University Hospitals Bristol
NHS Foundation Trust

# Public Trust Board Meeting Papers

Date: 29 November 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 Wednesday 29 November 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. | Patient Story | Information | *Chief Nurse* | **To follow** |
| 4. | Minutes of the last meeting<br>• **31 October 2017** | Approval | *Chairman* | **4** |
| 5. | Matters arising and action log | Approval | *Chairman* | **20** |
| 6. | Chief Executive's Report | Information | *Chief Executive* | **22** |
| **Care and Quality** | | | | |
| 7. | Quality and Performance Report | Assurance | *Chief Operating Officer & Deputy Chief Executive* | **28** |
| 8. | Quality and Outcomes Committee - Chair's Report | Assurance | *Quality & Outcomes Committee Chair* | **To be tabled** |
| **Financial Performance** | | | | |
| 9. | Finance Report | Assurance | *Director of Finance & Information* | **84** |
| 10. | Finance Committee Chair's Report | Assurance | *Finance Committee Chair* | **To be tabled** |
| 11. | Quarterly Update on Capital Projects | Assurance | *Chief Operating Officer & Deputy Chief Executive* | **104** |
| **Organisational and System Strategy and Transformation** | | | | |
| 12. | Sustainability Strategy – Update and Action Plan | Assurance | *Director of Strategy and Transformation* | **108** |
| **Governance** | | | | |
| 13. | Audit Committee Terms of Reference | Approval | *Trust Secretary* | **126** |
| **Items for Information** | | | | |

| NO. | AGENDA ITEM | PURPOSE | SPONSOR | PAGE NO. |
|---|---|---|---|---|
| 14. | Governors' Log of Communications | Approval | *Chairman* | **142** |
| **Concluding Business** | | | | |
| 15. | Any Other Urgent Business | Information | *Chairman* | **Verbal** |
| 16. | Date and time of next meeting<br>• **31 January 2018, 11.00 – 13.00** | | *Chairman* | **Verbal** |

University Hospitals Bristol
NHS Foundation Trust

**Cover report to the Public Trust Board meeting to be held on Wednesday, 29 November 2017, 11.00 am - 13:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 3 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Wednesday, 29 November 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. | ☒ | 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 John will share his reflections on the value of using patient stories to set a context for Trust Board meetings. He will explore the personal impact patient stories have had and how such stories have influenced the Trust Board in its approach to its role and the decisions it takes. |
| **Recommendations** |
| Members are asked to:<br>• Note the patient story |
| **Intended Audience**<br>(please select any which are relevant to this paper) |

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

| **Board Assurance Framework Risk**<br>(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**<br>(please tick any which are impacted on / relevant to this paper) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quality | ☐ | Equality | ☒ | Legal | ☐ | Workforce | ☐ |

| **Impact Upon Corporate Risk** |
|---|
| N/A |

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

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

**Minutes of the Public Trust Board Meeting**

**Held on Tuesday 31 October 2017, 11:00-13:00, Conference Room, Trust Headquarters**

**Present**

**Board Members**

| Member Name | Job Title/Position |
|---|---|
| John Savage | Chairman |
| Julian Dennis | Non-Executive Director |
| Emma Woollett | Vice Chair/Non-Executive Director |
| Steve West | Non-Executive Director (Designate) |
| Lisa Gardner | Non-Executive Director |
| Martin Sykes | Non-Executive Director |
| David Armstrong | Non-Executive Director |
| Jill Youds | Non-Executive Director |
| Robert Woolley | Chief Executive |
| Mark Callaway | Acting Medical Director |
| Carolyn Mills | Chief Nurse |
| Mark Smith | Chief Operating Officer and Deputy Chief Executive |
| Matthew Joint | Director of People |
| Paula Clarke | Director of Strategy and Transformation |
| Paul Mapson | Director of Finance and Information |
| Madhu Bhabuta | Non-executive Director (Designate) |

**In Attendance**

| Name | Job Title/Position |
|---|---|
| Joanna Lloyd-Jones | Director of Projects for the Sustainability Transformation Partnership |
| Julia Nolan | Staff Member |
| Kathy Baxter | Patient Governor |
| Flo Jordan | Staff Governor |
| Garry Williams | Patient Governor |
| Rashid Joomun | Patient Governor |
| Clive Hamilton | Foundation Trust Member |
| Tariq Khan | Member of the Public |
| Sophie Jenkins | Appointed Governor |
| Rhona Thomas | Staff Member |
| Fiona Read | Head of Communications |
| Mary Whittington | Public Governor |
| Bridget James | Bristol CCG |
| Carole Dacombe | Public Governor |
| Mary Backhouse | North Somerset CCG |
| Pam Wenger | Trust Secretary |
| Tony Watkin | Patient and Public Involvement Lead *attended for item 7* |

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|---|---|
| Ian Barrington | Divisional Director for Women's and Children's Services |
| NM | Service User *attended for item 7* |
| | |

**Minutes:**

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|---|---|
| Sara Kirby | Corporate Governance Administrator |

*The Chair opened the Meeting at 11.00*

| Minute Ref | Item Number | Action |
|---|---|---|
| **Preliminary Business** | | |
| 161/10/17 | **1. Welcome and Introductions/Apologies for Absence** | |
| | The Chairman welcomed everyone to the meeting.<br><br>Apologies for absence were noted from Non-executive Directors Guy Orpen and John Moore. | |
| 162/10/17 | **2. Declarations of Interest** | |
| | There were no declarations of interest. | |
| 163/10/17 | **3. Minutes of the last meeting** | |
| | The minutes of the meeting held on the 28 September 2017 were agreed as a true and accurate record.<br><br>**Members RESOLVED to:**<br>**Approve** the minutes of the meeting held on 28 September 2017 as a true and accurate record. | |
| 164/10/17 | **4. Patient Story** | |
| | The meeting began with a patient story, introduced by the Chief Nurse, Carolyn Mills.<br><br>In this story NM shared her experiences of taking an active role as a parent representative in the Independent Review of Children's Cardiac Services Steering Group. NM explained 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 felt her parent voice brought to the process in terms of actions. NM shared her personal reflections on what the process said about the organisation, the changes she had seen and her aspirations for how a continued parent voice could add value to the service in the future. | |

| Minute Ref | Item Number | Action |
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| | 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.<br><br>• NM started by explaining that C's cardiac condition was identified at birth and that this had not been picked up on their 20 week scan. NM was informed at another hospital that that scans were "Failing to find some major components of his heart." At 13 days old, C underwent his first surgery. This procedure was followed by 2 further surgeries at ages 4 and 6: C's most recent operation was completed in May 2017.<br><br>• NM explained that C's fourth operation in May 2017, to repair his aortic valve, was expected to take 7-8 hours. In total the operation took 12 hours due to a lot of scar tissue from previous surgeries.<br><br>• C had done a lot of work with the heart foundation and wanted to document his surgery journey. One of multiple YouTube videos of C's journey was shown to the Committee.<br><br>• During the 11 year journey, NM felt isolated as there was little social media support. This instigated NM to create the 'Heart Families South West' Facebook page to enable families to support each other through the day to day challenges of having a child with a heart condition.<br><br>Members of the Board discussed the following:-<br>• The Board were keen to hear about the support received during C's long surgery. NM explained that the extra 4 hours of surgery were tough but she had felt incredibly well supported.<br><br>• NM commended the Trust's openness and transparency on all action points following the Cardiac Review. Attendees of the Independent Review of Children's Cardiac Services Steering Group were given documentation prior to meetings, to give them the opportunity to comment. The Trust took feedback into consideration prior to closing actions, and it was clear that audits continued to ensure that the service progressed.<br><br>• NM confirmed that there were no issues with her son's care at UH Bristol. She was interviewed and questioned by the Care Quality Commission (CQC) during this time, and felt it was important for parents to give feedback and support the hospital. | |

| Minute Ref | Item Number | Action |
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| | • The Board asked about C's current progress. C had gone back to school in September 2017 full time. The emotional impact had been the hardest part, but he was very proud of his heart and received good ongoing support from the psychology team.<br><br>• The Board acknowledged the challenge of communication between clinical professionals and families with regards to the language and terminology that was used. However, NM noted that the consultants at UH Bristol had been good at communicating accessibly with her.<br><br>• The learning points that NM felt were most important were:<br>- The information given, the leaflets available and the consent process had become much more cohesive and streamlined.<br>- Processes around patient cancellations had been tightened, and parents felt reassured that their children would not be at greater risk due to cancellation.<br><br>• UH Bristol is a leading centre for research and often provided care that other centres may not. The Board queried whether this was something that parents were aware of. NM's perception was that UH Bristol was a leading centre for heart surgery for children, with amazing surgeons who gave children chances that they wouldn't have had before. NM noted the advances in clinical procedures that she had seen over the previous 11 years.<br><br>• The Chair thanked NM for sharing her experiences at UH Bristol, and expressed the extent of the value for the Board of hearing patient stories. The Board were conscious of developing processes following reviews and asked for feedback on how the Trust had gone about responding to the Eleanor Gray Report. NM informed the Board that engaging families in listening events was a really good move, and suggested that the Trust continued to capture those families who wanted to engage and be involved, to maintain patient and family participation going forward.<br><br>**Members RESOLVED to:**<br>• **Receive** the patient story. | |
| 165/10/17 | **5. Matters arising and Action Log** | |

| Minute Ref | Item Number | Action |
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| | Members received and reviewed the action log. Progress against completed actions was noted, and there were no outstanding actions to review in this meeting.<br><br>Non-executive Director Julian Dennis noted two action points from the minutes of the last meeting that had not been included on the action log. Updates were provided:-<br><br>Minute reference 151/09/17:– *"The Trust referral protocols had been re-written and GPs were asked to check that the patients that were on the lists were correct."* – There was a new protocol for sleep study pathways. The Clinical Commissioning Group had stated that they would get primary care doctors to look at the waiting lists. The Trust had proactively asked clinical staff to look at the waiting list. A high level of sickness had impaired the progress with this. This action was ongoing.<br><br>Minute reference 151/09/17: – *"A discussion was held in relation to the Australian outbreak of flu. The Chief Operating Officer and Deputy Chief Executive had asked the Emergency Planner to re-look at the flu pandemic preparedness plan."* – The Chief Operating Officer and Deputy Chief Executive advised the Board that the Emergency Resilience Plan had been reviewed, and gave assurance that I preparations were in place, in case a flu pandemic occurred. It was noted that a flu vaccine which protected against the Australian flu strain had been reported as 60-70% effective.<br><br>**Action: Trust Secretariat to ensure that these actions were reflected in the action log.**<br><br>**Members RESOLVED to:**<br>• **Note** the updates against the action log. | |
| 166/10/17 | **6. Chief Executive's Report** | |
| | Chief Executive Robert Woolley discussed 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:<br><br>• The business case for three emergency department consultants to improve the resilience of the Emergency Department had been agreed. This would increase the number of hours that a senior clinical decision maker would be available, 7 days a week (from 14 hours to 16 hours per day).<br>• The Emergency Department Safety Checklist was originally developed and tested by University Hospitals Bristol NHS Foundation Trust with | |

| Minute Ref | Item Number | Action |
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| | support from the West of England Patient Safety Collaborative and the Health Foundation. It was noted that the work led by Dr Emma Redfern had now been formally recommended by NHS Improvement that all Trusts should adopt this checklist.<br>• UH Bristol was successfully leading on the Prevention of Cerebral Palsy in Pre-term Labour (PReCePT) initiative, which was designed to reduce cerebral palsy in babies, with the use of magnesium sulphate at a cost of £1 per dose.<br>• The Board were informed that the formal programme framework for the refreshed priorities of the Sustainable Transformation Partnership (STP) would be in place in November 2017. There would be an increase in publicity around STP progress, and quarterly updates could be expected, with particular focus on how the financial pressures were being managed.<br>• In October 2017, members of primary, social and voluntary care came together to review the agenda set by the "Healthy Weston: joining up services for better care in the Weston area" proposal. There had been a great deal of support for the proposed direction of travel. UH Bristol was working with the Clinical Commissioning Group (CCG) to ensure there was appropriate oversight of this. Members noted that the Partnership Board continues to meet on a monthly basis and discussions were continuing in terms of the direction of travel which could include the possibility of a merger. It was agreed that the Council of Governors would be kept fully involved as the discussions progress and there is a clear timetable of any potential decision required.<br><br>The Board discussion highlighted the following:-<br>• The Board sought assurance that there was scope within the recruitment market to allow for the appointment of the three emergency department consultants. It was noted that consultants were actively networking on this – however, there was a limited pool of candidates. The Chief Operating Officer and Deputy Chief Executive assured the Board that, although this may take some time, there was definitely potential to recruit strong candidates.<br><br>**Members RESOLVED to:**<br>• **Receive** the Chief Executive report for information. | |
| 167/10/17 | **7. Board Assurance Framework – Q2** | |
| | Chief Executive Robert Woolley presented the Board Assurance Framework for Quarter 2. Members noted that the report was considered by the Audit Committee earlier in the week. | |

| Minute Ref | Item Number | Action |
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| | • There had been some significant changes and dynamism to strategic priorities 2 and 6 (Strategic Priority 2; *failure to develop and maintain the Trust estate* and Strategic Priority 6; *risk of being unable to deliver the 2017/18 financial plan*). As the Board were aware, the Trust was under financial pressures midway through financial year 2017/18: budgets in the divisions were significantly overspent and the trend of overspending continued. The Trust was therefore reassessing the risks attached to this to reflect the in-year revenue position.<br><br>• Robert Woolley explained that the criteria used in assessing risks was set out on page 38 which were the National Patient Safety Agency criteria for assessment. When looking at business risks the criteria applied stated that a loss of budget greater than 1% represented a catastrophic risk. He highlighted that the position was assessed at a point in time and before the month 6 financial position was available. He stated that if the assessment was completed again now, a different approach to probability would have been taken. It was therefore appropriate that the methodology that was in place was followed.<br><br>The Board discussion highlighted the following:<br><br>• Non-executive Director David Armstrong noted that he had been interviewed by the Internal Audit Team around assurance relating to the processes behind the development of the Board Assurance Framework.<br>• Strategic Priority 4 referred to an 'Innovation Strategy'. It was clarified that this should be amended to refer to a framework and not a strategy.<br>• Non-executive Director and Chair of Finance Committee Lisa Gardner highlighted that Strategic Priority 6 was discussed at the October 2017 Audit Committee meeting in some detail. The Committee had agreed that, rather than changing the measure, it was important to explain what was meant by 'Catastrophic' consequences. Members of the Audit Committee were satisfied that the actions that had been put in place were consistent with the reported financial position.<br><br>Members **RESOLVED** to:<br>• **Receive** the Board Assurance Framework report for assurance. | |
| **Care and Quality** | | |
| 168/10/17 | **8. Quality and Performance Report** | |
| | The Chief Operating Officer and Deputy Chief Executive presented the Quality and Performance Report. It was noted that: | |

| Minute Ref | Item Number | Action |
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| | • The Trust had achieved the Sustainability and Transformation Fund (STF) target of 90%, had not met the national standard of 95%. The Children's Hospital sustained good performance, and marked improvements were seen in the Bristol Royal Infirmary, with a renewed focus on patient flow and ambulatory care assessment units. Winter planning was now underway: the Emergency Care Improvement Programme (ECIP) was supporting the Trust to sustain performance during winter.<br>• The RTT national standard of 92% and recovery trajectory was not achieved in September 2017. The Board were assured that this continued to be monitored weekly. The Intensive Support Team (IST) had confidence in the new system rules: there would be a transition period of two weeks to the new system.<br>• The 62 day Cancer target of 85% was met but would probably not be sustained due to increased pressures; work was ongoing to mitigate this. The Commissioners had agreed the Trust's remedial action plan and recovery trajectory, which aimed to reach 85% in March 2018.<br>• Diagnostics experienced continued pressures on the Sleep Study and Cardiac CT departments remained high as expected. A pilot to increase the number of Cardiac CT slots by 10 per session had progressed well at the end of October 2017. LEAN processes were in place to increase productivity.<br>• As the Trust came in to winter it had seen an increase of 20-30 patients, predominantly walk in and minor injuries patients, to ED. As expected the department began to decompensate when numbers waiting in the department were 35 or more. There had been variability against the model predicted for increased winter pressures as a result of the Weston overnight emergency department closure: 15 patients had arrived in one night. There was anecdotal evidence that primary care had also been busy due to Urgent Care Centres closing, which caused increased pressures on Bristol's Emergency Departments.<br>• The Trust was looking at implementing the Rapid Assessment Triage and Treatment (RATT) checklist. This involved senior clinical review 'on the door' to aid patient flow through the Emergency Department.<br>• National care experts had been working with UH Bristol to support underdeveloped areas, by providing trusted assessors within the hospitals to reduce and eliminate delays when transferring patients in to care homes. The Continuing Healthcare Assessments (CHC) would take place in the community to shorten length of stay.<br>• The Divisions had used Clinical Utilisation Reviews (CUR) to objectively assess whether patients were receiving the right care in the right place, at the right time. Thematic, evidence based assessments were being used to identify delays and improve flow, productivity and | |

| Minute Ref | Item Number | Action |
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| | finances.<br><br>The Board discussion highlighted the following:<br>• The Chief Nurse updated the Board regarding action 5e: *'The Trust will be establishing a new complaints review panel in 2017.'* Complaints Review Panel meetings were in place. The Trust had recruited patient representatives to work with the Trust to review complaint responses to patients; three had been reviewed so far. The review process provided valuable lessons that the Trust could take away. The next review planned was with Diagnostics & Therapies in November 2017.<br>• Fractured Neck of Femur: A middle-grade Orthogeriatric consultant had successfully been recruited. Further recruitment was planned for December 2017.<br>• On workforce issues, the Director of People noted that the Trust was already managing to reduce its use of agencies, as planned.<br><br>**Members RESOLVED to:**<br>• **Receive** the Quality and Performance Report for assurance. | |
| 169/10/17 | **9. Quality and Outcomes Committee - Chair's Reports** | |
| | Members received a written report of the meeting of the Quality and Outcomes Committee of 27 October 2017.<br><br>Members also received a verbal account of the meeting from Non-executive Director and Chair of the Quality and Outcomes Committee (QoC) Julian Dennis.<br><br>Key issues raised included:<br>• The vast majority of Trust junior doctors (512 in total) had now been employed on the new contract. Implementation had been challenging but there had been positive engagement across the divisions. The Trust had agreed to fund additional clinical fellow posts where rota gaps had been identified.<br>• The Chief Operating Officer and Deputy Chief Executive was looking at a potential e-reporting system to enable the Trust to understand the use of locums 'on the ground'. The Committee had agreed that this was a positive step.<br>• The RTT trajectory had been deteriorating slowly since April 2017. It was noted that performance had worsened due to a rising demand - however there was now better understanding of RTT in terms of urgent versus elective cases. The Trust remained focused on improving RTT.<br>• It was reported that the quality objectives had been effectively rolled | |

| Minute Ref | Item Number | Action |
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| | out. Two objectives were at 'risk of slippage' (amber): to reduce the number of last minute cancelled operations, and to implement a new, more responsive, system for gathering patient feedback at point of care. The Committee had been pleased to note that the Trust seemed to be in a much stronger position against the delivery of quality objectives than in previous years.<br><br>The Board discussion highlighted the following:<br>• Members of the Board sought assurance that screening for sepsis was taking place as per the National standard. The Chief Nurse confirmed that although the Trust was in the 'red' with regards to documenting that screening had taken place, it was 100% compliant with completing screening and giving antibiotics within the 1 hour target. It was confirmed that patients were receiving the right treatment but documenting this correctly had been challenging.<br>• The Board were pleased to see progress with regards to the Fractured Neck of Femur service, and hoped to see the work done reflected in the figures in the future.<br>• The Board asked what areas specifically the Trust was targeting with regards to achieving the cancer standards. The Chief Operating Officer and Deputy Chief Executive advised that in each area consideration was being given to pathway delays specific to the service, e.g. the Thoracic Service were looking at the front end of the pathway; and colorectal were accepting of a straight to testing pathway to shorten the diagnostic timescale. Breach analysis was being looked at through the Multi-Disciplinary Team (MDT) meeting. Because departments were directly affected by breaches they were welcoming the support from executive management on this.<br>• It was noted that three falls which caused harm occurred during September 2017. Thematic review of all falls was completed on a quarterly basis. Members of the Board were assured this would be looked at in November 2017. It was suggested that the Trust could look at the effect that implementing the enhanced care observation policy had had on falls; and look at any potential negative effects. The Board agreed that this was worth looking at during a future meeting. A review would therefore be undertaken of action from the implementation of the policy (August 2017) onwards.<br>• The Senor Leadership Team confirmed that Trust policies allowed managers to impose sanctions on staff who were non-compliant with essential training; i.e. putting restrictions on annual or study leave.<br><br>**Action: Chief Nurse to provide a report to the Quality and Outcomes Committee on the impact of implementing the enhanced care observation policy at a future meeting.** | |

| Minute Ref | Item Number | Action |
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| | **Members RESOLVED to**:<br>• **Receive** the Quality and Outcomes Committee Chair's Report for assurance. | |
| 170/10/17 | **10. Independent Review of Children's Cardiac Services – Final Report** | |
| | Chief Nurse Carolyn Mills presented the Independent Review of Children's Cardiac Services Final Report. It was noted that:<br><br>• Ian Barrington, Divisional Director for the Women's and Children's Division, had been working closely with Chief Nurse Carolyn Mills, to lead on work streams.<br>• There had been a great amount of contribution from people behind the scenes, including patient representatives, with a good ethos and spirit of wanting to better the services provided, rather than only focusing on completing the actions.<br>• It was clear from the patient story heard at the beginning of the meeting that actions were being revisited to ensure the best care and service development were delivered. On occasions, time scales were not met, but this was with good reason as it had ensured a rigorous sign-off process prior to closing actions.<br>• An Internal Audit had been commissioned for 2017/18 in to 2018/19 to ensure that the actions had been completed and sustained.<br>• Over the past thirteen months, update reports had been brought directly to meetings of the Trust Board for transparency.<br>• A parent and carer reference group was in place to involve patients and families, and provide assurance that the Trust was hearing their views.<br><br>The Board discussion highlighted the following:<br>• The Chair expressed thanks for the work carried out by the Steering Group to implement the recommendations of the review.<br>• Members commended the report from a patient's perspective. It was noted that it is easy to write a report forgetting that the community is a big stakeholder. The Trust provided a report that that patients could understand.<br>• The Trust hoped to maintain the importance of the patient reference group for years to come.<br>• It was suggested that the Quality and Outcomes Committee meeting receive an annual review of what has been learnt from year to year. It was agreed that this would be reported at a future meeting to look at learning across the organisation as a whole.<br>• Ian Barrington, Divisional Director for Women's and Children's. was confident that the review had led to improvements to the Cardiac | |

| Minute Ref | Item Number | Action |
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| | Clinical service and that there was still room to continue to improve. The Board were assured that this would be revisited to ensure that the division were doing what they stated they would do. As a tertiary service, success was dependent on all constituent parts across the patch where outpatient appointments are held. The biggest challenge was networking. The Trust was in a much better and more informed position. Engagement had been seen from all the constituent parts, and better working relationships had been formed.<br>• The Chief Executive commended Chief Nurse Carolyn Mills's leadership and the division's hard work in this area.<br><br>**Action: Quality and Outcomes Committee to receive an annual review of Trust-wide learning.**<br><br>**Members RESOLVED to:**<br>• **Receive** the Final Report of the Independent Review of Children's Cardiac services for assurance and to;<br><br>• **Approve** formal closure of the improvement action plan 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. | |
| **Research and Innovation** | | |
| 171/10/17 | **11. Research and Innovation Quarterly Report** | |
| | Acting Medical Director Mark Callaway presented the Research and Innovation Quarterly report. It was noted that:<br><br>• Performance in recruiting patients to time and target for contract commercial research continued to improve for each quarter. There had also been an improvement in opening research and recruiting the first patient since the last quarter.<br>• The Trust was above the trajectory projected at the start of the financial year for weighted patient recruitment for 2017/18. There had been a decrease in primary care trials in the Clinical Trials Network. Therefore, the performance of the clinical research network region as a whole had declined. This in turn presented a financial risk to the Trust for 2019/20.<br>• The Trust was prioritising resources to open high recruiting studies where appropriate to contribute to Clinical Research Network (CRN) West of England recruitment activity with the aim of protecting delivery funding for 2019/20.<br>• National scaling-up funding had been awarded to roll out an | |

| Minute Ref | Item Number | Action |
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| | intervention to prevent cerebral palsy in pre-term babies, following the research led by St. Michael's Hospital.<br><br>The Board discussion highlighted the following:<br><br>• Non-executive Director David Armstrong stressed the importance of the research and innovation agenda. Members of the Board agreed that further emphasis should be given to this going forward.<br><br>**Members RESOLVED to:**<br>• **Receive** the Research and Innovation Quarterly Report for assurance. | |
| **Financial Performance** | | |
| 172/10/17 | **12. Finance Report** | |
| | The Director of Finance and Information, Paul Mapson, presented the Finance Report to the Board. It was noted that:<br><br>• The Trust had had a difficult year to month 5 with a £1million per month overspend. This had dropped by half in September 2017, which enabled the Trust to hit its quarter 2 target, and maintain the current position in September 2017.<br>• A significant amount of work was ongoing with regards to nursing pay. The Nursing Controls work stream had produced an action plan to address the continued overspend. It was encouraging to see a reduction in the use of agency staffing in month 6.<br>• Medical pay had not improved; mainly due to additional payments for medical cover. This would now be analysed in the same way as nursing pay to find a way to mitigate the overspend.<br>• September 2017 activity had increased as expected due to an increase in emergency income. Pressures were growing which gave some concern for winter, and the impact of emergencies on elective cases.<br><br>**Members RESOLVED to:**<br>• **Receive** the Finance Report for assurance. | |
| 173/10/17 | **13. Finance Committee Chair's Report** | |
| | Members received a written report of the meeting of the Finance Committee of 26 October 2017.<br><br>Members also received a verbal account of the meeting from Lisa Gardner, Non-executive Director and Chair of the Finance Committee.<br><br>Key issues raised included: | |

| Minute Ref | Item Number | Action |
|---|---|---|
| | • The Trust remained focused on the operational plan and whether the end of year forecast would be met. Trends were being monitored. Not meeting the forecast would mean the Trust would not receive its Sustainability and Transformation Funding for the period.<br>• The committee received assurance from the Executive Team that the current position with regards to medical pay across the Trust was being addressed. Medical pay would undergo the same analysis as nursing pay had done previously. A progress report would be received by the Finance Committee in January 2018.<br>• The Committee received an update on progress towards delivering the Trust's Cost Improvement Target. Assurance was received that the actions that had been taken by the Executive Team to improve the Trust's financial position would enable the forecast outturn to be met.<br>• There had been some challenges in procurement, particularly with medical equipment, due to capacity issues. However, plans were in place to prioritise the key items going forward.<br><br>**Members RESOLVED to**:<br>• **Receive** the Finance Committee Chair's Report for assurance. | |
| 174/10/17 | **14. Review of Finance Committee Terms of Reference** | |
| | The Trust Secretary presented the Review of the Finance Committee Terms of Reference to the Board.<br><br>The proposed amendments were as follows:-<br><br>• 4.2 (e) to be changed to '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.'<br>• 5.2 to include 'The Chair shall provide a report on the activities of the Finance Committee at each Audit Committee'.<br>• 8.1 (a) to be changed to include 'Use of Resources Ratings applied by NHS Improvement'<br><br>The Board discussion highlighted the following:<br><br>• Members noted that 4.2 (e) should be corrected to 'half a % of trust turnover up to and including 1%'<br><br>**Members RESOLVED to:**<br>• **Approve** the reviewed Finance Committee Terms of Reference. | |
| **Governance** | | |
| 175/10/17 | **15. Audit Committee Chair's Report** | |

| Minute Ref | Item Number | Action |
|---|---|---|
| | The Board received a copy of the Audit Committee Chair's report, from the meeting held on 30 October 2017 to the Board. It was noted that:<br><br>• Non-executive Director David Armstrong attended the Committee meeting and noted that the rigor and comprehensiveness of the Audit Committee was impressive.<br>• The Committee were assured of the actions taken and robustness of the scrutiny undertaken by the Divisional Management Team with regards to procurement.<br>• An excellent report was received on clinical audit for the year 2016/17. It was noted that a detailed discussion of the content would take place at the November 2017 meeting of the Quality and Outcomes Committee (QoC).<br>• Members reviewed the Board Assurance Framework. It was noted that there had been changes in relation to the level of assurances for Strategic Priority 2; *failure to develop and maintain the Trust estate* and Strategic Priority 6; *risk of being unable to deliver the 2017/18 financial plan.* Both of these changes had been discussed in detail at the Risk Management Group and Senior Leadership Team given the change in risk rating. Members received assurance that the actions that had been put in place were consistent with the reported financial position whilst noting the delivery of the Trust's financial plan for the year remains high risk.<br>• The Committee discussed that the Terms of Reference for Audit Committee could be tighter and clearer with regards to the relationship between QoC and Finance Committee and between QoC and Audit Committee.<br><br>**Members RESOLVED to:**<br>• **Receive** the Audit Committee Chair's Report of 30 October 2017 for assurance. | |
| 176/10/17 | **16. Register of Seals** | |
| | The Trust Secretary presented the Register of Seals to the Board for the period of May 2017 to October 2017.<br><br>• The Trust Secretary noted that the report included one record sealed outside the period, on the 3 March 2017, as this had been omitted from the previous report in error.<br><br>**Members RESOLVED to:**<br>• **Receive** the Register of Seals for assurance. | |
| **Items for Information** | | |
| 177/10/17 | **17. Governors' Log of Communications** | |

| Minute Ref | Item Number | Action |
|---|---|---|
| | The report provided the Board with an update on governors' questions and responses from Executive Directors.<br><br>**Members RESOLVED to:**<br>• **Note** the Governors' Log of Communications. | |
| **Concluding Business** | | |
| 178/10/17 | **18. Any Other Urgent Business** | |
| | There was no other business to be discussed. | |
| 179/10/17 | **19. Date and time of Next Meeting** | |
| | • 29 November 2017, 11.00 – 13.00, Conference Room, Trust **Headquarters** | |

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

University Hospitals Bristol
NHS Foundation Trust

**Public Trust Board of Directors meeting**
**29 November 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**<br>Chief Nurse to investigate whether the report could be amended to include an executive summary in future. | Chief Nurse | December 2017 | **Work in Progress**<br>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** |
| **1.** | 165/10/17 | Australian Flu Vaccine<br>Chief Operating Officer to request the Emergency Planner to re-look at the Emergency Resilience Plan to provide assurance to the board that preparations are in place. | Chief Operating Officer | October 2017 | **Complete**<br>The Board were assured at the October meeting that preparations were in place in case a flu pandemic occurred. |
| **2.** | 169/10/17 | Quality and Outcomes Committee - Chair's Report<br>Chief Nurse to provide a report to the Quality and Outcomes Committee on the impact of implementing the enhanced care observation policy at a future meeting. | Chief Nurse | December 2017 | **Complete**<br>This action has been added to the Quality and Outcomes committee business cycle as part of the Monthly Nurse Safe Staffing Report. |

**Cover report to the Public Trust Board. Meeting to be held on 29 November 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Wednesday, 29 November 2017 |
| **Report Title** | Chief Executive Report | | |
| **Author** | Robert Woolley, Chief Executive | | |
| **Executive Lead** | Robert Woolley, Chief Executive | | |
| **Freedom of Information Status** | | Open | |

| **Strategic Priorities**<br>**(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**<br>**(please select any which are relevant to this paper)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| For Decision | ☐ | For Assurance | ☐ | For Approval | ☐ | For Information | ☒ |

**Executive Summary**

Purpose

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

Key issues to note

The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in November 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.<br><br>Members are asked to:<br>• **Note** the report. |

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

| **Board Assurance Framework Risk**<br>**(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**<br>**(please tick any which are impacted on / relevant to this paper)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quality | ☐ | Equality | ☐ | Legal | ☐ | Workforce | ☐ |

| **Impact Upon Corporate Risk** |
|---|
| N/A |

| **Resource Implications**<br>**(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)** |
| **Insert Date** | **Insert Date** | **Insert Date** | **Insert Date** | **[Insert committee** |

| | | | | |
|---|---|---|---|---|
| | | | | **name and date]** |

# SENIOR LEADERSHIP TEAM

# REPORT TO TRUST BOARD – NOVEMBER 2017

## 1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in November 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, including the Operating Plan recovery and Divisional feedback in response to the Chief Executive's letter around financial recovery.

## 3. STRATEGY AND BUSINESS PLANNING

The group **noted** the five year Strategic Capital Investment Programme, which had been approved by the Finance Committee and Trust Board.

The group **noted** updates on the Adult Winter Plan, Escalation Plan and **received** the Bristol Royal Hospital for Children's Winter Plan.

The group **approved** a draft appendix to the job planning guidance for the allocation of additional SPAs going forward.

The group **received** options for amending the consultant acting down payments and **agreed** a preferred option, noting the need to proceed in a cautious way, accepting it would be several months before any implementation.

## 4. RISK, FINANCE AND GOVERNANCE

The group **approved** revised terms of reference for the Capital Programme Steering Group.

The group **noted** the Sustainable Development Strategy for onward submission to the Trust Board.

The group **received** two satisfactory Internal Audit Reports in relation to Data Quality and Procurement.

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

The group **noted** an update on the Referral to Treatment Times business rules.

The group **noted** an update on the Acute Assessment Unit Pilot on the Acute Medical Unit.

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**
**November 2017**

**Cover report to the Trust Board Meeting to be held on 29 November 2017, 11:00 – 13:00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 7 |
| **Meeting Title** | Quality and Outcomes Committee | **Meeting Date** | Wednesday, 29 November 2017 |
| **Report Title** | Quality and Performance Report | | |
| **Author** | James Rabbitts, Head of Performance Reporting<br>Anne Reader, Head of Quality (Patient Safety)<br>Alex Nestor, Interim Director of Workforce & Organisational Development | | |
| **Executive Lead** | Overview and Access – Mark Smith, Deputy Chief Executive and Chief Operating Officer<br>Quality – Carolyn Mills, Chief Nurse<br>Workforce – Alex Nestor, Interim Director of Workforce & Organisational Development | | |
| **Freedom of Information Status** | | Closed | |

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

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

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

| Recommendations |
|---|
| Members are asked to:<br>• **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 |
|---|
| |

| 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)** |
| | | | | |

NHS
University Hospitals Bristol
NHS Foundation Trust

# Quality & Performance Report

## November 2017

## Executive Summary

**Single Oversight Framework**

None of the four national standards were met for the latest month. Although recovery trajectories are being achieved in three of the areas.

- The 62 Day Cancer standard for GP referrals achieved 80.2% for September (national target 85%) and Quarter 2 currently at 80.1%. Commissioners have agreed the Trust's remedial action plan and recovery trajectory which aims to reach 85% in March 2018. The recovery trajectory quoted 80% for September, which was achieved.
- 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 October but not the national 95% standard. This is the fourth successive month above 90%. 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. Some risk remains around sustaining this performance based on a recent pattern of increase in minors.
- 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 October. Total numbers waiting and numbers waiting over 18 weeks remain above last year's levels. 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. However, the Trust is currently achieving on the plan to have zero patients waiting 52+ weeks by end of December 2017.
- The percentage of Diagnostic patients waiting under 6 weeks at end of October did not achieve the national 99% standard. The current recovery trajectory (of having fewer than 205 patients waiting 6+ weeks) was achieved. The recovery trajectory is in the process of being reviewed, in light of recovery plans being developed to improve the position in Sleep Studies, Cardiac Computed Tomography (CT) Scans and Paediatric Magnetic Resonance Imaging (MRI) scans.

**Headline Indicators**

Performance against Clostridium difficile Cases, Omitted Doses 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 and October, after both measures were not achieved in August. In October, falls per 1,000 beddays returned to a level below the red threshold of 5.0 following a small deterioration in September.

Last Minute Cancelled (LMC) Operations remain slightly above the required threshold of 0.8% of admissions, with 68 such cancellations in October. However the 28 day readmission standard of 95% was achieved in October for a fifth month.

In relation to Flow metrics, the level of patients outlying also remains below planned levels. However, the total number of Green to Go (delayed discharge) patients in hospital remains over double the jointly agreed planning assumption of 30 patients.

In the Workforce measures, percentage Agency Usage achieved the 1.0% target in October. However the other key measures remain Red or Amber rated this month. Sickness levels rose slightly to 4% and Vacancy levels remained at 5.1% in October. Bank Usage fell slightly to 5.7% in October.

