attendance at the Overview and Scrutiny Committee	Trust Board papers and agenda July 2016 Meeting minutes from the overview and scrutiny committee August 2016 and February 2017 2 Visits by local councillors in February 2017 Minutes of BSCB	Planned completion date: October 2016 Actual completion date: march 2017

Additional Actions	Assurance group	Completion/ Update timescales
Further attendance at the overview and scrutiny committee planned Further visits by local councillors invited by BRHC	Quality Assurance Committee	December 2017

Recommendation 32: That the Trust re-designate its activities regarding the safety of patients so as to replace the notion of "patient safety" with the reference to the safety of patients, thereby placing patients at the centre of its concern for safe care.	
Reference from original report/CQC review resulting in recommendation: Points 1.100	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Terms of Reference for the Trust Patient Safety Group and associated governance groups revised so that references to 'patient safety' have been replaced with the term 'safety of patients'. Role descriptions for members of staff with corporate or divisional roles in patient safety have been revised so that references to 'patient safety' have been replaced with the term 'safety of patients'. Training and development activities led by the Trust's Patient Safety Team and associated resources have been reviewed and the term 'safety of patients' has been adopted as described above.	Patient Safety Group minutes record the discussion and decision to amend terms of reference and role descriptions as described.	Planned completion date: December 2016 Actual completion date: March 2017

Additional Actions	Assurance group	Completion/ Update timescales

CQC 1: Recording the percentage risk of mortality or other major complications discussed with parents or carers on consent forms	
Reference from original report/CQC review resulting in recommendation:	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Trust Consent forms 1-3 have been amended to include percentage risk of mortality. BRHC produced bespoke consent information sheets including percentage risk.	Amended Trust-wide consent forms 1-3 including percentage risk 33 Paediatric Cardiac Information Sheets with % risk.	Planned completion date: January 2017 Actual completion date: April 2017

Additional Actions	Assurance group	Completion/ Update timescales

CQC 2: Provision of a formal report of transoesophageal or epicardial echocardiography performed during surgery	
Reference from original report/CQC review resulting in recommendation:	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Initial audit December 2016 Further audit February 2017.	Initial audit results Copy of new Echo form implemented demonstrating Evolve filing guidance Re-audit Email from clinical chair following March deliver group Further audit of compliance may 2017	Planned completion date: November 2016 Actual completion date: June 2017

Additional Actions	Assurance group	Completion/ Update timescales
Annual audit of compliance both with completion of the form and accurate filing in the Evolve system	Children's Hospital Quality Assurance Committee	June 2018

CQC 3: Recording pain and comfort scores in line with planned care and when pain relief is changed to evaluate practice	
Reference from original report/CQC review resulting in recommendation:	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Documentation developed to enable easy collection of pain data Audit of nursing documentation completed monthly on existing practice and findings reported. Targeted training based on audit findings. The nursing audit collection document amended to include question about reassessment 30 mins after pain relief has been administered.	Clinical protocol for recording and acting upon physiological observations in paediatric in-patient areas within UH Bristol NHS Foundation Trust. Nursing Observation Chart (example 0-12months) Nursing Daily Assessment plan Ward 32 Nursing documentation audit sheet and results – November '16	Planned completion date: November 2016 Actual completion date: December 2016

Additional Actions	Assurance group	Completion/ Update timescales

CQC 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)	
Reference from original report/CQC review resulting in recommendation:	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
New process developed to ensure that all conversations with families are recorded in patients' paper notes. 'Cardiac communications' page developed on the electronic patient record system, Medway, to record contact with any patient, accessible to all staff involved in a patient's care. Medway 'alerts' added to patients with a cardiac condition designed to signpost clinicians to additional cardiac communications systems for further information.	Example of a patient's notes with the sticker entry showing CNS communication with patient / parent Example of Medway communication record for use by all teams Email trail sent by Head of Nursing reminding all teams of requirement to record all conversations and where Clinical standard operating procedure detailing how to access Medway clinical record Example of Heart suite entry to be used in addition to Medway if required	Planned completion date: December 2016 Actual completion date: April 2017

Additional Actions	Assurance group	Completion/ Update timescales

CQC 5: Providing written material to families relating to diagnosis and recording this in the records. (links to review recommendation 3 & CQC 1)

Reference from original report/CQC review resulting in recommendation:	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Review of procedure specific consent forms utilised by Alder Hey Hospital. Produce BRHC versions pertinent to procedures carried out; including percentage risks, benefits and methods used to carry out the procedure. Sign off of content/structure at the cardiac clinical governance meeting, 24th March 2017	33 separate information sheets relating to different operations/procedures; includes 1 generic form for those operations that fall outside of the 32 procedure specific sheets. Agenda of the Cardiac Clinical Governance Meeting, 24th March 2017	Planned completion date: April 2017 Actual completion date: April 2017

Additional Actions	Assurance group	Completion/ Update timescales
AUDIT AND REVIEW family and young persons feedback on revised consent process/supporting information one year from implementation.	Children's Hospital Quality Assurance Committee	April 2018

CQC 6: Ensuring that advice from all professionals involved with individual children is included in discharge planning to ensure that all needs are addressed	
Reference from original report/CQC review resulting in recommendation:	
Responsible Delivery Group: Other	**Lead Officer: Commissioners and Trust**

Key actions taken to meet the requirements of the recommendation	Evidence to support action completion	Completion timescales
Review of the multi-professional input to the discharge planning process. Questionnaire to all allied health professionals involved in cardiac patient care. Multidisciplinary ward round held weekly as of February 2017 Ward multidisciplinary "Board round" weekly Continued documentation in the medical notes regarding any AHP involvement and ongoing plans A white board on ward with an "AHP / HCST" column, with coloured pens / magnets for each AHP / HCST group. A list of named contacts and telephone numbers for ward AHPs to be kept up-to-date on the ward and Doctors office, to enable quick and easy reference.	AHP questionnaire Briefing paper demonstrating outcomes of questionnaire Minutes available from Ward 32 sister on request – not included for confidentiality reasons	Planned completion date: January 2017 Actual completion date: February 2017

Additional Actions	Assurance group	Completion/ Update timescales
Further review to be conducted to ensure actions continue to benefit MDT and patients.	Children's Hospital Quality Assurance Committee	June 2017

Cover report to the Public Trust Board. Meeting to be held on 31 October 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	11
Meeting Title	Public Trust Board	**Meeting Date**	Tuesday, 31 October 2017
Report Title	Research and Innovation Quarterly Report		
Author	David Wynick		
Executive Lead	Mark Callaway, Acting Medical Director		
Freedom of Information Status		Open	

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

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

Executive Summary
Purpose The purpose of this report is to provide an update on performance and governance for the Board. Key issues to note See executive summary in report.
Recommendations

Members are asked to:

- **Note the Report.**

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

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

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

Impact Upon Corporate Risk
N/A

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

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

Executive Summary

Performance:

Our confirmed end of quarter 1 2017/18 performance figures showed a further improvement in recruiting patients to time and target into contract commercial trials with 60% meeting the target (Q4 2016/17: 55%; Q3 2016/17: 47%).

In the same period, performance in achieving the 70 day benchmark (time from valid application to first patient recruited) has increased to 75 % following the decrease reported in the previous quarter (64%).

We are currently above the trajectory projected at the start of the financial year for weighted patient recruitment for 2017/18. This is due to an increase in the degree of certainty relating to the portfolio of research open at the trust, now that we are half way through the financial year. However, due to a decrease in the number of patients being recruited into primary care across the thus the performance of the clinical research network region as a whole has declined. This in turn presents a financial risk to the Trust for 2019/20.

Partnerships and Governance:

*The partnership agreement for the **NIHR Biomedical Research Centre** has been signed within expected and planned timeframes. The short-term extension to the **CLAHRC (Collaboration for Leadership in Applied Health Research and Care)** award has been confirmed, with a bid for indicative funding for the extension period now submitted. Dr Kyla Thomas has taken up her post as co-Clinical Director for the **Local Clinical Research Network** and will work alongside the Clinical Director until the end of the contract in March 2019, bringing public health expertise to the leadership team.*

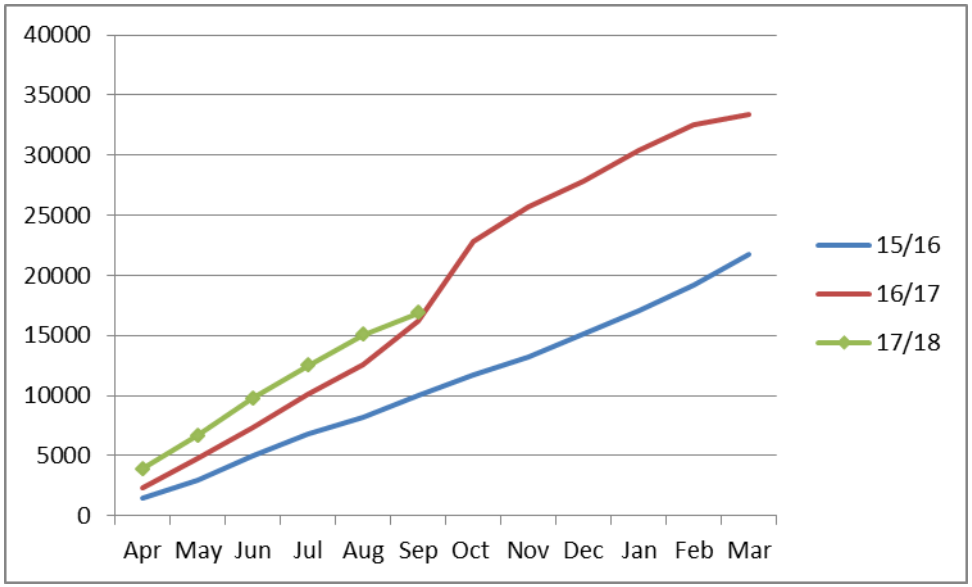
Overview

Successes	Priorities
• Performance in recruiting patients to time and target for contract commercial research continues to improve each quarter. • Performance in opening research and recruiting the first patient has improved since the previous quarter. • National scaling-up funding has been awarded to roll out an intervention to prevent cerebral palsy in pre-term babies, following research led by Dr Karen Luyt in St Michael's hospital.	• Prioritise resource into opening high recruiting studies where appropriate to contribute to CRN West of England recruitment activity with the aim of protecting delivery funding for 2019/20 financial year. • Explore feasibility of supporting new chief investigators to develop higher numbers of grants to increase research activity in two to three years.
Opportunities	**Risks and Threats**
• Work with the newly appointed Research Lead for the division of Surgery to map research activity and target areas to increase capacity and capability for developing new grants and recruiting to trials. • Commence ground work behind developing a strong and credible bid to become an Academic Health Science Centre along with our academic and health partners in the region.	• Lower than expected non commercial recruitment across the region in the current financial year to NIHR could lead to a reduction in funding in 2019/20

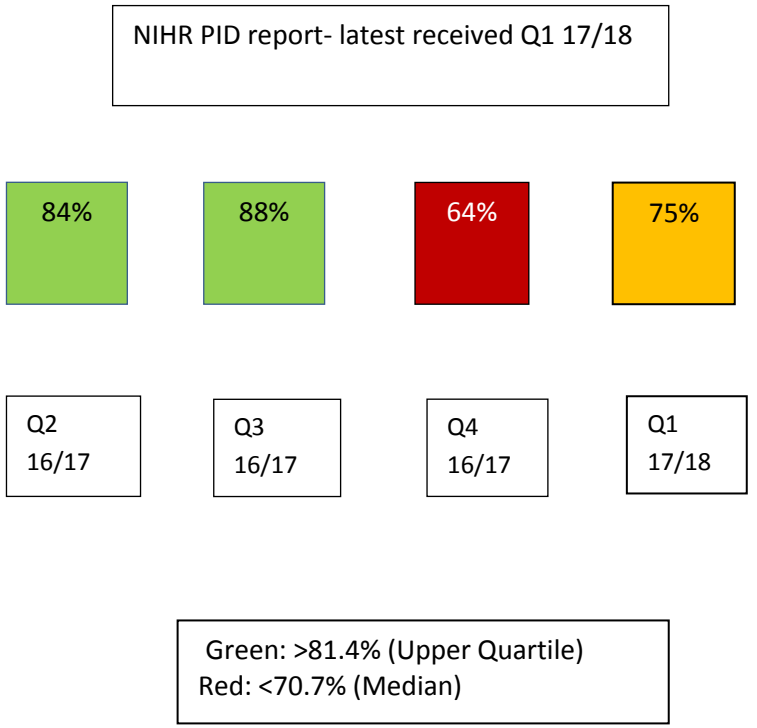
Performance Overview

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

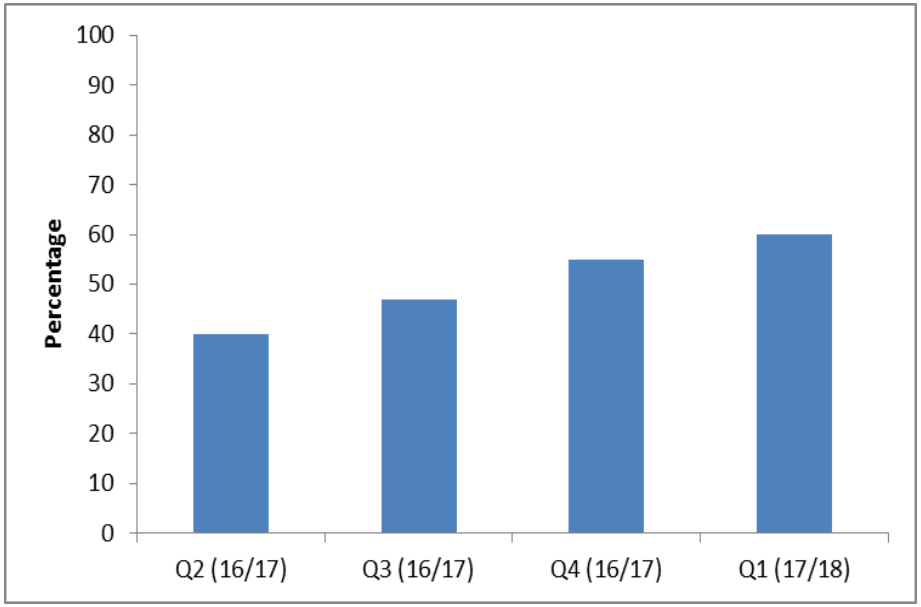
a) Cumulative weighted recruitment into NIHR portfolio studies 17-18. [NB. There is a 6 week lag in recruitment data becoming visible on the system.]



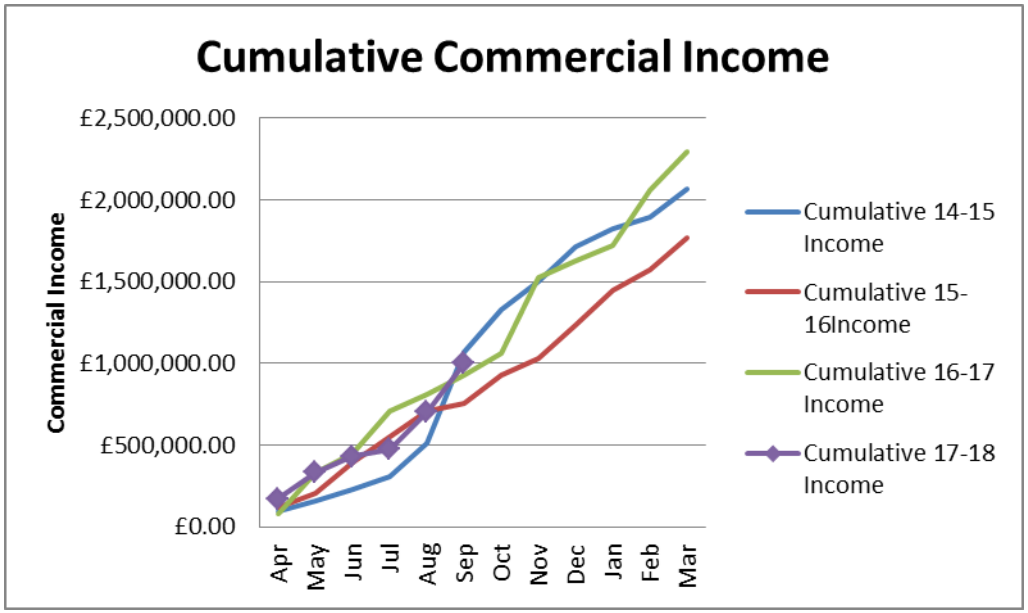
b) Performance in meeting the 70 day first patient first visit benchmark adjusted by NIHR in comparison to other Trusts



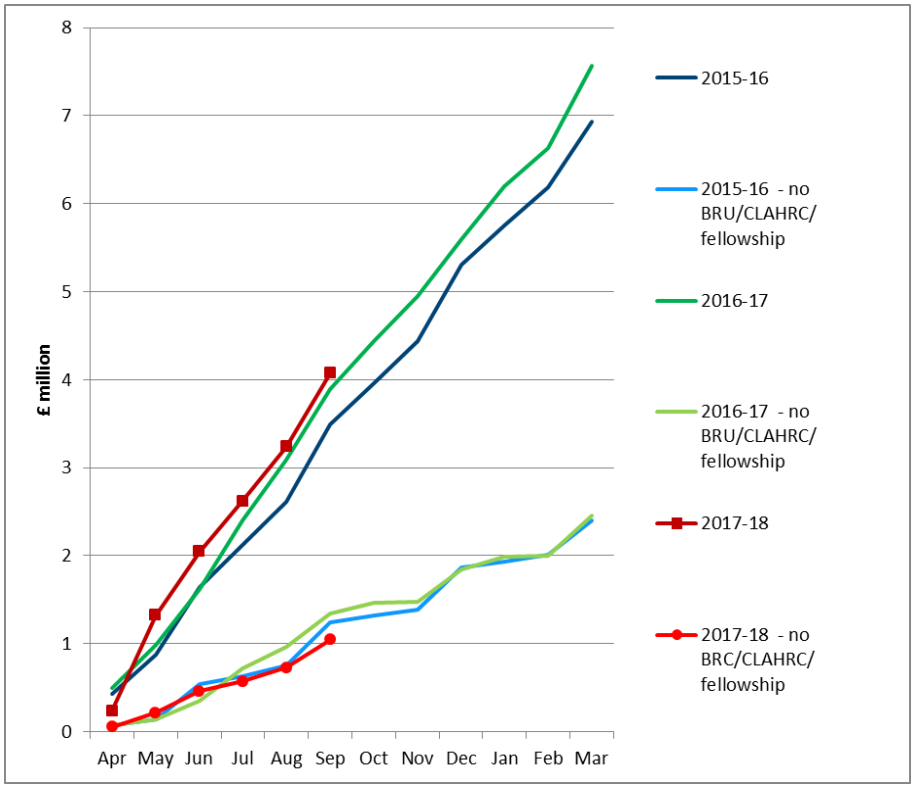
c) Percentage of closed commercial studies recruiting to time and target



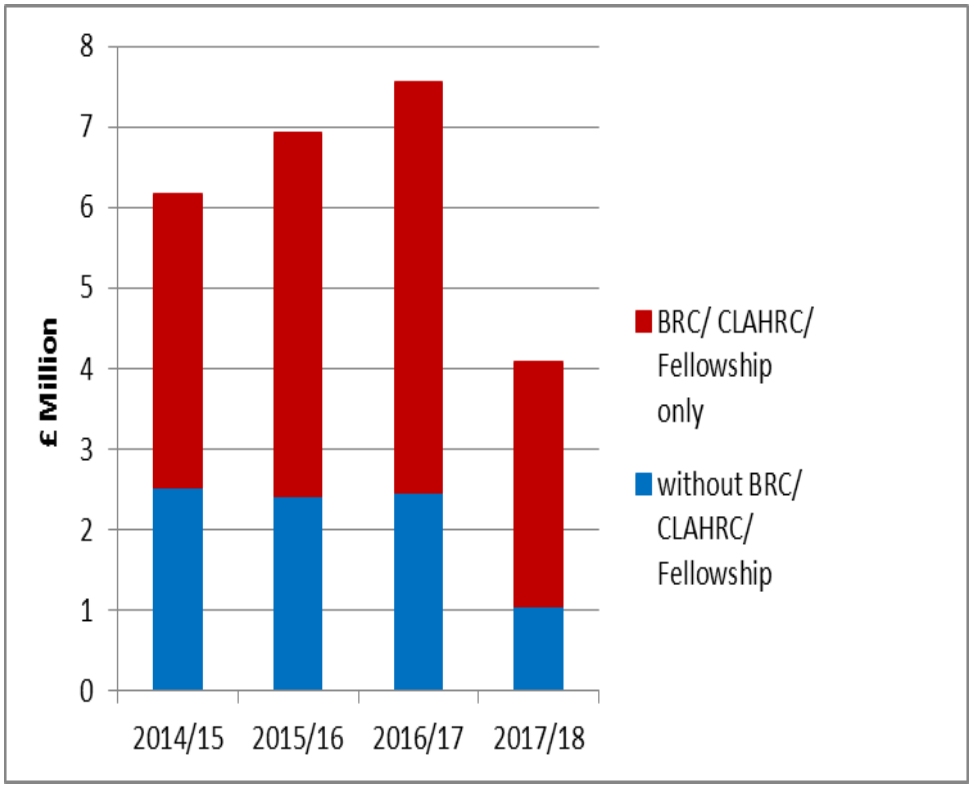
d) Monthly commercial income



NIHR monthly grant income – year on year comparison



NIHR grant income – drives research capability funding.