# 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 | 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

**A&E 4 Hours**

The national standard is for 95% of A&E patients to be discharged or admitted within 4 hours of arrival. This standard was not achieved in October but the Sustainability & Transformation Funds (STF) trajectory of 90% was achieved, for the fourth successive month.

**Cancer 62 Day**

The national standard is for 85% of cancer patients to begin first treatment within 62 days of urgent referral from GP. This standard was not achieved in September and also the STF trajectory of 83.6% was not achieved. However the Trust's recovery trajectory of 80% was achieved.

**Referral To Treatment (RTT)**

The national standard is to have 92% of patients on a Referral to Treatment (RTT) Pathway waiting under 18 weeks at month-end. This standard was not achieved in October. The STF trajectory is also at 92% so was not achieved.

**Diagnostic 6 Week Wait**

The national standard is to have 99% of patients waiting for one of 15 "key diagnostic tests" to be waiting under 6 weeks at month-end. This standard was not achieved in October. The STF trajectory is also at 99% so was not achieved. The Trust's recovery trajectory was to have fewer than 205 patients waiting over 6 weeks, which was achieved with 160 patients waiting 6+ weeks.

| Access Key Performance Indicator | | Quarter 1 2017/18 | | | Quarter 2 2017/18 | | | Quarter 3 2017/18 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | | |
| **A&E 4-hours** | Actual | 82.3% | 84.2% | 87.9% | 90.5% | 91.3% | 90.8% | 90.1% | | |
| | STF trajectory | 82.5% | 83.5% | 85.0% | 90.0% | 90.0% | 90.0% | 90.0% | | |
| **62-day GP cancer** | Actual | 76.5% | 77.8% | 81.7% | 74.7% | 85.2% | 80.2% | | | |
| | STF trajectory | 81.0% | 81.0% | 81.0% | 83.6% | 83.6% | 83.6% | | | |
| **Referral to Treatment Time (RTT)** | Actual | 91.1% | 91.1% | 91.0% | 90.2% | 89.9% | 89.4% | 90.0% | | |
| | STF trajectory* | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | | |
| **6-week wait diagnostic** | Actual | 98.6% | 98.8% | 98.6% | 98.5% | 97.6% | 97.7% | 98.2% | | |
| | STF trajectory* | 99.0% | 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:

AMBER to RED:
Dissatisfied Complaints

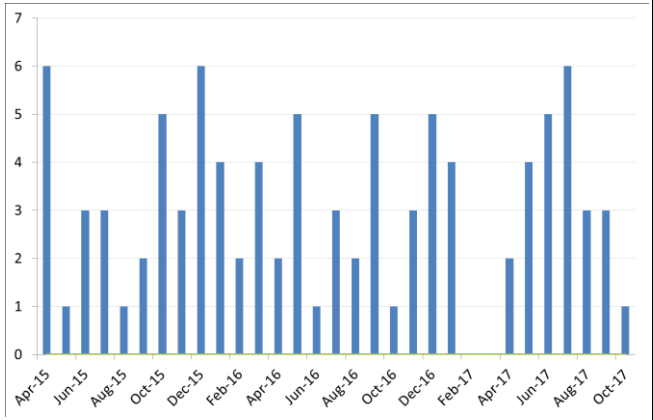
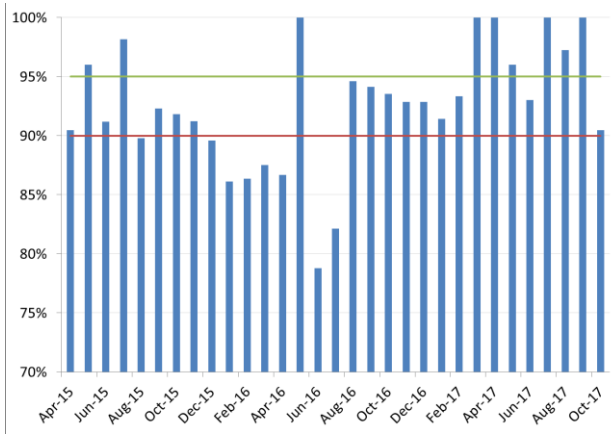
RED to GREEN:
Agency Use
Length of Stay

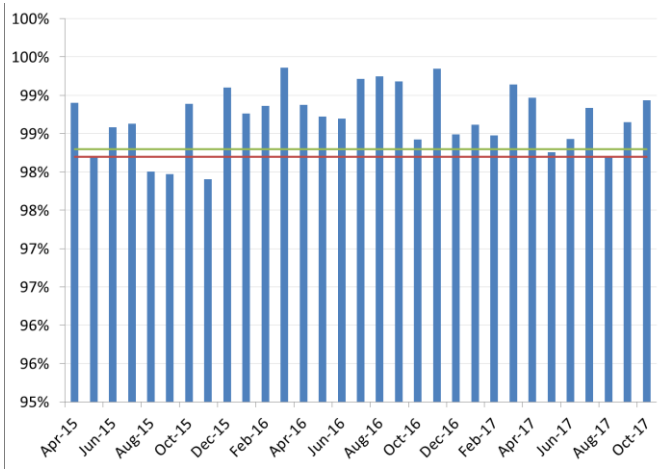
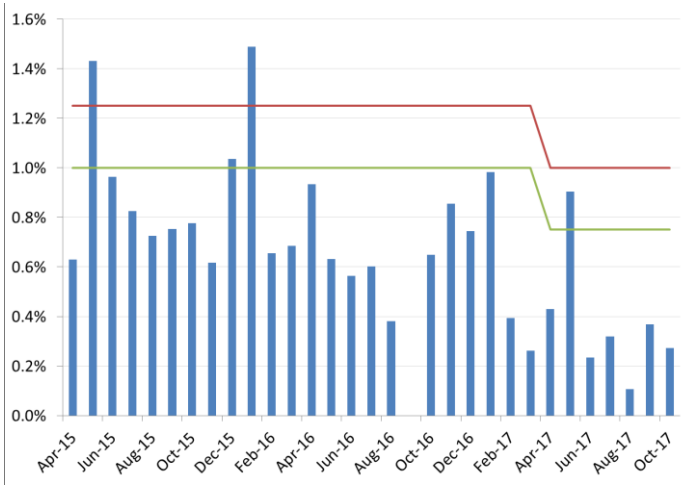
## Overview

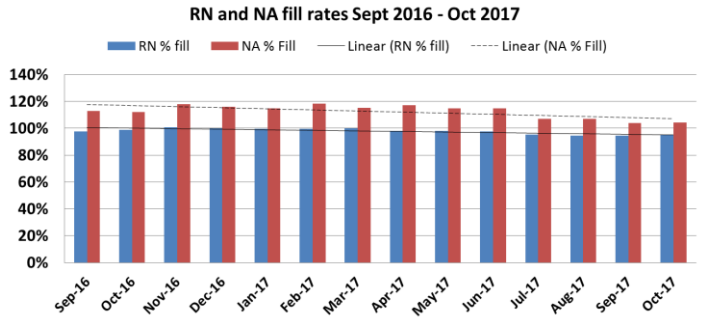
The following summarises the key successes in October 2017, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards.

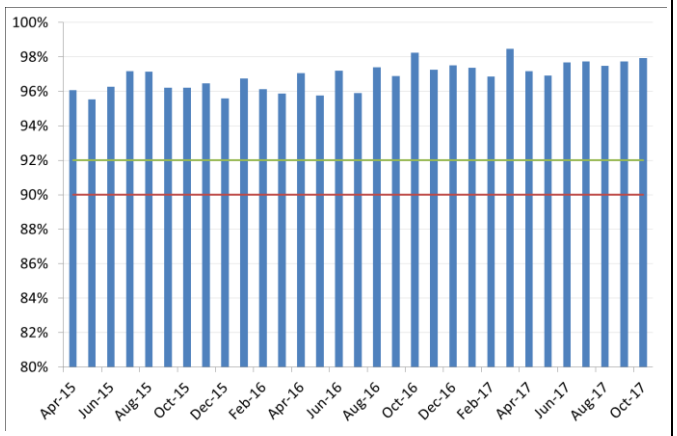
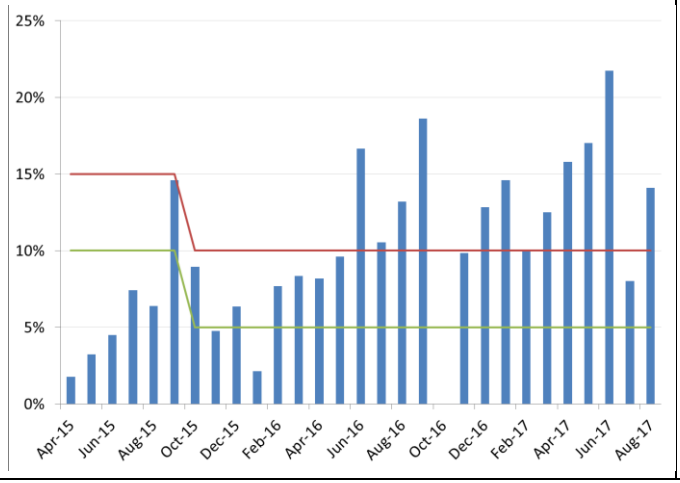
| Successes | Priorities |
|---|---|
| • Free staff access to new "Get U Better" back pain App via Physio Direct<br>• Significant reduction in high cost, non-framework agency use in the last month with ongoing tight controls to cut agency spend<br>• In October 2017, 0.27% of patients reviewed (2 out of 732) had one or more omitted critical medications in the past three days.<br>• Successful roll-out of upgrade to Medway Patient Administration System (PAS) has resulted in the implementation of improved Referral to Treatment (RTT) functionality.<br>• Referral to Treatment new Business Rules and Data Quality reports have been written and have been signed off by Intensive Support Team. Go-Live commences on 17th November 2017<br>• New functionality in Medway 4.8 allows better management of on-hold status flags by removing the previous on hold status flag when the next activity has been undertaken.<br>• National standard of 85% for Cancer 62 Day GP Referrals was achieved in August and recovery Trajectory for 62 day GP performance met for quarter 2 and for each month. All other cancer standards achieved national standard for the quarter<br>• Impact of Musculoskeletal (MSK) ultrasound activity from the Musculoskeletal Assessment and Treatment Service (MATS) has been mitigated in October. Follow up meeting with commissioners planned in November, where we will be able to report that referrals have now reduced and this is no longer a pressure area. | • Achievement of 2017-18 CQUIN target concerning the flu programme to achieve 70% front line staff vaccinations.<br>• Restore achievement of the 92% national standard as soon as possible (new trajectory figures for Divisions to be agreed at switch on of RTT4 new business rules).<br>• Focus on clearing of long waiters breaches and clearing in the backlog, particularly in Pediatric Services and Dentistry services<br>• Roll-out of Chronological bookings report to Divisions to focus on better management when dating patients<br>• Develop a strategy for revisiting and cleaning the legacy on-hold status flags within Medway – commence in January 2018<br>• 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.<br>• Minimise surgical cancellations of cancer patients and take actions to recover quickly when cancellations occur<br>• Implementation of revised Diagnostics 6 week trajectory for commissioner's Activity and Performance Sub Group: recovery of performance against the 6-week diagnostic waiting times standard by the end of December |

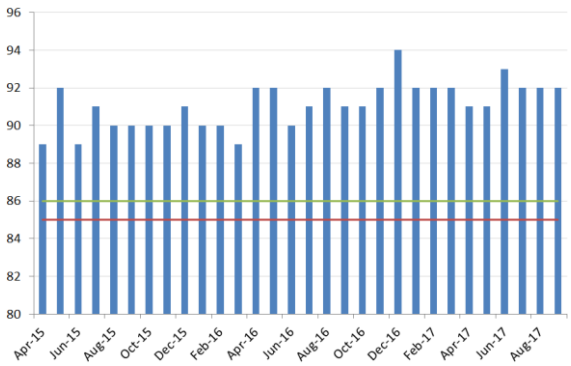
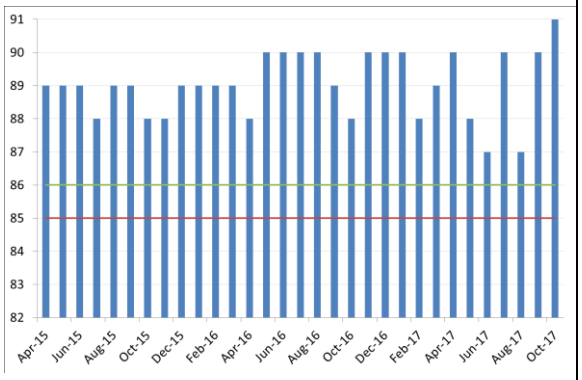
| Opportunities | Risks & Threats |
|---|---|
| • Joined Neutral Vendor contract (agreed across Bristol, North Somerset and South Gloucestershire region) which introduces tighter controls to reduce agency spend will go live 6th November 2017 across the NHS organisations in this region.<br>• System C (our Patient Administration System supplier) has made us aware of additional Medway functionality, including something that could be used to limit the risk of patients not being added to the waiting list following a decision to list at outpatients (which otherwise can result in patients' procedures being delayed and patients waiting over 52 weeks).<br>• Avoiding cancellation is the single most important high impact action for the Trust to improve and sustain performance against the cancer standards.<br>• Recovery plan being developed for Sleep Studies to support delivery of Diagnostic 6 Week Wait | • Understand and manage the impact of going live with the Neutral vendor model, from the 6th November.<br>• In October 2017 there were two reported Never Events. One was a retained foreign object post cardiac procedure and one wrong site surgery involving the extraction of the wrong tooth. Both incidents have resulted in serious incidents being undertaken, whose purpose will be to minimise the chances of a reoccurrence of similar events.<br>• In October 2017 the reported performance figure for inpatients meeting criteria screened for Sepsis was 16.7%. This is a significant deterioration on September figure of 50%.<br>• Although bank hours have been used to supporting clearing focus on patients with an On Hold status, the numbers of patients with an on-hold status continue to increase.<br>• There is likely to be a performance gap of 2% between the current Referral To Treatment (RTT) reporting and the real-time reporting that is currently under development<br>• Late referrals from other providers continue to impact on achievement of the 62-day GP cancer waiting times standard<br>• Surgical cancellations are a high risk to achievement of several cancer standards as well as to patient experience and quality<br>• Positron Emission Tomography (PET) scanning delays are a new risk for Cancer standards delivery in quarters 3 and 4, following a nationally determined provider change.<br>• The number of over 6-week waiters for Cardiac 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)<br>• Emerging risk in adult Magnetic Resonance Imagining (MRI) due to the upgrade of an MRI scanner; due to be completed mid December. Non-complex work has been outsourced and additional weekend lists are being run, however the demand for complex work is predicted to outstrip capacity. Mitigation plans being put in place. |

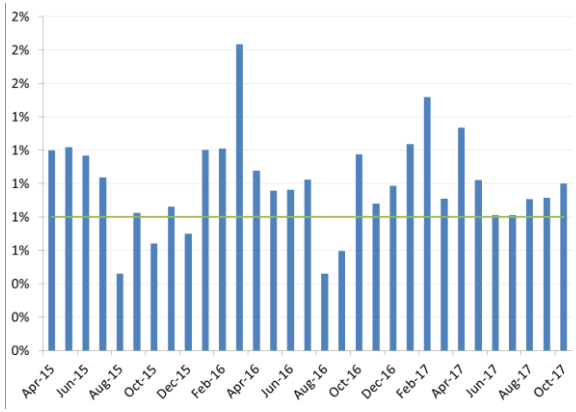
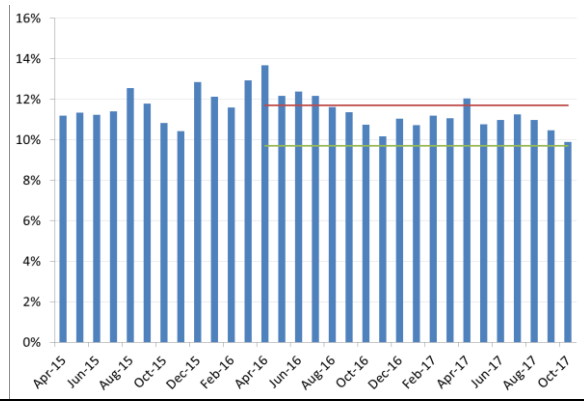
| Description | Current Performance | Trend | Comments |
|---|---|---|---|
| **Infection control**<br>The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16). | Performance in Trust acquired Clostridium *difficile* (C. diff) is good with low numbers of cases in relation to the limits set.<br>There was one case of C. diff attributed to the Trust in October 2017. However, this case is awaiting review by the commissioners to determine avoidability.<br>To date, this year, we have three hospital apportioned avoidable cases of clostridium difficile however there are further cases awaiting a decision by Bristol Clinical Commissioning Group. | **Total number of C. diff cases**<br>  | 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 wards. |
| **Deteriorating patient**<br>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 October 2017 was 90% (two breaches) against a three-year improvement goal of 95%. This is deterioration from September's position of 100 %.<br>Both breaches occurred within the Division of Medicine.<br>One breach was due to a patient who required escalation for clinical review but there was no documentary evidence of communication with or review by the medical team.<br>One breach was due to a patient who had a NEWS score of three in one parameter, but there was no documentation by the registered nurse or referral to the medical team. | **Percentage of early warning scores acted upon**<br>  | 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.<br>Details of the actions being taken are described in the actions section (Actions 1A to 1G). |

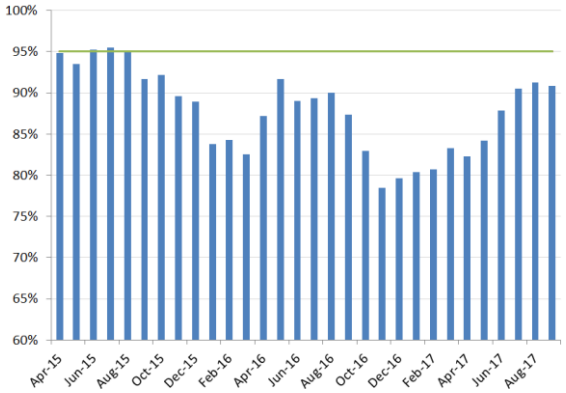
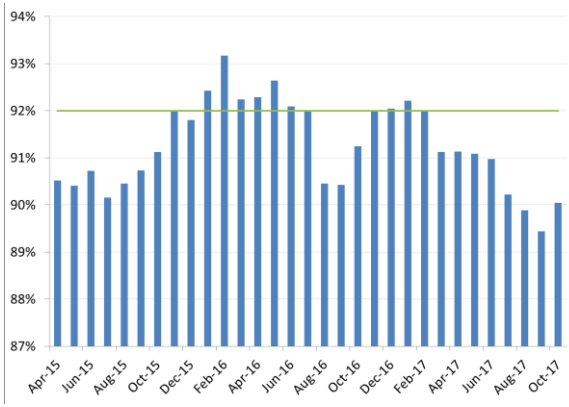
| Description | Current Performance | Trend | Comments |
|---|---|---|---|
| **Safety Thermometer – No new harm.** The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital. | In October 2017, the percentage of patients with no new harms was 98.9% (8 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 September' 2017 figure of 98.7% (10 patients had new harms) | **The percentage of patients surveyed showing No New Harm each month**<br>  | The October 2017 Safety Thermometer point prevalence audit showed two new catheter associated urinary tract infections, one fall with harm, two new pressure ulcers 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 October 2017, 0.27% of patients reviewed (2 out of 732) had one or more omitted critical medications in the past three days. The target for omitted doses is no more than 0.75%. The 0.27% for October 2017 is a slight improvement from the September 2017 figure of 0.37% (3 out of 816). | **Percentage of omitted doses of listed critical medicines**<br>  | The target for omitted doses in 2017/2018 has been revised and is now set at 0.75% (previous target was 1%).<br><br>Actions being taken are described in the actions section (Actions 2A and 2B). |

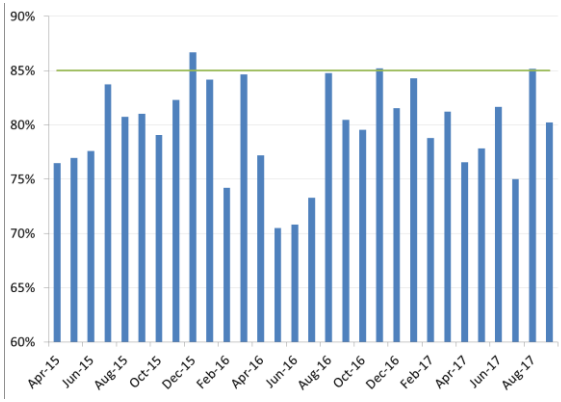
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Overall compliance is 89% (excluding Child Protection Level 3). Compliance with each of the reporting categories is provided below.
<table>
<tr><th>October 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>86%</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>83%</td></tr>
<tr><td>Safeguarding</td><td>87%</td></tr>
</table>
</td>
<td>Overall the compliance for the Trust has not changed from last month.</td>
<td>See Actions in 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 October 2017 the Trust had rostered 238,152 expected nursing hours, with the number of actual hours worked of 232,287. This gave a fill rate of 97.5%.
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>67,141</td><td>62,478</td><td>+4663</td></tr>
<tr><td>Specialised Services</td><td>41,359</td><td>40,983</td><td>+376</td></tr>
<tr><td>Surgery</td><td>43,578</td><td>44,632</td><td>-1054</td></tr>
<tr><td>Women’s & Children’s</td><td>80,209</td><td>90,059</td><td>-9850</td></tr>
<tr><td>Trust</td><td>232,287</td><td>238,152</td><td>-5865</td></tr>
</table>
</td>
<td>The percentage overall staffing fill rate by month<br> 
</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.</td>
</tr>
</table>

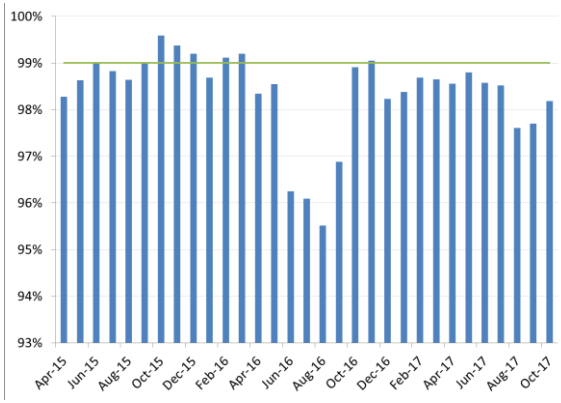
| Description | Current Performance | Trend | Comments |
|---|---|---|---|
| **Friends & Family Test inpatient score** is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level. | Performance for October 2017 was 97.9%. This metric combines Friends & Family Test scores from inpatient and day-case areas of the Trust, for both adult and paediatric services.<br><br>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**<br>  | 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.<br><br>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 August 2017.<br><br>As of 15th November 2017, 8 of the 71 responses sent out in August had resulted in dissatisfied replies (11.3% against a target of 5%). | **Percentage of compliantaints dissatisfied with the complaint response each month**<br>  | 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. Informal Benchmarking with other NHS Trusts suggests that the rates of dissatisfied complainants are typically in the range of 8% to 12%.<br><br>Actions continue as previously reported to the Board (Actions 5A to 5E). |

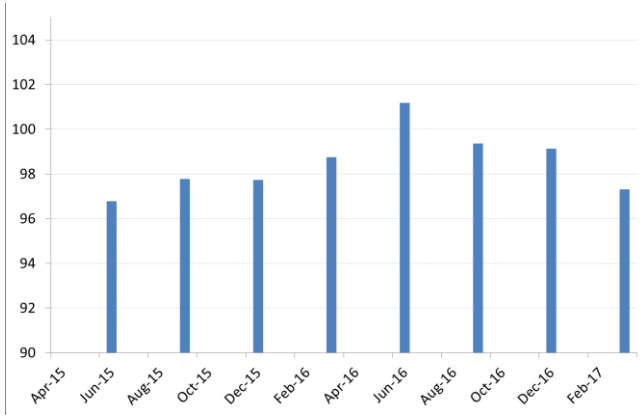
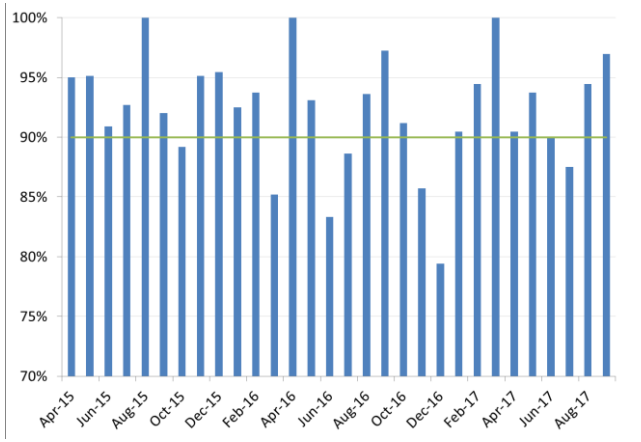
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as “key drivers” of patient satisfaction via analysis and focus groups.</td>
<td>For the month of October 2017, the score was 91 out of a possible score of 100. Divisional level scores are provided on a quarterly basis to ensure sample sizes are sufficiently reliable.
<table>
<tr><th></th><th>Q2 2017/18</th><th>Q3 2017/18</th></tr>
<tr><td>Trust</td><td>92</td><td>91</td></tr>
<tr><td>Medicine</td><td>89</td><td>87</td></tr>
<tr><td>Surgery</td><td>91</td><td>94</td></tr>
<tr><td>Specialised Services</td><td>92</td><td>91</td></tr>
<tr><td>Women's & Children's (Bristol Royal Hospital for Children)</td><td>94</td><td>92</td></tr>
<tr><td>Women's & Children's Division (Postnatal wards)</td><td>94</td><td>92</td></tr>
</table>
</td>
<td>Inpatient patient experience scores (maximum score 100) each month<br> 
</td>
<td>UH Bristol performs in line with national norms in terms of patient-reported experience. This metric would turn red if patient experience at the Trust began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the score remains green. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report.</td>
</tr>
<tr>
<td>Outpatient experience tracker comprises four scores from the Trust’s monthly survey of outpatients (or parents of 0-11 year olds):<br>1) Cleanliness<br>2) Being seen within 15 minutes of appointment time<br>3) Being treated with respect and dignity<br>4) Receiving understandable answers to questions.</td>
<td>The score for the Trust as whole was 91 in October 2017 (out of score of 100). Divisional scores for quarter 3 are provided as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful.
<table>
<tr><th></th><th>Q2 2017/18</th><th>Q3 2017/18</th></tr>
<tr><td>Trust</td><td>89</td><td>91</td></tr>
<tr><td>Medicine</td><td>88</td><td>89</td></tr>
<tr><td>Specialised Services</td><td>88</td><td>91</td></tr>
<tr><td>Surgery</td><td>88</td><td>89</td></tr>
<tr><td>Women's & Children's (Bristol Royal Hospital for Children)</td><td>86</td><td>89</td></tr>
<tr><td>Diagnostics & Therapies</td><td>93</td><td>96</td></tr>
</table>
</td>
<td>Outpatient Experience Scores (maximum score 100) each month<br> 
</td>
<td>The Trust’s performance is in line with national norms in terms of patient-reported experience.<br><br>This metric turns red if outpatient experience begins to deteriorate to a statistically significant degree and 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).</td>
</tr>
</table>

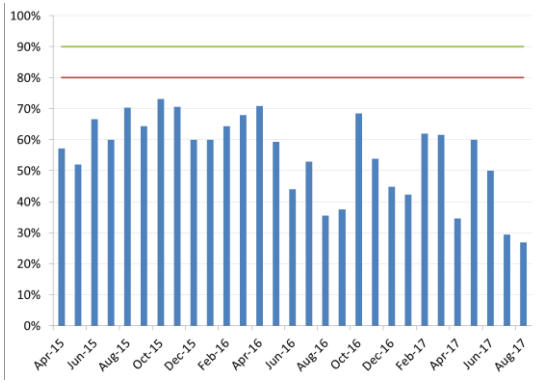
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In October the Trust cancelled 68 (1.0% 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>Emergency Patient Prioritised</td><td>11</td></tr>
<tr><td>Surgeon Taken Ill</td><td>10</td></tr>
<tr><td>No Beds Available</td><td>10</td></tr>
<tr><td>No CICU Beds</td><td>10</td></tr>
<tr><td>No HDU Beds</td><td>8</td></tr>
</table>
Of the 58 patients cancelled in September, 2 were not readmitted within 28 days. Meaning 96.6% were re-admitted within 28 days. This means the Trust achieved the former national standard of 95%, but failed the local target of 100%.</td>
<td>Percentage of operations cancelled at last-minute<br> 
</td>
<td>Not sustained the good performance through October, and missed the target for the second month running, by 0.2%. Large impact due to clinician sickness and loss of a whole list. Concern continues to be around the availability of High Dependency 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 October 9.9% 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.<br><br>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<br> 
</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>

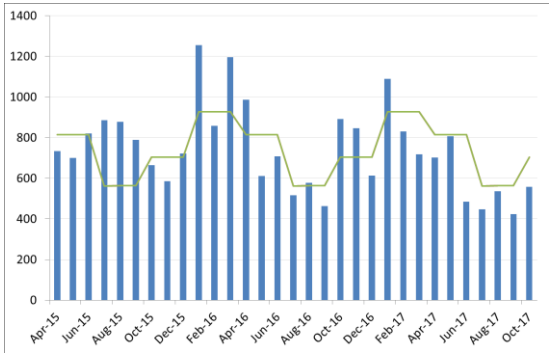
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% national standard was not achieved in October. However, Trust-level performance was 90.06%, and was above the in-month trajectory (90%). Performance and activity levels for the separate Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Aug 2017</th><th>Sep 2017</th><th>Oct 2017</th></tr>
<tr><td>Attendances</td><td>5684</td><td>5688</td><td>6288</td></tr>
<tr><td>Patients managed < 4 hours</td><td>4935<br>86.8%</td><td>4922<br>86.5%</td><td>5289<br>84.1%</td></tr>
<tr><th>BCH</th><th>Aug 2017</th><th>Sep 2017</th><th>Oct 2017</th></tr>
<tr><td>Attendances</td><td>2687</td><td>3316</td><td>3629</td></tr>
<tr><td>Patients managed < 4 hours</td><td>2589<br>96.4%</td><td>3150<br>94.99%</td><td>3496<br>96.3%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments<br> 
</td>
<td>A significant improvement has been seen and sustained in the performance against the A&E 4hr target leading to achievement of the Sustainability & Transformation (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>Aug</th><th>Sept</th><th>Oct</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>240</td><td>182</td><td>155</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>32</td><td>19</td><td>10</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month<br> 
</td>
<td>Performance against the RTT standard remains at the 89% level and continues to be a result of 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 2016/17. 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>September’s performance was 80.2% against the 85% 62-day GP standard, a Sustainability and Transformation trajectory of 83.6% and a recovery trajectory of 80%. September’s 62-day GP breach reasons were:
<table>
<tr><th>Breach reason</th><th>Sep 17</th></tr>
<tr><td>Medical deferral/clinical complexity</td><td>3.5</td></tr>
<tr><td>Late referral by/delays at other provider</td><td>5.5</td></tr>
<tr><td>Other causes (thirteen reasons)</td><td>10.0</td></tr>
<tr><td>TOTAL</td><td>19.0</td></tr>
</table>
</td>
<td>Percentage of patients treated within 62 days of GP Referral<br> 

Forecast for October will continue to be below the 92% standard, due to rising demand.</td>
<td>September’s performance met the recovery trajectory, as did the quarter as a whole. Cancellations have been incurred in recent months, which is impacting the position again, but achieving the trajectory is still possible. 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 remain a risk, 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 98.19% in October, which is below the 99% national standard. The recovery trajectory of fewer than 205 patients waiting 6+ weeks was achieved. The number of over 6-week waiters at month-end is:
<table>
<tr><th>Diagnostic test</th><th>Sep</th><th>Oct</th></tr>
<tr><td>MRI</td><td>30</td><td>25</td></tr>
<tr><td>Sleep</td><td>73</td><td>69</td></tr>
<tr><td>Endoscopies</td><td>29</td><td>17</td></tr>
<tr><td>CT</td><td>55</td><td>48</td></tr>
<tr><td>Echo</td><td>5</td><td>1</td></tr>
<tr><td>Other</td><td>0</td><td>0</td></tr>
<tr><td>TOTAL</td><td>192</td><td>160</td></tr>
<tr><td>Percentage</td><td>97.7%</td><td>98.2%</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 6 weeks at month-end<br> 
</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 3 main causes:
<ul>
<li>Demand for Cardiac CT remains high. Pilot for increasing capacity commenced in July. Capacity has increased from 6 slots per session to 10, however refer rates continue to grow, and outstrip capacity.</li>
<li>High demand for Sleep Studies tests, and ongoing shortfall in recurrent capacity, exacerbated by unexpected short and medium non-recurring capacity issues</li>
<li>Demand for paediatric MRI scans currently outstrips capacity. Work underway to secure appropriate levels of capacity</li>
</ul>
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<br>This statistical approach estimates that there were 47 fewer actual deaths than expected deaths in the 12-month period up to March 2017.<br>Note this national data is updated quarterly, so no change from last month. | **Summary Hospital Mortality Indicator (SHMI) for in hospital deaths each month**<br>  | Our overall performance continues to indicate that fewer patients died in our hospitals than would have been expected given their specific risk factors.<br>The Quality Intelligence Group continues to conduct assurance reviews of any specialties that have an adverse SHMI score in each quarter.<br>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 October, 32 out of 33 patients (97.0%) 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 92.1% | **Percentage of patients with a Door to Balloon Time < 90 minutes by month**<br>  | There was a slight dip in performance in July but year to date remains above the 90% target and performance recovered to above 90% in August and September. |

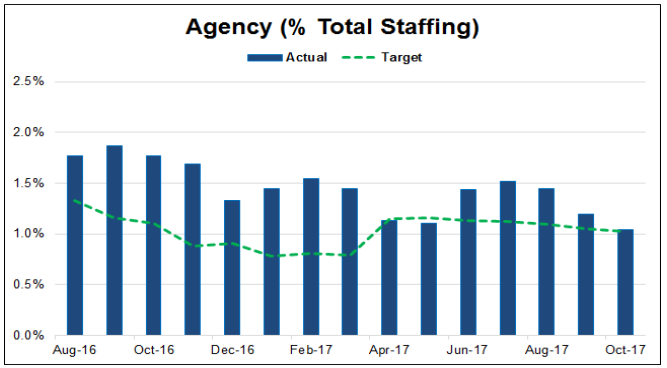
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In October 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 62% (13/21 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number of patients</th></tr>
<tr><td>Patient not operated on within the 36 hour timeframe due to other urgent trauma cases being prioritised</td><td>6</td></tr>
<tr><td>Patient had a delayed diagnosis.</td><td>1</td></tr>
<tr><td>Patient required further investigations before they could proceed to surgery</td><td>1</td></tr>
</table>
</td>
<td>Percentage of patients with fracture neck of femur who met best practice tariff


</td>
<td>Eleven patients did not receive any ortho-geriatrician review due to annual leave, transfer back to Weston, team not available to review the patient and clinician having to cover the Older Person Assessment Unit.<br><br>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 October 2017 there were 558 outlier bed-days against a target of 704 outlier bed-days.
<table>
<tr><th>Outlier bed-days</th><th>October 2017</th></tr>
<tr><td>Medicine</td><td>228</td></tr>
<tr><td>Surgery</td><td>208</td></tr>
<tr><td>Specialised Services</td><td>113</td></tr>
<tr><td>Women's & Children's Division</td><td>3</td></tr>
<tr><td>Diagnostics and Therapies</td><td>6</td></tr>
<tr><td>Total</td><td>558</td></tr>
</table>
</td>
<td>Number of days patients spent outlying from their specialty wards


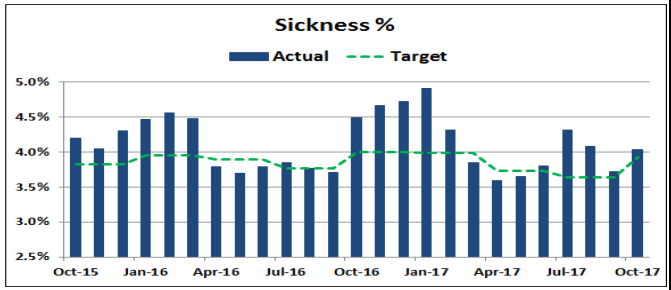
</td>
<td>The quarter three target has been set at 704 bed days per month and this was achieved in October 2017 by 146 bed days.<br>Ongoing actions are shown in the action plan section of this report. (Action 13A).</td>
</tr>
</table>

| 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 12.5 FTE, with reductions across all staff groups except ancillary. Reductions were seen across all clinical divisions apart from Women's and Children's. Further reductions have been seen in Nursing & Midwifery usage this month (down by 4.0 FTE), and bookings to cover vacancies for this staff group have reduced by 3.2 FTE. | Agency usage as a percentage of total staffing by month . | A summary of compliance with agency caps is attached in Appendix 2. See action 14 for a summary of key actions to target agency use. |
| **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 increased from 3.7% to 4.0%, with increases in all Divisions except Facilities and Estates. As would be expected at this time of year, sickness due to cold/cough/flu has increased. Stress/Anxiety continues to be the biggest reason for sickness, and has increased by 15.6% this month. | **Sickness absence as a percentage of full time equivalents by month** | See Appendix 2, action 15 for the sickness action plan. |

| October 2017 | FTE | Actual % | KPI |
|---|---|---|---|
| **UH Bristol** | **90.4** | **1.0%** | **1.0%** |
| Diagnostics & Therapies | 4.1 | 0.4% | 0.6% |
| Medicine | 22.7 | 1.7% | 1.1% |
| Specialised Services | 9.7 | 1.0% | 1.5% |
| Surgery | 8.1 | 0.4% | 1.1% |
| Women's & Children's | 29.1 | 1.5% | 0.5% |
| Trust Services | 11.5 | 1.4% | 2.0% |
| Facilities & Estates | 5.2 | 0.7% | 1.0% |



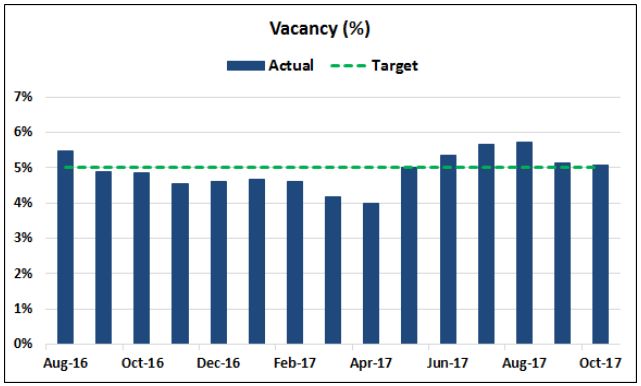

| October 2017 | Actual | KPI |
|---|---|---|
| **UH Bristol** | **4.0%** | **3.9%** |
| Diagnostics & Therapies | 3.2% | 2.8% |
| Medicine | 4.6% | 4.4% |
| Specialised Services | 3.2% | 3.7% |
| Surgery | 3.7% | 3.6% |
| Women's & Children's | 3.8% | 4.0% |
| Trust Services | 4.2% | 3.4% |
| Facilities & Estates | 6.7% | 6.0% |




*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.*

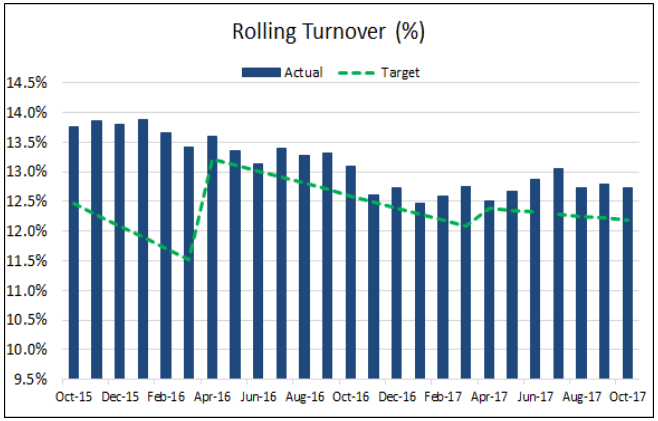
| Description | Current Performance | Trend | Comments |
|---|---|---|---|
| **Vacancies** - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%. | Overall vacancies remained at 5.1%, still slightly higher than the Trust target of 5%. Nursing vacancies reduced by 11.0 FTE in month to 181.3 (5.6%), with a 69.7% reduction in Women's and Children's, however there was a 28.0% increase in Surgery, although the Division still remains within KPI overall. | **Vacancies rate by month** | See Appendix 2, Action 16 for further details of the plans that continue to be implemented to reduce the vacancy rate. |

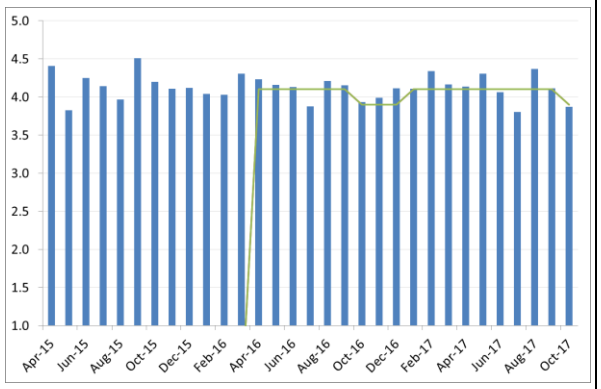
| October 2017 | Actual |
|---|---|
| **UH Bristol** | **5.1%** |
| Diagnostics & Therapies | 5.8% |
| Medicine | 6.4% |
| Specialised Services | 4.1% |
| Surgery | 4.9% |
| Women's & Children's | 1.5% |
| Trust Services | 7.2% |
| Facilities & Estates | 10.4% |




| Description | Current Performance | Trend | Comments |
|---|---|---|---|
| **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 reduced slightly to 12.7%, compared with 12.8% last month. There has been a combination of increases and decreases across the divisions, with the highest increase seen in Medicine. The largest reductions in staff group were seen in the Nursing and Midwifery Unregistered and Allied Health professionals. | **Staff turnover rate by month** | See Appendix 2, Action 17 for further details of the plans that continue to be implemented to reduce turn-over. |

| October 2017 | Actual | KPI |
|---|---|---|
| **UH Bristol** | **12.7%** | **12.2%** |
| Diagnostics & Therapies | 11.4% | 12.0% |
| Medicine | 13.8% | 14.5% |
| Specialised Services | 14.1% | 11.9% |
| Surgery | 12.5% | 11.8% |
| Women's & Children's | 10.6% | 10.7% |
| Trust Services | 13.4% | 12.2% |
| Facilities & Estates | 16.2% | 14.0% |



<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 October the average length of stay for inpatients was 3.87 days, which is just below the RED threshold of 3.9 days.<br><br>Number of patients in hospital at month-end with a “long” Length of Stay is below:
<table>
<tr><th></th><th>Aug 17</th><th>Sep 17</th><th>Oct-17</th></tr>
<tr><td>7+ Days</td><td>399</td><td>364</td><td>381</td></tr>
<tr><td>14+ Days</td><td>256</td><td>237</td><td>240</td></tr>
<tr><td>21+ Days</td><td>188</td><td>162</td><td>169</td></tr>
</table>
</td>
<td>Average length of stay (days)<br> 
</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 | Further targeted teaching for areas where National Early Warning Scores (NEWS) incidents have occurred. | On-going | Monthly progress reviewed in the deteriorating patient work stream and quarterly by the Patient Safety Improvement Programme Board, Clinical Quality Group and Quality and Outcomes Committee | Sustained improvement to 95% by 2018. |
| 1B | Accessing doctor education opportunities to assist with resetting triggers safely. | On-going | As above | Sustained improvement to 95% by 2018. |
| 1C | Conduct 1:1 debriefs to further understand the reasons why nurses and doctors are unable to escalate or respond to escalation and address these accordingly. Also please see 1E below. | Completed. Actions in response to thematic analysis now underway. | As above | Sustained improvement to 95% by 2018. |
| 1D | Spreading point of care simulation training in adult general ward areas to address human factors elements of escalating deteriorating patients and use of structured communication. | On-going | As above | Sustained improvement to 95% by 2018. |
| 1E | Additional time allocated for patient safety in doctors' induction to train new appointees on resetting triggers safely and human factors awareness of escalation conversations. | Ongoing | As above | Sustained improvement to 95% by 2018. |
| 1F | Review and response to outputs of mapping exercise of coverage of responders to escalation calls out of hours actions. | May 2017 review completed. Actions being fed into Urgent Care Group. | As above | Sustained improvement to 95% by 2018. |
| 1G | Procurement of e observations system to enable automatic calculation of NEWS and notification of elevated NEWS to responder. | System procured. Aiming for implementation in 80% of adult wards by April 2018. | 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 |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 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 |
| **SAFE – Essential Training** | | | | |
| 3A | Overall compliance for the Trust is holding at 89%, with aim of 90% compliance in all subjects. | January 2018 | Divisional Performance Review meetings.<br><br>Oversight of training compliance by the Education Board and Senior Leadership Team (SLT) | The Education Team and Information Governance (IG) Lead has developed a new IG presentation and is commencing at November inductions, which allows more staff to achieve compliance at induction. Current IG compliance is 82%, but expected to rise next month due to impact of November inductions. |
| 3B | The Education Board will consider focusing the monthly compliance report from the 35 current topics to 11 Core Skills of the UK Core Skills Framework. | December 2017 | | |
| 3C | The Trust will move to stricter enforcement of 4 Trust policies (annual leave, study leave, etc.) in January 2018, as a sanction to enforce training accomplishment and improve compliance. | January 2018 | | |
| **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. |
| **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 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 can then be discussed individually with the manager concerned and further training provided if necessary. | Achieve and maintain a green rating for this indicator |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 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 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 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 rating for this indicator |
| **CARING – Cancelled Operations** | | | | |
| 6A | Continued focus on recruitment and retention of staff to enable all adult BRI Critical Care beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited and in post.<br>Development and implementation of a strategy for managing Critical Care beds across general adult and cardiac units, to improve ability to manage peaks in demand. | Ongoing<br>End August | Monthly Divisional Review Meetings;<br>Senior Leadership Team sign-off | Sustained reduction in critical care related cancellations in 2017/18.<br>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. |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| **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 NHS England (NHSE) Paper Less initiative; Milestones across each quarter | Outpatient Steering Group | Ongoing delivery of plan continues in line with CQUIN milestones<br>(CQUIN is "Commissioning for Quality and Innovation") |
| 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 7B above |
| 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 Outpatient Steering Group in September 17 | Outpatient Steering Group | Ongoing work with divisions to identify specialities to support the reduction in follow-up work at Clinical Commissioning Group (CCG) level. |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 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 Outpatient Steering Group | Outpatient Steering Group | |
| **RESPONSIVE – A&E 4 Hour Wait** | | | | |
| 8A | Urgent Care Steering Group (UCSG) Improvement plan for the BRI has been refreshed to focus on the high impact schemes initially.<br>Pilot underway in Acute Medical Unit (AMU/A300) to increase ambulatory capacity.<br>Model agreed with team for adult ED streaming which is going to UCSG in August.<br>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 NHS Improvement's Emergency Care Improvement Programme (ECIP) has commenced; focussing on support IDS work and implementing trusted assessor | Ongoing | Progress tracked through Urgent Care Steering Group | |
| 8C | Progress and recommendations presented to Senior Leadership Team (SLT). Further update to be presented to November SLT | November | Service Delivery Group and A&E Delivery Board | |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| **RESPONSIVE – Referral to Treatment (RTT) Times** | | | | |
| 9A | Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory.<br>Continued weekly review of management of longest waiting patients through RTT Operations Group.<br>Additional request from the Clinical Commissioning Groups (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.<br>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.<br><br>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 Recovery Action Plan (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 zero 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 the Trust's 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. | |
| 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 | |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 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 December 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 December 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 planning meeting cancellations, for instance due to bank holiday | End January 2017 | As above | As above |
| 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 |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 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 consultant capacity commencing end October (however, capacity also affected by bereavement leave and ongoing absence in October and November)<br>Review of referral criteria and demand management being explored in conjunction with the Clinical Commissioning Groups (CCGs)<br>Loss of GP with Special Interest (GPSI) sessions late November and December. | TBC | Weekly monitoring by corporate team, with escalation to monthly Divisional Review meetings as required. | Additional capacity being organised where possible<br><br>Review with commissioners in December |
| 11B | Changes made to Cardiac CT scanning sessions to improve utilisation. Pilot commenced in July, slots increased from 6 per session to 10 per session. Work ongoing to review potential increase to 12.<br>Increase sessions being explored as part of Operating Plan process for 2018/19 | Ongoing | Weekly monitoring by corporate team, with escalation to monthly Divisional Review meetings as required. | Continued increase in referral rate affecting ability match capacity with demand |
| 11C | Paediatric General Anaesthetic (GA) MRI scans Review productivity of current sessions and use of GA funded in 2017/18 operating plan. Capacity modelling to determine if additional capacity is required. Waiting List Initiatives (WLIs) where possible | Review capacity modelling by end December | Weekly monitoring by corporate team, with escalation to monthly Divisional Review meetings as required. | Dependent on outcome of review |
| **EFFECTIVE – Fracture Neck of Femur** | | | | |
| 12A | Middle grade orthogeriatric support – to submit a proposal to establish a dedicated middle grade orthogeriatric role 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 has advertised and appointed to this post. | Awaiting start date, but should be in next couple of weeks. | Successful funding bid and subsequent recruitment to post |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 12B | Consultant orthogeriatric capacity – there are currently vacancies within the Care of the Elderly 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 Care of the Elderly 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 the Older Person's Assessment Unit and other Care of the Elderly 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.<br>The agreed funding for the middle grade orthogeriatrian post redirects funding from the orthogeriatric consultant vacancy.<br>The Medical Division is reviewing the Care of the Elderly team job plans. | Improvements in time to review by an orthogeriatrician. |
| 12C | Establishment of an elderly trauma and hip fracture ward – to cohort frail elderly trauma patients on A604. To facilitate direct admission from the Emergency Department 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.<br>The Deputy Chief Operating Officer will lead the planning process to | Improvements to the quality and coordination of patient care. |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| | | | establish the elderly trauma and hip fracture ward.<br>The proposed ward staffing enhancements at the weekend has been included in the Division of Surgery 2018/19 Operating Plan as a cost pressure. | |
| 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 Diagnostics & Therapies Division presenting different staffing models. An on-call model for patients with fractured neck of femur 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.<br>Investment proposal pending approval by executive team. | There are potential benefits associated with reduction in patient length of stay with earlier mobilisation.<br>The Diagnostics & Therapies Division are planning to commence a consultation process with a significant body of physiotherapy staff to facilitate Sunday on-call cover in the new year. | Improvements against the new quality standard measure of therapy review the day after surgery. |
| 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 trial of a dedicated theatre porter for trauma theatres has concluded by has not demonstrated a significant improvement in waiting times. The audit demonstrated the most significant factor was theatres not starting on time because of waiting for beds. So, a proposal is being developed to introduce automatic sending for trauma cases; cases will be treated in the same way as emergency surgery. | Improvements against time to theatre standard |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 12F | 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 |
| **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**:<br>• "Healthroster" – implemented and Key Performance Indicators 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 Key Performance Indicator 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. |
| 14B | **Controls and efficiency**:<br>• Revised agency rules in place for Nursing from 1st October 2017 with a particular focus on driving out high cost non-framework agency spend.<br>• Neutral Vendor contract going live across the BNSSG area 6th November 2017 which will help support an improved achievement with the national agency price caps.<br>• Operating plan agency trajectories monitored by divisional reviews. | • Ongoing<br>• Ongoing<br>• Monthly/ quarterly reviews | Nursing agency: oversight by Savings Board and Nursing Agency Controls Group.<br>Medical agency: oversight through the Medical Efficiencies Group.<br>Oversight by Workforce and Organisational Development (WFOD) Board. | |
| 14C | **Enhancing bank provision:**<br>• Recruitment and marketing plan for all staff groups in place for 2017/18. Phase 1 of marketing live from October 2017 across Bristol. | • Ongoing | Performance against target for Bank recruitment is monitored by the Recruitment Sub Group. | |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| | • Employee On-Line access (for Bank-only Registered Nurses, Nursing Assistants, Domestics) is now live so staff can view available shifts and give their availability to work. Direct booking through the employee on-line functionality is being further explored. | • April 2018 | | |
| **EFFICIENT – Staff Sickness** | | | | |
| 15A | **Supporting Attendance Policy:**<br>Revised policy; implementation plan and training programme in place for when policy is agreed. Supporting attendance surgeries ongoing to expedite individual cases. | December 2017 | Oversight by Workforce and Organisational Development (OD) Board via the Staff Health and Wellbeing Sub Group<br>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. |
| 15B | **Supporting Attendance Surgeries**<br>To expedite cases where possible.<br>Improve the process for referral to Occupational Health (OH). From 13th November, management referral to OH is to be completed and submitted online through the OH portal, providing swifter process and return of OH reports and recommendations. | Ongoing<br><br>November 2017 | | |
| 15C | **Psychological wellbeing**<br>Consider the implementation of Mindful Employer to offer support beyond the recruitment process currently utilised by the resourcing team. | December 2017 | | |
| 15D | **Musculo-skeletal**<br>By the end of the year, the Manual Handling Training team will have provided additional 1000 – 1100 attendee places, with more sessions planned from January onwards. Revised training schedules for 2018 aim to reduce waiting time for training.<br><br>Provide free staff 24/7 access to new "Get U Better" back pain App via Physio Direct service. | Ongoing<br><br>October 2017 | | |

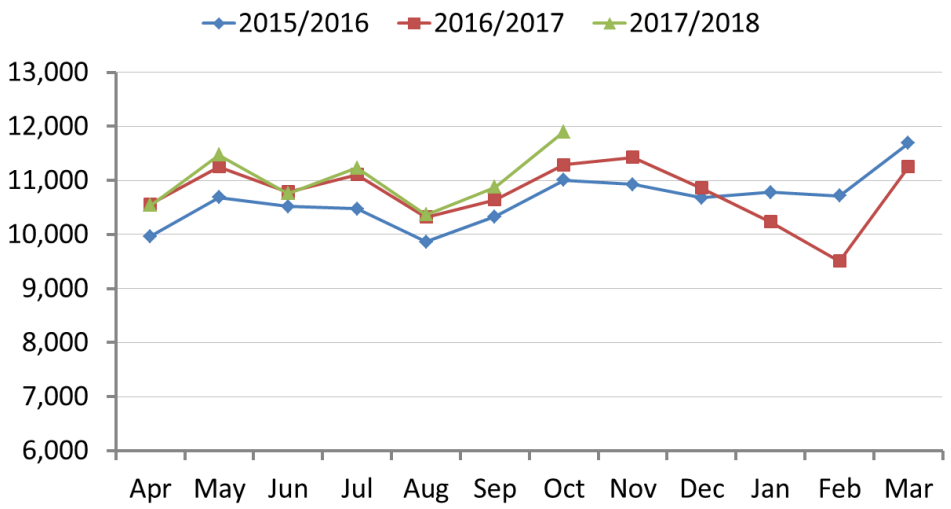
| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 15E | **General wellbeing**<br>Develop a workshop and accompanying guidance booklet to support individuals and managers experiencing menopause within the workplace as this is prevalent.<br><br>Formulate awareness materials to support managers and teams around suicide and steps to take when dealing in a potential crisis situation. | January 2018<br><br>December 2017 | | |
| **EFFICIENT – Vacancy** | | | | |
| 16A | **Recruitment Performance**<br>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.<br>Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings. |
| 16B | **Marketing and advertising**<br>• Recruitment and marketing plan for nursing in place for 2017/18.<br>• Marketing for Radiology in place 2017/18 maximising new recruitment website.<br>• Marketing plan for Domestic Assistants continues with positive demonstrable outcomes.<br>• Divisional Nurse Recruitment Leads in bed-holding divisions supported by the Nurse Recruitment Manager.<br>• "Head-hunter" agency approach has been extended to hard to fill areas e.g. Sonography, Trauma & Orthopaedics and Care of the Elderly nursing.<br>• Active attendance at careers events continues, with a particular focus in the last month on local career fairs | • Ongoing<br>• Ongoing<br>• Rolling programme starting September 2017<br>• April 2017-18<br>• From April 2017<br>• Ongoing | Divisional Performance & Operational Review Meetings and the Recruitment Sub Group. | |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| **EFFICIENT - Turnover** | | | | |
| 17A | Exit interview process requires further development in order to improve uptake. Options are currently being costed including writing to each leaver at their home address. This would improve the quality of information received to help identify and address reasons for turnover and inform recruitment strategies. | January 2018 | Workforce and Organisational Development 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.

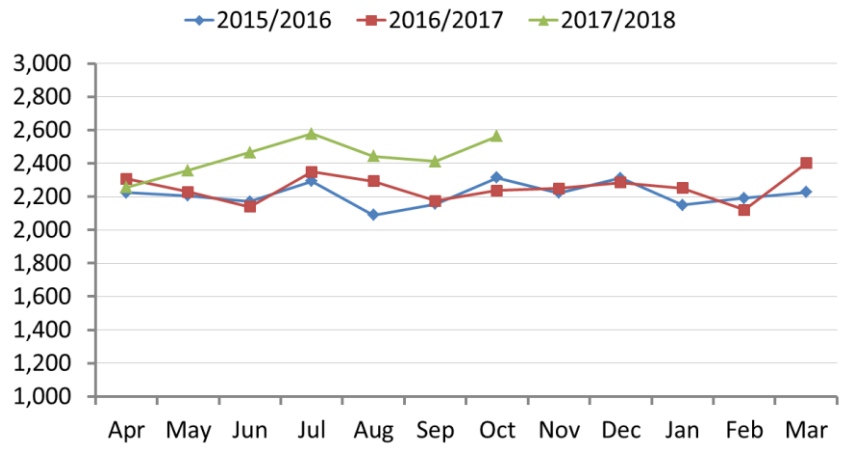
### Emergency Department (ED) attendances



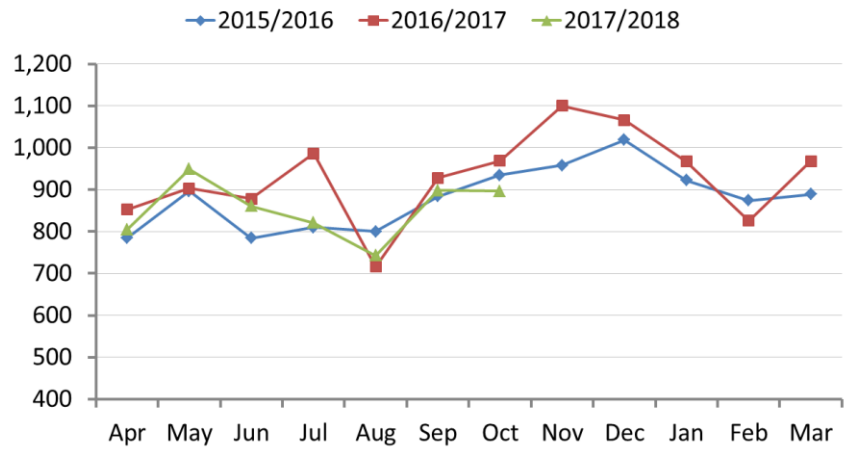

### Summary points:

- Emergency Department attendances reached a three year high in October 2017, although attendance numbers had been in-line with previous year's trend. Too early to know if this is a sustained increase.
- Total number of emergency admissions into the BRI is above the seasonal norm. This is being driven by a rise in short stay (0 or 1 day) Medical admissions in Ambulatory Care and Acute Medicine Unit (AMU).
- The number of new outpatient attendances has remained above previous year's level but is following seasonal trends.
- The number of elective admissions has remained reasonably constant (around 7,000 per month) since May 2017, with a small drop in August.

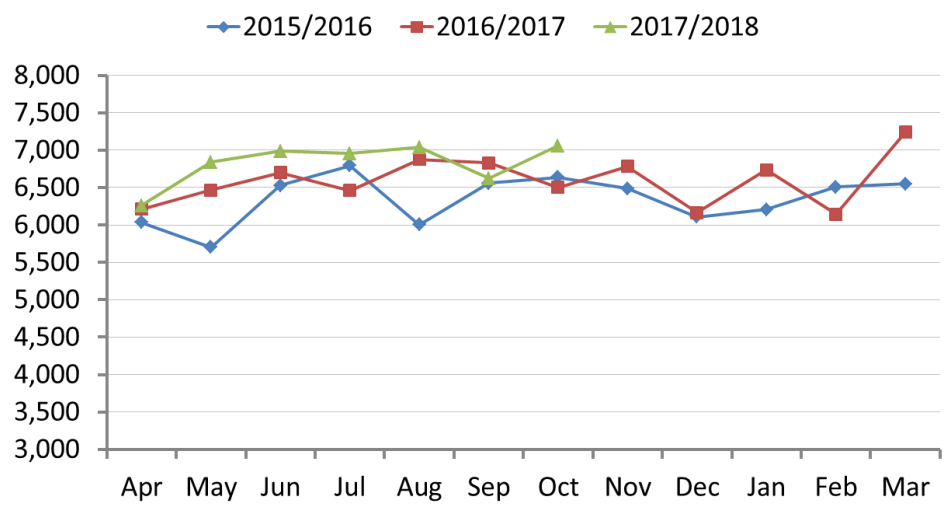
### Emergency Inpatient Activity (BRI Discharges)



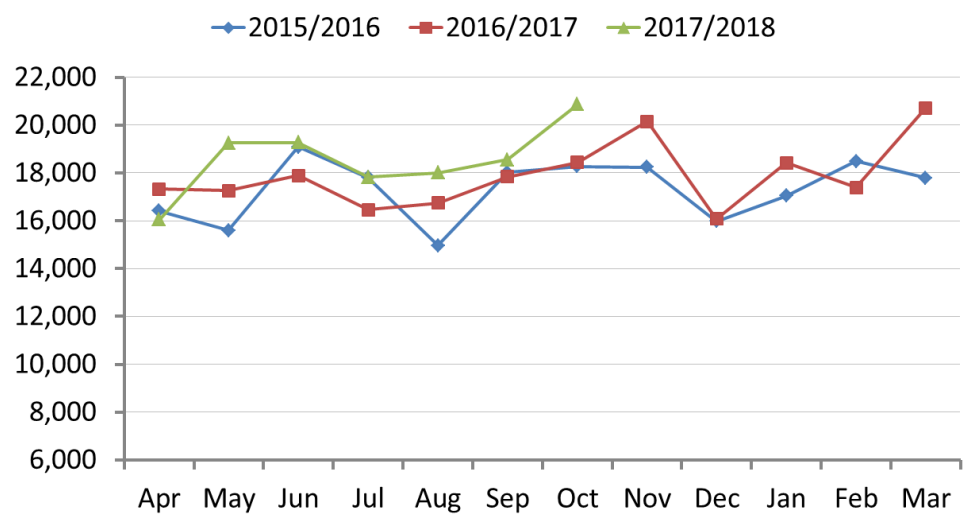

### Emergency Inpatient Activity (BCH Discharges)



**Elective Inpatient/Day Cases (number of Discharges)**



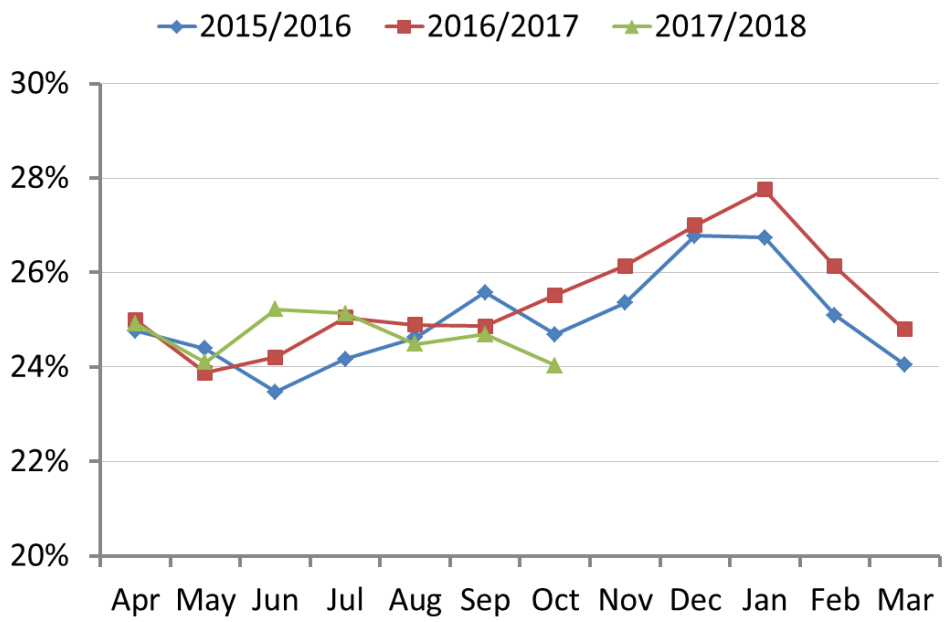

**New outpatient attendances**



## 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.

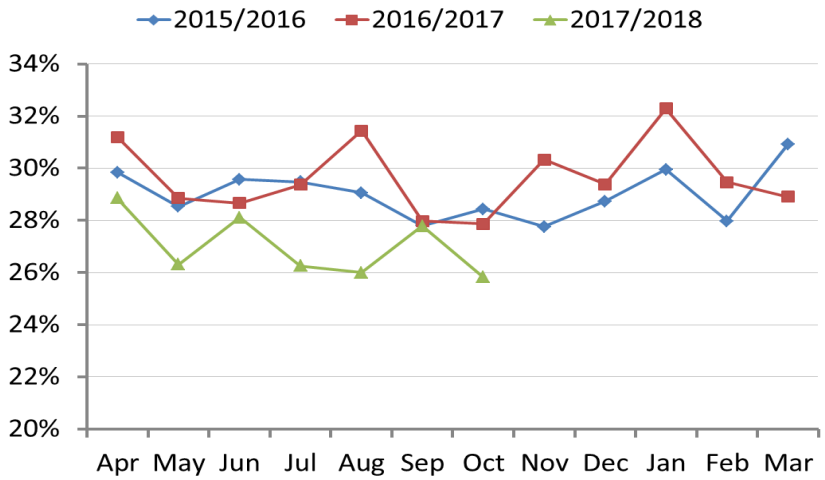
**Percentage ED attendances resulting in admission**



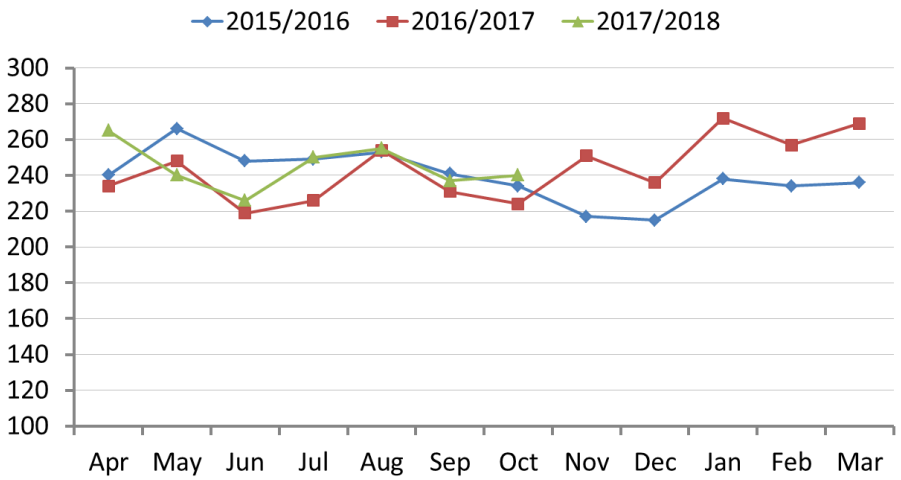

**Summary points:**

- The percentage of patients arriving in our Emergency Departments and converting to an admission I showing a small percentage reduction.
- The number of over 14 days stays remains is in-line with last year's level.
- The BRI bed occupancy level had fallen from May through to September, but rose again in October. However it remains below 2016/17 levels.
- 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 Referral To Treatment (RTT) patients waiting over 18 weeks fell in October, alongside a rise in RTT Clock Stops.
- The number of patients referred by their GP with a suspected cancer (2-week waits) fell in September but has remained above 2016/17 levels all year.
- Elective waiting list remains above 2016/17 levels.