Cover report to the Public Trust Board. Meeting to be held on 31 October 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	12
Meeting Title	Public Trust Board	**Meeting Date**	Tuesday, 31 October 2017
Report Title	Finance Report		
Author	Paul Mapson, Director of Finance		
Executive Lead	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Strategic Priorities (please choose 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 inform the Finance Committee of the financial position of the Trust for September.

Key issues to note

The summary income and expenditure statement shows a surplus for the period to the end of September 2017 (before technical items) of £4.519m. The Trust's Operational Plan for September is a surplus of £4.765m (before technical items), therefore the position is £0.246m adverse to plan.

Excluding STF funding the Trust is reporting a surplus of £0.158m against a planned (phased)

surplus of £0.105m. Therefore the control total for month six excluding STF funding has been met.
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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
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.	☐		

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

Impact Upon Corporate Risk

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 October 2017			

University Hospitals Bristol
NHS Foundation Trust

REPORT OF THE FINANCE DIRECTOR

1. Summary

The summary income and expenditure statement (appendix 1) shows a surplus for the period to the end of September 2017 (before technical items) of £4.519m. The Trust's Operational Plan for September is a surplus of £4.765m (before technical items), therefore the position is £0.246m adverse to plan.

The £13.313m Sustainability and Transformation Funding (STF) for the year is dependent on achieving the 'core' control total excluding STF funding (70%), achieving the A&E performance target (15%) and the A&E streaming target (15%).

Excluding STF funding the Trust is reporting a surplus of £0.158m against a planned (phased) surplus of £0.105m. Therefore the control total for month six excluding STF funding has been met. Receipt of STF core funding is dependent on achieving the control total at each quarter hence the Trust will receive STF core funding for the first two quarters.

After technical items the planned surplus is £2.670m and the actual surplus is £4.299m. The plan includes the impairment of the BRI level 8/9 scheme at quarter two which will not be transacted until quarter three.

A&E performance was not met for the first quarter with performance of 87.9% against the joint NHS England / NHS Improvement nationally required trajectory of 90.0%, resulting in a loss of STF performance funding of £0.300m. The performance target was however met in quarter two and the Trust's A&E front door streaming initiatives have been recognised to date. Therefore, the STF performance funding has been assessed as achieved for quarter two.

The position (excluding technical items) is summarised in the table below:

	Income / (Expenditure)		Variance
	Plan to date £m	Actual to date £m	Favourable /(Adverse) £m
Corporate Income	295.224	296.329	1.105
Divisions & Corporate Services	(273.598)	(279.386)	(5.788)
Financing	(17.471)	(16.785)	0.686
Reserves	(4.050)		4.050
Surplus/(deficit) excluding STF funding	**0.105**	**0.158**	**0.053**
STF Core Funding	3.262	3.262	-
STF Performance Funding	1.398	1.099	(0.299)
Surplus/(deficit) including STF funding	**4.765**	**4.519**	**(0.246)**

Despite the improvement in the financial position in month six (September) the delivery of the Trust's financial plan for the year remains high risk due to factors such as the impact of the winter and Commissioner contractual challenges.

Divisions and Corporate Services are £5.788m adverse to plan after six months, a deterioration of £0.549m in September. This compares favourably with the August deterioration of £1.398m.

It is encouraging that the Divisional overspending run rate slowed this month, although this would have been anticipated for September given the Trust's operating plans are established and the month is outside of the main holiday period and winter pressures.

There has been a material improvement in the nursing pay position due to a greater focus on rostering and controls of agency spending. It is expected this will improve further through the new neutral vendor arrangements from November. This is monitored through the Corporate Nursing workstream

Medical pay, however, remains a problem – the overspending now exceeds that of nursing. A corporate Medical pay workstream has been established to tackle the key areas of overspending across the Trust, working with Divisions.

Other corporate workstreams which will contribute towards the reduction in run-rate overspending include:

- Non-pay including controls
- Income Fines and External
- HR Pay and Productivity
- Productivity
- Communications

However the nursing pay (£0.250m) and medical pay (£0.298m) overspends in month remain the two drivers of the Divisional run-rate overspend.

As reported last month, the forecast outturn is still to achieve the core control total, thus receiving the core STF funding, recognising the significant risk to this from the Divisions not delivering their recovery plans. The improvement in run rate in September supports this position and therefore the Trust has submitted this forecast outturn to NHS Improvement in the quarter two return.

2. Division and Corporate Services Performance

Clinical Divisions and Corporate Services overspend against budget increased by £0.549m in September to a cumulative position of £5.788m adverse. All Divisions and Corporate Services are adverse to their Operating Plan trajectory. This is summarised in the table below:

	Variance to Budget favourable/(adverse)			Operating Plan trajectory favourable/(adverse)	
	To 31 Aug £m	Sep £m	To 30 Sep £m	Trajectory To Sep £m	Variance £m
Diagnostic & Therapies	0.064	0.159	0.223	0.084	0.139
Medicine	(1.765)	(0.113)	(1.878)	(0.217)	(1.661)
Specialised Services	(0.508)	(0.114)	(0.622)	0.171	(0.793)
Surgery	(1.645)	(0.301)	(1.946)	(0.095)	(1.851)
Women's & Children's	(1.260)	(0.200)	(1.460)	(0.011)	(1.449)
Estates & Facilities	(0.032)	0.005	(0.027)	(0.018)	(0.009)
Trust Services	(0.028)	(0.019)	(0.047)	(0.001)	(0.046)
Other corporate services	(0.065)	0.034	(0.031)	-	(0.031)
Total	**(5.239)**	**(0.549)**	**(5.788)**	**(0.087)**	**(5.701)**

Diagnostic and Therapies

The favourable variance in month of £0.159m is largely related to income from activities, reflecting the share from services hosted by other Divisions as well as Diagnostic and Therapies services. The cumulative income from activities variance is a significant factor in the Division being £0.139m favourable against its operating plan trajectory.

Medicine

The Division was £0.113m adverse to plan in the month increasing the cumulative adverse position to £1.878m. Pay was adverse to plan by £0.151m in the month, predominantly due to nursing costs although this represented a significant improvement from previous months. The Division is adverse to its revised Operating Plan by £1.661m.

Specialised Services

In month the Division was adverse to plan by £0.114m driven by an underperformance in income from activities. Cardiac Surgery was £0.129m adverse to plan in the month, Bone Marrow Transplant (BMT) £0.090m, Clinical Haematology £0.093 and Clinical Genetics £0.086m.

Non-delivery of Cardiac Surgery, BMT and Clinical Genetics activity are the key drivers for the £0.793m adverse variance to the Operating Plan trajectory to date.

Surgery

The Division was £0.301m adverse to plan in September, of which £0.258m was related to pay expenditure. Medical and dental pay costs were adverse to plan by £0.211m due to additional hours payments to deliver activity and cover sickness.

The Division is £1.851m adverse against its Operating Plan. This is driven by its share of Cardiac Surgery activity shortfall of £0.223m and adverse positions on nursing and in particular medical staff pay.

Women's and Children's

The Division was adverse to plan by £0.200m in the month, with pay expenditure £0.273m adverse to plan; medical and dental staff being £0.139m adverse and nursing and midwifery £0.117m. Payments to medical staff for additional hours to cover sickness, maternity leave and vacancies are significant and the high cost of covering nursing sickness and vacancies continues. Income from activities improved this month, being £0.111m favourable against plan. This reflected activity in Cardiac Surgery, Cardiology and Critical Care.

The Division is £1.449m adverse against its Operating Plan with medical and dental pay accounting for £0.687m, nursing pay £0.679m and other pay £0.106m.

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

Divisional Forecast Outturns

In support of the formal forecast outturn the Trust needs to report to its regulator (NHS Improvement) quarterly the Divisions have been asked to assess their individual forecast outturns. The table below shows that Clinical Divisions are forecasting an adverse position of £8.9m against plan.

	Month 06 YTD £m	Straight line Projection £m	Month 06 FOT £m
Diagnostics and Therapies	0.223	0.446	0.438
Medicine	(1.878)	(3.756)	(3.051)
Specialised Services	0.622)	(1.244)	(1.097)
Surgery Head and Neck	(1.946)	(3.892)	(2.998)
Women's and Children's	(1.460)	(2.920)	(2.200)
Clinical Divisions Total	**(5.683)**	**(11.366)**	**(8.908)**

This will not deliver the Trust's overall financial plan which has been reviewed in detail with the assessment that Clinical Divisions cannot exceed a £8m overspend in year. In addition this level of monthly run-rate would not be an acceptable assurance in releasing any strategic capital schemes.

Divisions' forecasts will be further analysed and improvements in spend rates required. These will be discussed at individual Divisional Performance Reviews.

3. Subjective Analysis

The adverse variances of £0.549m in September and £5.788m to date are analysed subjectively in the table below:

Favourable/(Adverse)	April £m	May £m	June £m	July £m	August £m	Sept £m	2017/18 to date £m	2016/17 Outturn £m
Nursing & midwifery pay	(0.501)	(0.090)	(0.501)	(0.518)	(0.474)	(0.250)	(2.335)	(4.811)
Medical & dental staff pay	(0.205)	(0.272)	(0.391)	(0.350)	(0.289)	(0.298)	(1.806)	(1.380)
Other pay	0.032	0.042	0.108	0.006	0.056	0.159	0.404	2.645
Non-pay	0.400	(0.102)	(0.789)	(0.094)	(0.182)	(0.860)	(1.627)	(6.340)
Income from operations	(0.161)	(0.346)	0.462	(0.147)	(0.017)	(0.011)	(0.219)	0.751
Income from activities	(0.188)	0.618	0.061	(0.279)	(0.424)	0.719	0.505	(0.983)
Savings programme (CIP)	(0.239)	(0.217)	(0.096)	(0.082)	(0.067)	(0.008)	(0.710)	(4.231)
Total	**(0.862)**	**(0.367)**	**(1.146)**	**(1.466)**	**(1.398)**	**(0.549)**	**(5.788)**	**(14.349)**

The analysis this month has incorporated the Operating Department Practitioners (ODPs) into nursing and midwifery pay as they are included within the nursing pay control work stream, (previously reported within other in line with statutory reporting requirements).