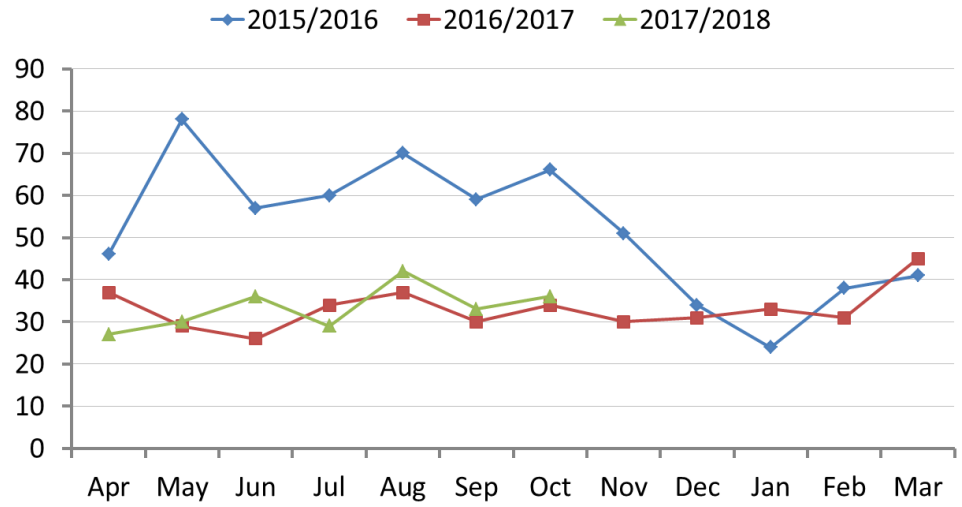
**Percentage of Emergency BRI spells patients aged 75 years and over**



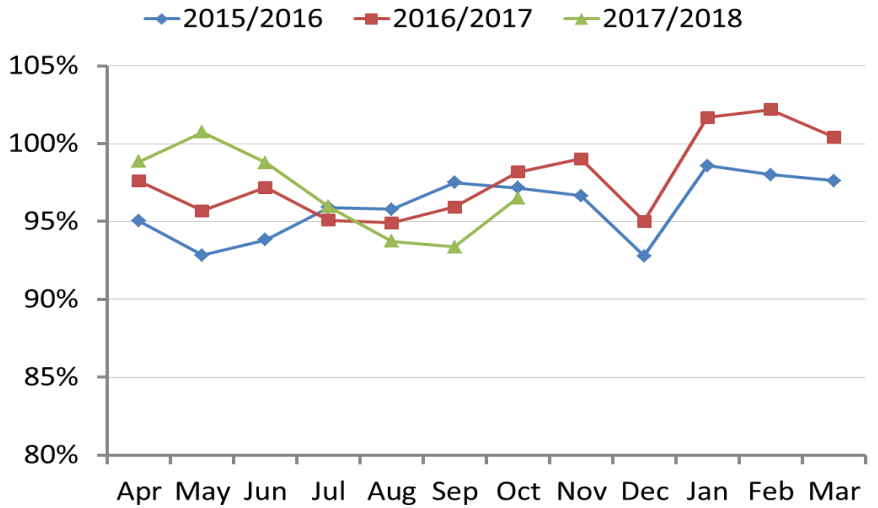

**Over 14 day stays , at month-end**



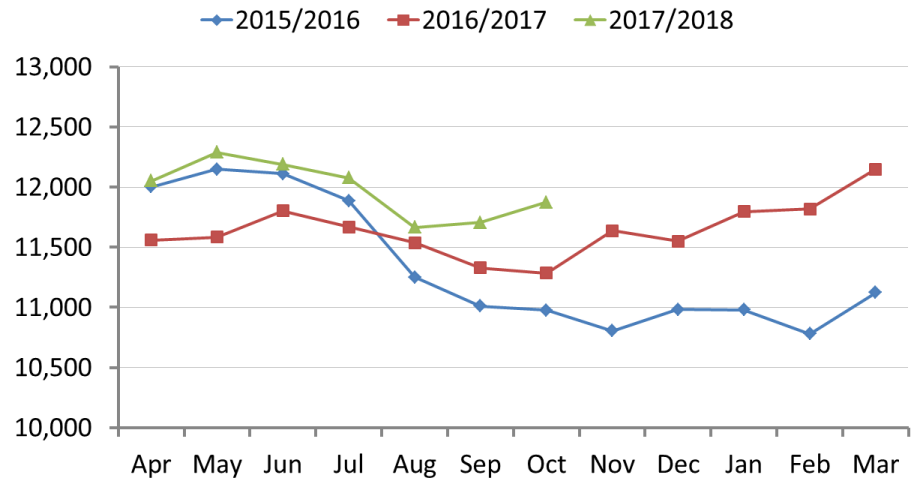
**Delayed Transfers of Care (Number of patients at month-end)**



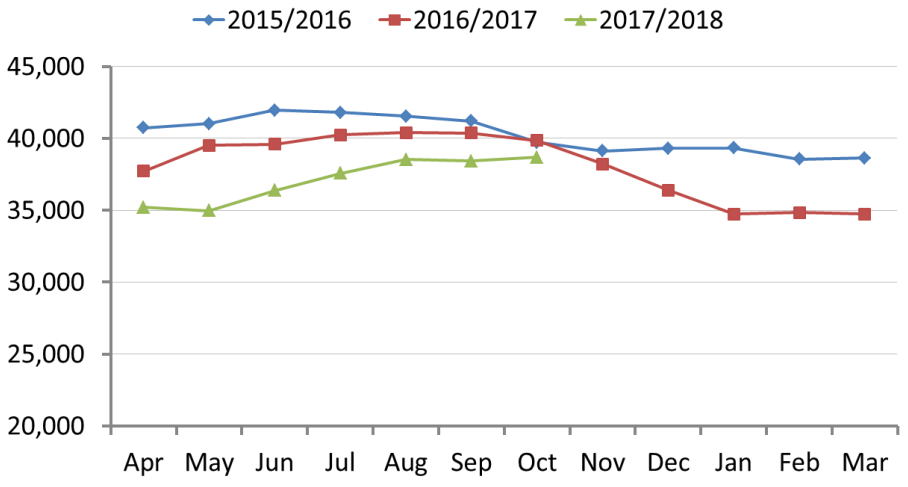

**BRI Bed Occupancy (Overnight)**



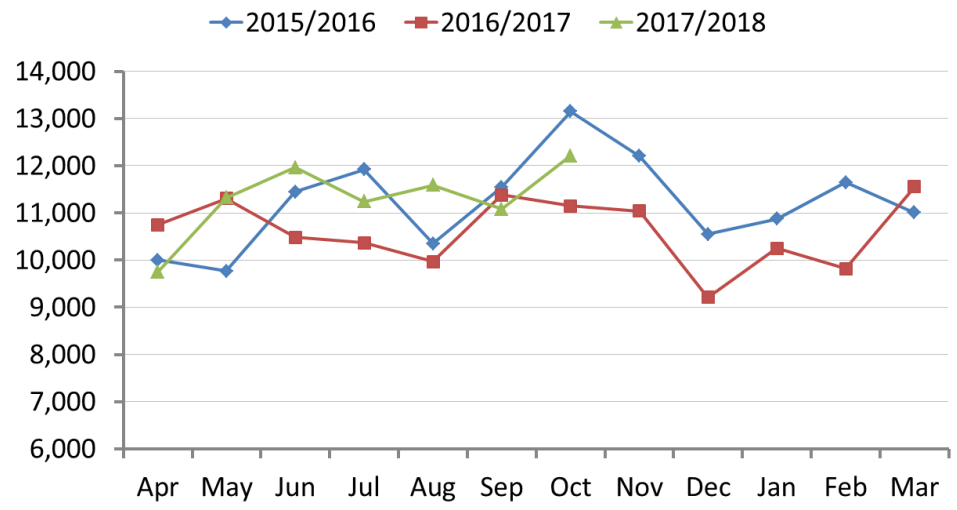

**Elective waiting list size**



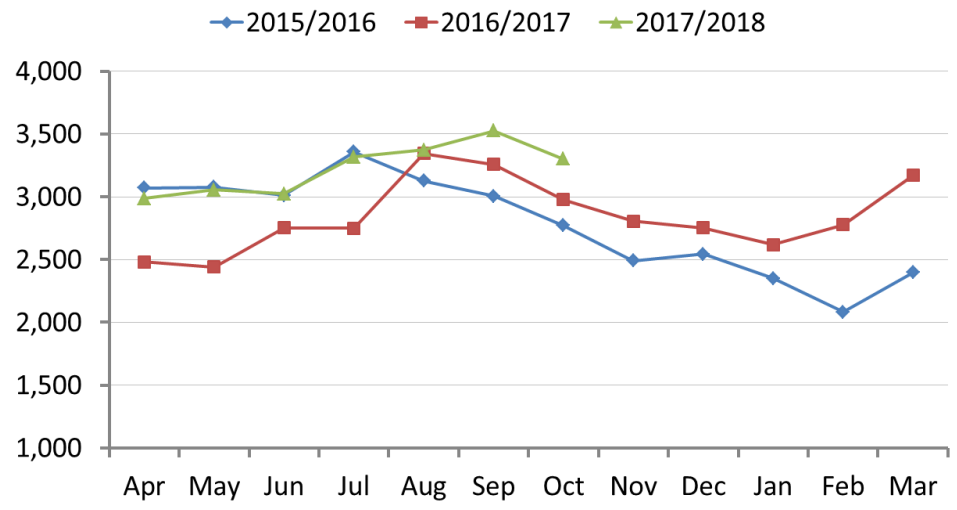

**Outpatient waiting list size**



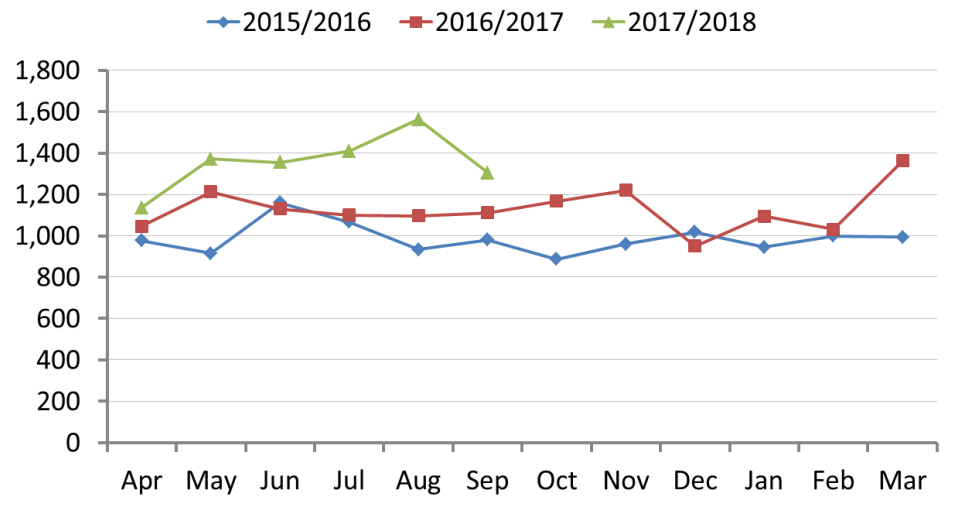
**Number of RTT pathways stopped (i.e. treatments)**



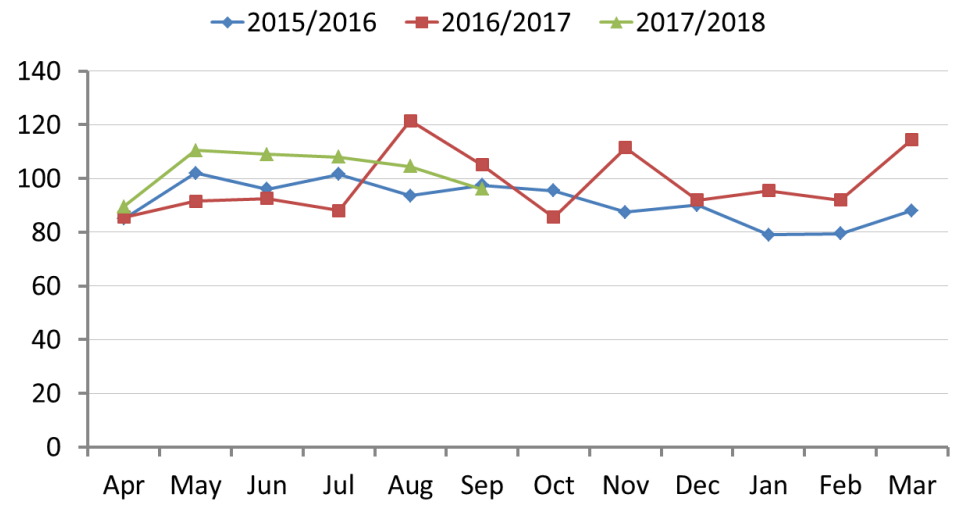

**Number of RTT pathways over 18 weeks**




**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 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | 16/17 Q4 | 17/18 Q1 | 17/18 Q2 | 17/18 Q3 |
| **Patient Safety** | | | | | | | | | | | | | | | | | | | | |
| Infections | DA01a | MRSA Bloodstream Cases - Cumulative Totals | - | - | 1 | 1 | 1 | 1 | 1 | - | 0 | 1 | 1 | 2 | 3 | 3 | - | - | - | - |
| | DA01 | MRSA Bloodstream Cases - Monthly Totals | 1 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 2 | 0 |
| | DA03 | C.Diff Cases - Monthly Totals | 31 | 24 | 3 | 5 | 4 | 0 | 0 | 2 | 4 | 5 | 6 | 3 | 3 | 1 | 4 | 11 | 12 | 1 |
| | DA02 | MSSA Cases - Monthly Totals | 37 | 12 | 6 | 2 | 3 | 3 | 2 | 0 | 1 | 3 | 0 | 3 | 0 | 5 | 8 | 4 | 3 | 5 |
| C.Diff "Avoidables" | DA03c | C.Diff Avoidable Cases - Cumulative Totals | - | - | 8 | 9 | 10 | 10 | 10 | 0 | 2 | 2 | 3 | - | - | - | - | - | - | - |
| Infection Checklists | DB01 | Hand Hygiene Audit Compliance | 96.6% | 97.6% | 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% | 96.4% |
| | DB02 | Antibiotic Compliance | 88.3% | 86.1% | 90.3% | 91.2% | 91.7% | 92% | 88.1% | 87.7% | 89.6% | 87.4% | 87.8% | 81.3% | 84.4% | 85.1% | 90.8% | 88.3% | 84.3% | 85.1% |
| Cleanliness Monitoring | DC01 | Cleanliness Monitoring - Overall Score | - | - | 96% | 96% | 96% | 94% | 95% | 96% | 96% | 96% | 96% | 97% | 97% | 96% | - | - | - | - |
| | DC02 | Cleanliness Monitoring - Very High Risk Areas | - | - | 97% | 97% | 98% | 97% | 97% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | - | - | - | - |
| | DC03 | Cleanliness Monitoring - High Risk Areas | - | - | 96% | 97% | 96% | 96% | 95% | 96% | 96% | 97% | 97% | 97% | 97% | 96% | - | - | - | - |
| Serious Incidents | S02 | Number of Serious Incidents Reported | 52 | 34 | 5 | 3 | 5 | 2 | 5 | 2 | 7 | 6 | 5 | 3 | 9 | 2 | 12 | 15 | 17 | 2 |
| | S02a | Number of Confirmed Serious Incidents | 49 | 20 | 5 | 3 | 5 | 2 | 5 | 2 | 5 | 6 | 5 | 2 | - | - | 12 | 13 | 7 | - |
| | S02b | Number of Serious Incidents Still Open | - | 13 | - | - | - | - | - | - | 1 | 0 | 0 | 1 | 9 | 2 | - | 1 | 10 | 2 |
| | 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% | 97.1% | 80% | 66.7% | 100% | 100% | 100% | 100% | 100% | 83.3% | 100% | 100% | 100% | 100% | 100% | 93.3% | 100% | 100% |
| | S04 | Serious Incident Investigations Completed Within Timescale | 98% | 96.8% | 100% | 75% | 100% | 100% | 100% | 100% | 75% | 100% | 100% | 100% | 100% | 100% | 100% | 91.7% | 100% | 100% |
| | S04a | Overdue Exec Commissioned Non-SI Investigations | - | 10 | - | - | - | - | - | 1 | 2 | 2 | 1 | 1 | 2 | 1 | - | 5 | 4 | 1 |
| Never Events | S01 | Total Never Events | 2 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 1 | 0 | 0 | 2 | 0 | 3 | 1 | 2 |
| Patient Safety Incidents | S06 | Number of Patient Safety Incidents Reported | 14866 | 7614 | 1389 | 1185 | 1335 | 1211 | 1332 | 1203 | 1315 | 1330 | 1288 | 1249 | 1229 | - | 3878 | 3848 | 3766 | - |
| | S06b | Patient Safety Incidents Per 1000 Beddays | 47.82 | 49.76 | 52.93 | 46.21 | 48.94 | 48.67 | 48.47 | 47.02 | 49.94 | 53.99 | 49.49 | 48.38 | 49.91 | - | 48.69 | 50.27 | 49.25 | - |
| | S07 | Number of Patient Safety Incidents - Severe Harm | 95 | 46 | 12 | 10 | 10 | 7 | 5 | 7 | 11 | 8 | 6 | 7 | 7 | - | 22 | 26 | 20 | - |
| Patient Falls | AB01 | Falls Per 1,000 Beddays | 4.23 | 4.63 | 4.04 | 3.74 | 3.74 | 4.9 | 3.89 | 4.85 | 3.91 | 4.91 | 4.53 | 4.76 | 5.04 | 4.48 | 4.16 | 4.55 | 4.77 | 4.48 |
| | AB06a | Total Number of Patient Falls Resulting in Harm | 36 | 14 | 2 | 4 | 3 | 3 | 5 | 2 | 3 | 4 | 0 | 0 | 3 | 2 | 11 | 9 | 3 | 2 |
| Pressure Ulcers Developed in the Trust | DE01 | Pressure Ulcers Per 1,000 Beddays | 0.148 | 0.128 | 0.114 | 0.195 | 0.11 | 0.201 | 0.182 | 0.078 | 0.076 | 0.203 | 0.154 | 0.155 | 0.203 | 0.038 | 0.163 | 0.118 | 0.17 | 0.038 |
| | DE02 | Pressure Ulcers - Grade 2 | 40 | 18 | 3 | 5 | 3 | 3 | 3 | 1 | 1 | 5 | 2 | 4 | 4 | 1 | 9 | 7 | 10 | 1 |
| | DE04A | Pressure Ulcers - Grade 3 or 4 | 6 | 5 | 0 | 0 | 0 | 2 | 2 | 1 | 1 | 0 | 2 | 0 | 1 | 0 | 4 | 2 | 3 | 0 |
| Venous Thrombo-embolism (VTE) | N01 | Adult Inpatients who Received a VTE Risk Assessment | 99.1% | 98.5% | 99.4% | 99% | 99.1% | 98.9% | 99.1% | 98.9% | 98.9% | 98.7% | 98.8% | 97.4% | 98.3% | 98.4% | 99% | 98.8% | 98.2% | 98.4% |
| | N02 | Percentage of Adult Inpatients who Received Thrombo-prophylaxis | 96.4% | 95.7% | 96.5% | 97% | 97.8% | 98% | 96.6% | 94.5% | 97.6% | 97% | 97.4% | 94.9% | 92.3% | 97.1% | 97.4% | 96.3% | 94.7% | 97.1% |
| | N04 | Number of Hospital Associated VTEs | 63 | 20 | 9 | 7 | 11 | 3 | 2 | 5 | 3 | 6 | 4 | 2 | - | - | 16 | 14 | 6 | - |
| | N04A | Number of Potentially Avoidable Hospital Associated VTEs | 7 | 1 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | - | - | 2 | 1 | 0 | - |
| | N04B | Number of Hospital Associated VTEs - Report Not Received To Date | 13 | 5 | 4 | 2 | 3 | 1 | 0 | 0 | 3 | 0 | 2 | 0 | - | - | 4 | 3 | 2 | - |
| Nutrition | WB03 | Nutrition: 72 Hour Food Chart Review | 89.6% | 92% | 87.1% | 94.3% | 92.7% | 89.1% | 90.2% | 89.9% | 87.7% | 91.5% | 96.2% | 94.6% | 92.6% | 91% | 90.6% | 89.7% | 94.5% | 91% |
| Nutrition Audit | WB10 | Fully and Accurately Completed Screening within 24 Hours | 86.9% | 92.1% | - | 91.2% | - | - | 87.9% | - | - | 92.2% | - | - | 92% | - | 87.9% | 92.2% | 92% | - |
| Safety | Y01 | WHO Surgical Checklist Compliance | 99.1% | 99.8% | - | 97.7% | 98.4% | 98% | 97.8% | 99.5% | 99.7% | 99.8% | 99.8% | 99.8% | 99.9% | 99.8% | 98.1% | 99.7% | 99.8% | 99.8% |

## SAFE, CARING & EFFECTIVE (continued)

| | | | Annual | | Monthly Totals | | | | | | | | | | | | Quarterly Totals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Topic | ID | Title | 16/17 | 17/18 YTD | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | 16/17 Q4 | 17/18 Q1 | 17/18 Q2 | 17/18 Q3 |
| Medicines | WA01 | Medication Incidents Resulting in Harm | 0.37% | 0.62% | 1.19% | 0% | 0% | 0.53% | 0% | 0.98% | 0.44% | 0% | 1.35% | 0.51% | 0.48% | - | 0.16% | 0.46% | 0.8% | - |
| | WA03 | Non-Purposeful Omitted Doses of the Listed Critical Medication | 0.59% | 0.38% | 0.86% | 0.74% | 0.98% | 0.39% | 0.26% | 0.43% | 0.9% | 0.24% | 0.32% | 0.11% | 0.37% | 0.27% | 0.52% | 0.53% | 0.25% | 0.27% |
| Safety Thermometer | AK03 | Safety Thermometer - Harm Free Care | 97.9% | 97.5% | 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% | 97.5% |
| | AK04 | Safety Thermometer - No New Harms | 98.9% | 98.6% | 99.3% | 98.5% | 98.6% | 98.5% | 99.1% | 99% | 98.3% | 98.4% | 98.8% | 98.2% | 98.7% | 98.9% | 98.7% | 98.6% | 98.6% | 98.9% |
| Deteriorating Patient | AR03 | National Early Warning Scores (NEWS) Acted Upon | 92% | 97% | 93% | 93% | 91% | 93% | 100% | 100% | 96% | 93% | 100% | 97% | 100% | 90% | 95% | 96% | 99% | 90% |
| Out of Hours | TD05 | Out of Hours Discharges (8pm-7am) | 7% | 8.5% | 6.8% | 7.2% | 7.4% | 8% | 5.8% | 7.6% | 7% | 6.7% | 8.4% | 10.9% | 9.7% | 9.1% | 7% | 7.1% | 9.7% | 9.1% |
| Timely Discharges | TD03 | Percentage of Patients With Timely Discharge (7am-12Noon) | 22.3% | 23% | 22.6% | 22.4% | 21.7% | 21.6% | 21.3% | 22.3% | 22.6% | 23.3% | 22.9% | 21.9% | 24% | 24.2% | 21.5% | 22.7% | 22.9% | 24.2% |
| | TD03D | Number of Patients With Timely Discharge (7am-12Noon) | 11063 | 6639 | 951 | 916 | 887 | 799 | 914 | 867 | 950 | 944 | 962 | 909 | 983 | 1024 | 2600 | 2761 | 2854 | 1024 |
| Staffing Levels | RP01 | Staffing Fill Rate - Combined | 103.7% | 100.1% | 105.3% | 104.2% | 103.6% | 104.5% | 104.1% | 107.1% | 102.6% | 102.4% | 98.6% | 98% | 97.1% | 97.5% | 104% | 103.7% | 97.9% | 97.5% |
| **Clinical Effectiveness** | | | | | | | | | | | | | | | | | | | | |
| Mortality | X04 | Summary Hospital Mortality Indicator (SHMI) - National Data | 99.2 | - | - | 99.1 | - | - | 97.3 | - | - | - | - | - | - | - | 97.3 | - | - | - |
| | X02 | Hospital Standardised Mortality Ratio (HSMR) | 91.4 | 83.7 | 110.4 | 92.2 | 87.2 | 90.9 | 92.1 | 88.6 | 80.4 | 93 | 80.3 | 75.7 | - | - | 89.9 | 87.3 | 78.1 | - |
| Mortality Review | tbc | Number of Deaths | | | | | | | | | | 229 | | | | | | | 229 | |
| | tbc | Number of Deaths Subject to Casenote Review | | | | | | | | | | 55 | | | | | | | 55 | |
| | tbc | Number of Deaths Reviewed Under Serious Incident Framework | | | | | | | | | | 14 | | | | | | | 14 | |
| | tbc | Number of Deaths With More Than 50:50 Chance of Being Avoidable | | | | | | | | | | 1 | | | | | | | 1 | |
| Readmissions | C01 | Emergency Readmissions Percentage | 2.66% | 3.08% | 2.64% | 2.92% | 2.73% | 2.89% | 2.45% | 2.98% | 3.77% | 3.57% | 3.33% | 2.32% | 2.46% | - | 2.68% | 3.45% | 2.71% | - |
| Sepsis (Inpatients) | AG02a | Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients) | 21.6% | 34.2% | 21.7% | 27.3% | 27.8% | 28.6% | 41.7% | 38.5% | 37.5% | 38.1% | 21.1% | 50% | 16.7% | - | 31.8% | 38.1% | 29.7% | - |
| | AG03a | Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatient | 65.7% | 78.3% | 85.7% | 71.4% | 100% | 50% | 42.9% | 100% | 50% | 62.5% | 66.7% | 100% | 100% | - | 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% | - |
| Sepsis (Emergency Department) | AG02b | Percentage of Patients Meeting Criteria Screened for Sepsis (ED) | 74.4% | 87% | 80% | 80% | 90% | 80% | 100% | 85.7% | 76.9% | 78.3% | 93.8% | 95% | 92.9% | - | 90% | 80% | 94% | - |
| | AG03b | Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (ED) | 56.3% | 83.1% | 50% | 60% | 77.8% | 70% | 25% | 85.7% | 63.6% | 77.8% | 84.6% | 88.2% | 100% | - | 59.3% | 76.7% | 90% | - |
| | AG04b | Sepsis Patients Percentage with a 72 Hour Review (ED) | 94.3% | 100% | 100% | 70% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | - | 100% | 100% | 100% | - |
| Maternity | G01 | Percentage of Low Weight Babies | 2.7% | 2.2% | 3.3% | 2.3% | 2.4% | 3.9% | 3.3% | 2.3% | 3.5% | 0.5% | 1.5% | 3.3% | 3.4% | 0.9% | 3.2% | 2.2% | 2.7% | 0.9% |
| | G01A | Number of Low Weight Babies | 137 | 62 | 13 | 9 | 10 | 14 | 14 | 9 | 15 | 2 | 6 | 13 | 13 | 4 | 38 | 26 | 32 | 4 |
| Fracture Neck of Femur | U02 | Fracture Neck of Femur Patients Treated Within 36 Hours | 70.5% | 75.3% | 69.2% | 51.7% | 69.2% | 81% | 80.8% | 57.7% | 86.7% | 85% | 67.6% | 84.6% | 85.7% | 61.9% | 76.7% | 76.3% | 77.8% | 61.9% |
| | U03 | Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours | 74% | 53.4% | 69.2% | 86.2% | 61.5% | 71.4% | 73.1% | 73.1% | 73.3% | 60% | 47.1% | 34.6% | 33.3% | 47.6% | 68.5% | 69.7% | 39.5% | 47.6% |
| | U04 | Fracture Neck of Femur Patients Achieving Best Practice Tariff | 51.9% | 37.1% | 53.8% | 44.8% | 42.3% | 61.9% | 61.5% | 34.6% | 60% | 50% | 29.4% | 26.9% | 28.6% | 28.6% | 54.8% | 48.7% | 28.4% | 28.6% |
| | U05 | Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours) | - | - | 51.7 | 53.2 | 48.8 | 43.3 | 37.3 | 67.4 | 38 | 37.1 | 45.9 | 43.8 | 37.1 | 53.3 | - | - | - | - |

## SAFE, CARING & EFFECTIVE (continued)

| | | | Annual | | Monthly Totals | | | | | | | | | | | | Quarterly Totals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Topic | ID | Title | 16/17 | 17/18 YTD | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | 16/17 Q4 | 17/18 Q1 | 17/18 Q2 | 17/18 Q3 |
| Stroke Care | O01 | Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour | 58.6% | 67% | 61.8% | 35.3% | 52.4% | 50% | 64.3% | 80.8% | 51.4% | 66.7% | 72.9% | 61.9% | 70% | - | 55.5% | 64.9% | 68.5% | - |
| | O02 | Stroke Care: Percentage Spending 90%+ Time On Stroke Unit | 90.2% | 84.9% | 88.2% | 94.1% | 90.5% | 84.1% | 88.6% | 90.9% | 80.6% | 81.8% | 83.3% | 81% | 92.5% | - | 87.7% | 84.3% | 85.4% | - |
| | O03 | High Risk TIA Patients Starting Treatment Within 24 Hours | 66.8% | 60% | 65.2% | 81.8% | 51.7% | 72.2% | 61.5% | 56.3% | 50% | 77.3% | 27.3% | 66.7% | 75% | - | 60% | 62.5% | 55.9% | - |
| Dementia | AC01 | Dementia - FAIR Question 1 - Case Finding Applied | 90.4% | 89.5% | 88.9% | 89.1% | 80.8% | 80.1% | 84% | 87.2% | 88.3% | 89.4% | 91.1% | 89.9% | 93.5% | 87.7% | 81.6% | 88.3% | 91.5% | 87.7% |
| | AC02 | Dementia - FAIR Question 2 - Appropriately Assessed | 97.2% | 97.7% | 94.1% | 97.6% | 97.6% | 88.9% | 100% | 97.3% | 97.6% | 100% | 100% | 97.7% | 97.9% | 94% | 96.2% | 98.3% | 98.6% | 94% |
| | AC03 | Dementia - FAIR Question 3 - Referred for Follow Up | 94.7% | 90.5% | 100% | 71.4% | 100% | 100% | 100% | 100% | 66.7% | 100% | 100% | 100% | 100% | 75% | 100% | 88.9% | 100% | 75% |
| | AC04 | Percentage of Dementia Carers Feeling Supported | 75% | 100% | - | - | - | - | - | - | - | 100% | - | - | - | - | - | 100% | - | - |
| Outliers | J05 | Ward Outliers - Beddays Spent Outlying. | 8854 | 3961 | 847 | 614 | 1089 | 830 | 717 | 702 | 807 | 485 | 448 | 537 | 424 | 558 | 2636 | 1994 | 1409 | 558 |

**Patient Experience**

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Monthly Patient Surveys | P01d | Patient Survey - Patient Experience Tracker Score | - | - | 92 | 94 | 92 | 92 | 92 | 91 | 91 | 93 | 92 | 92 | 92 | 91 | 91 | 91 | 92 | 91 |
| | P01g | Patient Survey - Kindness and Understanding | - | - | 96 | 97 | 96 | 95 | 96 | 96 | 95 | 97 | 96 | 94 | 96 | 96 | 95 | 96 | 95 | 96 |
| | P01h | Patient Survey - Outpatient Tracker Score | - | - | 90 | 90 | 90 | 88 | 89 | 90 | 88 | 87 | 90 | 87 | 90 | 91 | 89 | 88 | 89 | 91 |
| Friends and Family Test Coverage | P03a | Friends and Family Test Inpatient Coverage | 35.5% | 36.6% | 35.9% | 30.6% | 31.7% | 34.8% | 36.8% | 34.6% | 38.3% | 37.4% | 35.8% | 35.1% | 35.3% | 39.5% | 34.5% | 36.8% | 35.4% | 39.5% |
| | P03b | Friends and Family Test ED Coverage | 16.4% | 17.8% | 18.9% | 15.4% | 21.2% | 17.7% | 18.4% | 15.9% | 16.1% | 20.9% | 17.2% | 18.5% | 18.3% | 17.9% | 19.1% | 17.6% | 18% | 17.9% |
| | P03c | Friends and Family Test MAT Coverage | 22.5% | 19.8% | 22.1% | 19.8% | 24.6% | 29.7% | 25.3% | 23.6% | 17.1% | 21.8% | 20% | 17.3% | 18.3% | 21% | 26.4% | 20.7% | 18.6% | 21% |
| Friends and Family Test Score | P04a | Friends and Family Test Score - Inpatients | 97.2% | 97.5% | 97.3% | 97.5% | 97.4% | 96.9% | 98.5% | 97.2% | 96.9% | 97.7% | 97.7% | 97.5% | 97.7% | 97.9% | 97.6% | 97.3% | 97.6% | 97.9% |
| | P04b | Friends and Family Test Score - ED | 78.2% | 81.6% | 78.9% | 74.1% | 80.8% | 79.6% | 80.2% | 83.2% | 77% | 84.4% | 77.4% | 81.9% | 83.5% | 83.3% | 80.2% | 81.7% | 81% | 83.3% |
| | P04c | Friends and Family Test Score - Maternity | 96.8% | 96.9% | 94.3% | 94.5% | 98.2% | 96.2% | 97.4% | 96.9% | 95.8% | 96.9% | 94.9% | 96.5% | 99.2% | 98% | 97.3% | 96.6% | 96.8% | 98% |
| Patient Complaints | T01 | Number of Patient Complaints | 1875 | 1139 | 139 | 118 | 129 | 144 | 168 | 247 | 158 | 150 | 146 | 146 | 138 | 154 | 441 | 555 | 430 | 154 |
| | T01a | Patient Complaints as a Proportion of Activity | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| | T03a | Complaints Responded To Within Trust Timeframe | 86.1% | 82.4% | 93.4% | 97.4% | 87.5% | 87.5% | 83.3% | 76.3% | 83% | 80.4% | 82% | 87.3% | 78.7% | 85.1% | 86% | 80.2% | 83% | 85.1% |
| | T03b | Complaints Responded To Within Divisional Timeframe | 86.6% | 83.2% | 85.2% | 76.9% | 85.4% | 85% | 72.9% | 76.3% | 83% | 78.3% | 90% | 81.7% | 86.9% | 83.6% | 80.9% | 79.4% | 85.7% | 83.6% |
| | T04c | Percentage of Responses where Complainant is Dissatisfied | 11.41% | 7.36% | 9.84% | 12.82% | 14.58% | 10% | 12.5% | 15.79% | 17.02% | 21.74% | 8% | 14.09% | - | - | 12.5% | 18.32% | 5.81% | 0% |
| Cancelled Operations | F01q | Percentage of Last Minute Cancelled Operations (Quality Objective) | 0.98% | 0.97% | 0.88% | 0.99% | 1.24% | 1.52% | 0.91% | 1.34% | 1.02% | 0.81% | 0.81% | 0.91% | 0.91% | 1% | 1.2% | 1.05% | 0.88% | 1% |
| | F01a | Number of Last Minute Cancelled Operations | 734 | 442 | 57 | 58 | 79 | 89 | 63 | 80 | 67 | 54 | 54 | 61 | 58 | 68 | 231 | 201 | 173 | 68 |

## RESPONSIVE

| Topic | ID | Title | Annual Target Green | Annual Target Red | Annual 16/17 | Annual 17/18 YTD | Monthly Totals Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Quarterly Totals 16/17 Q4 | 17/18 Q1 | 17/18 Q2 | 17/18 Q3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referral to Treatment (RTT) Performance | A03 | Referral To Treatment Ongoing Pathways Under 18 Weeks | 92% | 92% | 91.7% | 90.4% | 92% | 92% | 92.2% | 92% | 91.1% | 91.1% | 91.1% | 91% | 90.2% | 89.9% | 89.4% | 90% | 91.8% | 91.1% | 89.8% | 90% |
| | A03a | Referral To Treatment Number of Ongoing Pathways Over 18 Weeks | - | - | - | - | 2805 | 2751 | 2619 | 2777 | 3171 | 2985 | 3056 | 3023 | 3317 | 3372 | 3524 | 3300 | - | - | - | - |
| Referral to Treatment (RTT) Wait Times | A06 | Referral To Treatment Ongoing Pathways Over 52 Weeks | 0 | 1 | 11 | 153 | 1 | 1 | 3 | 3 | 2 | 5 | 11 | 46 | 30 | 32 | 19 | 10 | 8 | 62 | 81 | 10 |
| | A07 | Referral To Treatment Ongoing Pathways 40+ Weeks | - | - | 696 | 1286 | 78 | 93 | 86 | 106 | 133 | 153 | 165 | 193 | 198 | 240 | 182 | 155 | 325 | 511 | 620 | 155 |
| New Outpatient Wait List | L02L | New Outpatient List (RTT Specialties) - Numbers Waiting 12+ Weeks | - | - | - | - | 7986 | 8521 | 7372 | 7068 | 6307 | 6723 | 7105 | 7586 | 7453 | 9537 | 11273 | 12709 | - | - | - | - |
| | L02M | New Outpatient List (RTT Specialties) - Percentage Waiting 12+ Weeks | - | - | - | - | 29.8% | 32.3% | 28.5% | 28.9% | 27.5% | 27.6% | 28.7% | 28.3% | 25.6% | 30.4% | 34.7% | 38.3% | - | - | - | - |
| Cancer (2 Week Wait) | E01a | Cancer - Urgent Referrals Seen In Under 2 Weeks | 93% | 93% | 94.8% | 94.3% | 96.2% | 96% | 95.9% | 95.5% | 96.3% | 95.1% | 95.6% | 94.3% | 93.4% | 93.2% | 94.6% | - | 95.9% | 95% | 93.7% | - |
| | E01c | Cancer - Urgent Referrals Stretch Target | 80% | 80% | 68.4% | 59.4% | 71% | 60.8% | 75.3% | 76% | 79.7% | 52.5% | 55.4% | 62.1% | 63.6% | 62.4% | 59.9% | - | 77.2% | 56.8% | 62% | - |
| Cancer (31 Day) | E02a | Cancer - 31 Day Diagnosis To Treatment (First Treatments) | 96% | 96% | 96.7% | 95.9% | 98.3% | 96.1% | 96.5% | 96.8% | 97.4% | 91.3% | 96.6% | 95.1% | 97% | 97.9% | 96.9% | - | 96.9% | 94.5% | 97.3% | - |
| | E02b | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug) | 98% | 98% | 98.7% | 98.5% | 100% | 99.1% | 100% | 100% | 98.4% | 99.2% | 97.5% | 98.7% | 98.6% | 98.6% | 98.5% | - | 99.5% | 98.4% | 98.6% | - |
| | E02c | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) | 94% | 94% | 94.4% | 91.9% | 98% | 95.9% | 93.8% | 92.3% | 96.5% | 83.3% | 92.2% | 93.2% | 91.7% | 96.3% | 94.7% | - | 94.3% | 89.5% | 94.3% | - |
| | E02d | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) | 94% | 94% | 96.6% | 96.5% | 98.1% | 98.2% | 96.9% | 97.6% | 96.7% | 98.1% | 96.6% | 95.9% | 93.9% | 97.3% | 98% | - | 97% | 96.7% | 96.3% | - |
| Cancer (62 Day) | E03a | Cancer 62 Day Referral To Treatment (Urgent GP Referral) | 85% | 85% | 79.3% | 79.4% | 85.2% | 81.5% | 84.3% | 78.8% | 81.2% | 76.5% | 77.8% | 81.7% | 75% | 85.2% | 80.2% | - | 81.5% | 78.8% | 80.1% | - |
| | E03b | Cancer 62 Day Referral To Treatment (Screenings) | 90% | 90% | 69.4% | 83% | 83.3% | 100% | 57.1% | 100% | 83.3% | 71.4% | 44.4% | 100% | 87.5% | 100% | 100% | - | 77.8% | 65% | 96.3% | - |
| | E03c | Cancer 62 Day Referral To Treatment (Upgrades) | 85% | 85% | 87.9% | 85.1% | 90.1% | 82.1% | 93.2% | 77.8% | 88.4% | 93% | 77.7% | 87% | 78.6% | 84.8% | 90.7% | - | 86.8% | 85.5% | 84.6% | - |
| | E03f | Cancer Urgent GP Referrals - Numbers Treated after Day 103 | - | - | 62 | 30 | 6.5 | 4 | 5.5 | 4.5 | 7.5 | 4 | 5 | 5 | 8 | 5 | 3 | - | 17.5 | 14 | 16 | - |
| Cancelled Operations | F01 | Last Minute Cancelled Operations - Percentage of Admissions | 0.8% | 0.8% | 0.98% | 0.97% | 0.88% | 0.99% | 1.24% | 1.52% | 0.91% | 1.34% | 1.02% | 0.81% | 0.81% | 0.91% | 0.91% | 1% | 1.2% | 1.05% | 0.88% | 1% |
| | F01a | Number of Last Minute Cancelled Operations | - | - | 734 | 442 | 57 | 58 | 79 | 89 | 63 | 80 | 67 | 54 | 54 | 61 | 58 | 68 | 231 | 201 | 173 | 68 |
| | F02c | Number of LMCs Not Re-admitted Within 28 Days | 22 | 22 | 72 | 18 | 6 | 4 | 4 | 6 | 15 | 4 | 6 | 2 | 0 | 1 | 3 | 2 | 25 | 12 | 4 | 2 |
| Admissions Cancelled Day Before | F07 | Percentage of Admissions Cancelled Day Before | - | - | 1.36% | 1.4% | 1.61% | 1.38% | 0.67% | 1.16% | 1.13% | 1.05% | 1.86% | 1.82% | 1.2% | 0.88% | 1.73% | 1.28% | 0.99% | 1.59% | 1.26% | 1.28% |
| | F07a | Number of Admissions Cancelled Day Before | - | - | 1021 | 642 | 104 | 81 | 43 | 68 | 78 | 63 | 122 | 121 | 80 | 59 | 110 | 87 | 189 | 306 | 249 | 87 |
| Primary PCI | H02 | Primary PCI - 150 Minutes Call to Balloon Time | 90% | 70% | 72.4% | 80% | 57.1% | 64.7% | 69% | 86.1% | 83.3% | 83.3% | 78.1% | 77.5% | 75% | 80.6% | 84.8% | - | 79.2% | 79.8% | 80.2% | - |
| | H03a | Primary PCI - 90 Minutes Door to Balloon Time | 90% | 90% | 91.7% | 92.1% | 85.7% | 79.4% | 90.5% | 94.4% | 100% | 90.5% | 93.8% | 90% | 87.5% | 94.4% | 97% | - | 95% | 91.2% | 93.1% | - |
| Diagnostic Waits | A05 | Diagnostics 6 Week Wait (15 Key Tests) | 99% | 99% | 97.79% | 98.28% | 99.05% | 98.23% | 98.38% | 98.69% | 98.65% | 98.56% | 98.8% | 98.58% | 98.52% | 97.61% | 97.7% | 98.19% | 98.58% | 98.65% | 97.94% | 98.19% |
| Outpatients | R03 | Outpatient Hospital Cancellation Rate | 9.7% | 11.7% | 11.5% | 10.9% | 10.2% | 11% | 10.7% | 11.2% | 11.1% | 12% | 10.8% | 11% | 11.2% | 11% | 10.5% | 9.9% | 11% | 11.2% | 10.9% | 9.9% |
| | R05 | Outpatient DNA Rate | 5% | 10% | 7.3% | 7.3% | 6.9% | 7.8% | 7.3% | 6.9% | 6.9% | 7.1% | 7.2% | 7.5% | 7.4% | 7.2% | 7.4% | 7.1% | 7% | 7.3% | 7.4% | 7.1% |
| Outpatient Ratio | R01 | Follow-Up To New Ratio | 2.03 | 2.03 | 2.24 | 2.21 | 2.17 | 2.2 | 2.29 | 2.3 | 2.27 | 2.2 | 2.25 | 2.23 | 2.25 | 2.26 | 2.16 | 2.1 | 2.28 | 2.23 | 2.22 | 2.1 |
| ERS | BC01 | ERS - Available Slot Issues Percentage | - | - | 31% | 20.2% | 25.3% | 34.3% | 26.1% | 25.2% | 26.4% | 24.4% | 24% | 21.7% | 18.8% | 16.8% | 15.8% | 20.2% | 25.9% | 23.4% | 17.1% | 20.2% |