Further information is provided below however savings are not able to be allocated to the detail within this analysis and are therefore shown as one line.

With the contra between non-pay and income described below, the overspends on nursing and medical staff pay are the key drivers in the adverse financial position.

Nursing (including ODP) & Midwifery Pay

The year to date nursing and midwifery pay variance including theatre ODP's for September is £2.334m adverse which reflects a continued adverse, albeit improved, position in the month. The table below shows analysis between substantive, bank and agency:

Favourable/(Adverse)	April	May	June	July	August	September	2017/18 to date	2016/17 Outturn
	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	0.555	0.849	0.796	0.827	0.857	0.938	4.822	8.822
Bank	(0.632)	(0.523)	(0.627)	(0.698)	(0.671)	(0.668)	(3.819)	(6.408)
Agency	(0.434)	(0.436)	(0.692)	(0.668)	(0.676)	(0.526)	(3.432)	(7.397)
Total inc CIP	**(0.511)**	**(0.110)**	**(0.523)**	**(0.539)**	**(0.490)**	**(0.256)**	**(2.429)**	**(4.983)**
Less CIP	(0.010)	(0.020)	(0.022)	(0.021)	(0.016)	(0.007)	(0.095)	(0.300)
Total excl CIP	**(0.501)**	**(0.090)**	**(0.501)**	**(0.519)**	**(0.474)**	**(0.249)**	**(2.334)**	**(4.683)**

The position has improved in month 6 compared to the previous three months, reflecting a reduction in agency expenditure and continued underspends against substantive budgets.

In September there has been a reduction in vacancy levels across all Divisions and reduced sickness levels in particular in Medicine (reduced from 4.7% to 3.7%) and Women's and Children's (reduced from 4.6% to 3.9%).

There also continues to be reduced levels of one to one care following the introduction of the new enhanced care policy at the start of August. Trustwide nursing (including ODPs) finished month 6 with an adverse variance of £0.256m, this was an improvement of £0.215m from month 5.

As with previous months the main area for the adverse variance was the Clinical Divisions' wards and theatres which accounts for £0.291m. They have also seen the biggest improvement in month by £0.125m. One of the main drivers for the improvement was the introduction of the new Enhanced Care Observation (ECO) and Meaningful Activities Policy in Adult Services which has seen a reduction in the RMN and NA 1:1 variance of £0.063m.

A review of the use of temporary staffing to cover gaps in rotas and improved process of authorising agency shifts has resulted in a reduction of the adverse agency variance by £0.150m. This can be seen in the price and volume variance where there has been an improvement in the price variance of £0.251m. The volume variance showed an increase of £0.100m in month, meaning we are still using above funded establishment.

The Nursing Controls workstream (chaired by the Chief Nurse) has produced an action plan to address the continued overspends. New controls that have been put into place which include a review of the RAG rating of unfilled shifts, lockdown of rotas so that additional shifts have to be authorised by Matrons or above, restriction of NHSI non-framework agencies, improved agency controls in preparation for the implementation of the neutral vendor in November and a review of the application of the Trustwide supernumerary policy.

All Divisions show a reduction in agency expenditure compared to August reflecting the above changes with the most significant reduction in the Division of Medicine.

The nursing control dashboard is attached at appendix 3.

Medical & Dental Pay

The year to date variance on Medical and Dental staff is £1.810m compared with £1.442m for the whole of 2016/17. The adverse variance of £0.292m in September and the year to date position is summarised in the table below:

Favourable/(Adverse)	April £m	May £m	June £m	July £m	August £m	September £m	2017/18 to date £m	2016/17 Outturn £m
Consultant								
Substantive costs	0.131	0.135	0.068	0.122	0.164	0.073	0.693	0.277
Additional hours payments	(0.157)	(0.149)	(0.208)	(0.243)	(0.272)	(0.221)	(1.250)	
- Locum	(0.023)	0.013	(0.044)	(0.036)	0.015	(0.031)	(0.106)	(0.143)
- Agency	(0.020)	(0.028)	(0.064)	(0.040)	0.008	(0.013)	(0.157)	(0.741)
Other medical								
- Substantive costs	0.095	(0.027)	0.139	0.260	0.133	0.232	0.832	(0.369)
- Additional hours payments	(0.192)	(0.197)	(0.196)	(0.300)	(0.244)	(0.236)	(1.365)	
- Exception reporting payments	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
- Locum	(0.045)	(0.058)	(0.057)	(0.114)	(0.091)	(0.102)	(0.467)	(0.469)
- Agency	0.003	0.042	(0.036)	(0.003)	(0.002)	0.006	0.010	0.003
Totals inc CIP	**(0.208)**	**(0.269)**	**(0.398)**	**(0.354)**	**(0.289)**	**(0.292)**	**(1.810)**	**(1.442)**
Less CIP	0.003	(0.003)	0.007	0.004	(0.001)	0.006	(0.009)	0.062
Totals excl CIP	**(0.205)**	**(0.272)**	**(0.391)**	**(0.350)**	**(0.290)**	**(0.298)**	**(1.801)**	**(1.380)**

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

The adverse variance for medical and dental pay continues in September at a similar value to that seen in August. There has been no significant change in the drivers behind this variance previously reported.

Additional hours payments have reduced slightly in month to £0.457m compared with £0.516m in August, but this reduction has not resulted in an overall change to the variance as agency and locum use is slightly higher. Work to improve data flows around the use of additional hours and analyse the drivers in more detail continues.

The Divisions of Women's and Children's and Surgery continue to have the most significant overspend in month. Surgery has worsened to an adverse variance of £0.224m compared to £0.135m in August, mainly due to locum spend. Sickness cover continues along with additional cover for rota gaps in the Eye Hospital and in Trauma and Orthopaedics which are proving difficult to recruit to. The Women's and Children's Division improved slightly from £0.165m adverse to £0.139m due to lower additional payments in month, although locum and agency staff continue to be utilised.

The new Junior Doctor contract has now been implemented. Funding issued for 2017/18 to date is £1.112m with the expected full year cost being c£2m.

Non Pay

The non pay variance deteriorated by £0.850m in September. An analysis is shown below:

Favourable/(Adverse)	April £m	May £m	June £m	July £m	August £m	September £m	2017/18 to date £m	2016/17 Outturn £m
Blood	0.008	(0.027)	0.085	(0.027)	(0.067)	(0.012)	(0.040)	(0.552)
Clinical supplies & services	0.025	(0.210)	(0.215)	0.005	(0.002)	0.000	(0.397)	(1.730)
Drugs	(0.111)	0.092	(0.055)	(0.079)	(0.060)	0.011	(0.202)	(0.362)
Establishment	0.054	(0.004)	(0.018)	(0.037)	0.011	0.008	0.014	(0.091)
General supplies & services	0.023	0.011	(0.010)	0.004	(0.015)	(0.140)	(0.127)	(0.124)
Outsourcing	(0.098)	(0.176)	(0.164)	(0.163)	(0.105)	(0.049)	(0.755)	(1.241)
Premises	0.003	0.032	(0.056)	(0.015)	(0.019)	0.111	0.056	0.111
Services from other bodies	(0.209)	0.141	(0.104)	(0.083)	(0.026)	(0.112)	(0.393)	(2.788)
Research	0.245	0.067	(0.310)	(0.006)	0.007	(0.005)	(0.002)	0.030
Other non-pay expenditure	0.326	(0.198)	0.032	0.283	0.094	(0.662)	(0.125)	(2.745)
Totals inc CIP	**0.266**	**(0.272)**	**(0.815)**	**(0.118)**	**(0.183)**	**(0.850)**	**(1.972)**	**(9.492)**
Less CIP	0.135	0.168	0.026	0.024	0.003	0.010	(0.346)	3.152
Totals excl CIP	**0.401**	**(0.104)**	**(0.789)**	**(0.094)**	**(0.180)**	**(0.860)**	**(1.626)**	**(6.340)**

The most significant change in the month was seen in 'other non pay expenditure' which had an adverse variance of £0.662m. Improved coding has seen a change between premises and other expenditure of £0.111m but the majority, £0.428m, reflects a retrospective change in accounting treatment for SLA margins in Medicine which is not a change in expenditure trend and is offset in income from activities.

The main reason for the adverse year to date non pay position remains Outsourcing, £0.755m and Services from other Bodies, £0.393m. This is offset by clinical SLA income earned.

The level of outsourcing has reduced in September leaving cumulative adverse variances of £0.336m relating to South West Eye Surgeons, £0.303m to Glanso, and £0.089m to Dermatology. The remaining balance relates to the virtual ward provided by Orla, which has now closed.

Notable variances on Services from Other Bodies year to date are external tests £0.134m, recharges for Cellular Pathology £0.021m and Dermatology Services £0.046m, supplies consortia costs £0.029m, and the cystic fibrosis pathway £0.038m.

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.

	September 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	8.673	8.991	0.318
Emergency Inpatients	0.653	43.459	45.815	2.356
Day Cases	(0.176)	19.498	19.415	(0.083)
Elective Inpatients	0.236	28.085	27.635	(0.450)
Non-Elective Inpatients	(0.229)	16.048	15.571	(0.477)
Excess Beddays	(0.051)	2.711	2.979	0.268
Outpatients	(0.106)	38.618	38.392	(0.227)
Bone Marrow Transplants	(0.020)	4.140	4.151	0.010
Critical Care Beddays	0.196	22.018	22.307	0.288
Other	(0.315)	46.649	45.541	(1.108)
Total Activity Based	**0.257**	**229.899**	**230.796**	**0.897**
Contract Rewards	0.639	4.731	4.874	0.143
Contract Penalties	0.126	(0.482)	(0.925)	(0.443)
Pass through payments	(0.315)	42.696	42.022	(0.673)
Sustainability and Transformation Funding	0.000	4.660	4.360	(0.300)
2017/18 Total	**0.707**	**281.504**	**281.128**	**(0.376)**
Prior year income	0.000	0.000	1.302	1.302
Overall Total	**0.707**	**281.504**	**282.430**	**0.926**

Activity based income was £0.257m favourable to plan in September, increasing the cumulative over performance to date to £0.897m.