## RESPONSIVE (continued)

| Topic | ID | Title | Annual Target Green | Annual Target Red | Annual 16/17 | Annual 17/18 YTD | Monthly Totals Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Quarterly Totals 16/17 Q4 | 17/18 Q1 | 17/18 Q2 | 17/18 Q3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Delayed Discharges | Q01A | Acute Delayed Transfers of Care - Patients | - | - | - | - | 28 | 28 | 29 | 29 | 29 | 19 | 24 | 30 | 18 | 31 | 22 | 26 | - | - | - | - |
| | Q02A | Non-Acute Delayed Transfers of Care - Patients | - | - | - | - | 2 | 3 | 4 | 2 | 16 | 8 | 6 | 6 | 11 | 11 | 11 | 10 | - | - | - | - |
| | Q01B | Acute Delayed Transfers of Care - Beddays | - | - | 10232 | 4759 | 802 | 834 | 891 | 750 | 809 | 655 | 604 | 577 | 745 | 647 | 757 | 774 | 2450 | 1836 | 2149 | 774 |
| | Q02B | Non-Acute Delayed Transfers of Care - Beddays | - | - | 2167 | 1920 | 138 | 131 | 106 | 183 | 252 | 306 | 145 | 259 | 278 | 374 | 243 | 315 | 541 | 710 | 895 | 315 |
| Green To Go List | AQ06A | Green To Go List - Number of Patients (Acute) | - | - | - | - | 54 | 51 | 59 | 52 | 47 | 43 | 42 | 43 | 46 | 51 | 36 | 46 | - | - | - | - |
| | AQ06B | Green To Go List - Number of Patients (Non Acute) | - | - | - | - | 8 | 8 | 6 | 9 | 22 | 14 | 13 | 11 | 15 | 17 | 22 | 22 | - | - | - | - |
| | AQ07A | Green To Go List - Beddays (Acute) | - | - | - | - | 1864 | 1691 | 1937 | 1575 | 1716 | 1400 | 1371 | 1403 | 1430 | 1580 | 1502 | 1461 | - | - | - | - |
| | AQ07B | Green To Go List - Beddays (Non-Acute) | - | - | - | - | 249 | 270 | 189 | 334 | 450 | 503 | 383 | 419 | 401 | 572 | 515 | 671 | - | - | - | - |
| Length of Stay | J03 | Average Length of Stay (Spell) | - | - | 4.11 | 4.09 | 3.99 | 4.11 | 4.11 | 4.34 | 4.17 | 4.14 | 4.31 | 4.06 | 3.8 | 4.37 | 4.12 | 3.87 | 4.2 | 4.17 | 4.09 | 3.87 |
| | J04D | Percentage Length of Stay 14+ Days | - | - | 6.9% | 6.9% | 6.4% | 7.1% | 6.6% | 7.6% | 7.1% | 7% | 7.8% | 6.7% | 6.2% | 7% | 6.8% | 6.8% | 7.1% | 7.2% | 6.7% | 6.8% |
| 14 Day LOS Patients | C07 | Number of 14+ Day Length of Stay Patients at Month End | - | - | - | - | 251 | 236 | 272 | 257 | 269 | 265 | 240 | 226 | 250 | 255 | 237 | 240 | - | - | - | - |
| AMU | J35 | Percentage of Cardiac AMU Wardstays | - | - | 4.1% | 4.1% | 5.6% | 2.8% | 2.9% | 2.2% | 4.1% | 1.4% | 3.9% | 5.2% | 4.2% | 4.3% | 4.2% | 5% | 3.2% | 3.5% | 4.2% | 5% |
| | J35A | Percentage of Cardiac AMU Wardstays Under 24 Hours | - | - | 39.2% | 48.1% | 52.6% | 33.3% | 57.1% | 57.1% | 44.1% | 63.6% | 61.3% | 37.2% | 39.5% | 50% | 32.4% | 63.6% | 50.7% | 49.4% | 40.9% | 63.6% |

### Emergency Department Indicators

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED - Time In Department | B01 | ED Total Time in Department - Under 4 Hours | 95% | 95% | 85.01% | 88.17% | 78.45% | 79.64% | 80.37% | 80.73% | 83.25% | 82.31% | 84.21% | 87.89% | 90.53% | 91.26% | 90.84% | 90.06% | 81.53% | 84.81% | 90.87% | 90.06% |
| | *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% | 88.17% | 78.45% | 79.64% | 80.37% | 80.73% | 83.25% | 82.31% | 84.21% | 87.89% | 90.53% | 91.26% | 90.84% | 90.06% | 81.53% | 84.81% | 90.87% | 90.06% |
| | BB07 | BRI ED - Percentage Within 4 Hours | - | - | 77.42% | 80.76% | 71.69% | 73.47% | 68.86% | 68.15% | 73.89% | 69.16% | 73.76% | 79.01% | 85.11% | 86.82% | 86.53% | 84.11% | 70.4% | 73.99% | 86.14% | 84.11% |
| | BB03 | BCH ED - Percentage Within 4 Hours | - | - | 89.89% | 96.01% | 78.6% | 79.38% | 90.19% | 92.11% | 88.92% | 96.83% | 94.05% | 97.14% | 96.62% | 96.35% | 94.99% | 96.34% | 90.28% | 95.93% | 95.97% | 96.34% |
| | BB04 | BEH ED - Percentage Within 4 Hours | 99.5% | 99.5% | 98.97% | 96.95% | 99.06% | 99.15% | 98.56% | 99% | 99.18% | 96.52% | 96.57% | 97.9% | 96.58% | 97.04% | 96.58% | 97.43% | 98.93% | 97% | 96.74% | 97.43% |
| | *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 | 1 | 11 | 19 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 24 | 0 | 0 | 0 |
| Time to Initial Assessment | B02c | ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH) | 95% | 95% | 97.6% | 98.3% | 97.9% | 97.9% | 98% | 98.5% | 98.8% | 98.9% | 96.3% | 98.3% | 98.5% | 99.3% | 97.8% | 98.8% | 98.4% | 97.8% | 98.5% | 98.8% |
| | B02b | ED Time to Initial Assessment - Data Completness | 95% | 95% | 92.8% | 92.3% | 92.7% | 93.7% | 93.6% | 94.1% | 93.9% | 92.1% | 91.6% | 92.8% | 91.8% | 92.6% | 90.7% | 94.2% | 93.8% | 92.1% | 91.7% | 94.2% |
| Time to Start of Treatment | B03 | ED Time to Start of Treatment - Under 60 Minutes | 50% | 50% | 52.6% | 53.2% | 48.2% | 50.5% | 53.3% | 54.3% | 51% | 50.8% | 52.3% | 52.8% | 54% | 55.4% | 54.1% | 53.2% | 52.8% | 52% | 54.5% | 53.2% |
| | B03b | ED Time to Start of Treatment - Data Completeness | 95% | 95% | 98.5% | 97.3% | 98.5% | 98.3% | 98.7% | 98.1% | 98.1% | 97.8% | 97.2% | 97.1% | 97.4% | 97.3% | 97.5% | 97.1% | 98.3% | 97.4% | 97.4% | 97.1% |
| Others | B04 | ED Unplanned Re-attendance Rate | 5% | 5% | 2.6% | 2.5% | 2.5% | 3.3% | 2.5% | 3.1% | 2.5% | 2.6% | 2.6% | 2.7% | 2.7% | 1.9% | 2.3% | 2.9% | 2.7% | 2.6% | 2.3% | 2.9% |
| | B05 | ED Left Without Being Seen Rate | 5% | 5% | 2.2% | 2.4% | 2.2% | 2.4% | 1.4% | 1.8% | 2% | 2.8% | 2.6% | 2.5% | 2% | 2.1% | 3.7% | 1.1% | 1.8% | 2.6% | 2.6% | 1.1% |
| Ambulance Handovers | BA09 | Ambulance Handovers - Over 30 Minutes | - | - | 1216 | 484 | 119 | 114 | 138 | 83 | 11 | 111 | 82 | 84 | 46 | 54 | 44 | 63 | 232 | 277 | 144 | 63 |
| Acute Medical Unit (AMU) | J35 | Percentage of Cardiac AMU Wardstays | - | - | 4.1% | 4.1% | 5.6% | 2.8% | 2.9% | 2.2% | 4.1% | 1.4% | 3.9% | 5.2% | 4.2% | 4.3% | 4.2% | 5% | 3.2% | 3.5% | 4.2% | 5% |
| | J35a | Percentage of Cardiac AMU Wardstays Under 24 Hours | - | - | 39.2% | 48.1% | 52.6% | 33.3% | 57.1% | 57.1% | 44.1% | 63.6% | 61.3% | 37.2% | 39.5% | 50% | 32.4% | 63.6% | 50.7% | 49.4% | 40.9% | 63.6% |

## EFFICIENT

| Topic | ID | Title | Annual | | Monthly Totals | | | | | | | | | | | | Quarterly Totals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 16/17 | 17/18 YTD | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | 16/17 Q4 | 17/18 Q1 | 17/18 Q2 | 17/18 Q3 |
| Sickness | AF02 | Sickness Rate | 3.9% | 3.9% | 4.7% | 4.7% | 4.9% | 4.3% | 3.8% | 3.6% | 3.7% | 3.8% | 4.4% | 4.1% | 3.7% | 4% | 3.8% | 3.8% | 3.7% | |
| | | *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 | 8599.7 | 8402.2 | 8407.6 | 8434.2 | 8436 | 8446.1 | 8367.1 | 8479.3 | 8491.6 | 8499.7 | 8547.6 | 8557.9 | 8599.7 | 8446.1 | 8491.6 | 8557.9 | |
| | AF09A | Actual Staff FTE (Including Bank & Agency) | 8566.5 | 8665.1 | 8468.8 | 8412.7 | 8458.1 | 8496.4 | 8566.5 | 8510.5 | 8546.3 | 8584.7 | 8602.5 | 8641.4 | 8642 | 8665.1 | 8566.5 | 8584.7 | 8642 | |
| | AF13 | Percentage Over Funded Establishment | 1.4% | 0.8% | 0.8% | 0.1% | 0.3% | 0.7% | 1.4% | 1.7% | 0.8% | 1.1% | 1.2% | 1.1% | 1% | 0.8% | 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 | 495.3 | 387 | 358.5 | 378.3 | 398.9 | 427.9 | 446.7 | 476.6 | 501.8 | 531 | 536.4 | 503.4 | 495.3 | 427.9 | 501.8 | 503.4 | |
| | AF11A | Percentage Bank Usage | 5% | 5.7% | 4.6% | 4.3% | 4.5% | 4.7% | 5% | 5.2% | 5.6% | 5.8% | 6.2% | 6.2% | 5.8% | 5.7% | 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 | 90.4 | 142.7 | 111.5 | 122.5 | 131 | 123.7 | 96.7 | 94.1 | 123.4 | 130.6 | 125.3 | 102.9 | 90.4 | 123.7 | 123.4 | 102.9 | |
| | AF11B | Percentage Agency Usage | 1.4% | 1% | 1.7% | 1.3% | 1.4% | 1.5% | 1.4% | 1.1% | 1.1% | 1.4% | 1.5% | 1.5% | 1.2% | 1% | 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 | 431.3 | 379.6 | 383.7 | 389.4 | 384 | 349.8 | 331.4 | 420.4 | 451 | 477.3 | 483.8 | 434.4 | 431.3 | 349.8 | 451 | 434.4 | |
| | AF07 | Vacancy Rate (Vacancy FTE as Percent of Funded FTE) | 4.2% | 5.1% | 4.6% | 4.6% | 4.7% | 4.6% | 4.2% | 4% | 5% | 5.4% | 5.7% | 5.7% | 5.1% | 5.1% | 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 | 132 | 115 | 137 | 170 | 148 | 157 | 177 | 174 | 148 | 189 | 365 | 226 | 132 | 157 | 148 | 226 | |
| | AF10 | Workforce Turnover Rate | 12.8% | 12.7% | 12.6% | 12.7% | 12.5% | 12.6% | 12.8% | 12.5% | 12.7% | 12.9% | 13.1% | 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% | 89% | 89% | 89% | 85% | 85% | 89% | 89% | 88% | 86% | 87% | 87% | 85% | 89% | 87% | |
| | AF21b | Essential Training Compliance - Annual Training (Fire & IG) | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | |
| | AF21f | Essential Training Compliance - Fire Safety | 83% | 87% | 80% | 81% | 82% | 82% | 83% | 82% | 84% | 84% | 86% | 87% | 87% | 87% | 83% | 84% | 87% | |
| | AF21g | Essential Training Compliance - Information Governance | 76% | 82% | 76% | 76% | 76% | 77% | 76% | 75% | 75% | 75% | 80% | 82% | 82% | 82% | 76% | 75% | 82% | |
| | AF21c | Essential Training Compliance - Induction | 97% | 98% | 96% | 96% | 96% | 97% | 97% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 97% | 98% | 98% | |
| | AF21d | Essential Training Compliance - Resuscitation Training | 75% | 83% | 81% | 83% | 85% | 85% | 75% | 75% | 71% | 71% | 77% | 80% | 81% | 83% | 75% | 71% | 81% | |
| | AF21e | Essential Training Compliance - Safeguarding Training | 91% | 87% | 90% | 90% | 90% | 90% | 91% | 90% | 90% | 90% | 89% | 87% | 87% | 87% | 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 |
| CT | Computed Tomography |
| 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<br>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:<br>1. Surgery within 36 hours from admission to hospital<br>2. Multi-disciplinary Team rehabilitation led by an Ortho-geriatrician<br>3. Ortho-geriatric review within 72 hours of admission<br>4. Falls Assessment<br>5. Joint care of patients under Trauma & Orthopaedic and Ortho-geriatric Consultants<br>6. Bone Health Assessment<br>7. Completion of a Joint Assessment<br>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 |
| MRI | Magnetic Resonance Imaging |
| NA | Nursing Assistant |

| | |
|---|---|
| NBT | North Bristol Trust |
| NICU | Neonatal Intensive Care Unit |
| NOF | Abbreviation used for Neck of Femur |
| NRLS | National Learning & Reporting System |
| PET | Positron Emission Tomography |
| PICU | Paediatric Intensive Care Unit |
| RAG | Red, Amber Green – the different ratings applied to categorise performance for a Key Performance Indicator |
| RCA | Root Cause Analysis |
| RN | Registered Nurse |
| RTT | Referral to Treatment Time – which measures the number of weeks from referral through to start of treatment. This is a national measure of waiting times. |
| STM | St Michael's Hospital |

# Appendix 2

**BREAKDOWN OF ESSENTIAL TRAINING COMPLIANCE FOR OCTOBER 2017:**

**All Essential Training**

| | UH Bristol | Diagnostic & Therapies | Facilities & Estates | Medicine | Specialised Services | Surgery | Trust Services | Women's & Children's |
|---|---|---|---|---|---|---|---|---|
| Three Yearly | 87% | 87% | 88% | 88% | 88% | 88% | 88% | 85% |
| Annual Fire | 86% | 88% | 84% | 87% | 89% | 87% | 88% | 83% |
| Annual IG | 82% | 85% | 83% | 80% | 86% | 83% | 84% | 76% |
| Induction & Orientation | 98% | 99% | 99% | 97% | 98% | 97% | 98% | 98% |
| Medical & Dental Induction | 89% | 50% | N/A | 87% | 96% | 88% | 67% | 97% |
| Resuscitation | 83% | 87% | 9% | 89% | 87% | 86% | 78% | 78% |
| Safeguarding | 87% | 87% | 86% | 88% | 85% | 86% | 90% | 86% |

**Timeline of Trust Essential Training Compliance:**

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

**Safeguarding Adults and Children**

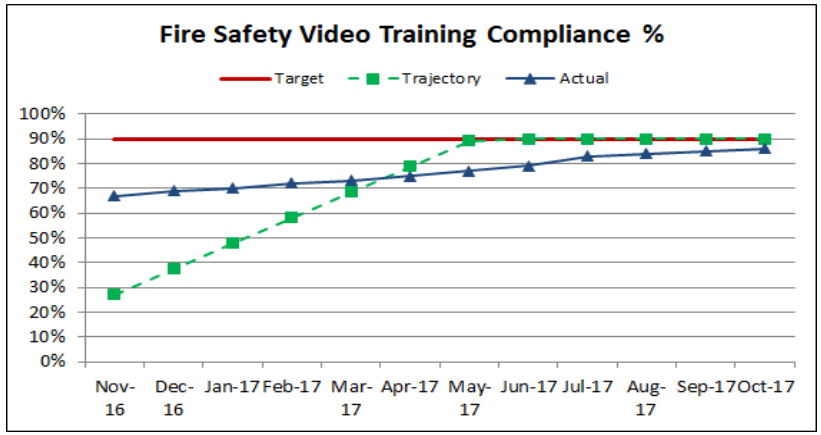
| | UH Bristol | Diagnostics & Therapies | Facilities & Estates | Medicine | Specialised Services | Surgery | Trust Services | Women's & Children's |
|---|---|---|---|---|---|---|---|---|
| Safeguarding Adults L1 | 87% | 86% | 86% | 82% | 86% | 88% | 90% | 89% |
| Safeguarding Adults L2 | 87% | 88% | 85% | 90% | 87% | 88% | 86% | 85% |
| Safeguarding Adults L3 | 84% | 100% | N/A | 86% | 100% | 80% | 87% | 55% |
| Safeguarding Children L1 | 89% | 90% | 83% | 90% | 94% | 91% | 93% | N/A |
| Safeguarding Children L2 | 85% | 85% | 95% | 88% | 81% | 84% | 77% | 92% |

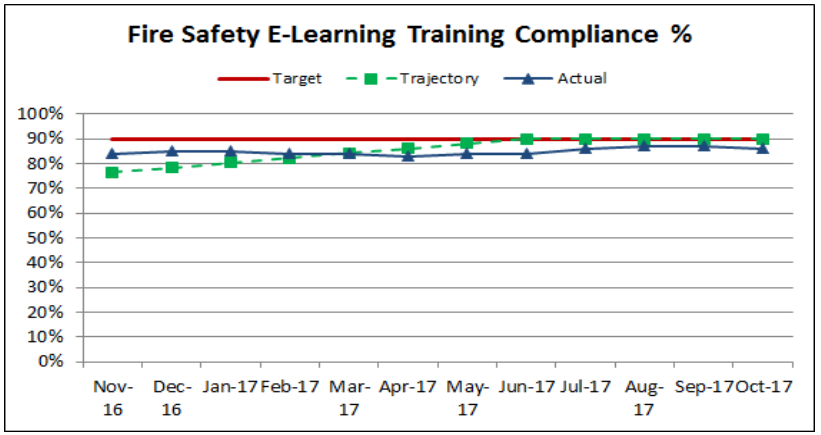
**Child Protection Level 3**

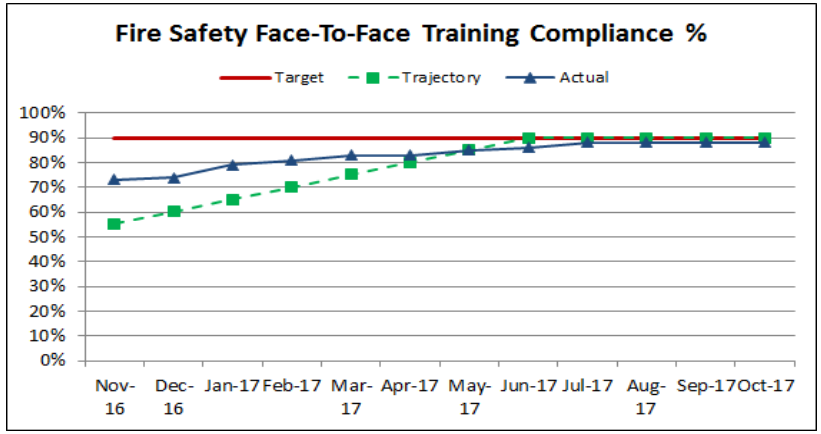
| | UH Bristol | Diagnostic & Therapies | Medicine | Specialised Services | Surgery | Trust Services | Women`s & Children`s |
|---|---|---|---|---|---|---|---|
| Core | 79% | 76% | 69% | 96% | 71% | 100% | 80% |
| Specialist | 73% | N/A | N/A | N/A | N/A | 100% | 73% |

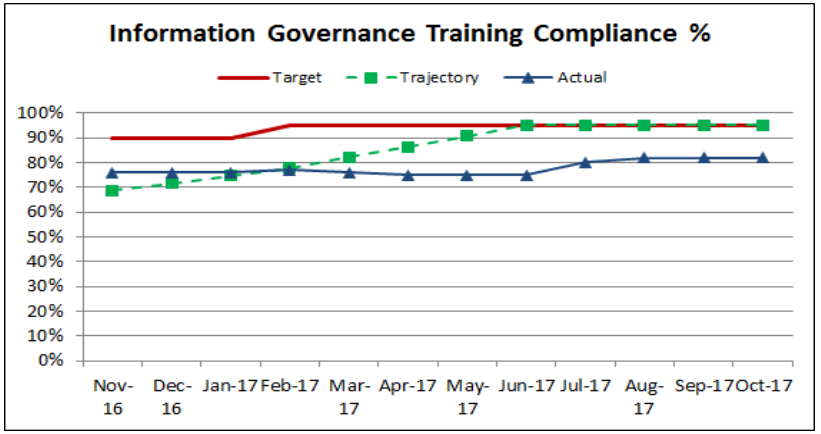
## Appendix 2 (continued)

### 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 (18/09/17 – 15/10/17)**

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 | 353 | 0 | 102 | 487 | 942 |
| Health Care Assistant & other Support | 26 | 3 | 12 | 4 | 0 | 45 |
| Medical & Dental | 0 | 0 | 0 | 0 | 35 | 35 |
| Scientific, Therapeutic/ Technical Allied Health Professional (AHP) & Healthcare Science | | 0 | | | 0 | 0 |
| Administrative & Clerical and Estates | 1245 | | | | | 1245 |

# Appendix 3

## Access standards – further breakdown of figures

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

| Tumour Site | UH Bristol | Internal operational target | National |
|---|---|---|---|
| Brain*† | - | - | - |
| Breast† | 100% | - | 93.3% |
| Gynaecology | 55.6% | 85% | 76% |
| Haematology (excluding acute leukaemia) | 84.6% | 85% | 81.6% |
| Head and Neck | 88.9% | 79% | 64.2% |
| Lower Gastrointestinal | 100% | 79% | 72.3% |
| Lung | 64.3% | 79% | 68.9% |
| Other* | - | - | - |
| Sarcoma*† | 50% | - | 64.5% |
| Skin | 98.7% | 96% | 94.8% |
| Upper Gastrointestinal | 52% | 79% | 75.2% |
| Urology*† | 0% | - | 78.8% |
| Total (all tumour sites) | **80.2%** | **85.0%** | **82.5%** |
| Improvement trajectory (Sustainability and Transformation) | **83.6%** | | |
| Improvement trajectory (recovery trajectory) | **80.0%** | | |
| Performance for internally managed pathways | **85.5%** | | |
| Performance for shared care pathways | **55.8%** | | |
| Performance with breach reallocation applied | **78.3%** | | |

*3 or fewer patients treated in accountability terms

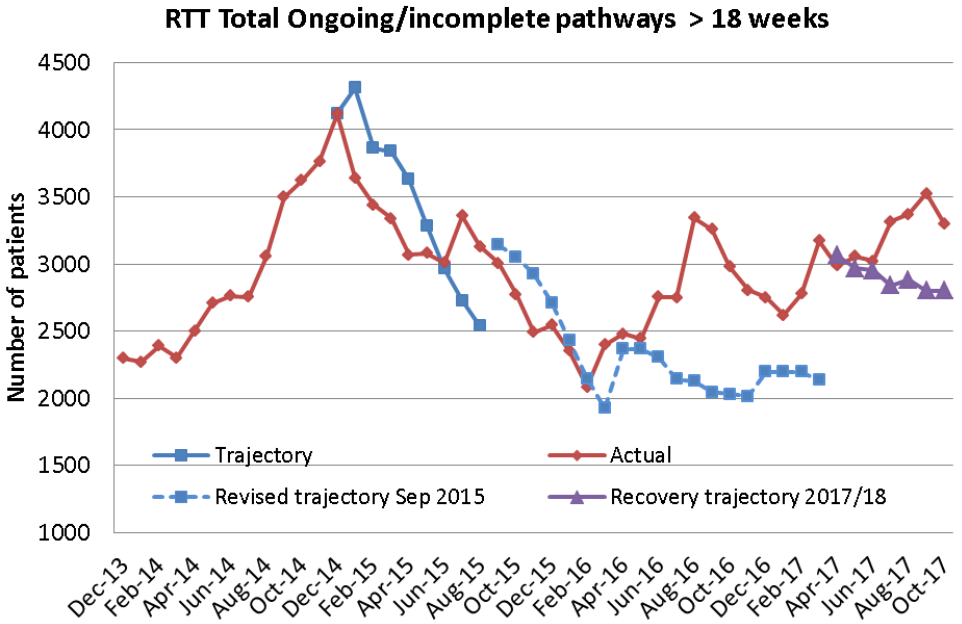
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

## 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 October 2017**

| RTT Specialty | Ongoing Over 18 Weeks | Ongoing Pathways | Ongoing Performance |
|---|---|---|---|
| Cardiology | 345 | 2,382 | 85.5% |
| Cardiothoracic Surgery | 51 | 361 | 85.9% |
| Dermatology | 95 | 2,331 | 95.9% |
| E.N.T. | 47 | 1,911 | 97.5% |
| Gastroenterology | 22 | 392 | 94.4% |
| General Medicine | 0 | 62 | 100.0% |
| Geriatric Medicine | 0 | 139 | 100.0% |
| Gynaecology | 121 | 1,399 | 91.4% |
| Neurology | 47 | 445 | 89.4% |
| Ophthalmology | 391 | 4,725 | 91.7% |
| Oral Surgery | 152 | 1,965 | 92.3% |
| Other | 1,917 | 14,428 | 86.7% |
| Rheumatology | 9 | 512 | 98.2% |
| Thoracic Medicine | 18 | 1,130 | 98.4% |
| Trauma & Orthopaedics | 85 | 972 | 91.3% |
| **Grand Total** | **3,330** | **33,155** | **90.0%** |

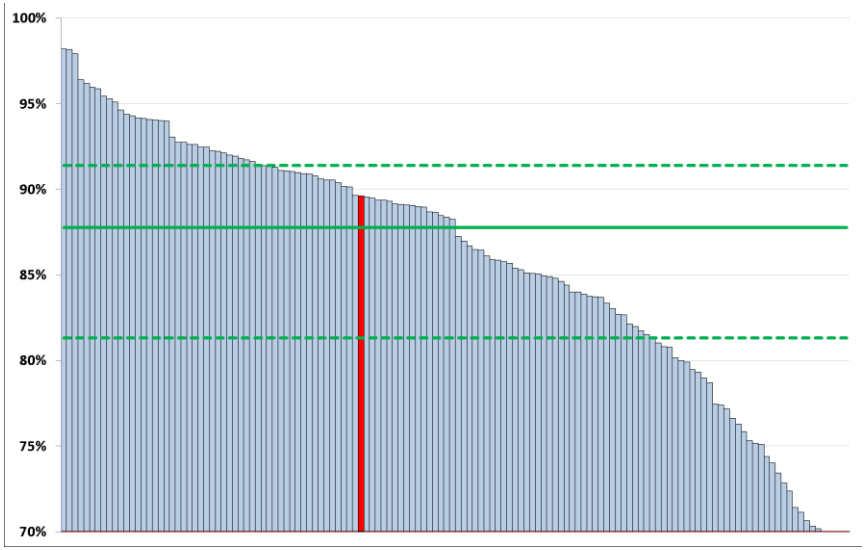



| | Feb 17 | Mar 17 | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 |
|---|---|---|---|---|---|---|---|---|---|
| Non-admitted pathways > 18 weeks | 1592 | 1826 | 1705 | 1744 | 1750 | 2006 | 2107 | 2221 | 1962 |
| Admitted pathways > 18 weeks | 1185 | 1345 | 1280 | 1312 | 1273 | 1311 | 1265 | 1303 | 1338 |
| Total pathways > 18 weeks | 2777 | 3171 | 2895 | 3056 | 3023 | 3317 | 3372 | 3524 | 3300 |
| Actual % incomplete < 18 weeks | 92.0% | 91.1% | 91.1% | 91.1% | 91.0% | 90.2% | 89.9% | 89.4% | 90.0% |
| Recovery forecast | 92.0% | 92.0% | 90.9% | 91.4% | 91.8% | 92.0% | 92.0% | 92.0% | 92.0% |

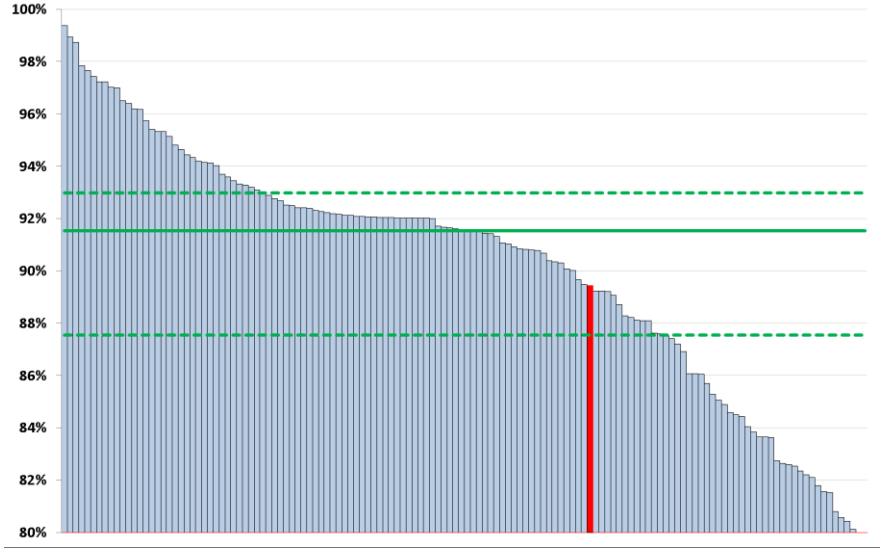
# Appendix 4

## Benchmarking Reports

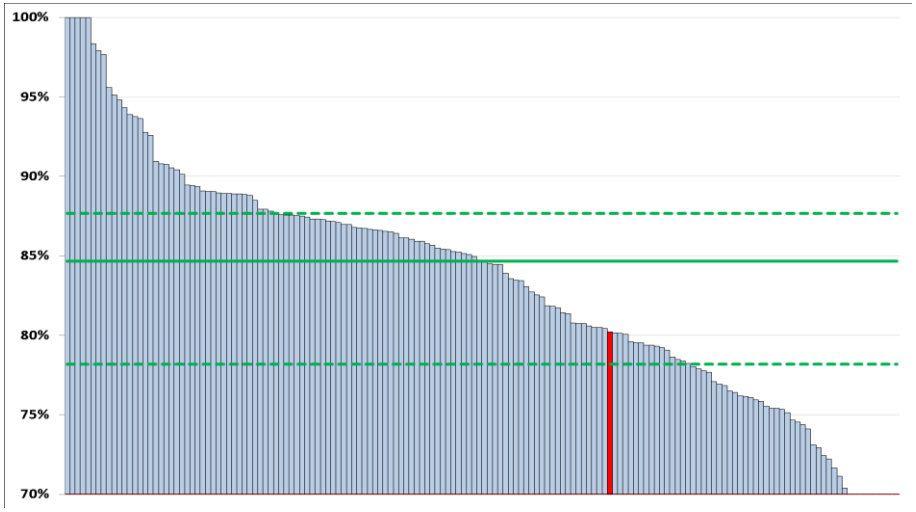
### A&E 4-hours (Quarter 2 – July to September 2017)



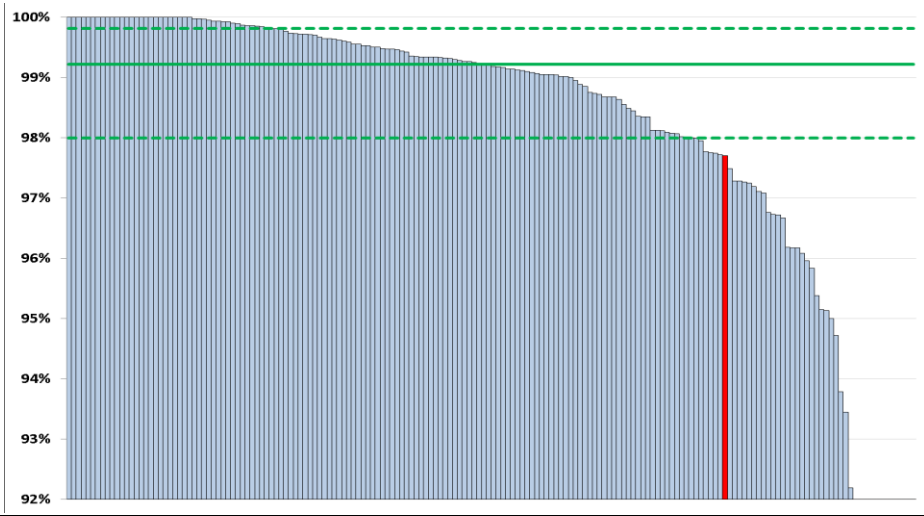

### Referral to Treatment Time (September 2017)




### 62-day GP cancer (Quarter 2 2017/18)



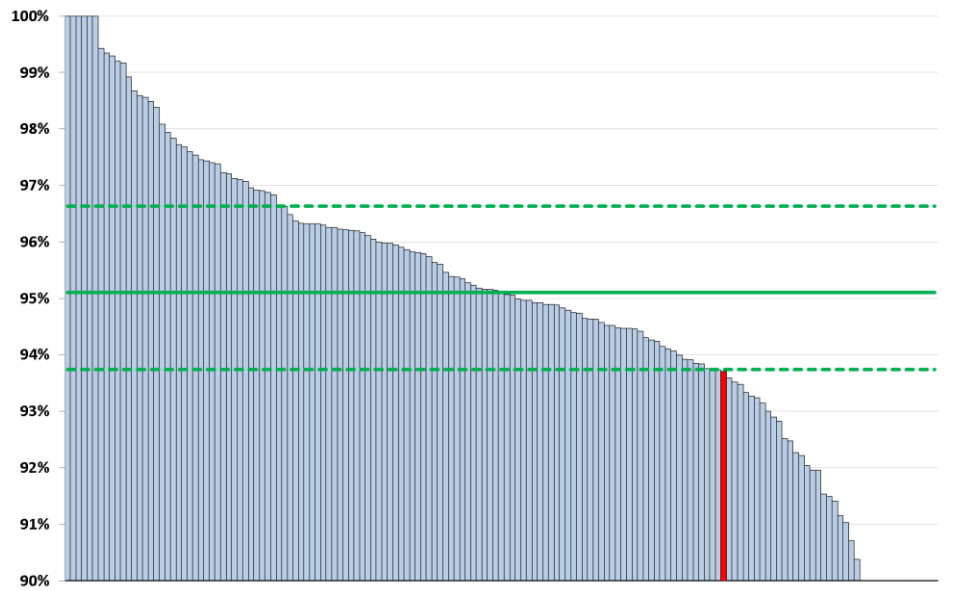

### 6-week diagnostic (September 2017)



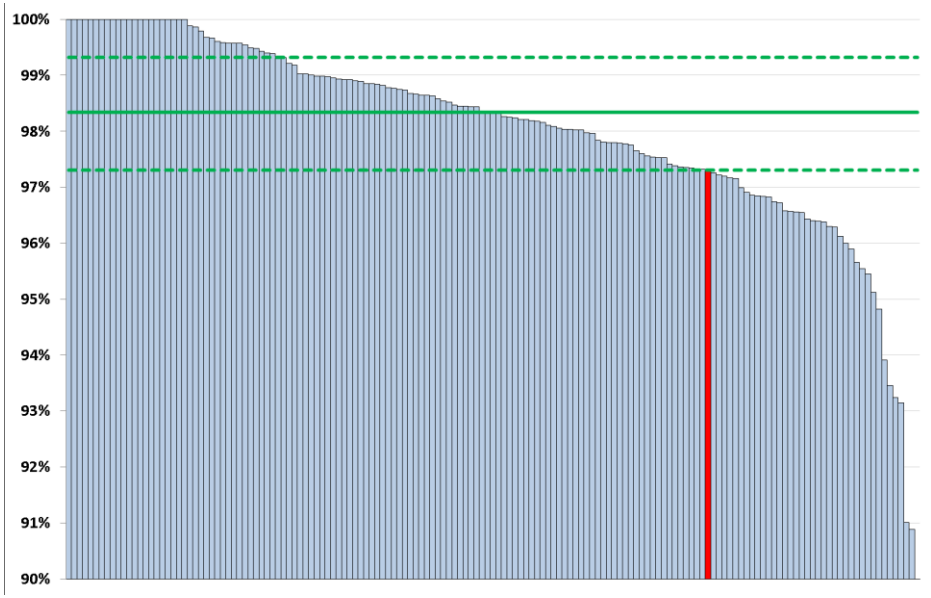
## Appendix 4 (continued)

### Benchmarking Reports

**2-Week wait (Quarter 2 2017/18)**




**31-day first definitive cancer (Quarter 2 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.

**Cover report to the Trust Board meeting to be held on Wednesday 29 November 2017 at 11:00am – 13:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 8 |
| **Report Title** | Chair's Report Quality and Outcomes Committee | | |
| **Author** | Julian Dennis, Non- Executive Director | | |
| **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 November 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 November 2017.