Non elective and emergency inpatients were £0.424m above plan in the month, primarily in paediatric surgery, paediatric cardiology and medicine.

Elective inpatients was £0.236m above plan in the month, of which £0.152m was within Specialised Services, cardiology being £0.168m above plan, oncology and haematology £0.079m above pan and cardiac surgery £0.095m below plan.

Critical care beddays were £0.196m above plan in the month. Within Women and Children's, PICU was above plan by £0.131m, although NICU was £0.107m below plan. Medicine was £0.099m above plan.

Outpatient activity was £0.106m below plan in the month, of which £0.111m related to Dental services.

Other activity worsened in the month by £0.315m reducing the cumulative underperformance to £1.108m. The year to date position includes an underperformance within Radiotherapy (£0.351m), Bowel Cancer Screening (£0.272m) and Cystic Fibrosis (£0.175m).

The plan assumes 82% achievement of CQUINs, which is £9.43m.The latest assessment is that 85.3% or £9.7m of the total £11.5m available is likely to be achieved. This significant improvement from last month reflects the outcome of discussions with

Commissioners. Therefore there has been a significant improvement in month (£0.639m) increasing the year to date position to £0.143m above plan

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 £0.925m to date, £0.443m worse than plan. This is primarily due to the emergency marginal tariff adjustment, although the position improved by £0.126m in the month.

Pass through payments were £0.315m below plan in September, reducing the year to date position to £0.673m behind plan. In particular blood products and excluded devices continued to be behind plan in the month and excluded drugs and donor charges were broadly in line with plan.

5. Savings Programme

The savings requirement for 2017/18 is £11.520m. To date the Trust has achieved savings of £5.050m against a plan of £5.772m. 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.

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

	2017/18 Plan	Year to date			Forecast Outturn
		Plan	Actual	Variance fav / (adv)	Variance fav / (adv)
	£m	£m	£m	£m	£m
Pay	1.823	0.864	0.718	(0.146)	(0.086)
Drugs	0.400	0.204	0.361	0.157	0.267
Clinical Supplies	2.229	1.108	1.158	0.050	0.478
Non Clinical Supplies	3.178	1.614	1.103	(0.511)	(0.496)
Other Non-Pay	0.216	0.104	0.089	(0.015)	(0.029)
Income	2.582	1.332	1.121	(0.211)	0.050
Capital Charges	1.000	0.500	0.500	-	-
Unidentified	0.092	0.046	-	(0.046)	(0.092)
Totals	**11.520**	**5.772**	**5.050**	**(0.722)**	**0.092**

Whilst income is behind plan to date, it is expected that this position will improve and the planned savings will be achieved. Of greatest concern are non-clinical supplies. With regards to unidentified savings, Divisions have £2.702m savings in the pipeline but these remain in their very early stages.

The forecast outturn variance reduced by £0.164m in September. The Divisions of Medicine and Surgery continue to forecasting significant under delivery of savings. Medicine has increased its adverse forecast outturn by £0.157m in the month, although Surgery improved its forecast slightly by £0.058m.

Savings performance by Division is shown in the table below with further information provided at agenda item 2.4.

	2017/18 Plan £m	Year to Date			Forecast Outturn Variance fav / (adv) £m
		Plan £m	Actual £m	Variance fav / (adv) £m	
Diagnostics and Therapies	1.386	0.693	0.619	(0.074)	(0.113)
Medicine	2.071	0.970	0.648	(0.322)	(0.507)
Specialised Services	1.192	0.597	0.809	0.212	0.602
Surgery	2.393	1.303	0.767	(0.536)	(0.218)
Women's and Children's	2.036	1.003	1.006	0.003	0.188
Facilities and Estates	0.817	0.391	0.366	(0.025)	0.070
Trust Services	0.545	0.275	0.251	(0.024)	(0.018)
Corporate	1.080	0.540	0.584	0.044	0.088
Totals	**11.520**	**5.772**	**5.050**	**(0.722)**	**0.092**

6. Use of Resources Rating

The Use of Resources Rating (URR) for the Trust to date is 1, against the plan of 1. The variance in income and expenditure margin scores a metric rating of 2 compared with a plan of 1 due to the net surplus to date of £4.519m being £0.246m adverse to plan. The following table summarises the position.

		30th September 2017	
	Weighting	Plan	Actual
Liquidity			
Metric Result – days		13.8	17.7
Metric Rating	20%	1	1
Capital Servicing Capacity			
Metric Result – times		2.4	2.4
Metric Rating	20%	2	2
Income & expenditure margin			
Metric Result		1.5%	1.4%
Metric Rating	20%	1	1
Variance in I&E margin			
Metric Result		0.00%	-0.10%
Metric Rating	20%	1	2
Variance from agency ceiling			
Metric Result		42.7%	22.6%
Metric Rating	20%	1	1
Overall URR		**1.2**	**1.4**
Overall URR (rounded)		**1**	**1**
Overall URR (subject to override)		**1**	**1**

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 was assumed.

The capital programme has increased by £2.565m, from £47.885m to £50.450m largely due to the receipt of £1.794m Radiotherapy Modernisation Programme funding to purchase a replacement linear accelerator. A further £0.200m increase is in relation to the Tissue Culture Lab scheme funded by a donation from the University of Bristol.

The forecast outturn has been re-assessed at quarter two and reduced from £35.253m to £29.259m. The slippage continues to be predominantly from the Phase 5 allocation of £15.765m, the strategic scheme contingency of £1.200m, the Medical School allocation of £1.000m and the funding awarded for the linear accelerator of £1.794m.

Expenditure in the month was £1.421m and at the end of September, capital expenditure totalled £9.754m, £5.409m behind plan. Operational capital is £1.775m behind plan and relates to a large number of schemes. Expenditure on medical equipment is £2.631m behind plan, of which £2.230m relates to five significant schemes which are in progress and forecast to complete within the financial year.

Operational Plan £m	Subjective Heading	Year to date			Year end		
		Internal Plan £m	Actual spend £m	Variance £m	Internal Plan £m	Forecast £m	Variance £m
	Sources of Funding						
3.800	PDC	2.200	2.200	-	5.785	5.785	-
	Donations	0.570	0.400	(0.170)	0.806	0.806	-
	Cash:						
22.764	Depreciation	11.002	10.960	(0.042)	22.447	22.346	(0.101)
21.321	Cash balances	1.391	(3.806)	(5.197)	21.412	0.322	(21.090)
47.885	**Total Funding**	**15.163**	**9.754**	**(5.409)**	**50.450**	**29.259**	**(21.191)**
	Application/Expendi						
(16.035)	Strategic Schemes	(1.000)	(1.140)	(0.140)	(19.888)	(1.894)	17.994
(10.278)	Medical Equipment	(4.050)	(1.419)	2.631	(13.043)	(8.931)	4.112
(11.370)	Operational Capital	(4.338)	(2.561)	1.775	(10.845)	(7.560)	3.285
(7.328)	IT	(4.642)	(3.977)	0.665	(9.276)	(8.409)	0.867
(2.874)	Estates Replacement	(1.135)	(0.657)	0.478	(2.932)	(2.465)	0.467
(47.885)	**Gross Expenditure**	**(15.163)**	**(9.754)**	**5.409**	**(55.584)**	**(29.259)**	**26.325**
	In-year Slippage				5.534		(5.534)
(47.885)	**Net Expenditure**	**(15.163)**	**(9.754)**	**5.409**	**(50.450)**	**(29.259)**	**21.191**

Further information is provided at agenda item 3.1.

8. Statement of Financial Position and Cashflow

Net current assets as at 30 September 2017 were £42.390m, £8.158m higher than the Operational Plan. Current assets are £17.150m higher than plan and current liabilities are £8.992m higher than plan.

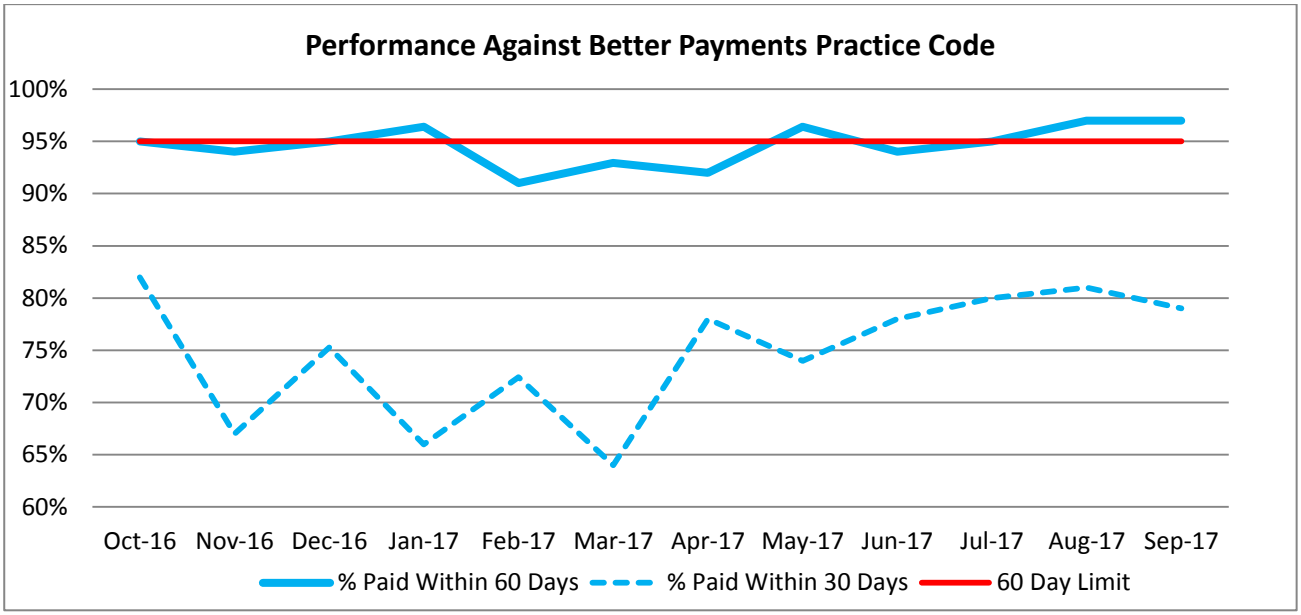
Trade and other receivables are £6.764m higher than plan reflecting the level of outstanding NHS debt. Inventories have not reduced from the opening levels of stock as has been the case in previous years.

The Trust's cash and cash equivalents balance at the end of September was £66.839m, which is £7.469m higher than the Operating Plan primarily due to slippage on capital expenditure. Forecast cash at the year end is £64.537m.

The total value of debtors was £22.271m (£12.100m SLA and £10.171m non-SLA). This represents a decrease in the month of £0.625m (SLA decrease of £2.207m and non-SLA increase of £1.582m). Debts over 60 days old have increased by £2.524m (£1.793m SLA increase and £0.731m non-SLA decrease) to £12.237m (£7.759m SLA and £4.478m non-SLA). The SLA increase primarily relates to the net movement of NHS England. The Non SLA increase primarily relates to North Bristol in relation to invoices for Sustainability and Transformation Partnership fees and the junior doctor rotation for anaesthesia.

In September, 94% of invoices were paid within the 60 day target set by the Prompt Payments Code and 79% were paid within the 30 day target set by the Better Payment 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 September 2017- Summary Income & Expenditure Statement

Approved Budget / Plan 2017/18	Heading	Position as at 30th September			Actual to 31st August
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income				
554,286	From Activities	277,113	278,958	1,845	232,113
90,729	Other Operating Income (Excluding Sustainability and Transformation funding)	46,428	46,126	(302)	37,285
645,015	**Sub totals income**	**323,541**	**325,084**	**1,543**	**269,398**
	Expenditure				
(373,194)	Staffing	(187,444)	(191,376)	(3,932)	(159,413)
(229,780)	Supplies and Services	(114,471)	(116,765)	(2,292)	(96,422)
(602,974)	**Sub totals expenditure**	**(301,915)**	**(308,141)**	**(6,226)**	**(255,835)**
(7,511)	Reserves	(4,050)	–	4,050	–
34,530	Earnings before Interest,Tax,Depreciation and Amortisation	**17,576**	**16,943**	**(633)**	**13,563**
5.35	**EBITDA Margin - %**		**5.21**		**5.03**
	Financing				
(22,792)	Depreciation & Amortisation - Owned	(11,396)	(10,960)	436	(9,128)
108	Interest Receivable	54	55	1	45
(268)	Interest Payable on Leases	(134)	(134)	–	(112)
(2,687)	Interest Payable on Loans	(1,371)	(1,371)	–	(1,150)
(9,247)	PDC Dividend	(4,624)	(4,375)	249	(3,645)
(34,886)	**Sub totals financing**	**(17,471)**	**(16,785)**	**686**	**(13,990)**
(356)	NET SURPLUS / (DEFICIT) before Technical Items excluding Sustainability and Transformation funding	**105**	**158**	**53**	**(427)**
3,994	Sustainability & Transformation funding - Performance	1,398	1,099	(299)	832
9,319	Sustainability & Transformation funding - Core	3,262	3,262	–	2,641
12,957	SURPLUS / (DEFICIT) before Technical Items including Sustainability & Transformation funding	**4,765**	**4,519**	**(246)**	**3,046**
	Technical Items				
–	Profit/(Loss) on Sale of Asset	–	(2)	(2)	(2)
–	Donations & Grants (PPE/Intangible Assets)	–	560	560	400
(1,314)	Impairments	(1,314)	–	1,314	–
–	Reversal of Impairments	–	–	–	–
(1,561)	Depreciation & Amortisation - Donated	(781)	(778)	3	(647)
10,082	SURPLUS / (DEFICIT) after Technical Items including Sustainability & Transformation funding	**2,670**	**4,299**	**1,629**	**2,797**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report September 2017- Divisional Income & Expenditure Stateament

Approved Budget / Plan 2017/18	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance 31st August	Operating Plan Trajectory Year to Date	Variance from Operating Plan Year to Date
				Pay	Non Pay	Operating Income	Income from Activities	CIP				
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income (excluding Sustainability & Transformation funding)											
35,524	Contract Income	18,115	18,115	-	-	-	-	-	-	-		
265	Penalties	265	-	-	-	-	(303)	-	(303)	(451)		
-	Contract Rewards	-		-	-	-	143	-	143	(496)		
-	Overheads	-	1,071	-	(320)	299	1,286	-	1,265	1,555		
553,382	NHSE Income	276,844	277,143	-	-	(293)	293	-	-	-		
589,171	**Sub Total Corporate Income**	**295,224**	**296,329**	**-**	**(320)**	**6**	**1,419**	**-**	**1,105**	**608**		
	Clinical Divisions											
(51,369)	Diagnostic & Therapies	(25,596)	(25,373)	417	(342)	(42)	263	(73)	223	64	84	139
(79,981)	Medicine	(40,125)	(42,003)	(1,389)	(314)	(88)	301	(388)	(1,878)	(1,765)	(217)	(1,661)
(111,603)	Specialised Services	(55,812)	(56,434)	(313)	(90)	(13)	(420)	214	(622)	(508)	171	(793)
(109,541)	Surgery	(55,014)	(56,960)	(1,516)	(690)	22	667	(429)	(1,946)	(1,645)	(95)	(1,851)
(125,485)	Women's & Children's	(62,636)	(64,096)	(1,393)	369	(20)	(403)	(13)	(1,460)	(1,260)	(11)	(1,449)
(477,979)	**Sub Total - Clinical Divisions**	**(239,183)**	**(244,866)**	**(4,194)**	**(1,067)**	**(141)**	**408**	**(689)**	**(5,683)**	**(5,114)**	**(68)**	**(5,615)**
	Corporate Services											
(36,887)	Facilities And Estates	(18,317)	(18,344)	60	(61)	4	13	(43)	(27)	(32)	(18)	(9)
(26,873)	Trust Services	(13,748)	(13,795)	216	(204)	(37)	-	(22)	(47)	(28)	(1)	(46)
(5,391)	Other	(2,352)	(2,383)	181	(295)	(45)	84	44	(31)	(65)	-	(31)
(69,151)	**Sub Totals - Corporate Services**	**(34,415)**	**(34,520)**	**457**	**(560)**	**(78)**	**97**	**(21)**	**(105)**	**(125)**	**(19)**	**(86)**
(547,130)	**Sub Total (Clinical Divisions & Corporate Services)**	**(273,598)**	**(279,386)**	**(3,737)**	**(1,627)**	**(219)**	**505**	**(710)**	**(5,788)**	**(5,239)**	**(87)**	**(5,701)**
(7,511)	Reserves	(4,050)	-	-	4,050	-	-	-	4,050	3,413		
(7,511)	**Sub Total Reserves**	**(4,050)**	**-**	**-**	**4,050**	**-**	**-**	**-**	**4,050**	**3,413**		
34,530	**Earnings before Interest,Tax,Depreciation and Amortisation**	**17,576**	**16,943**	**(3,737)**	**2,103**	**(213)**	**1,924**	**(710)**	**(633)**	**(1,218)**		
	Financing											
(22,792)	Depreciation & Amortisation - Owned	(11,396)	(10,960)	-	436	-	-	-	436	369		
108	Interest Receivable	54	55	-	1	-	-	-	1	-		
(268)	Interest Payable on Leases	(134)	(134)	-	0	-	-	-	-	-		
(2,687)	Interest Payable on Loans	(1,371)	(1,371)	-	0	-	-	-	-	-		
(9,247)	PDC Dividend	(4,624)	(4,375)	-	249	-	-	-	249	208		
(34,886)	**Sub Total Financing**	**(17,471)**	**(16,785)**	**-**	**686**	**-**	**-**	**-**	**686**	**577**		
(356)	**NET SURPLUS / (DEFICIT) before Technical Items excluding Sustainability and Transformation funding**	**105**	**158**	**(3,737)**	**2,789**	**(213)**	**1,924**	**(710)**	**53**	**(641)**		
3,994	Sustainability & Transformation funding - Performance	1,398	1,099			(299)			(299)	(299)		
9,319	Sustainability & Transformation funding - Core	3,262	3,262			-			-	-		
13,313	**Sub Total Sustainability & Transformation funding**	**4,660**	**4,361**			**(299)**			**(299)**	**(299)**		
12,957	**SURPLUS / (DEFICIT) before Technical Items including Sustainability & Transformation funding**	**4,765**	**4,519**	**(3,737)**	**2,789**	**(512)**	**1,924**	**(710)**	**(246)**	**(940)**		
	Technical Items											
-	Profit/(Loss) on Sale of Asset	-	(2)	-	(2)	-	-	-	(2)	(2)		
-	Donations & Grants (PPE/Intangible Assets)	-	560	-	-	560	-	-	560	400		
(1,314)	Impairments	(1,314)	-	-	1,314	-	-	-	1,314	-		
-	Reversal of Impairments	-	-	-	-	-	-	-	-	-		
(1,561)	Depreciation & Amortisation - Donated	(781)	(778)	-	3	-	-	-	3	3		
(2,875)	**Sub Total Technical Items**	**(2,095)**	**(220)**	**-**	**1,315**	**560**	**-**	**-**	**1,875**	**401**		
10,082	**SURPLUS / (DEFICIT) after Technical Items including Sustainability & Transformation funding**	**2,670**	**4,299**	**(3,737)**	**4,104**	**48**	**1,924**	**(710)**	**1,629**	**(539)**		

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	2.9%	3.3%	3.4%	4.5%	4.7%	3.7%						
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	3.4%	3.8%	4.4%	4.2%	3.8%	3.8%						
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	4.4%	4.0%	3.3%	3.9%	3.1%	2.9%						
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%	4.4%	4.5%	4.7%	4.6%	3.9%						

Source: HR info available after a weekend

Graph 2 **Vacancies**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Medicine	Actual	6.9%	9.4%	9.9%	10.6%	10.4%	8.6%						
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%	6.0%	7.3%	7.1%	6.5%						
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%	8.1%	8.1%	8.2%	5.2%						
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%	4.4%	4.7%	5.9%	2.5%						

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%	13.1%	12.1%	12.4%	12.4%						
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%	15.0%	15.7%	15.1%	14.8%						
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%	11.8%	12.7%	12.3%	12.5%	13.5%						
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	13.0%	12.6%	12.7%	12.9%	11.7%	11.2%						

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	215.9	228.7	243.5	167.9						
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	106.5	84.6	95.1	73.5						
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	157.9	166.8	117.7	85.6						
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	216.6	204.4	238.1	207.3						
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	696.9	684.5	694.5	534.1	-	-	-	-	-	-