**Quarterly Workforce and Organisational Development Report**

*Key points to note included:*

- A detailed, division-led, mid-year review against the key workforce indicators was presented to compare actual year to date performance with the 2017/18 Operating Plan It particularly focussed on vacancy and absence rates and the reasons for high agency use (for example, sickness rates). Key priorities for action are on sickness, completion of appraisals, ensuring leadership behaviours are embedded and improving essential training completion rates (including implementation of a new policy (from 2018) that will require staff to complete essential training before annual/study leave is granted).

**Serious Incident Report**

*Key points to note included:*

- Two serious incidents (both 'never' events) were reported within October 2017.
- At the end of October 2017 a total of 13 serious incidents remained open: 12 within the 60 day timescale and 1 within an agreed extended timescale (subsequently closed by when the Committee meet).
- As noted at the previous Committee meeting, the Trust was working with NHS Improvement to support them to undertake a review of surgical processes in the dental hospital. The terms of reference and a date for the review are awaited.
- The Trust had received a Contract Performance Notice from the Clinical Commissioning Group regarding the 6 never events that had occurred in the Trust in the last 7 months, and had shared all Root Cause Analysis Reports, reflective learning documents and other information with the CCG for review.

**Bristol Orthopaedic Association (BOA) Recommendations Presentation**

Divisional Director of the Division of Surgery Phillip Kiely and Clinical Lead Sanjoy Shah presented an update to the Committee on progress against the Bristol Orthopaedic Association (May 2016) Review Recommendations.

*Key points to note included:*

- The key focus was on fracture care, and the effective use of Nice Guidelines.
- Mortality rates for fractured neck of femur had improved markedly since 2015: 30-day mortality was now above the 95% confidence limit.
- Time from emergency admissions to surgery had improved significantly. There was continuing work to improve productivity of trauma wards There were changes to 2017 to the Best Practice Tariff (BPT)
- The Committee were pleased with progress and supported the proposed next steps.

**Children's Theatres Quality Improvement Plan – Update**

Divisional Director of the Division of Women's and Children's Ian Barrington and the Head of Nursing Mark Goninon presented the Children's Theatres Quality Improvement Plan

*Key points to note included:*

- The key performance measures in regard to safe/clinically effective surgery are being consistently delivered.
- The challenges of recruiting and retaining theatre staff
- The negative impact of a long-term absence of a Clinical Director for surgery
- The challenges of leadership within the theatre team
- The presence of a clear action plan to address key areas identified as requiring improvement with defined timescales

**Monthly Nurse Staffing Report**

*Key points to note included:*

- The data showed under 100% fill rate for RN's in the month and over 100% fill rate for nursing assistants. The over 100% fill rate for NA's was due primarily to provision of enhanced observation/under 100% fill rate for RN's was due to some reductions in activity and increased controls on use of agency staff.
- The Trust-level quality performance dashboard for October showed that the standard of patient care was safe.
- Whilst there were a number of red rated areas for staffing in the month (mainly nursing assistants) the Chief Nurse was confident that from the information she has that these gaps had not resulted in any risks to patient care.

**Quality Performance Report**

*Key points to note included:*

- A&E was at 90.2% against the 4 hour waiting target, The quarter's trajectory had been achieved, £1million of STF funding would be available. Performance against the cancer and diagnostic targets had shown improvement, whilst RTT performance remained stable.

**Carter Hospital Pharmacy Transformation Plan**

The Director of Pharmacy Jonathan Standing updated the Committee on progress against

| | |
|---|---|
| the Carter Hospital Pharmacy Transformation Plan<br><br>*Key points to note included:*<br>• There had been a number of key changes, including a move to 'generic' drugs,<br>• The Pharmacy was moving toward a seven day service.<br>• Recruitment of pharmacists continued to be a challenge.<br><br>**Assurance Reports**<br>Members received the following reports for assurance:<br><br>• **Education and Training Report**<br>• **Clinical Quality Group Meeting Report** | |
| **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** | 22 December 2017 |

**Cover report to the Public Trust Board. Meeting to be held on 29 November 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 9 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Wednesday, 29 November 2017 |
| **Report Title** | **Finance report** | | |
| **Author** | Paul Mapson, Director of Finance and Information | | |
| **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. | ☐ | 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><br><br>To inform the Finance Committee of the financial position of the Trust for October.<br><br><u>Key issues to note</u><br><br>The Operational Plan for October is a surplus of £7.358m (before technical items). The Trust achieved a surplus of £7.024m and is therefore £0.334m adverse to plan.<br><br>Excluding STF funding, the Trust is reporting a surplus of £1.332m against a planned surplus of £1.367m. Therefore, for October, the control total excluding STF funding has not been met. Receipt of STF core funding is dependent on achieving the control total at each quarter. The |

current assessment is that the control total excluding STF still could be met at quarter three and therefore the core STF funding for month seven has been included in this month's position. There is a high risk however, that quarter four will not be met. The Trust will continue to assess its position over the next few months before making any revised declarations at quarter three.

Last month's improvement in the Clinical Divisions and Corporate Services position has not continued, with the overspend increasing by £1.246m in October to a cumulative adverse variance of £7.034m. Delivery of the Trust's financial plan for the year is now at high risk of not being delivered. Of the £1.246m adverse variance in the month, Women's and Children's accounted for £0.517m and Surgery £0.463m

**Recommendations**

Members are asked to:

- Note the contents of this report

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

| **Board Assurance Framework Risk**<br>**(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**<br>**(please tick any which are impacted on / relevant to this paper)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quality | ☐ | Equality | ☐ | Legal | ☐ | Workforce | ☐ |

| **Impact Upon Corporate Risk** |
|---|
| Risk 1843 – Failure to deliver the Trust's Operating Plan control total surplus of £12.957m based on the Divisions current rate of overspend.<br>Risk 951 – Risk of the loss of S&T funding due to the failure to achieve the "core" control total from quarter 2. |

| Resource Implications<br>(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)** |
| | **24 November 2017** | | | |

University Hospitals Bristol
NHS Foundation Trust

# REPORT OF THE FINANCE DIRECTOR

## 1. Summary

The Operational Plan for October is a surplus of £7.358m (before technical items). The Trust achieved a surplus of £7.024m and is therefore £0.334m adverse to plan (appendix 1).

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 £1.332m against a planned surplus of £1.367m. Therefore, for October, the control total excluding STF funding has not been met. Receipt of STF core funding is dependent on achieving the control total at each quarter. The current assessment is that the control total excluding STF still could be met at quarter three and therefore the core STF funding for month seven has been included in this month's position. There is a high risk however, that quarter four will not be met. The Trust will continue to assess its position over the next few months before making any revised declarations at quarter three.

After technical items the planned surplus is £5.134m and the actual surplus is £6.749m. 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 84.8% against the joint NHS England / NHS Improvement nationally required trajectory of 90.0%, resulting in a loss of STF performance funding of £0.299m. The performance target was however met in quarter two. For October, the Trust achieved performance of 90.1% against the required trajectory of 90.0%. 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 and October and is projected to be met for quarter three.

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 | 345.744 | 346.901 | 1.157 |
| Divisions & Corporate Services | (318.999) | (326.033) | (7.034) |
| Financing | (20.383) | (19.536) | 0.847 |
| Reserves | (4.995) | | 4.995 |
| **Surplus/(deficit) excluding STF funding** | **1.367** | **1.332** | **(0.035)** |
| STF Core Funding | 4.194 | 4.194 | - |
| STF Performance Funding | 1.797 | 1.498 | (0.299) |
| **Surplus/(deficit) including STF funding** | **7.358** | **7.024** | **(0.334)** |

Last month's improvement in the Clinical Divisions and Corporate Services position has not continued, with the overspend increasing by £1.246m in October to a cumulative adverse variance of £7.034m. Delivery of the Trust's financial plan for the year is now at high risk of not being delivered. Of the £1.246m adverse variance in the month, Women's and Children's accounted for £0.517m and Surgery £0.463m.

The subjective analysis shown in section three shows the following key variances:

The Nursing and Midwifery reduction in run rate seen last month was not fully sustained with an adverse variance in month of £0.350m. Of this Women's and Children's accounts for £0.169m of the overspend.

Medical and Dental pay, although slightly lower this month at an adverse variance of £0.384m, continues to a cause for concern. Of this £0.063m overspend is within Women's and Children's and £0.201m in Surgery.

Income from activities overall deteriorated significantly from a £0.719m favourable variance in September to a £0.373m adverse variance in October. Of this change, however, £0.428m of the favourable variance in September related to a one off adjustment in Medicine removing prior year income related savings targets (reported last month). Several major issues this month resulted in an underperformance described in section four.

In short the Trust spent more and earnt less income in October.

## 2. Division and Corporate Services Performance

Clinical Divisions and Corporate Services overspend against budget increased by £1.246m in October, (compared to £0.549m in September) to a cumulative adverse position of £7.034m. 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 30 Sep<br>£m | Oct<br>£m | To 31 Oct<br>£m | Trajectory To Oct<br>£m | Variance<br>£m |
| Diagnostic & Therapies | 0.223 | 0.048 | 0.271 | 0.094 | 0.177 |
| Medicine | (1.878) | (0.188) | (2.066) | (0.165) | (1.901) |
| Specialised Services | (0.622) | (0.066) | (0.688) | 0.187 | (0.875) |
| Surgery | (1.946) | (0.463) | (2.409) | (0.111) | (2.298) |
| Women's & Children's | (1.460) | (0.517) | (1.977) | (0.013) | (1.964) |
| Estates & Facilities | (0.027) | 0.013 | (0.014) | (0.015) | 0.001 |
| Trust Services | (0.047) | - | (0.047) | (0.001) | (0.046) |
| Other corporate services | (0.031) | (0.073) | (0.104) | - | (0.104) |
| **Total** | **(5.788)** | **(1.246)** | **(7.034)** | **(0.024)** | **(7.010)** |

Diagnostic and Therapies

The favourable variance in month of £0.048m 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 £0.177m favourable against its operating plan trajectory.

Medicine

The Division was £0.188m adverse to plan in the month increasing the cumulative adverse position to £2.066m. Pay was adverse to plan by £0.235m in the month, predominantly due to nursing costs (£0.163m). This represented a worsening from last month. The cost of covering RMNs and 1 to 1 nursing increased. Income from activities improved by £0.106m in month, primarily due to emergency activity. The Division is adverse to its revised Operating Plan by £1.901m.

Specialised Services

In month the Division was adverse to plan by £0.066m. Savings delivery continued to be above plan. Income from activities was above plan but within this cardiac surgery was below plan by £0.212m with blood and marrow transplants and cardiology above plan by £0.238m and £0.138 respectively. Use of agency within CICU contributed to the £0.076m overspend in month on nursing budgets. Non pay expenditure was adverse to plan by £0.135m in month. Whilst an element reflected the costs of additional activity, £0.048m related to other non-pay.

Non-delivery of Cardiac Surgery, Haematology and Clinical Genetics activity are the key drivers for the £0.875m adverse variance to the Operating Plan trajectory to date.

Surgery

The Division was £0.463m adverse to plan in October, of which £0.189m related to pay expenditure and £0.176m to income from activities. Medical and dental pay costs were adverse to plan by £0.201m due to locum and additional hours payments to deliver activity and cover sickness. Trauma and Orthopaedic activity was £0.177m below plan in the month reducing the year to date overperformance to £0.193m. The share of cardiac surgery underperformance was £0.072m.

The Division is £2.298m adverse against its Operating Plan. This is driven by the adverse position on pay with medical staff £0.888m adverse to plan and nursing £0.419m. Other significant drivers are OMFS prior year costs of £0.101m and Surgery's share of Cardiac Surgery activity shortfall of £0.295m.

Women's and Children's

The Division was adverse to plan by £0.517m in the month, with pay expenditure £0.239m adverse to plan and income from activities £0.337m adverse to plan. 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 worsened significantly this month. There were no BMTs performed in October and was therefore £0.190m adverse to plan, although planned activity in November and December is expected to recover this position.

The Division is £1.964m adverse against its Operating Plan with medical and dental pay accounting for £0.747m, nursing pay £0.850m and other pay £0.118m. Income from activities is £0.661m adverse.

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

Divisional Forecast Outturns

As reported last month, the Clinical Divisions assessed their forecast outturns at month six. The table below shows the October position against these forecast outturns.

| favourable/(adverse) | October Year to Date £m | Forecast outturn at month 6 £m |
|---|---|---|
| Diagnostics and Therapies | 0.271 | 0.438 |
| Medicine | (2.066) | (3.051) |
| Specialised Services | (0.688) | (1.097) |
| Surgery | (2.409) | (2.998) |
| Women's and Children's | (1.977) | (2.200) |
| Clinical Divisions Total | **(7.034)** | **(8.908)** |

The Trust's overall financial plan, which has been reviewed in detail, can only be achieved provided the Clinical Divisions do not exceed an £8m overspend in year. A run rate of £0.250m per month for three consecutive months is required to support the Trust's strategic capital investment plans. The Divisions' forecasts at month six clearly required additional actions to achieve this. The failure to address this and the continued level of monthly overspending within the Divisions of Surgery and Women's and Children's significantly risk achieving the Trust's financial plan.

## 3. Subjective Analysis

The adverse variances of £1.246m in October and £7.034m to date are analysed subjectively in the table below:

| Favourable/(Adverse) | Quarter 1 £m | July £m | August £m | September £m | October £m | 2017/18 to date £m | 2016/17 Outturn £m |
|---|---|---|---|---|---|---|---|
| Nursing & midwifery pay | (1.092) | (0.518) | (0.474) | (0.250) | (0.350) | (2.686) | (4.606) |
| Medical & dental staff pay | (0.868) | (0.350) | (0.289) | (0.447) | (0.384) | (2.339) | (1.380) |
| Other pay | 0.183 | 0.006 | 0.056 | 0.159 | 0.179 | 0.583 | 2.140 |
| Non-pay | (0.491) | (0.094) | (0.182) | (0.711) | (0.352) | (1.830) | (6.340) |
| Income from operations | (0.045) | (0.147) | (0.017) | (0.011) | (0.138) | (0.357) | 0.751 |
| Income from activities | 0.490 | (0.279) | (0.424) | 0.719 | (0.373) | 0.132 | (0.983) |
| **Total excl CIP** | (1.823) | (1.384) | (1.331) | (0.541) | (1.418) | (6.496) | (10.418) |
| (CIP) | (0.552) | (0.082) | (0.067) | (0.008) | 0.172 | (0.538) | (4.231) |
| **Total incl CIP** | **(2.375)** | **(1.466)** | **(1.398)** | **(0.549)** | **(1.246)** | **(7.034)** | **(14.649)** |

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.

*Nursing (including ODP) & Midwifery Pay*

The year to date nursing and midwifery pay variance including theatre ODP's for October is £2.781m adverse (including CIP delivery) which reflects a continued adverse position in the month. The table below shows analysis between substantive, bank and agency:

| Favourable/(Adverse) | Quarter 1 £m | July £m | August £m | September £m | October £m | 2017/18 to date £m | 2016/17 Outturn £m |
|---|---|---|---|---|---|---|---|
| Substantive | 2.200 | 0.827 | 0.857 | 0.938 | 0.791 | 5.613 | 8.822 |
| Bank | (1.782) | (0.698) | (0.671) | (0.668) | (0.635) | (4.454) | (6.408) |
| Agency | (1.562) | (0.668) | (0.676) | (0.526) | (0.508) | (3.940) | (7.397) |
| **Total inc CIP** | **(1.144)** | **(0.539)** | **(0.490)** | **(0.256)** | **(0.352)** | **(2.781)** | **(4.983)** |
| CIP | (0.052) | (0.021) | (0.016) | (0.007) | (0.002) | (0.097) | (0.300) |
| **Total excl CIP** | **(1.092)** | **(0.519)** | **(0.474)** | **(0.249)** | **(0.350)** | **(2.684)** | **(4.683)** |

The position has worsened in month 7 compared to month 6, although remains better than the early part of the year. Bank and agency expenditure have remained at a similar level to month 6 but the offsetting underspend on substantive lines has reduced.

In October there has been a reduction in vacancy levels across all Divisions reflecting the intake of newly qualified staff. Vacancy levels have reduced significantly in three of the Clinical Divisions (Medicine 8.6% to 6.8%, Specialised Services 6.5% to 4.2% and Women's and Children's Services 2.5% to 0.5%). There were 113 wte new Registered Nurses who started in September and October. The majority of these staff will be supernumerary for a period of time depending on the area they work in and as such will not be included in the rostered RN numbers but will show in post and their expenditure during this time will contribute to the overspend. The Heads of Nursing are participating in an audit of all new starters during this time to ensure the supernumerary SOP is being consistently applied. It is expected that November will include the additional supernumerary costs for the new starters that joined the Trust in the latter part of October.

The new enhanced care policy is still showing improvements compared to the first four months of the year (prior to the new policy being implemented) with the monthly average of £0.163m compares with £0.127m in month 7. The Division of Women's and Children's Services saw an increase of £0.015m this month due to a specific patient needing additional care.

The Trust has seen a reduction in agency expenditure, with Thornbury reducing to £0.060m in month which represents 14% of total agency spend (6% of hours) compared to an average of £0.184m or 31% for the first six months of the year. Further improvement in agency expenditure is expected now that the neutral vendor arrangement is in place with further work region wide to reduce the rates using this arrangement. A prudent approach was taken in assessing this month's agency accrual and it is likely that following further review this can be lowered next month to improve the position further.

The nursing control dashboard is attached at appendix 3.

*Medical & Dental Pay*

The year to date adverse variance on Medical and Dental staff is £2.337m (including CIP delivery) compared with £1.442m for the whole of 2016/17. The adverse variance of £0.378m in October and the year to date position is summarised in the table below:

| Favourable/(Adverse) | Quarter 1 £m | July £m | August £m | September £m | October £m | 2017/18 to date £m | 2016/17 Outturn £m |
|---|---|---|---|---|---|---|---|
| Consultant | | | | | | | |
| - Substantive costs | 0.334 | 0.122 | 0.164 | (0.076) | 0.045 | 0.589 | 0.277 |
| - Additional hours payments | (0.514) | (0.243) | (0.272) | (0.221) | (0.185) | (1.435) | |
| – Locum | (0.054) | (0.036) | 0.015 | (0.031) | (0.071) | (0.177) | (0.143) |
| – Agency | (0.112) | (0.040) | 0.008 | (0.013) | 0.025 | (0.132) | (0.741) |
| Other medical | | | | | | | |
| – Substantive costs | 0.207 | 0.260 | 0.133 | 0.232 | 0.184 | 1.016 | |
| – Additional hours payments | (0.585) | (0.300) | (0.244) | (0.236) | (0.196) | (1.561) | (0.369) |
| – Exception reporting payments | 0.000 | 0.000 | 0.000 | 0.000 | (0.002) | (0.002) | |
| – Locum | (0.160) | (0.114) | (0.091) | (0.102) | (0.140) | (0.607) | (0.469) |
| – Agency | 0.009 | (0.003) | (0.002) | 0.006 | (0.038) | (0.028) | 0.003 |
| **Totals inc CIP** | **(0.875)** | **(0.354)** | **(0.289)** | **(0.441)** | **(0.378)** | **(2.337)** | **(1.442)** |
| CIP | (0.007) | (0.004) | 0.001 | 0.006 | 0.006 | 0.003 | (0.062) |
| **Totals excl CIP** | **(0.868)** | **(0.350)** | **(0.290)** | **(0.447)** | **(0.384)** | **(2.340)** | **(1.380)** |

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

The adverse variance for medical and dental pay in October reflects continuing overspends in all Clinical Divisions although Surgery and Women's and Children's are the most significant. The drivers behind this variance remain broadly as previously reported.

Additional hours payments have reduced in month to £0.381m compared with £0.457m in September, but locum spend has increased, £0.211m this month compared to £0.133m in September. The use of additional hours is being analysed in more detail as part of the controlling medical pay work stream.

The Divisions of Women's and Children's and Surgery have the most significant overspend. Surgery continues to have pressures due to sickness cover and rota gaps in the Eye Hospital and in Trauma and Orthopaedics in particular which are proving difficult to recruit to. The Women's and Children's Division improved in the month reducing from £0.139m adverse in September to £0.065m adverse in October, reflecting a reduction in Additional Hours payments and allocation of funding for the Spinal service development.
The new Junior Doctor contract has now been implemented. Funding issued for 2017/18 to date is £1.253m with the expected full year cost being c£2m.

Non Pay

The non pay variance deteriorated by £0.235m (including CIP delivery) in October. An analysis is shown below:

| Favourable/(Adverse) | Quarter 1 £m | July £m | August £m | September £m | October £m | 2017/18 to date £m | 2016/17 Outturn £m |
|---|---|---|---|---|---|---|---|
| Blood | 0.066 | (0.027) | (0.067) | (0.012) | (0.048) | (0.088) | (0.552) |
| Clinical supplies & services | (0.400) | 0.005 | (0.002) | 0.000 | 0.075 | (0.322) | (1.730) |
| Drugs | (0.074) | (0.079) | (0.060) | 0.011 | (0.051) | (0.253) | (0.362) |
| Establishment | 0.032 | (0.037) | 0.011 | 0.008 | (0.075) | (0.061) | (0.091) |
| General supplies & services | 0.024 | 0.004 | (0.015) | 0.009 | 0.001 | 0.023 | (0.124) |
| Outsourcing | (0.438) | (0.163) | (0.105) | (0.068) | (0.090) | (0.864) | (1.241) |
| Premises | (0.021) | (0.015) | (0.019) | 0.111 | 0.026 | 0.082 | 0.111 |
| Services from other bodies | (0.172) | (0.083) | (0.026) | (0.112) | (0.022) | (0.415) | (2.788) |
| Research | 0.002 | (0.006) | 0.007 | (0.005) | 0.098 | 0.096 | 0.030 |
| Other non-pay expenditure | 0.160 | 0.283 | 0.094 | (0.643) | (0.149) | (0.255) | (2.745) |
| **Totals inc CIP** | **(0.821)** | **(0.118)** | **(0.183)** | **(0.701)** | **(0.235)** | **(2.058)** | **(9.492)** |
| CIP | (0.329) | (0.024) | (0.003) | 0.010 | 0.117 | (0.229) | (3.152) |
| **Totals excl CIP** | **(0.492)** | **(0.094)** | **(0.180)** | **(0.711)** | **(0.352)** | **(1.829)** | **(6.340)** |

The most significant change in the month was seen in 'other non-pay expenditure' which had an adverse variance of £0.643m in September compared to £0.149m adverse in October. A significant amount of this related to the £0.428m retrospective change in accounting treatment for SLA margins in Medicine which occurred in September and does not represent a fundamental change in expenditure.

The main reason for the adverse year to date non pay position remains Outsourcing, £0.864m and Services from other Bodies, £0.415m. This is offset by clinical SLA income earned.

The level of outsourcing has increased slightly in October leaving cumulative adverse variances of £0.373m relating to South West Eye Surgeons, £0.333m to Glanso, and £0.113m to Dermatology. The remaining balance relates to the virtual ward provided by Orla, which has now closed.

Variances on Services from Other Bodies year to date include external tests £0.151m, recharges for Cellular Pathology £0.016m and Dermatology Services £0.052m, supplies consortia costs £0.051m, and the cystic fibrosis pathway £0.044m.

Effectively outsourcing and services from other bodies are clinical activity related hence the combined adverse variance of £1.279m accounts for the bulk of the non-pay overspend and essentially offsets the income from activities position leaving the income plan in deficit.

## 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.

| | October 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 | 0.127 | 10.172 | 10.617 | 0.444 |
| Bone Marrow Transplants | 0.102 | 4.869 | 4.981 | 0.112 |
| Critical Care Beddays | (0.030) | 25.738 | 25.996 | 0.258 |
| Day Cases | 0.110 | 22.930 | 22.957 | 0.028 |
| Elective Inpatients | (0.149) | 33.028 | 32.429 | (0.599) |
| Emergency Inpatients | 0.104 | 50.900 | 53.360 | 2.460 |
| Excess Beddays | (0.125) | 3.174 | 3.317 | 0.143 |
| Non-Elective Inpatients | (0.134) | 18.767 | 18.156 | (0.611) |
| Outpatients | 0.238 | 45.403 | 45.414 | 0.011 |
| Other | (0.357) | 54.567 | 53.101 | (1.465) |
| **Total Activity Based** | **(0.114)** | **269.548** | **270.328** | **0.781** |
| Contract Rewards | 0.061 | 5.533 | 5.736 | 0.204 |
| Contract Penalties | 0.072 | (0.564) | (0.935) | (0.371) |
| Pass through payments | 0.472 | 49.928 | 49.737 | (0.201) |
| Sustainability and Transformation Funding | - | 5.991 | 5.692 | (0.299) |
| **2017/18 Total** | **0.491** | **330.436** | **330.558** | **0.114** |
| Prior year income | 0.000 | 0.000 | 1.302 | 1.302 |
| **Overall Total** | **0.491** | **330.436** | **331.860** | **1.416** |

Activity based income was £0.114m adverse to plan in October, reducing the cumulative over performance to date to £0.781m.

Excess beddays were £0.125m below plan in October, primarily in Women's and Children's.

Bone Marrow Transplants were £0.102m above plan in the month, although adult BMTs were £0.324m above plan whilst paediatrics were £0.222m below plan. The paediatric activity is expected to increase over the next few months. Year to date the adult service is £0.164m above plan whilst the paediatric service is £0.052m behind plan.

Outpatient activity was £0.238m above plan in the month, of which £0.161m was within adult cardiology. Women's and Children's outpatient activity improved by £0.092m in the month. Dental services worsened by £0.076m.

Other activity worsened in the month by £0.357m reducing the cumulative underperformance to £1.465m. The year to date position includes an underperformance within Radiotherapy (£0.528m), Bowel Cancer Screening (£0.293m), Paediatric Neurosurgery (£0.220m) and Cystic Fibrosis (£0.211m).

The plan assumes 82% achievement of CQUINs, which is £9.43m.The latest assessment is that 85.5% or £9.78m of the total £11.5m available is likely to be achieved.

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

£0.935m to date, £0.371m worse than plan. This is primarily due to the emergency marginal tariff adjustment, although the position improved by £0.072m in the month.

Pass through payments were £0.472m ahead of plan in October, reducing the year to date adverse position to £0.201m behind plan. In particular, excluded drugs were £0.370m ahead of plan for the month.

## 5. Savings Programme

The savings requirement for 2017/18 is £11.520m. To date the Trust has achieved savings of £6.182m against a plan of £6.766m. 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.

| | 2017/18 Plan | Year to date | | | Forecast Outturn |
|---|---|---|---|---|---|
| | | Plan | Actual | Variance fav / (adv) | Variance fav / (adv) |
| | £m | £m | £m | £m | £m |
| Pay | 1.823 | 1.027 | 0.878 | (0.149) | (0.093) |
| Drugs | 0.400 | 0.241 | 0.449 | 0.208 | 0.293 |
| Clinical Supplies | 2.229 | 1.301 | 1.449 | 0.148 | 0.638 |
| Non Clinical Supplies | 3.178 | 1.893 | 1.335 | (0.558) | (0.484) |
| Other Non-Pay | 0.216 | 0.123 | 0.105 | (0.018) | (0.029) |
| Income | 2.582 | 1.544 | 1.383 | (0.161) | 0.116 |
| Capital Charges | 1.000 | 0.583 | 0.583 | - | - |
| Unidentified | 0.092 | 0.054 | - | (0.054) | (0.092) |
| **Totals** | **11.520** | **6.766** | **6.182** | **(0.584)** | **0.349** |

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 £2.684m savings in the pipeline, £1.950m of which remain in their very early stages.

The forecast outturn variance improved by £0.257m in October, with increases in non-pay and medicines. The Divisions of Medicine and Surgery continue to forecasting significant under delivery of savings. Medicine has increased its adverse forecast outturn slightly by £0.009m in the month, whilst Surgery improved its forecast by £0.027m.

Savings performance by Division is shown in the following table 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 | 0.805 | 0.753 | (0.053) | (0.059) |
| Medicine | 2.071 | 1.154 | 0.789 | (0.365) | (0.515) |
| Specialised Services | 1.192 | 0.701 | 1.024 | 0.324 | 0.687 |
| Surgery | 2.393 | 1.516 | 0.948 | (0.567) | (0.191) |
| Women's and Children's | 2.036 | 1.178 | 1.243 | 0.065 | 0.288 |
| Facilities and Estates | 0.817 | 0.462 | 0.449 | (0.014) | 0.065 |
| Trust Services | 0.545 | 0.320 | 0.295 | (0.025) | (0.014) |
| Corporate | 1.080 | 0.630 | 0.680 | 0.050 | 0.088 |
| **Totals** | **11.520** | **6.766** | **6.181** | **(0.585)** | **0.349** |

## 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 £7.024m being £0.334m adverse to plan. The following table summarises the position.

| | | 30th October 2017 | |
|---|---|---|---|
| | Weighting | Plan | Actual |
| **Liquidity** | | | |
| Metric Result – days | | 14.6 | 19.6 |
| Metric Rating | 20% | 1 | 1 |
| **Capital Servicing Capacity** | | | |
| Metric Result – times | | 2.7 | 2.7 |
| Metric Rating | 20% | 1 | 1 |
| **Income & expenditure margin** | | | |
| Metric Result | | 1.9% | 1.8% |
| Metric Rating | 20% | 1 | 1 |
| **Variance in I&E margin** | | | |
| Metric Result | | 0.0% | -0.1% |
| Metric Rating | 20% | 1 | 2 |
| **Variance from agency ceiling** | | | |
| Metric Result | | 43.4% | 25.0% |
| Metric Rating | 20% | 1 | 1 |
| **Overall URR** | | **1** | **1.2** |
| **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 £2.629m, from £47.885m to £50.514m 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 with the remainder being further changes to donated assets.

The forecast outturn is £29.366m. The slippage continues to be predominantly from the Phase 5 allocation, the strategic scheme contingency, the Medical School allocation and the funding awarded for the linear accelerator.

Expenditure in the month was £1.419m and at the end of October, capital expenditure totalled £11.173m, £7.830m behind plan. Expenditure on medical equipment is £3.430m behind plan, of which £2.518m relates to five significant schemes which are in progress and forecast to complete within the financial year. Operational capital is £1.851m behind plan and relates to a large number of schemes.

| 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 | 3.000 | 2.200 | (0.800) | 5.785 | 5.785 | - |
| | Donations | 0.400 | 0.286 | (0.114) | 0.837 | 0.837 | - |
| | Cash: | | | | | | |
| 22.764 | Depreciation | 12.883 | 12.813 | (0.070) | 22.346 | 22.346 | - |
| 21.321 | Cash balances | 2.720 | (4.126) | (6.846) | 21.546 | 0.398 | (21.148) |
| **47.885** | **Total Funding** | **19.003** | **11.173** | **(7.830)** | **50.514** | **29.366** | **(21.148)** |
| | **Application/Expendi** | | | | | | |
| (16.035) | Strategic Schemes | (1.097) | (1.546) | (0.449) | (19.888) | (1.902) | 17.986 |
| (10.278) | Medical Equipment | (4.984) | (1.554) | 3.430 | (13.192) | (8.094) | 5.098 |
| (11.370) | Operational Capital | (4.925) | (3.074) | 1.851 | (10.658) | (8.393) | 2.265 |
| (7.328) | IT | (6.264) | (4.140) | 2.124 | (9.378) | (8.510) | 0.868 |
| (2.874) | Estates Replacement | (1.733) | (0.859) | 0.874 | (2.932) | (2.467) | 0.465 |
| **(47.885)** | **Gross Expenditure** | **(19.003)** | **(11.173)** | **7.830** | **(56.048)** | **(29.366)** | **26.682** |
| | In-year Slippage | | | | 5.534 | | (5.534) |
| **(47.885)** | **Net Expenditure** | **(19.003)** | **(11.173)** | **7.830** | **(50.514)** | **(29.366)** | **21.148** |

Further information is provided at agenda item 3.1.

## 8. Statement of Financial Position and Cashflow

Net current assets as at 31 October 2017 were £45.372m, £9.736m higher than the Operational Plan. Current assets are £17.349m higher than plan and current liabilities are £7.613m higher than plan.