Source: Finance GL (excludes NA 1:1)

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*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	25.4	29.3	30.2	24.9						
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	11.5	7.9	9.4	9.1						
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	15.1	17.9	14.1	11.8						
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	18.3	23.4	26.6	23.1						
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	70.2	78.4	80.3	68.9	-	-	-	-	-	-

Source: Finance GL (excludes NA 1:1)

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*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%	11.2%	12.0%	12.6%	9.0%						
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%	7.2%	5.9%	6.4%	5.1%						
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%	8.3%	8.9%	6.4%	4.7%						
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%	6.0%	5.7%	6.6%	5.7%						
Trust Total	Actual	5.5%	5.4%	7.8%	7.8%	7.8%	5.9%						

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	9,042	9,364	9,098	8,711						
Specialised Services	Actual	4,392	4,719	4,517	4,626	4,622	4,390						
Surgery, Head & Neck	Actual	4,481	4,616	4,414	4,472	4,471	4,329						
Women's & Children's	Actual	6,179	6,658	5,959	6,821	6,863	6,395						
Trust Total	Actual	24,123	25,535	23,932	25,283	25,054	23,825						

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	117	83	93	99	80	73						
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	11	33	29	9	11	10						
Surgery, Head & Neck	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery, Head & Neck	Actual	43 -	6	31	59	24	20						
Women's & Children's	*Target*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
Women's & Children's	Actual	9	7	27	10	5	5						
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	179.2	116.6	180.0	176.8	120.2	107.7	-	-	-	-	-	-

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	60	77	99	129						

Source: Service Improvement Team - Amy

Key Financial Metrics -Sept 2017

Appendix 4

		Diagnostic & Therapies	Medicine	Specialised Services	Surgery	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	-	(16)	(2)	(8)	(4)	-		(55)	(85)
	Actual	-	(25)	(3)	(18)	(6)	-		93	41
	Variance Fav / (Adv)	-	(9)	(1)	(10)	(2)	-	-	148	126
	Year to date									
	Budget	-	(98)	(14)	(43)	(19)	-		(307)	(481)
	Actual	-	(140)	(17)	(132)	(25)	-		(610)	(924)
	Variance Fav / (Adv)	-	(42)	(3)	(89)	(6)	-	-	(303)	(443)
Contract Income - Activity based										
	Current Month									
	Plan	3,459	4,923	5,449	7,015	9,278	333		7,797	38,254
	Actual	3,446	5,189	5,293	6,990	9,350	337		7,906	38,511
	Variance Fav / (Adv)	(13)	266	(156)	(25)	72	4	-	109	257
	Year to date									
	Plan	20,733	29,758	32,724	42,154	55,676	2,004		46,850	229,899
	Actual	20,856	30,386	31,996	42,929	55,407	2,009		47,213	230,796
	Variance Fav / (Adv)	123	628	(728)	775	(269)	5	-	363	897
					Information shows the financial performance against the planned penalties as per agenda item 5.2					
Contract Income - Rewards										
	Current Month									
	Plan	-	-	-	-	-	-	-	777	777
	Actual	-	-	-	-	-	-	-	1,416	1,416
	Variance Fav / (Adv)	-	-	-	-	-	-	-	639	639
	Year to date									
	Plan	-	-	-	-	-	-	-	4,731	4,731
	Actual	-	-	-	-	-	-	-	4,874	4,874
	Variance Fav / (Adv)	-	-	-	-	-	-	-	143	143
					Information shows the financial performance against the planned rewards as per agenda item 5.2					
Cost Improvement Programme										
	Current Month									
	Plan	115	185	103	217	168	71	45	90	994
	Actual	100	123	167	155	188	81	39	97	950
	Variance Fav / (Adv)	(15)	(62)	64	(62)	20	10	(6)	7	(44)
	Year to date									
	Plan	693	970	597	1,303	1,003	391	274	540	5,771
	Actual	619	648	809	767	1,006	366	250	584	5,049
	Variance Fav / (Adv)	(74)	(322)	212	(536)	3	(25)	(24)	44	(722)

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report September 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	Risk of failing to deliver the Trust's 2017/18 Operational Plan Control Total surplus of £12.957m due to a significant deterioration in the Divisions underlying run rate.	20 - Very High	£12m	With the support of Executive Directors and corporate staff, Clinical Divisions are required to deliver the actions detailed in "Review of 2017/18 Financial Position" paper to mitigate expenditure and bring their run rate back to their agreed Operating Plans.	PM	25 - Very High	£15m	4 - Moderate	£0m
959	Risk that Trust does not deliver the Operational Plan due to Divisions not achieving their current year savings target.	16 - Very High	£3m	The Trust has made progress in closing the unidentified savings gap of £0.6m in May to £0.04m in August. 100% delivery of these plans will be key. Delivery to date is 87% of the plan. Divisions, Corporate and transformation team are actively working to ensure delivery of savings schemes.	MS	20 - Very High	£6m	4 - Moderate	£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	20 - Very High	£15m	4 - Moderate	-
951	Risk of the loss of Sustainability & Transformation Funding (STF) due to the failure to achieve the Trust's Operational Plan Control Total from quarter 2 resulting in the loss of all STF in Q3 and Q4 of £8.7m.	20 - Very High	£13.3m	Clinical Divisions are required to deliver the actions detailed in "Review of 2017/18 Financial Position" paper to mitigate expenditure and bring their run rate back to their agreed Operating Plans.	PM	25 - Very High	£8.7m	3 - Low	£0m
50	Risk of Commissioner Income challenges	6 - Moderate	£3m	The Trust has strong controls of the SLA management arrangements.	PM	9 - High	£5m	3 - Low	£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 31 October 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	13
Meeting Title	Public Trust Board	**Meeting Date**	Tuesday, 31 October 2017
Report Title	Review of Finance Committee Terms of Reference		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Strategic Priorities (please choose 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 contains the proposed revised Terms of Reference for the Finance Committee, in line with the delegated authority from the Trust Board of Directors.

Key issues to note

The Finance Committee reviewed the terms of reference on 26 October 2017 and have recommended minor amendments.

The Terms of Reference attached at Annex (i) indicate the proposed amendments and include:

4.2 (e) Approve business cases with a value greater than 0.5% of the Trust's turnover and up to and including 1% per the Capital Investment Policy

	approved in May 2017.
5.2	The Chair shall provide a report on the activities of the Finance Committee at each Audit Committee.
8.1 (a) (x)	Use of Resources Ratings applied by NHS Improvement

Recommendations

Members are asked to:

- **Approve** the Terms of Reference

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

There are no risks associated with this report. The approval of the terms of reference ensures that the Board of Directors operates within a clear governance framework.

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 October 2017			

University Hospitals Bristol NHS
NHS Foundation Trust

Terms of Reference – Finance Committee

Document Data	
Corporate Entity	Finance Committee
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Chief Executive
Document Owner	Trust Secretary
Approval Authority	Trust Board of Directors
Document Reference	Not Applicable
Review Cycle	12 months
Next Review Date	31/10/18
Estimated Reading Time	7 Minutes

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
November 2007	N/a	Not recorded	Pre-FT	Not recorded
March 2008	N/a	Not recorded	Pre-FT	Not recorded
07 October 2008	N/a	Not recorded	FT	First Foundation Trust version
March 2009	N/a	Not recorded	Not recorded	Not recorded
22 June 2012	1.1	Trust Secretary	Redraft	To ensure congruence with the Terms of Reference of other committees of the Trust Board of Directors as revised at the beginning of 2011-2012. Endorsed by Finance Committee for approval by Trust Board of Directors with addition of footnote 4.
28 June 2012	2.0	Trust Secretary	Major Version	Approved by Trust Board of Directors.
26 September 2014	3.0	Joint Interim Head of Membership & Governance	Redraft	To ensure congruence with the Terms of Reference of other committees of the Trust Board of Directors ahead of the well led Governance Review to be undertaken in late 2014.
28 July 2016	4.0	Trust Secretary	Minor	1. Changes to job titles and quorum for the committee. 2. Change from Monitor to NHS Improvement. 3. Additional section 7.2 in relation to the quorum. 4. Change from the Trust Secretary attending from time to time, to each meeting. (6.6 (b)

13/10/2017	5.0	Trust Secretary	Minor	1. Minor typographical amendments 2. Inclusion of the reporting requirement to the Audit Committee (section 5.2)

Table of Contents

1. Constitution of the Committee

1.1 The Finance Committee (the Committee) is a non-statutory committee established by the Trust Board of Directors to discharge the duties set out in these Terms of Reference.

2. Purpose and role

2.1 The purpose of the Finance Committee is to support the Board's strategic direction and stewardship of the Trust's finances, investments and sustainability. In particular, the Committee is to provide the Board with assurance concerning all aspects of finance and operational performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients.

2.2 Additionally, the Finance Committee shall carry out the role of 'investment committee' for the purposes of the Trust's Capital Investment Policy.

3. Function

3.1 The function of the Committee is to review, maintain and monitor, on behalf of the Trust Board of Directors, strategic principles, priorities and performance parameters for:

(a) Delivery of the financial aspects of the Operational Plan

(b) The annual Trust Service and financial plans: revenue, budgets, capital, working and associated targets for savings to ensure sustainability going forward

(f) The availability of financial management information (to ensure a consistent approach to financial management);

(g) Sustainable service commissioning;

(h) Review and maintain an overview of financial and service delivery agreements and key contractual arrangements

(i) Oversee the development, management and delivery of the Trust's annual capital programme [1]

(j) Consider key financial policies e.g. investment policy, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately.

(k) To consider and recommend for approval by the Trust Board of Directors any proposed changes to Trust Standing Financial Instructions.

4. Authority

[1] The Finance Committee shall carry out the role of "investment committee" for the purposes of the Trust's Capital Investment Policy.

4.1 The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. The Committee is authorised by the Board to:

(a) Review, monitor, and where appropriate, investigate any financial matter within its terms of reference, and seek such information as it requires to facilitate this activity;

(b) Obtain whatever advice it requires, including external professional or legal advice if deemed necessary (as advised by the Trust Secretary). In so doing, it may require directors and other officers, or independent specialists to attend meetings to provide such advice.

4.2 The Committee discharges the authority delegated to the members of the Committee (when present) both in the Scheme of Delegation, and from time to time by the Chief Executive as recorded in the minutes of meetings.

4.3 Additionally, the Committee has delegated authority to:

(a.) Approve the investment and borrowing strategy and associated policies;

(b.) Set financial performance benchmarks;

(c.) Approve Project Initiation Documents (as recommended by the Trust Senior Leadership Team) for capital schemes above the de minimis amount[2];

(d.) Approve capital investments and divestments above the de minimis amount[2];

(e.) Approve business cases with a value greater than 0.50% of the Trust's turnover and including 1% as per the Capital Investment Policy approved in May 2017.

4.4 *Limitations*

(a) Unless expressly provided for in Trust Standing Orders or Standing Financial Instructions the Committee shall have no further powers or authority to exercise on behalf of the Trust Board of Directors.

5. Reporting

5.1 The Chair of the Committee shall report to the Trust Board of Directors on the activities of the Committee and shall make whatever recommendations the Committee deems appropriate (on any area within the Committee's remit where disclosure, action or improvement is considered necessary).

5.2 The Chair shall provide a report on the activities of the Finance Committee at each Audit Committee.

5.3 The Committee shall prepare a statement for inclusion in the Annual Report about its activities.

6. Membership

[2] As set out in the Trust's Standing Financial Instructions.

6.1 Members of the Committee shall be appointed by the Trust Board of Directors and shall include:

i. Four Non-executive Directors;

ii. The Chief Executive;

iii. The Director of Finance;

iv. The Chief Operating Officer[3].

6.2 The Chair of the Trust may be a member of the Finance Committee.

6.3 The Chair of the Audit Committee shall not be a member of the Finance Committee.

6.4 One of the Non-Executive members will be appointed Chair of the Committee by the Board and will not Chair any other standing Committee of the Board.

6.5 ***Attendance***

It is expected that members will or a nominated appropriate representative will attend a minimum of 75% of committee meetings a year.

6.6 In - Attendance

(a) The following officers may be required to attend meetings of the Committee at the invitation of the Chair:

(i) Deputy Director of Finance[4]

(ii) Associate Director of Finance

(iii) Head of Financial Management and Service Improvement;

(iv) Head of Contract Management and Costing;

(v) Clinical Chairs;

(vi) Divisional Directors;

(vii) Divisional Finance Managers,

(viii) Only members of the Committee have the right to attend Committee meetings. However, other individuals, including external advisors, may be invited to attend for all or part of any meeting, as and when appropriate.

(b) The Trust Secretary shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.

[3] In circumstances where the Chief Operating Officer is unable to attend a meeting, a suitable deputy shall be designated to attend. Attendance by the designated deputy shall be subject to approval by the Chair of the Finance Committee and the Chief Executive jointly. Their presence shall not contribute to the quorum.

[4] In the event that the Director of Finance is unable to attend, the Deputy Director of Finance is a required attendee. In those circumstances the presence of the Deputy Director of Finance does contribute to the quorum.

7. Quorum

7.1 The quorum necessary for the transaction of business shall be four members, including two Executive Directors (one of whom shall be the Director of Finance or nominated deputy) and two Non-executive Directors.

7.2 In the event the Chief Executive is unable to attend a duly convened meeting, then another Executive Director (other than the Director of Finance) will be nominated to attend on behalf of the Chief Executive.

7.3 A duly convened meeting of the 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 by the Committee as set out in these Terms of Reference.

8. Duties

8.1 The duties of the Committee are:

(a) To consider and examine on behalf of, and subject to review by the Trust Board of Directors:

(i) Key financial performance indicators;

(ii) Monthly/annual consolidated financial performance summaries and related budgets;

(iii) The monthly / annual statement of financial position;

(iv) Working capital performance;

(v) Cash flow status;

(vi) Capital investment programme;

(vii) Recommendations from the Capital Programme Steering Group;

(viii) Risks associated with financial plans (finance risk);

(ix) Financial relationships with the Trust's Commissioners;

(x) Financial Risk Ratings applied by NHS Improvement

(xi) Financial performance forecasts;

(xii) Financial aspects of the Board Assurance Framework document; and,

(xiii) Business cases classed as 'major' or 'high' risk; making recommendations approval or rejection to the Board, and,

(b) To:

(i) Approve the investment and borrowing strategy and associated policies;

(ii) Set financial performance benchmarks and monitor the performance of investments;

(iii) Review proposed revisions to the Capital Investment Policy for approval by the Trust Board of Directors each year;

(iv) Seek and consider evidence of organisational compliance with the Capital Investment Policy;

(v) Approve Project Initiation Documents for all capital schemes above the de minimis amount;

(vi) Approve capital investments and divestments above the de minimis amount, ensuring in each case that the Trust has the legal power to enter into the investment;

(vii) Approve business cases within its delegated authority.

9. Secretariat Services

9.1 The Finance Department Secretariat shall co-ordinate secretariat services to the Committee.

9.2 **Notice and Conduct of Meetings**

(a) Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.

(b) 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, any other person required to attend and all other non-executive directors, no later than seven working days before the date of the meeting.

(c) Supporting papers shall be made available to Committee members and to other attendees as appropriate, no later than three working days before the date of the meeting.

9.3 **Minutes of Meetings**

(a) The secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and those in attendance.

(b) Draft Minutes of Committee meetings shall be made available promptly to all members of the Committee and, once agreed, to all other members of the Board, unless a conflict of interest exists.

10. Frequency of Meetings

10.1 The Committee shall meet every month, and at such other times as the chair of the Committee shall require.

11. Review of Terms of Reference

11.1 The Committee shall, at least once a year, review its own performance, constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

University Hospitals Bristol
NHS Foundation Trust

Paper to be tabled:

Agenda item 14

Finance Committee Chair's Report

University Hospitals Bristol
NHS Foundation Trust

Paper to be tabled:

Agenda item 15

Audit Committee Chair's Report

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 31 October 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	16
Meeting Title	Trust Board	**Meeting Date**	Tuesday, 31 October 2017
Report Title	Register of Seals		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

To report applications of the Trust Seal as required by the Foundation Trust Constitution.

Key issues to note

Standing Orders for the Trust Board of Directors stipulates that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the person who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust Seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing.

The attached report includes all new applications of the Trust Seal since the previous report

on April 2017. NB. The report includes one record sealed on the 3 March 2017 as this was omitted from the previous report in error.

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 recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☒
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.	☐		

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

Impact Upon Corporate Risk
N/A

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

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

Register of Seals – May 2017 – October 2017

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
800	03/03/2017	Lease of 4a + 4b whitefriars + 4c whitefriars. Topland Mercury ltd. / UHBristol	Paul Mapson, Director of Finance	Robert Woolley, Chief Executive	Pam Wenger, Trust Secretary
801	05/09/2017	Licence to use fire escape	Paul Mapson, Director of Finance	Mark Smith, Deputy Chief Executive	Sophie Melton Bradley, Deputy Trust Secretary
802	09/10/2017	Intermediate Building contract with Dribuild Ltd.	Paul Mapson, Director of Finance	Robert Woolley, Chief Executive	Sophie Melton Bradley, Deputy Trust Secretary
803	09/10/2017	Intermediate building contract with Oakland	Paul Mapson, Director of Finance	Robert Woolley, Chief Executive	Sophie Melton Bradley, Deputy Trust Secretary
804	23/10/2017	Unit 3c Whitefriars Lewins Mead, Bristol	Mark Smith, Deputy Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary

Cover report to the Public Trust Board. Meeting to be held on 31 October 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	17
Meeting Title	Public Trust Board	**Meeting Date**	Tuesday, 31 October 2017
Report Title	Governors Log of Communication		
Author	Kate Hanlon, Membership Engagement Manager		
Executive Lead	John Savage, Chairman		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous Board.

The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust. The log is distributed to all Board members, including Non-executive Directors when new items are received and when new responses have been provided.

Recommendations

Members are asked to:

- **Note the Report.**

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

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

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

Impact Upon Corporate Risk

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**

193 **Neil Morris** ***Theme:*** Sexual orientation monitoring ***Source:*** Governor Direct

Query **19/10/2017**

Following the recent release of NHS guidance regarding the recording of the sexual orientation of patients over 16, can the Trust confirm its position on this matter and what steps it plans to take?

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:*** 03/11/2017

Response

Status: *Assigned to Executive Lead*

192 **Carole Dacombe** ***Theme:*** Clinic letters ***Source:*** From Constituency/ Members

Query **06/10/2017**

What assurance do we have that clinic letter turnaround times are being monitored to ensure that they are meeting, and continue to meet, an appropriate standard?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 17/10/2017

Response

Status: *Pending Assignment*

ID	Governor Name		
191	Rashid Joomun	***Theme:*** Staff training	***Source:*** Governor Direct

Query **28/09/2017**

I am concerned to see from the latest Quality and Performance Report that overall compliance with staff essential training is 88%. What assurance can you provide that staff are adequately trained to safely carry out their roles?

Division: Trust-wide ***Executive Lead:*** *Director of Human Resources and Organisational Development* ***Response requested:*** 12/10/2017

Response **02/10/2017**

Despite best Trust-wide efforts to continually raise Essential Training (ET) compliance, the month of August sees our overall compliance at 88% (a drop from last month's 89%).

We continually scrutinise remedies to respond to drops in compliance and not only consider staff who may have let training lapse, but also those relatively newer staff who are encountering their annual, bi-annual, and 3-yearly update requirements for the first time. Awareness of training requirements is continually re-emphasised, to all staff, at all levels. Regular reminders are provided to staff directly from the system via e-mails, and also through Newsbeat. Log-in guidance and a link to the log in page are also regularly provided.

There are various aspects to take into account when looking at August's report:

• Compliance for Dementia Awareness (DA) training (3 yearly update) has been added in this month's report, as work was required to refine the target audience for those required to undertake updates. This inclusion has resulted in lower compliance for DA in this month.

• The audience at Doctors' induction has expanded with new F1 and F2 doctors, and their compliance decreased slightly, this is a relatively small audience.

• As this is a compliance report only, bookings for future training are not part of the calculation. HR Business Partners (HRBPs) in each Division are using more detailed compliance reporting to encourage individual staff to complete their training. Bookings are noted in these reports. HRBPs also have tailored recovery plans to increase their compliance in their areas.

• All ET attendance registers that are returned to the Learning & Development Admin Team are recorded in the Portal within 24 hours. All ET attendance received and administered up to 31 August has been included in this most recent report.

• All dates for training are accessible on the Learning and Development Portal. Additional training dates are being arranged where training needs exceed supply. 2018 dates are now being published.

Status: *Closed*