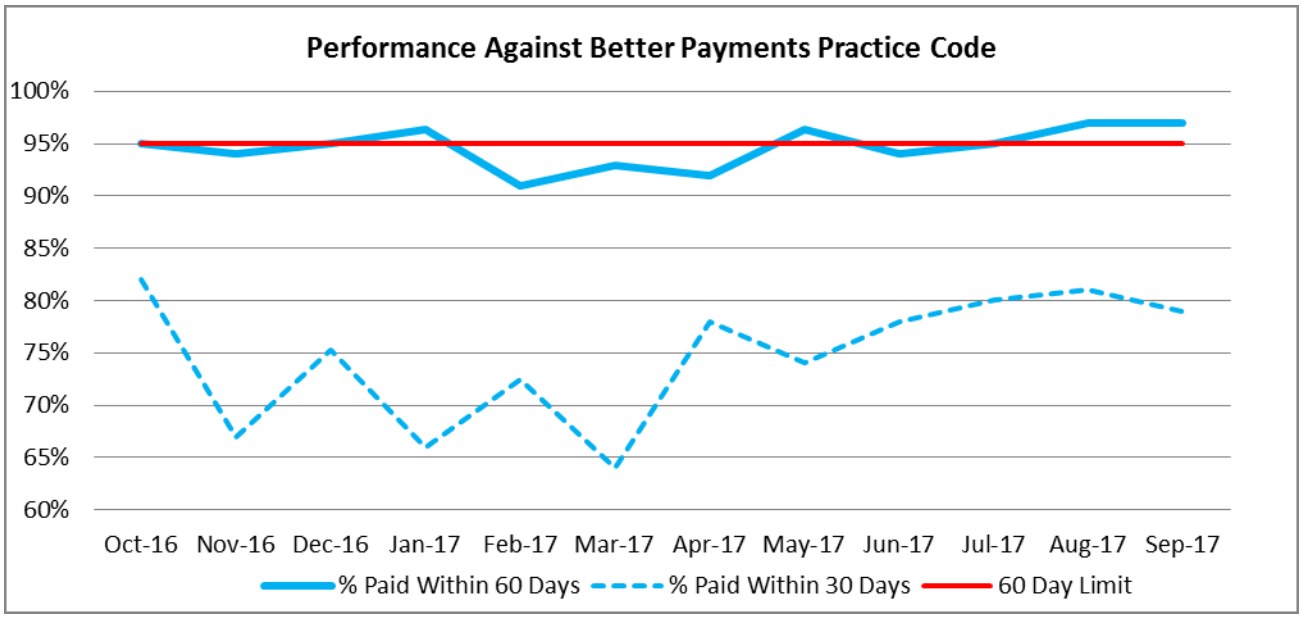
Trade and other receivables are £14.713m higher than plan, reflecting the outstanding income due for the STF funding and quarter one and two activity reconciliation invoices. However, a payment of £6.1m was received on 1st November relating to NHS England South West, reducing this balance. Inventories 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 October was £63.323m, which is £2.098m lower than the Operating Plan reflecting the level of outstanding debt, offset by slippage on capital expenditure. Forecast cash at the year-end is £62.785m which is £11.020m higher than the Operating Plan primarily due to the net effect of forecast loss of STF funding, additional PDC funding and a reduction in capital expenditure and PDC dividend payable.

The total value of debtors was £32.515m (£22.370m SLA and £10.145m non-SLA). This represents an increase in the month of £10.244m (SLA increase of £10.270m and non-SLA decrease of £0.026m). This reduces to a total increase of £3.838m excluding the payment received on 1st November. Debts over 60 days old have increased by £0.762m (£0.619m SLA increase and £0.143m non-SLA increase) to £12.999m (£8.378m SLA and £4.621m non-SLA).

In October, 96% of invoices were paid within the 60 day target set by the Prompt Payments Code and 78% 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*

# UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

## Finance Report October 2017– Summary Income & Expenditure Statement

| Approved Budget / Plan 2017/18 | Heading | Position as at 31st October | | | Actual to 3oth September |
|---|---|---|---|---|---|
| | | Plan | Actual | Variance Fav / (Adv) | |
| £'000 | | £'000 | £'000 | £'000 | £'000 |
| | **Income** | | | | |
| 555,022 | From Activities | 325,435 | 326,827 | 1,392 | 278,958 |
| 91,764 | Other Operating Income (Excluding Sustainability and Transformation funding) | 54,201 | 53,788 | (413) | 46,126 |
| **646,786** | **Sub totals income** | **379,636** | **380,615** | **979** | **325,084** |
| | **Expenditure** | | | | |
| (375,039) | Staffing | (219,140) | (223,768) | (4,628) | (191,376) |
| (229,446) | Supplies and Services | (133,751) | (135,979) | (2,228) | (116,765) |
| **(604,485)** | **Sub totals expenditure** | **(352,891)** | **(359,747)** | **(6,856)** | **(308,141)** |
| (7,771) | Reserves | (4,725) | – | 4,725 | – |
| – | NHS Improvement Plan Profile | (270) | – | 270 | – |
| **34,530** | Earnings before Interest,Tax,Depreciation and Amortisation | **21,750** | **20,868** | **(882)** | **16,943** |
| **5.34** | **EBITDA Margin - %** | | **5.48** | | **5.21** |
| | **Financing** | | | | |
| (22,792) | Depreciation & Amortisation - Owned | (13,296) | (12,814) | 482 | (10,960) |
| 108 | Interest Receivable | 63 | 64 | 1 | 55 |
| (268) | Interest Payable on Leases | (156) | (156) | – | (134) |
| (2,687) | Interest Payable on Loans | (1,600) | (1,600) | – | (1,371) |
| (9,247) | PDC Dividend | (5,394) | (5,030) | 364 | (4,375) |
| **(34,886)** | **Sub totals financing** | **(20,383)** | **(19,536)** | **847** | **(16,785)** |
| **(356)** | NET SURPLUS / (DEFICIT) before Technical Items excluding Sustainability and Transformation funding | **1,367** | **1,332** | **(35)** | **158** |
| 3,994 | Sustainability & Transformation funding - Performance | 1,797 | 1,498 | (299) | 1,099 |
| 9,319 | Sustainability & Transformation funding - Core | 4,194 | 4,194 | – | 3,262 |
| **12,957** | SURPLUS / (DEFICIT) before Technical Items including Sustainability & Transformation funding | **7,358** | **7,024** | **(334)** | **4,519** |
| | **Technical Items** | | | | |
| – | Profit/(Loss) on Sale of Asset | – | (2) | (2) | (2) |
| – | Donations & Grants (PPE/Intangible Assets) | – | 637 | 637 | 560 |
| (1,314) | Impairments | (1,314) | – | 1,314 | – |
| – | Reversal of Impairments | – | – | – | – |
| (1,561) | Depreciation & Amortisation - Donated | (910) | (910) | 0 | (778) |
| **10,082** | SURPLUS / (DEFICIT) after Technical Items including Sustainability & Transformation funding | **5,134** | **6,749** | **1,615** | **4,299** |

**UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST**

**Finance Report October 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 30th September | Operating Plan Trajectory Year to Date | Variance from Operating Plan Year to Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Pay | Non Pay | Operating Income | Income from Activities | CIP | | | | |
| £'000 | | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| | **Corporate Income (excluding Sustainability & Transformation funding)** | | | | | | | | | | | |
| 35,784 | Contract Income | 21,037 | 21,037 | - | - | - | - | - | - | - | | |
| 265 | Penalties | 265 | - | - | - | - | (214) | - | (214) | (303) | | |
| - | Contract Rewards | - | | - | - | - | 204 | - | 204 | 143 | | |
| - | Overheads | - | 1,123 | - | (169) | - | 1,336 | - | 1,167 | 1,265 | | |
| 553,383 | NHSE Income | 324,442 | 324,741 | - | - | - | - | - | - | - | | |
| **589,432** | **Sub Total Corporate Income** | **345,744** | **346,901** | **-** | **(169)** | **-** | **1,326** | **-** | **1,157** | **1,105** | | |
| | **Clinical Divisions** | | | | | | | | | | | |
| (51,415) | Diagnostic & Therapies | (29,961) | (29,690) | 531 | (447) | (73) | 316 | (56) | 271 | 223 | 94 | 177 |
| (80,066) | Medicine | (46,839) | (48,905) | (1,624) | (345) | (85) | 407 | (419) | (2,066) | (1,878) | (165) | (1,901) |
| (111,644) | Specialised Services | (65,248) | (65,936) | (392) | (225) | (13) | (387) | 329 | (688) | (622) | 187 | (875) |
| (109,510) | Surgery | (64,123) | (66,532) | (1,705) | (771) | 24 | 491 | (448) | (2,409) | (1,946) | (111) | (2,298) |
| (125,855) | Women's & Children's | (73,348) | (75,325) | (1,632) | 388 | (48) | (740) | 55 | (1,977) | (1,460) | (13) | (1,964) |
| **(478,490)** | **Sub Total - Clinical Divisions** | **(279,519)** | **(286,388)** | **(4,822)** | **(1,400)** | **(195)** | **87** | **(539)** | **(6,869)** | **(5,683)** | **(8)** | **(6,861)** |
| | **Corporate Services** | | | | | | | | | | | |
| (36,959) | Facilities And Estates | (21,282) | (21,296) | 70 | (75) | 6 | 13 | (28) | (14) | (27) | (15) | 1 |
| (27,260) | Trust Services | (16,143) | (16,190) | 294 | (257) | (61) | - | (23) | (47) | (47) | (1) | (46) |
| (4,422) | Other | (2,055) | (2,159) | 15 | (96) | (107) | 33 | 51 | (104) | (31) | - | (104) |
| **(68,641)** | **Sub Totals - Corporate Services** | **(39,480)** | **(39,645)** | **379** | **(428)** | **(162)** | **46** | **0** | **(165)** | **(105)** | **(16)** | **(149)** |
| **(547,131)** | **Sub Total (Clinical Divisions & Corporate Services)** | **(318,999)** | **(326,033)** | **(4,443)** | **(1,828)** | **(357)** | **133** | **(539)** | **(7,034)** | **(5,788)** | **(24)** | **(7,010)** |
| (7,771) | Reserves | (4,725) | - | - | 4,725 | - | - | - | 4,725 | 4,050 | | |
| - | NHS Improvement Plan Profile | (270) | - | - | 270 | - | - | - | 270 | 0 | | |
| (7,771) | **Sub Total Reserves** | **(4,995)** | **-** | **-** | **4,995** | **-** | **-** | **-** | **4,995** | **4,050** | | |
| **34,530** | **Earnings before Interest,Tax,Depreciation and Amortisation** | **21,750** | **20,868** | **(4,443)** | **2,998** | **(357)** | **1,459** | **(539)** | **(882)** | **(633)** | | |
| | **Financing** | | | | | | | | | | | |
| (22,792) | Depreciation & Amortisation - Owned | (13,296) | (12,814) | - | 482 | - | - | - | 482 | 436 | | |
| 108 | Interest Receivable | 63 | 64 | - | 1 | - | - | - | 1 | 1 | | |
| (268) | Interest Payable on Leases | (156) | (156) | - | 0 | - | - | - | - | - | | |
| (2,687) | Interest Payable on Loans | (1,600) | (1,600) | - | 0 | - | - | - | - | - | | |
| (9,247) | PDC Dividend | (5,394) | (5,030) | - | 364 | - | - | - | 364 | 249 | | |
| **(34,886)** | **Sub Total Financing** | **(20,383)** | **(19,536)** | **-** | **847** | **-** | **-** | **-** | **847** | **686** | | |
| **(356)** | **NET SURPLUS / (DEFICIT) before Technical Items excluding Sustainability and Transformation funding** | **1,367** | **1,332** | **(4,443)** | **3,845** | **(357)** | **1,459** | **(539)** | **(35)** | **53** | | |
| 3,994 | Sustainability & Transformation funding - Performance | 1,797 | 1,498 | - | - | (299) | - | - | (299) | (299) | | |
| 9,319 | Sustainability & Transformation funding - Core | 4,194 | 4,194 | - | - | - | - | - | - | - | | |
| **13,313** | **Sub Total Sustainability & Transformation funding** | **5,991** | **5,692** | **-** | **-** | **(299)** | **-** | **-** | **(299)** | **(299)** | | |
| **12,957** | **SURPLUS / (DEFICIT) before Technical Items including Sustainability & Transformation funding** | **7,358** | **7,024** | **(4,443)** | **3,845** | **(656)** | **1,459** | **(539)** | **(334)** | **(246)** | | |
| | **Technical Items** | | | | | | | | | | | |
| - | Profit/(Loss) on Sale of Asset | - | (2) | - | (2) | - | - | - | (2) | (2) | | |
| - | Donations & Grants (PPE/Intangible Assets) | - | 637 | - | - | 637 | - | - | 637 | 560 | | |
| (1,314) | Impairments | (1,314) | - | - | 1,314 | - | - | - | 1,314 | 1,314 | | |
| - | Reversal of Impairments | - | - | - | - | - | - | - | - | - | | |
| (1,561) | Depreciation & Amortisation - Donated | (910) | (910) | - | - | - | - | - | - | 3 | | |
| **(2,875)** | **Sub Total Technical Items** | **(2,224)** | **(275)** | **-** | **1,312** | **637** | **-** | **-** | **1,949** | **1,875** | | |
| **10,082** | **SURPLUS / (DEFICIT) after Technical Items including Sustainability & Transformation funding** | **5,134** | **6,749** | **(4,443)** | **5,157** | **(19)** | **1,459** | **(539)** | **1,615** | **1,629** | | |

**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% | 3.1% | 4.2% | 4.4% | 3.4% | 3.4% | | | | | |
| *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% | 3.9% | 4.1% | | | | | |
| *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% | 3.0% | 2.8% | 4.1% | | | | | |
| *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% | 4.3% | 4.5% | 4.7% | 4.6% | 3.9% | 4.2% | | | | | |

*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% | 6.8% | | | | | |
| *Specialised Services* | *Target* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* |
| Specialised Services | Actual | 4.0% | 4.5% | 6.0% | 7.3% | 7.1% | 6.5% | 4.2% | | | | | |
| *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% | 6.5% | | | | | |
| *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% | 0.5% | | | | | |
| *Source: HR* | | | | | | | | | | | | | |

**Graph 3** **Turnover**

| Division | Target/Actual | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Medicine* | *Target* | *15.8%* | *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% | 12.6% | | | | | |
| *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% | 14.7% | 14.3% | | | | | |
| *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% | 13.8% | | | | | |
| *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% | 11.8% | 11.3% | 11.0% | | | | | |
| *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 | 145.8 | | | | | |
| *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 | 80.9 | | | | | |
| *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 | 60.2 | | | | | |
| *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 | 215.8 | | | | | |
| *Trust Total* | *Target* | *354.9* | *373.4* | *367.9* | *360.5* | *346.5* | *342.3* | *281.9* | *251.9* | *280.6* | *291.9* | *288.1* | *283.2* |
| Trust Total | Actual | 472.1 | 477.5 | 696.9 | 684.5 | 694.5 | 534.1 | 502.6 | - | - | - | - | - |

*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 | 21.6 | | | | | |
| *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 | 9.4 | | | | | |
| *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 | 7.6 | | | | | |
| *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 | 24.6 | | | | | |
| *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 | 63.2 | - | - | - | - | - |

*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% | 7.8% | | | | | |
| *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% | 5.2% | | | | | |
| *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% | 3.4% | | | | | |
| *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% | 5.8% | | | | | |
| Trust Total | Actual | 5.5% | 5.4% | 7.8% | 7.8% | 7.8% | 5.9% | 0.1 | | | | | |

*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 | 9,260 | | | | | |
| Specialised Services | Actual | 4,392 | 4,719 | 4,517 | 4,626 | 4,622 | 4,390 | 4,658 | | | | | |
| Surgery, Head & Neck | Actual | 4,481 | 4,616 | 4,414 | 4,472 | 4,471 | 4,329 | 4,670 | | | | | |
| Women's & Children's | Actual | 6,179 | 6,658 | 5,959 | 6,821 | 6,863 | 6,395 | 6,646 | | | | | |
| Trust Total | Actual | 24,123 | 25,535 | 23,932 | 25,283 | 25,054 | 23,825 | 25,234.0 | | | | | |

*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 | 86 | | | | | |
| *Specialised Services* | *Target* | *20* | *20* | *20* | *20* | *20* | *20* | *20* | *20* | *20* | *20* | *20* | *20* |
| Specialised Services | Actual | 11 | 33 | 29 | 9 | 11 | 10 | 16 | | | | | |
| *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 | 6 | | | | | |
| *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 | 20 | | | | | |
| *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 | 127.8 | - | - | - | - | - |

*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 | 165 | | | | | |

*Source: Service Improvement Team - Amy*

**Key Financial Metrics -Oct 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 | - | (17) | (2) | (8) | (4) | - | | (51) | (82) |
| | Actual | - | (23) | (3) | (17) | (4) | - | | 38 | (9) |
| | Variance Fav / (Adv) | - | (6) | (1) | (9) | 0 | - | - | 89 | 73 |
| | Year to date | | | | | | | | | |
| | Budget | - | (115) | (17) | (51) | (23) | - | | (358) | (564) |
| | Actual | - | (163) | (20) | (149) | (30) | - | | (572) | (934) |
| | Variance Fav / (Adv) | - | (48) | (3) | (98) | (7) | - | - | (214) | (370) |
| **Contract Income - Activity based** | | | | | | | | | | |
| | Current Month | | | | | | | | | |
| | Plan | 2,776 | 5,068 | 6,472 | 7,296 | 9,606 | 343 | | 8,085 | 39,646 |
| | Actual | 2,918 | 5,280 | 6,419 | 7,208 | 9,287 | 343 | | 8,078 | 39,533 |
| | Variance Fav / (Adv) | 142 | 212 | (53) | (88) | (319) | 0 | - | (7) | (113) |
| | Year to date | | | | | | | | | |
| | Plan | 23,509 | 34,827 | 39,196 | 49,449 | 65,282 | 2,347 | | 54,935 | 269,545 |
| | Actual | 23,774 | 35,665 | 38,415 | 50,137 | 64,694 | 2,352 | | 55,291 | 270,328 |
| | Variance Fav / (Adv) | 265 | 838 | (781) | 688 | (588) | 5 | - | 356 | 783 |

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

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Contract Income - Rewards** | | | | | | | | | | |
| | Current Month | | | | | | | | | |
| | Plan | - | - | - | - | - | - | - | 801 | 801 |
| | Actual | - | - | - | - | - | - | - | 862 | 862 |
| | Variance Fav / (Adv) | - | - | - | - | - | - | - | 61 | 61 |
| | Year to date | | | | | | | | | |
| | Plan | - | - | - | - | - | - | - | 5,533 | 5,533 |
| | Actual | - | - | - | - | - | - | - | 5,736 | 5,736 |
| | Variance Fav / (Adv) | - | - | - | - | - | - | - | 203 | 203 |

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

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Cost Improvement Programme** | | | | | | | | | | |
| | Current Month | | | | | | | | | |
| | Plan | 112 | 184 | 104 | 213 | 175 | 71 | 46 | 90 | 995 |
| | Actual | 134 | 141 | 215 | 181 | 237 | 83 | 45 | 96 | 1,132 |
| | Variance Fav / (Adv) | 22 | (43) | 111 | (32) | 62 | 12 | (1) | 6 | 137 |
| | Year to date | | | | | | | | | |
| | Plan | 805 | 1,154 | 701 | 1,516 | 1,178 | 462 | 320 | 630 | 6,766 |
| | Actual | 753 | 789 | 1,024 | 948 | 1,243 | 449 | 295 | 680 | 6,181 |
| | Variance Fav / (Adv) | (52) | (365) | 323 | (568) | 65 | (13) | (25) | 50 | (585) |

# UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

## Finance Report October 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's forecast outturn to £0.09m in October's forecast outturn. 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 | - |

*Please note - the risk scores above will be reviewed on the Corporate Risk Register alongside a review of the thresholds used in the current scoring system.

University Hospitals Bristol
NHS Foundation Trust

**Cover report to the Public Trust Board meeting to be held on Wednesday 29 November 2017 2017 at 11:00 am – 13:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 10 |
| **Meeting Title** | Finance Committee | | |
| **Report Title** | Chair's Report Finance Committee | | |
| **Author** | Pam Wenger, Trust Secretary | | |
| **Executive Lead(s)** | Paul Mapson, Director of Finance and Information | | |
| **Freedom of Information Status** | | Open | |

| | | |
|---|---|---|
| **Reporting Committee** | Finance Committee | |
| **Chaired by** | | |
| **Lead Executive Director (s)** | Pam Wenger, Trust Secretary | |
| **Date of last meeting** | 24 November 2017 | |

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

This report provides a summary of the key issues considered at the Finance Committee on 24 November 2017

**Finance Directors Report**

Paul Mapson, Finance Director presented the Finance Report at month 7 and outlined the summary income and expenditure statement showing a surplus for the period to the end of October 2017 (before technical items) of £7.024m and is therefore £0.334m adverse to plan. Excluding Sustainability and Transformation Funding (STF), the Trust had reported a surplus of £1.332m against a planned surplus of £1.367m. Therefore, for October, the control total excluding STF funding had not been met.

Members noted that 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%).

Key issues of discussion included:

- *Supernumerary Policy* - Members received assurance that the application of the Trust's Supernumerary Policy had been recently being reviewed and that an audit of new starters was underway to ensure the consistent application of the policy.
- *Medical Staffing* - Members discussed the challenging position in relation to medical staffing and whilst slightly lower this month, the adverse variance reflected continuing overspends in all Clinical Divisions although Surgery and Women's and Children's were the most significant. Members noted that challenges and risks in terms of Medical Staffing and that the internal group was being led by Paul Mapson, Director of Finance and Information.

- *Nursing Controls* – Members noted that whilst the position worsened in month 7 compared to month 6, there had been a reduction in vacancy levels across all Divisions reflecting the intake of newly qualified staff. It was noted that further improvement in agency expenditure is expected with the introduction of the neutral vendor arrangement.

**Contract and Activity Reports**
Members received an update in relation to the Trust's contract and activity income and noted that the contract income was £0.49m higher than plan in October. It was noted that whilst Cardiac Surgery was £0.36m lower than plan in October. This was due, in part, to continued patient acuity in the cardiac intensive care unit.

Members received an update on the trust commissioning for quality and innovation (CQUIN) scheme and noted that the CQUIN performance was £9.78m of the total £11.5m available. This is an improvement of £0.11m from the previous month.

**Divisional Finance Reports**
Members received the detailed financial reports for the clinical and non–clinical divisions.

**Service Line Reporting (quarter 4)**
Members received the quarter 4 Service Line Reporting (SLR) position and supported the management action to continue to work with divisional management teams using reference costs and other available tools to support service line reporting and help identify savings opportunities.

**Quarterly Workforce Report**
Members received a detailed quarterly workforce report that provided assurance on the actions being taken to address the vacancy hotspots in relation to agency spend and sickness.

**Savings Programme**
Members received an update on the progress towards delivering the Trust's Cost Improvement Target. It was noted that for the month ending 31 October 2017, the Trust achieved savings of £6.1820m against a plan of £6.766m, leaving a shortfall of £0.548m.

**Capital Programme**
Members received an update on the capital programme and noted that the forecast outturn of £29.366m is £18.519m lower than the Operational Plan and £21.148m lower than the Annual Plan. The variance reflects slippage on the Phase 5 programme and the Medical School.

Members received the minutes of the Capital Steering Group held in November 2017.

**Statement of Financial Position**
Members noted that the Trust continues to have a strong statement of financial position with net current assets of £45.372m, £9.736m higher than the Operational Plan.

**Members received the following report for assurance**

- NHS Improvement Monthly Return

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

None identified.

| | |
|---|---|
| **Matters requiring Committee level consideration and/or approval** | |
| None identified. | |
| **Matters referred to other Committees** | |
| None identified. | |
| **Date of next meeting** | 21 December 2017 |

**Cover report to the Public Trust Board. Meeting to be held on 29 November 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** | Wednesday, 29 November 2017 |
| **Report Title** | **Quarterly Update on Capital Projects** | | |
| **Author** | Andy Headdon, Interim Director of Facilities and Estates | | |
| **Executive Lead** | Mark Smith, Chief Operating Officer/Deputy Chief Executivem Chief Operating Officer | | |
| **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. | ☐ | 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><br>This status report provides a summary update for Quarter 2 on the Trust's strategic capital schemes<br><br><u>Key issues to note</u><br>There is a delay to the programme to deliver the Medical Education facility on the Old Building site due to inability to secure planning approval by Unite.<br>The Phase 4 development programme is now complete, with the final office move into level 8 of the Queens Building and there are no residual risks.<br>The bus shelter has been installed as part of the Queens Façade works, and any residual defects completed.<br>Reinstatement of the three trees, by Bristol City Council, still awaited |

| Recommendations |
|---|
| Members are asked to:<br>• **Note the Report.** |

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

| Board Assurance Framework Risk<br>(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<br>(please tick any which are impacted on / relevant to this paper) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quality | ☐ | Equality | ☐ | Legal | ☐ | Workforce | ☐ |

| Impact Upon Corporate Risk |
|---|
| N/A |

| Resource Implications<br>(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)** |
| | | | | |

**STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT**
**Quarter 2**
**29th November 2017, Trust Board**

1. **Introduction**

This status report provides a summary update for Quarter 2 on the Trust's strategic capital schemes, all of which are managed through their respective project boards, which in turn report to the Senior Leadership Team.

2. **Project Updates**

| **BRISTOL ROYAL INFIRMARY Phase 4 & Queens Facade** | | |
|---|---|---|
| 1 | **Decisions required** | None |
| 2 | **Progress** | **Old Building**<br>The Old Building site owned by Unite has failed to secure a planning permission, which has been further hampered by the English Heritage decision to list the Fripps Chapel.<br>There are ongoing discussions between the Trust, Unite and UoB regarding the options to create a Medical Education Facility on the lower part of the site.<br><br>**Office accommodation**<br>The completion of the office accommodation on level 8 of the Queens building signals the full completion of all phase 4 works. Level 8 was handed over on the 10th Nov 2017 and staff relocated from the temporary site village on the 28-30 Nov 2017.<br>The site village will continue to be used as an office decant facility to support the proposed phase 5 strategic programme and is currently being used as a temporary IT training facility.<br><br>**BRI Phase 4**<br>All phase 4 works are now complete.<br>**Queens Façade**<br>Remedial works to the paving have now been completed and the Council have now installed the permanent bus stop.<br>Three trees are due for reinstatement by Bristol Council and we await their programme for these works. |
| 3 | **Budget** | A total capital allocation for Phase 4 and the Façade of £28.944m is in the |

| | | | |
|---|---|---|---|
| | | capital programme which includes funding for façade and assumes charitable funding support of £2m. | |
| 4 | **Programme** | The phase 4 programme is complete as of 10th Nov 2017 | |
| 5 | **Risks** | **Risk** | **Mitigation Actions** |
| | | There are no residual risks relating to this programme. | |

**3. Conclusion**

The Trust Board is requested to receive this report for information, noting that the Phase 4 redevelopment programme is now fully complete.

**Author:** Andy Headdon, Director of Estates and Facilities
**Date updated:** 09.10.2017

**Cover report to the Public Trust Board. Meeting to be held on 29 November 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** | Wednesday, 29 November 2017 |
| **Report Title** | **Sustainability Strategy: Update and Action Plan** | | |
| **Author** | Sam Willitts, Energy Manager | | |
| **Executive Lead** | Paula Clarke, Director of Strategy and Transformation | | |
| **Freedom of Information Status** | | Open | |

| **Strategic Priorities**<br>**(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. | ☐ | 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**<br>**(please select any which are relevant to this paper)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| For Decision | ☐ | For Assurance | ☒ | For Approval | ☐ | For Information | ☐ |

## Executive Summary

The “Big Green Scheme Vision and Strategy – Care Without Costing the Earth” - was approved by Trust Board in November 2015. This set out the Trust’s Sustainable Development Strategy and objectives for 2020.

The key aims of our strategy are expressed across the domains of:

- Buildings without Costing the Earth
- Journeys without Costing the Earth
- Procurement without Costing the Earth
- A Culture without Costing the Earth
- Productivity without Costing the Earth
- A future without Costing the Earth
- Pioneering without Costing the Earth

This report sets out the objectives we committed to in our Vision and Strategy and provides a brief update on progress to date; identifies where we have challenges with delivery and how we are adapting; and includes a Sustainability Development Action Plan (SDAP) to drive delivery of objectives by 2020.

The measurement, performance and continual relevance of this SDAP will be monitored, reviewed and updated regularly through the Sustainability Forum to ensure the objectives of the Sustainability Strategy and Policy are being achieved.

**Recommendations**

Members are asked to:

- **Note** the update and support delivery of the Sustainability Strategy

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

| **Board Assurance Framework Risk**<br>**(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**<br>**(please tick any which are impacted on / relevant to this paper)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quality | ☐ | Equality | ☐ | Legal | ☐ | Workforce | ☐ |

| **Impact Upon Corporate Risk** |
|---|
| None identified. |

| Resource Implications<br>(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)** |
| | | | | |

**Big Green Scheme Vision 2015-2020 Care Without Costing the Earth**
**Sustainable Development Action Plan**

## 1. Introduction

Because we understand that our health is influenced by the environment, we are working to reduce our environmental impact, particularly, seeking to manage our carbon footprint and reduce our contribution to climate change. Reducing these impacts also enables us to address our key challenge which is to maintain and develop the quality of our services, whilst managing with fewer available resources. In response to the challenges we face across all our available resources - financial, social and environmental - the "Big Green Scheme Vision and Strategy – Care Without Costing the Earth" - was approved by Trust Board in November 2015. This set out the Trust's Sustainable Development Strategy and objectives for 2020.

The key aims of our strategy are expressed across the domains of:

- Buildings without Costing the Earth
- Journeys without Costing the Earth
- Procurement without Costing the Earth
- A Culture without Costing the Earth
- Productivity without Costing the Earth
- A future without Costing the Earth
- Pioneering without Costing the Earth

Across these domains we aspire to delivering care in a way that eliminates harmful environmental impacts, particularly greenhouse gas emissions and in doing so, increase efficiency of the use of all our resources and put sustainability at the core of our business model. In practice, this requires us to aspire towards meeting a number of **key goals:**

*Leading in partnership for carbon reduction across the health and care system*

*Wellbeing and engagement of our staff and communities*

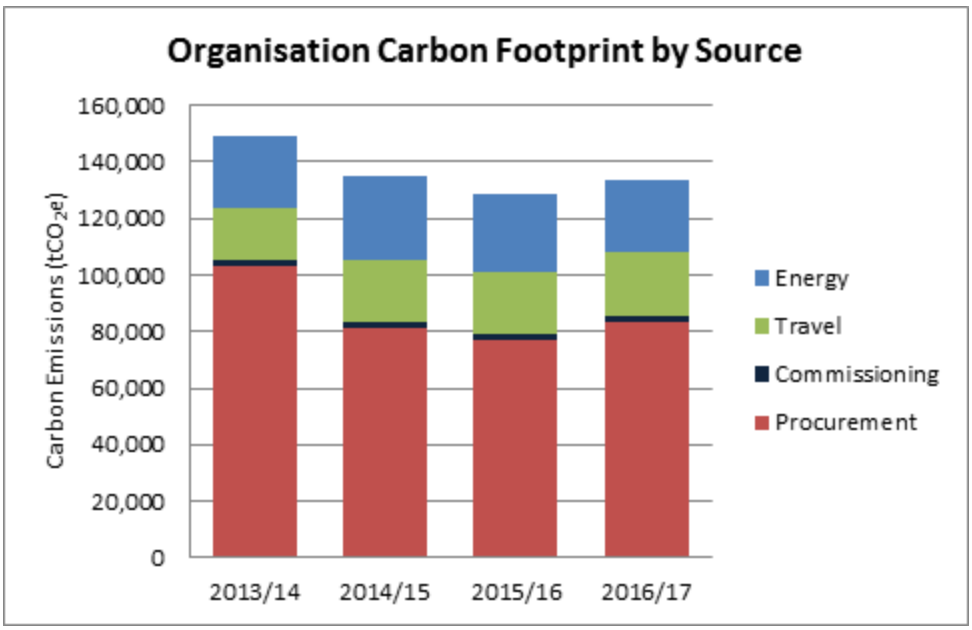
*Financial savings through resource efficiency*

This report sets out the objectives we committed to in our Vision and Strategy and provides a brief update on progress to date; identifies where we have challenges with delivery and how we are adapting; and includes a clear action plan to drive delivery of objectives by 2020.

## 2. Progress Overview

To drive delivery of the strategic objectives, a Sustainability Forum was established within the Trust, sponsored by the Executive Director Big Green Champion (Director of Strategy and Transformation). The Forum includes representatives from across all Divisions and relevant departments to ensure local ownership. The Forum has supported delivery against a number of key targets with highlights including:

- An 8.7% reduction in energy spend in 2016/17 from 2015/16.
- Carbon emissions from energy consumption have reduced by 1822 tonnes (7%) in the past year.
- Despite increased activity, we have reduced our consumption of water in 2016/17.
- We are working to improve our Good Corporate Citizen score of 32 in 2015/16.
- Improved the level of recycled or reused waste from 24% to 31% in the past year.
- Green impact awards in 2016/17 - 450 staff directly involved in teams engaged 1800 staff in undertaking sustainability actions and achieved £53k savings, as well as team building, engagement and empowerment.
- Development and approval of a Trust Sustainability Development Policy in September 2017.




Over the past 3 years the Trust has achieved an 11% reduction in emissions against our target reduction of CO2 emissions that is at least in line with NHS and UK targets under the Climate Change Act 2008 (28% reduction by 2020 against our 2013 baseline) . Achieving the remaining 17% by 2020 will require the Board's support. In the past year, emissions from energy have reduced but procurement emissions have gone up so overall 2016/17 emissions have increased.

The Sustainability Development policy set out the Trust's commitment to embed the principles of sustainable development in the activities of the Trust and in how we engage with our staff, our patients, our contractors and our suppliers, and specifies the KPIs, responsibilities and reporting framework for delivery. The Policy is driven by legislative, contractual and policy requirements placed upon the NHS and directly contributes to the delivery of the National NHS Sustainability Strategy (2014-2020), the NHS Five Year Forward View, the local Sustainability and Transformation Plan and the Trust's Big Green Scheme Strategy and Vision (2015-2020).

The Key Performance Indicators identified for each domain in the Sustainable Development Strategy and Policy are as follows:

- Cost savings from absolute CO2 reduction from buildings energy consumption that is in line with NHS and UK targets under the Climate Change Act 2008 (28% reduction against our 2013 baseline)

- Cost savings through driving a reduction in procurement scope 3 (supply chain) CO2 emissions that is at least in line with NHS and UK targets under the Climate Change Act 2008 (28% reduction against our 2013 baseline)

- Cost savings from absolute reduction in CO2 emissions from all travel and transport operations (Trust fleet, grey fleet, commuting and patient travel) that is in line with NHS and UK targets under the Climate Change Act 2008 (28% reduction against our 2013 baseline)

- Members of the community play an integral role in our sustainability decision making process through effective engagement and involvement in our governance structure. This will be achieved through public reporting and events to enable engagement and consultation with the Trust membership and the public

- Reduce the percentage of staff reporting that they have suffered work related stress and increase the percentage of staff participating in physical activity during the working day,

including active travel to work - Supporting the delivery of reduced rates of turnover and sickness absence which take the Trust to upper quartile compared with our peers;

- Staff Engagement: 20% of staff engaged through Green Impact or other activity. Sustainability in healthcare, including carbon reduction and climate change adaptation, to be an element of all aspects of staff training regardless of topic.

- Reduction in the risk rating of Annual Climate Change Adaptation risk assessment that is undertaken as a routine component of Emergency Planning and Business Continuity procedures.

## 3. Sustainable Development Action Plan (SDAP)

### 3.1 Approach

In 2017, the Sustainability Forum completed a review of all the objectives in our strategy and developed a clear action plan, setting out responsibility, action, measurement and timeframe for each action (attached at Appendix 1). These actions align to delivery of the KPIs in section 2 above. The action plan is intended to ensure that the Trust is operating in accordance with current legislation as well as embedding sustainability throughout its operations and includes actions to improve sustainability performance in the following workstreams:

- Physical infrastructure: Buildings – Energy -Waste
- Transport: Journeys without costing the Earth
- People: Culture, Productivity, and Wellbeing
- Procurement
- Pioneering

Achieving these actions requires ownership and activity by staff across the whole Trust. Extensive consultation has been undertaken to ensure the engagement of staff to test that the actions are appropriate, achievable and can be delivered over the agreed timescales.

The consultation process has been very valuable in refining the actions and improving them to embed them in Trust activity. It found that rather than introducing new activities, many actions could be delivered by aligning them with existing Trust activities and ensuring they incorporate sustainable development elements.

For example the consultation with Education regarding sustainability training identified that rather than having sustainability training as a stand-alone activity as had been originally proposed, the action should be to embed sustainability into all relevant training across induction, face to face and e-learning. This will ensure staff receive consistent messages e.g. around avoiding waste and maximising re-use.

### 3.2 Remaining Challenges

Whilst the consultation review process enabled many actions to be adjusted to make them deliverable, there are outstanding challenges. These reflect the continual need for the Trust to assess and prioritise our resources and to ensure that the actions we have planned consider the cost / benefit and value for money to be secured. Where we believe that this is not currently demonstrated for the objectives and actions from our strategy, we have assessed whether alternative actions or mitigations can be achieved. Examples of this include:

- Recording patient travel - the cost/benefit of gathering patient travel information suggests this action is not deliverable. We are considering approaches undertaken at other hospitals such as an annual sample survey approach which may allow us to minimise the resource requirement to obtain representative dataset.
- Improving wellbeing for staff - our primary focus is to invest in developing our clinical services, however we will seek to incorporate improvements to the environment for staff as part of these developments.

- Government guidelines are to achieve BREEAM “excellent” on new build premises and “very good” on refurbishments. Trust building schemes currently achieve BREEAM “very good” for new builds, refurbishments are not BREEAM assessed. This approach has been taken to prioritise scarce capital resources and will be kept under review.

- Capacity issues in Bristol and Weston Purchasing Consortium have meant we have been unable to complete the consultation in procurement related actions. However, we have been working alongside North Bristol Trust to support BWPC with ways to embed sustainability into procurement processes.

**3.3 Delivery**

The measurement, performance and continual relevance of this SDAP will be monitored, reviewed and updated regularly through the forum to ensure the objectives of the Sustainability Strategy and Policy are being achieved.

Successful delivery will require commitment and leadership across the whole Trust, empowering staff to develop and enact local ideas, as well as requiring investment. This includes investing staff time in supporting sustainability actions, as well as direct investment in more energy efficient buildings and equipment. Much of this investment (for example in reducing water consumption or medicines savings projects) represents invest to save performance, however achieving funding or match funding for travel or wellbeing projects such as bike stands or gardens remain challenging.

**4. Recommendation**

Trust Board are asked to note and support delivery of the SDAP to enable achievement of our strategy objective.

| Pioneering | | | | | | |
|---|---|---|---|---|---|---|
| **Objective** | **Responsibility** | **Action** | **Measurement** | **Time Frame** | **Achievable** | **If not achievable suggestions as to how to improve** |
| Become leading Good Corporate Citizen | Executive Green Champion | 1. Annual Good Corporate Citizen review | Improved ratings showing leading Trust | 2017 and annually thereafter | Yes | |
| | | 2. Benchmark rating against other Trusts | | | Yes | |
| Lead by example and publish a detailed sustainability report alongside our Annual Report each year, to chart progress. | The Big Green Scheme | 1. Report on progress against actions set out from the Big Green Scheme Vision and Strategy | Annual Sustainability report published | 2018 and annually | Yes | |
| | | | | | Yes | |
| Seek opportunities to share best practice with other NHS bodies and openly share information on our sustainability initiatives with providers and commissioners. | Big Green Scheme representatives | 1. Research examples of best practice and attend opportunities for sharing information on our sustainability initiatives | Network events attended and information shared | 2017 and annually therafter | Yes | |
| Sustainability is part of our decision making and business planning process for the design and delivery of health and social care services. | Divisions | 1. Divisional OPP | Evidence of sustainably impact assessment of developments in divisional operating plans. This should apply both in terms of the sustainability impact of service delivery models and capital developments (as per actions on physical infrastructure tab) Completion of sustainability section Annual Operating Plans. | 2017 and annually thereafter | Yes | The Annual Operating Plans (OPP) template has a mandatory section for sustainability: *7.8 Sustainability Please outline the top three actions you will take to improve environmental sustainability in your division. These can be the same three as in 2016/17 plans if delivery of these remains the focus through 2017/18 and 2018/19.* Our Full Business Case template also has an 'Estates strategy 'section which will address environmental and sustainability concerns e.g. impact of new builds and new services on energy consumption. |
| Increase, where appropriate, non-contact first specialist appointments, Telemedicine interventions, user experience of using services and reducing journeys. Providing training to interact with service users using multiple methods and technologies | Transformation team | 1. Identify examples for where non-contact appointments could take place in current workflow | 1. Examples identified of where non-contact appointments could be take place in current workflow | 2018 | Yes | |
| | IM&T | 2. Identify and implement technologies that could enable these developments and promote services at a distance | 2. Technologies identified and implemented that enable non-contact appointments and promote services at a distance. | 2018 | Yes | |
| We will work in partnership to demonstrate a shift in the way services are delivered and how this contributes to carbon reduction and sustainability across the system. | All employees | 1. Practice and promote sustainable healthcare delivery throughout all specialities/departments that support public health campaigns and have a positive impact on the health and wellbeing of the community. Taking a system-wide approach pioneer the development of care pathway approaches to carbon foot-printing and CO2 reduction | 1.Sustainability and Transformation plan delivery | 2018 | Yes | |

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|---|---|---|---|---|---|---|
| Employ the UK Climate Change Risk Assessment tools and guidance to assess local risks to our patients and staff, infrastructure, supply chain and clinical services and inform our Emergency Planning & Business Continuity procedures | Operational managers/Sustainability Manager | 1. Employ the UK Climate Change Risk Assessment tools and inform Emergency Planning & Business Continuity procedures of outcomes | 1. UK Climate Change Risk Assessment tool employed and Emergency Planning & Business Continuity procedures informed of outcomes | 2018 and ongoing | Yes | |
| | Emergency planning | 2. Develop joint city wide adaptation plans through Local Resilience Forum and other organisations. | 2. City wide adaptation plan developed through Bristol Resilience Committee and STP Estates group | 2018 and ongoing | Yes | Risks we plan for are taken off the Local Resilience Forum Community Risk Register which is annually assessed. We link in with local NHS and city council partners through various forums to ensure these are joined up plans rather than organisations planning in isolation. |
| Monitor climate change risks to the areas and communities we serve | Resilience Manager | 1. Conduct regular Climate Change Impact Risk Assessments covering the areas and communities we serve and ensure that high level risks are registered on the Trust's Risk Register. | 1. Completed annual risk assessment and high level risks registered on Trust's Risk Register. | 2017 and ongoing | Yes | |
| Develop a Climate Change Adaptation Action Plan to reduce impact on and ensure continuation of care for our most vulnerable patients during extreme weather events including rising temperatures and heat waves, flooding and storm events, cold weather spells, increased pollution and increased UV sunlight exposure. Identify cool rooms for use during heat waves. | Operational managers | 1. To develop service based business continuity plans based on the Climate Change Risk Assessment in the case of extreme weather events | 1. Completed service based business continuity plans | 2019 | Yes | |
| | | 2. Integrate with existing plans such as compliance with heat wave plans. | 2. Business continuity plans are integrated with existing plans | 2019 | Yes | |
| | | 3. Develop longer term strategy for expected extremes | 3. Completed long term strategy for expected future climate changes induced extremes in weather. | 2019 | Yes | |
| We will raise awareness of climate change and communicate progress with our own CO2 reduction efforts to our Board, our staff, our patients and other external stakeholders. | Big Green Scheme Executive representative | 1. Representative from Executive Management will be present at BGS meetings quarterly, will keep the board up to date and inspire board support | 1. Comms plan | 2017 and annually thereafter | Yes | |
| | Communications Team | 2. Communications team will prompt the Big Green Scheme for regular stories and promote sustainable development in the most effective way | | | Yes | |
| Work closely with our local strategic partnership and other key strategic partnerships to promote the delivery of health and sustainability outcomes, when planning the built environment. | Estates Capital | 1.Liase with Planning Authorities | Regular meetings | 2017 and ongoing | Yes | |
| | | 2. Liase with Transport Forum | | | Yes | |
| Enable our assets and resources to be used by the local community wherever possible and appropriate and demonstrate the positive effects of this work on health and wellbeing in our community. | Director of Facilities and Estates | 1. Develop partnerships: Bristol Health Partners, Green Capital Partnership, Helathy City Week, Bristol Health and sustainability Group, Health and sustainability network southern Region, NHS PHE Sustainable Development Unit | Improved Good Corporate Citizen Score for Partnerships | 2017 | Yes | |
| | Executive lead for Strategy | 2. Promote use of hospital buildings through the IDEA group | Increased use of assets by community | 2018 | Yes | |

# Vision and Action Plan

**To protect the wellbeing of the UK population the NHS, public health and social care system has set an ambitious goal to reduce carbon dioxide equivalent emissions across building energy use,**

- **Physical infrastructure: Buildings – Energy -Waste**
- **Transport: Journeys without costing the Earth**
- **People: Culture, Productivity, and Wellbeing**
- **Procurement**
- **Pioneering**

**The actions arise from the Board approved "Vision and Strategy – Care without costing the Earth". Associated plans that align their actions are: Green Travel Plan, Staff Wellbeing plan, Energy**

| Physical Infrastructure-Building-Energy-Waste | | | | | | |
|---|---|---|---|---|---|---|
| **Objective** | **Title** | **Action** | **Measurement** | **Time Frame** | **Achievable** | **If not achievable suggestions as to how to improve** |
| Obtain independent, validation of our carbon footprint each year, publishing the results on our website and Annual Report. | Energy manager | 1. Define scope of carbon footprint | Carbon reduction reporting | 2018 | Yes | |
| | | 2. Secure funding and then appoint independent auditor | ERIC reporting | 2018 | Yes | |
| | | 3. Produce report against carbon footprint | SDU reporting | 2018 | Yes | |
| | | | Annual account sustainability reporting | 2018 | Yes | |
| Reduce the amount of greenhouse gas emissions from energy use (An increase of 3856 tCO2e 2014/2015). | Energy Manager | 1. Develop energy saving projects in a carbon reduction plan in line with UK targets | Carbon reduction reporting | 2018 | Yes | |
| | | 2. Implement energy saving technologies throughout buildings | Number of technologies implemented | Every year from 2017 | Yes | |
| | All employees | 3. Practice energy saving behaviours | Number of green impact actions completed | 2018 | Yes | |
| | Sustainability Officer | 4. Engage staff in energy saving behaviours | Number of Green Impact teams | 2018 | Yes | |
| Develop our Environmental Management System (EMS) with the objective of achieving ISO14001 certification across all operations. | Sustainability Manager | 1. Develop our EMS following the steps to accreditation | Achieving ISO14001 certification | 2019 | Yes | |
| | Quality Systems Manager | 2. NHS Premises Assurance Model (PAM) compliance building towards externally accredited standard | PAMS compliance | Every year from 2017 | Yes | |
| | | | External accreditation | Annual external review | Yes | |
| Achieve the BREEAM Excellent Standard for any new build premises.In line with the Office of Government Commerce's (2000) 'Constructing the best government client: achieving sustainability in construction procurement – sustainability action plan' | Director of Facilities and Estates | 1. Compliance with Health Technical Memorandum (HTM) 0707 | HTM 0707 compliant | 2019 | Yes | Current briefing to design teams requires projects to be HTM compliant unless derogation is agreed |
| | Estates Capital and maintenance | 2. Challenge building contractors to propose cost-effective, low carbon solutions when undertaking refurbishment projects and monitor the benefits including savings from recycling/reusing materials. | BREEAM excellent rating achieved for new builds and very good rating for refurbishments. | 2019 | No | Trust building schemes currently achieve BREEAM very good for new builds, refurbishments not BREEAM assessed. This is due to capital constraints. No future plans to change this approach |
| Achieve BREEAM standard very good for all refurbishment projects | | 3. Benchmark and explore the market in terms of other NHS building projects to gain knowledge on building opportunities against other Trusts | Standard specification updated with top sustainability opportunities to consider | 2018 | Yes | Standard specification due to be updated |
| | Finance | 4. Completion of CAPEX forms to capture whole life costings of refurbishment | Number of Lifecycle assessments included in business cases | 2017 and ongoing | Yes | |
| Provide green spaces across our estate to support patients, public and staff health, wellbeing and biodiversity, even where land is constrained. | Estates Capital | 1. Include in Estates strategy | Increase the amount of existing green space land that is managed to support patients, public and staff health, wellbeing and biodiversity | 2019 and ongoing | Yes | Woodland walk, staff allotment, Education out door space all improved land management with biodiversity in mind. We will continue to retain the current levels of green space. |
| | Director of Facilities and Estates | | | | | |
| Reduce the energy consumption of our IT infrastructure through the introduction of energy efficient technology and power management techniques. | IM&T Management | 1. Paperless systems | Figures on reduction in paper use and waste diverted from landfill | Implemented:<br>1a) St Michaels-2015<br>1b) BCHI-2016<br>1c) BRI/SBCH/BHI-March/April 2017<br>1d) BEH/BDH/BHOC-late summer 2017 | Yes | |
| | | 2. Investing in energy efficient equipment | Figures on energy saved | 2017 and ongoing | Yes | |
| | | 3. PC Power management tool | Figures on computers installed on as percentage of total and energy saved | All PCs (eligible) in Trust by end of 2017 | Yes | |
| Ensure that any electricity we purchase from the national grid is generated from 100% renewable energy sources. | Energy Manager | 1. Explore ways in which our energy procurement can meet our sustainable procurement policy requirements and those of the Public Services (Social Value) Act 2012 | Quarterly reports | 2017 and ongoing | Yes | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Reduce water consumption | Energy Manager | 1. Reduce leaks – develop strategy | Leak detection | Every year | Yes | |
| | | 2. Introduce water saving technologies such as flow restrictors | Water bills | 2018 | Yes | |
| | Civil contingency lead | 3. Develop an action plan to safeguard the Trust from future water shortages | New schemes | 2019 | Yes | The Trust has business continuity plans for water loss as well as a heatwave plan in place for severe weather. This is managed and updated by estates and will shortly be tested as part of a planned shutdown for some mains water works. |
| Zero waste to landfill across all of our operations and turning residual waste into a resource opportunity wherever possible. | Waste Manager | 1. Continue to reduce the amount of domestic waste and increase recycling by 3% each year. Audit current systems and address issues | Reduction in domestic waste and increase in recycling figure by >3% each year | 2017 and ongoing | Yes | |
| | | 2. Communicate expectations to waste contractors | Evidence of expectations communicated to contractors | 2017 and ongoing | Yes | |
| | | 3. Improve reuse system eg Warpit replacing bulletin board | New waste streams developed | 2017 and ongoing | Yes | |
| | Sustainability Officer | 4. Incentivise staff to increase recycling, promote national campaigns | Production of resources and promotion of waste streams info and national campaigns | 2017 and ongoing | Yes | |
| | Estates Capital | 5. Introduce standard operating procedure for disposals of surplus equipment during refurbishment works | New waste streams developed | 2019 | Yes | Current practice is to recycle any major medical equipment and to minimise any waste going to landfill. We will seek to develop a SOP to incorporate within contractors information pack |
| | | 6. Communicate expectations to suppliers and switch to more resourceful option where necessary | Ref'd in Operating Plans | 2019 | Yes | |
| | Departmental buyers/Procurement | 7. Ensure that buyers in the divisions consider disposal/reuse/recyclability in their purchase choices | Evidence of disposal/reuse/recycliability consideration for purchase choices | Please complete as appropriate | Yes/No | Not yet updated by Procurement |
| Reduce to the lowest practicable level the number of hazardous substances used by the Trust. | Procurement | 1. Identify the hazardous substances that the Trust procures and allocate them to the relevant department | Develop EMS records | 2017 | Yes/No | Not yet updated by Procurement |
| | | 2. Procurement source a more sustainable option | Operating plans | 2019 | Yes/No | Not yet updated by Procurement |
| | Health & Safety | 3. Discuss options for changing current practices | Identify responsible persons | 2018 | Yes | Current review of cleaning chemicals used by Facilities in an effort to reduce the number of products used, limit the number of suppliers and introduce uniformity across all hospital sites. Limited opportunities at South Bristol Community Hospital as cleaning service not provided by UHB. Very little potential to reduce hazardous medication such as cytotoxic drugs. Same for biological agents and medical gases. Also reduce use of formalin through introduction of vacuum packing of specimens. |
| Reduce food waste across the Trust | Estates and Facilities | 1. Pilot initiatives to reduce food waste e.g. timing of menu distributuion | Tonnage of food waste produced | Jan-17 | Yes | The whole Trust now use frozen food for patient feeding, this will have a signifacant impact in reducing food wastage, as food can now be stored in the freezer and not disposed off due to the short shelf life ( 2 day maximum) of chilled foodstuffs. It is envisage the introduction of an electronic patient meal ordering system will support the reduction of food wastage as meals will be ordered more timely. |
| Implement sustainable methods of food waste disposal | Estates and Facilities | 1. Introduce sustainable food waste disposal methods either on-site or to be collected and taken offf site by a contractor. Options include but are not restricted to composting or Anaerobic Digestion. | Tonnage of food waste diverted from landfill/sewage system and carbon dioxide equivalent saved | 2019 | Yes | All food waste is currently disposed of through food waste disposal units on each ward. Going forward this element of waste management could be considered as part of an options appraisal document (planned for summer 2018) to review options and associated feasability to create a centralised waste segregation and depository site on trust property. (Considering location SWEB car park) |

| Transport: Journeys without costing the Earth | | | | | | |
|---|---|---|---|---|---|---|
| **Objective** | **Title** | **Action** | **Measurement** | **Time Frame** | **Achievable** | **If not achievable suggestions as to how to improve** |
| Increase staff uptake of active/sustainable travel | Procurement/finance | 1. Monitor travel by staff - Implement an electronic business travel claim system | Electronic system | 2018 | Yes | |
| | Operations ,Transport and Green Travel Manager | 2. Encourage use of more eco-friendly hire vehicles | Increased usage of eco-friendly vehicles | 2017 | Yes | Improve communication to staff to raise awareness of hire vehicles and tender for supplier to include eco-friendly vehicles |
| | | 3. Encourage use of City car Club for Business journeys | City car club vehicles usage | 2017 | Yes | Improve communication and awareness of resources |
| | Operations, Transport and Green Travel Manager | 4. Utilise info on Grey Fleet use-info to be provided by Finance | Grey Fleet mileage | 2017-2018 financial year | Yes | Finance to provide annual Grey fleet mileage report |
| | Communications team | 5. Promote the staff travel survey to staff to encourage active/sustainable travel | Weekly promotion of the staff travel survey, when open, via Newsbeat and Connect. Promote results in Voices article. | Every year | Yes | |
| Monitor travel by patients to record uptake of active/sustainable travel | Operations, Transport and Green Travel Manager | 1. Measuring patient travel becomes part of the departments operations | Patient travel records | 2019 | Yes | No current process to monitor patients travel. Propose annual sample survey of patients travel to gain data at minimum cost. |
| Implement the Green Travel Plan and access information for staff, patients and visitors and support staff with low carbon efficient travelling within our communities. | Operations ,Transport and Green Travel Manager | 1. Continue to advocate and implement more sustainable methods of patient/staff/visitor and resource transportation. Provide comprehensive and current information to the Comms team. | Staff Wellbeing CQUIN Implementation Plan, Indicator 1A , Workplace Wellbeing Charter | Every year | Yes | Engage with TravelWest to deliver 2 roadshows per year |
| | Communications team | 2. Support teams and departments to ensure information is available in a logical place, is comprehensive and current. | Frequency of comms annually: 12x Newsbeat, 4xconnect, facilitate article in Voices. | Every year | Yes | |
| | Sustainability Officer | 3. Ensure green travel plans are integrated with the Green Impact Awards and promoted in general staff engagement activities | Green travel actions within Green Impact Award criteria and promotion of green travel in staff engagement | 2018 and ongoing | Yes | |
| | Staff Health and Wellbeing lead AND Transport Manager | 4. Encourage and support active travel Through our Staff Heath & Wellbeing Framework and Health Wellbeing Steering Group, ensuring it is aligned to our Green Travel Plan objectives | Workforce Wellbeing Framework, Physical Activity Domain | In place and ongoing | Yes | |
| Provide all new starters with information on our Green Travel Plan, including how to commute to work, public transport and active travel options and information on other Trust schemes (e.g. Cycle to Work scheme) and these are included in the benefits booklet. | Operations,Transport and Green Travel Manager | 1. Create a comprehensive guide to the Green Travel options available to Trust staff | Staff Benefits Booklet page 11 | 2017 | Yes | TravelWest options to be added to staff benefits |
| | Staff Health and Wellbeing lead | 2. Include green travel options in the staff benefits booklet | Cyclescheme – salary sacrifice scheme | In place and ongoing | Yes | |
| Develop flexible working arrangements to enable staff to work from home or travel off peak. | Comms/Staff Health and Wellbeing lead | 1. Promote the flexible working policy | Dedicated Flexible Working Page on HR Web with Policy and guidance docs | In place and ongoing | Yes | |
| | Line managers. | Line managers familiar with the flexible working policy and promote | Line managers aware of current flexible working policy | 2018 and ongoing | Yes | |
| | HR | 3. Ensure information about the flexible working policy is mentioned in job adverts and issued with contracts | Evidence of flexible working policy information in job adverts and contracts | In place and ongoing | Yes | |
| Strengthen our strategic relationship with local government partners to support implementation of our Green Travel Plan, reducing traffic impacts and promoting the use of public transport and active travel. | Operations,Transport and Green Travel Manager | Identify partners and lead organisation to develop transport lobby group (equivalent to Suscom group for central Bristol) | Lead organisation identified and transport group set up | 2018 | Yes | UHB will join transport lobby group once it is set up by lead organisation |
| Develop our electric powered fleet , adapt our commercial fleet through the adoption of cleaner, lower emission technologies and maximise the efficient use of our transport resources. Develop an electric bicycle fleet. | Operations ,Transport and Green Travel Manager | 1. Promote the successes of the electric fleet and increase the number of clean, low emissions technologies amongst the rest of the fleet and any new vehicles | Promotion of electric fleet. Increased numbers of clean, low emission technologies amongst existing and new vehicles. | 2017 and ongoing | Yes | |
| | | 2. Review transport strategies, identify and implement any opportunities to make them more efficient | Increased efficiency of transport strategies | 2018 and ongoing | Yes | Tracking introduced to check routing |
| | | 3. Seek to reduce the fleet size encourage the use of City Car Club/CO-Wheels for other departments in the trust | Reduction in fleet size | Every year | Yes | Enterprise car club and independent car hire available |
| | | 4. Seek opportunities to establish a fleet of electric bicycles | Established (and ever growing) electric bike fleet | 2018 | Yes | |

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| Identify risks of disruption to our transport operations and community services and put in place contingency plans to cope with extreme or unexpected events. | Trust Resilience Manager | 1. Devise strategies for dealing with extreme or unexpected weather events which could affect work | Adaptation plan | 2018 | Yes | The transport manager has a business continuity plan which focuses on delivering services when business is disrupted. This focuses on the impacts of a hazard as opposed to specific strategies as per national guidance. |
| Identify supply chain risks through disruption of transport. | Procurement | 2. Develop emergency plans to mitigate supply chain risks | Emergency plans | 2019 | Yes / No | Not yet updated by Procurement |

| People: Culture, productivity and wellbeing | | | | | | |
|---|---|---|---|---|---|---|
| **Objective** | **Title** | **Action** | **Measurement** | **Time Frame** | **Achievable** | **If not achievable suggestions as to how to improve** |
| Include sustainable development objectives into staff contracts, staff induction, local orientation checklist, development and appraisal processes and encourage all clinical staff to include sustainability as a dimension of their daily work; reducing waste and improving resource efficiency. | HR | 1. Ensure sustainable development objectives are included in staff contracts | Sustainable development objectives in all existing and new Trust staff contracts. | 2017 | Yes | |
| | Departmental managers | 2. Ensure sustainable development is included in local inductions and recognised as a general duty in the daily work of all roles | Sustainable development included in all local inductions. Include correct waste disposal and energy efficiency duties in all roles. | 2018 | Yes / No | Sustainability and green impact is promoted and recently updated as part of the Corporate induction and the Staff Handbook |
| | Line managers | 3. Ensure sustainable development is addressed in appraisals and developmental opportunities | Sustainable development section in all appraisals and developmental opportunities. | 2018 | Yes / No | Not yet updated by HR |
| | Sustainability Officer | 4. Recognise staff for their achievements and promote success stories | Green Impact Awards and promotion of success stories. | 2017 and ongoing | Yes | |
| Support and recognise the efforts of staff who are working on sustainable behaviours and campaigns throughout the hospital. | Sustainability Officer | 1. Line managers are encouraged to ensure the Big Green Scheme is aware of the sustainable efforts made by staff throughout the Trust | Special Award nominations and emails to the big green scheme@uhbristol.nhs.uk | 2018 and ongoing | Yes | |
| | | 2. Award Green Impact special awards to achievements across the hospitals | Green Impact Special Awards | 2019 and ongoing | Yes | |
| Enhance staff engagement through active engagement with sustainability initiatives including developing existing and new teams to join in the Green Impact Awards. | | 1. Continue with primary target of increasing and maintaining Green Impact participation | Annual team numbers have increased | 2017 and ongoing | Yes | |
| | Communications | 3. Publicise the facility which exists for staff to receive a proportion of their salary in Bristol Pounds to support local sustainable businesses | Information available to staff on how to receive a proportion of their salary in Bristol Pounds. | 2017 and ongoing | Yes | |
| Ensure the Trust's existing training provision has appropriate incorporation of sustainability training. | HR Training | 1. Check the Trust's existing training provision e.g. Productive Series and the Quality, Innovation, Productivity and Prevention (QIPP) programme has appropriate incorporation of sustainability training | Updated Training | 2018 | Yes | |
| | HR leadership training | 2. Check that the HR leadership training programme has appropriate sustainability training incorporation | Updated HR leadership training | 2018 | No | We do not have specific training on sustainability within our Leadership programmes . Our Leadership training covers skills based training i.e. behaviours of Managers and how to manager staff and deal with difficult situations. |
| Integrate sustainability into the design, delivery and quality of care we provide. | Sustainability Officer | 1. Good environmental practice should be part of everyone's day-to-day job, in the same way that infection control is everyone's responsibility | Departments log the ideas that they come up with and make a plan for associated actions. Ref'd in Operating Plans | 2018 | Yes | |
| | Big Green Scheme | 2. Introduce Sustainable Action Planning (SAP). SAP to be produced and presented to Sarah Nadin for summer 2018. SN to then introduce into Operating Plans for 2019. | Number of sustainable action planning workshops run. Ref'd in Operating Plans | 2018-19 | Yes | |
| | Director of Transformation | 3. Support embedding sustainability in care pathway redesign and support patient engagement in process as an effort on the ground | Sustainability and Transformation plan delivery | 2018 | Yes | |
| Enable more patient care and support services to be delivered in the home. | Divisions/service lines | 1. Review patient pathways | Evidence of active development of home care and closer to home services in Divisional Operating Plans (outreach services, peripheral clinics, day attendance, early supported discharge, virtual ward models etc.,). Evidence of engagement with community providers, charitable partners and other providers in the provision of home delivered care. | 2019 | Yes | |
| | External partners | 2. Engagement with external partners | | 2018 | Yes | |
| | Public and patient involvement | 3. OPP and commissioning | | Every year | Yes | |

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| Involve patients, carers and other communities of interest in the strategic development of the Trust and its services, including ways the organisation could be more sustainable and achieve resource efficiencies such as reducing waste and increasing recycling. | Patient Engagement Team | 1. Explore, using existing patient experience and involvement activities, methods for patients to express their awareness and understanding of the Trust's sustainability efforts, and influence the Trust's strategic development | Utilise existing and, where appropriate, develop new methods for patients to express their expectations and influence the Trust's strategic development | 2018 | Yes | |
| | Communications | 2. Create methods for community interest groups to feed into the strategic development of the Trust | Creation of methods for our communities and membership to feed into the strategic development of the Trust | 2019 | Yes | |
| | | 3. Improve the ways in which we share learning from our patient experience work. | Proven improved communication of learning from patient experience work. | 2018 | Yes | |
| Contribute to local and regional networks to support sustainable development and monitor the impact of this co-operation. | Big Green Scheme representatives. | 1. Attend and be active members of Bristol Sustainability and Health Group<br><br>2. Attend and be active members of NHS/PHE Southern Sustainability and Health Network. Big Green Scheme representatives from each department ensure that they are aware of the networking opportunities relevant to them and attend where possible | Participation reported in Annual Report | 2018 | Yes | |
| | | | | 2019 | Yes | |
| Achieve accreditation under the 'Bristol's Workplace wellbeing charter' and NICE guidelines. Ensure that changes to our property portfolio produce an on-going improvement in working environment for staff and the provision of adequate facilities for break and rest periods. Develop staff access to healthy food choices. | Estates Capital | 1. Introduce guidance based on the Workplace Wellbeing Charter and NICE guidelines to ensure appropriate developments are being made to improve the working environment for staff | Staff Wellbeing CQUIN Implementation Indicator evidence | 2018 | No | Our primary focus is to invest in the development of clinical services, however we will seek to incorporate improvements to staff areas as part of these developments.<br><br>Re: staff access to healthy food choices - see procurment section, line 21 |
| | Staff Health and Wellbeing lead | | Workplace Wellbeing Charter report. Promotion of Workplace Wellbeing Week . NICE guidelines being met. | In place and ongoing | Yes | |
| | | 2. Develop our Occupational Health services which provides confidential counselling. | Evidence that Occupational Services are continually developing their confidential counselling service. | In place and ongoing | Yes | |
| | | 3. Continue to provide comprehensive and up to date information for staff on the range of services available to them to support their wellbeing | Information on services available to staff on Connect is up to date and comprehensive. | In place and ongoing | Yes | |
| Communication of staff health and wellbeing as a key contributor to sustainability - Engage with unions, service managers and specialists through the Staff Health and Wellbeing Steering Group to develop a work plan that will further support the initiatives that will improve staff wellbeing. | Big Green Scheme reps | 1. Ensure Big Green Scheme reps are working to inform and support the Health and Wellbeing steering group on initiatives that will benefit their staff | Health and Wellbeing steering group are being regularly uodated by Big Green Scheme represaentatives about initiatives that will benefit staff | In place and ongoing | Yes | |
| | Staff Health and Wellbeing Steering Group | 2. Target service managers and specialists throughout the Trust to ensure that there are the necessary staff wellbeing initiatives available for everyone | Produce report to feedback at monthly Sustainability Forum | In place and ongoing | Yes | |
| | Staff Health and Wellbeing lead | 3. Work life balance continues to be a strong message in staff health and wellbeing communications | Policies regarding work/life balance are regualry communicated to staff and are easily located and kept up to date on Connect. | In place and ongoing | Yes | |
| | Staff Health and Wellbeing lead | 4. Continue to ensure there are the services available to support staff health and wellbeing and that they are effectively promoted | Evidence of continual improvement of staff health and wellbeing services and regular promotion of these services and any updates. | In place and ongoing | Yes | |
| | Sustainability Officer | 5. Communicate effectively with the Wellbeing lead to promote the relevant services through existing sustainability communications. | Evidence of relevant staff health and wellbeing services promoted through sustainability communications. | In place and ongoing | Yes | |

| Procurement | | | | | | |
|---|---|---|---|---|---|---|
| **Objective** | **Responsibility** | **Action** | **Measurement** | **Time Frame** | **Achievable** | **If not achievable suggestions as to how to improve** |
| Ensure there are policies in place to enable procurement to adhere to purchasing the most sustainable option possible. | Procurement | 1. Finalisation and sign off of Sustainable Procurement Policy | Sign off of Sustainable Procurement Policy. | 2017 | Yes / No | Quarter 4 of 2019 - BWPC to support<br>Not yet updated by Procurement |
| | | 2. UHBT adoption of Sustainable Procurement policy covering non BWPC procurement | Trust adoption of Sustainable Procurement Policy. | 2019 | Yes / No | |
| | | 3. Training for procurement staff on sustainable procurement practices | Sustainable Procurement training developed and implemented for all existing and new staff. | 2018 | Yes / No | |
| | | 4. Delivery of Sustainable Procurement Policy Action Plan | Evidence that staff are complying with the Sustainable Procurement Policy Action Plan. | 2019 | Yes / No | |
| | Finance | 5. Delivery of servies following the Sustainable Procurment Policy. | Evidence that all divisions are complying with the Sustainable Procurement Policy. | 2019 | Yes / No | |
| | Divisions | | | | | |
| Promote our 'Sustainable Procurement Policy' to all potential suppliers and train staff to ensure that anyone procuring for our Trust understands what is required to procure in a sustainable way. | Procurement | 1. All potential suppliers are supplied with the Trust's Sustainable Procurement Policy. | All potential suppliers have been given the Trust's Sustainable Procurement Policy. | 2019 | Yes / No | Not yet updated by Procurement |
| | Transformation team | 2. Deliver a training package that is tailored to the requirements of the department | All existing and new staff complete training on sustainable procurement. | 2018 | Yes | |
| Devise ways of measuring emissions from our waste and our supply chain activities in order that we can report on them and measure achievements to reduce. | Procurement | 1. Calculate emissions from our waste generation and supply chain activities based on NHS/PHE SDU reporting model. This is based on financial information | Spend data provided for emissions calculation | | Yes / No | Not yet updated by Procurement |
| | Pharmacy (anaesthetic gases) | | carbon emissions calculated from financial spend or actual quantities (volume) of Anaesthetic gases | 2018 | Yes | Reducing phamacy emissions can be achieved by putting pressure on our medicines supply chain (eg wholesalers). This develops on the conversation with them about improving their processes from a sustainability perspective. |
| | Facilities and Estates | 2. Identify highest emission areas in annual sustainability reporting | Identified highest emission areas in annual sustainability reporting | 2018 | Yes | |
| | Procurement | 3. Implement a new 'Sustainable Procurement Policy', ensuring that sustainability and social responsibility considerations are introduced at the earliest possible opportunity as a business-as-usual feature of our procurement activity | Client Engagement and Perfomance Tracker records. Finance Quarterly reports | 2018 | Yes / No | Not yet updated by Procurement |
| Integrating ethical trade principles into our core procurement practices. | Procurement | 4. Join and fully adopt the Ethical Trading Initiative (ETI) Principles of Implementation and incorporate the ETI Base Code into all major tenders. | Joined and fully adopted the ETI and incorporated the ETI Base Code in to all new tenders | 2018 | Yes / No | The detail of the ETI requires furthe investigation and then decide how ethical issues are best incorporated into procurement process |
| Incorporate rigorous and measureable sustainability criteria into tendering processes and contracts. | Procurement | 5. Ensure new Sustainable Procurement Policy incorporates these features | Performance Tracker, Action plan and Training | 2018 | Yes / No | Not yet updated by Procurement |
| Actively research sustainable goods and services and encourage the development of sustainability certification schemes to increase the range of products covered. | Procurement/ Divisions | 1. Provide sustainable options through client engagement process to make available on EROS | Sustainable options available on EROS - Client engagement records | 2018 | Yes / No | |
| | EROS users | 2. Complete supplier surveys and put pressure on suppliers to disclose their ethics and increase green credentials | Evidence of EROS users basing decisions on supplier ethics and green credentials | 2018 and annually thereafter | Yes / No | This needs to be defined at client engagement stage. Need to review new product requests process (particularly one-off and urgent requests) to improve Divisional purchasing controls and good procurement practice |
| Incorporate health and sustainability benefits into the tender process for procurement of food and ingredients. Consider | Procurement | 1.Use Government Buying Standards - Food buying Guide. | Government buying standards used in procurement | Please complete as appropriate | Yes / No | Not yet updated by Procurement |

| | | | | | | |
|---|---|---|---|---|---|---|
| process for procurement of food and ingredients. Consider collaborative procurement with sustainable food leaders (eg. North Bristol Trust). | Facilities | 2. Ensure healthy food options are readily available for patients and staff | Patient menu options and Staff menu options throughout organisation | 2017 | Yes | New patients menus in place as of 4th Sept following patient food tender process, which includes dietary and healthy options. Cquins target for healthy options in all food outlets and vending machines being achieved. |
| Develop a Procurement Stock Review programme to reduce waste generated by our clinical services. | Transformation team | 1. Assist with implementation, development and spread of Non-Pay Managed Inventory Systems through-out the Trust. | Stock reduction and savings | Please complete as appropriate | Yes | |
| | Head of Pharmacy | 2. Conduct and record regular stock audits | Value of medication returned for re-issue | Monthly data collection by Division | Yes | |
| | Big Green Scheme | 3. Raise awareness about the wastage issues and potential for saving money | Production of resources and communication of waste statistics to Trust employees. | 2018 | Yes | Not yet updated by Procurement |
| Engage in collaborative initiatives with suppliers to identify and address known carbon "hotspots" to deliver measureable environmental performance improvements and cost savings. | Procurement Finance (Non BWPC Spend) | 1.Use spend profiles to identify carbon hotspots. Identify areas where suppliers fall short and suggest alternatives in line with the Sustainable Procurement Policy | Identification of supplier carbon hotspots | Please complete as appropriate | Yes / No | |
| Consider costs of disposal in procurement assessments | Finance<br>Procurement | 1. Include costs of disposal in procurement assessments where significant. This should include product life expectancy, reusability, recyclability | Costs of disposal are included in procurement assessments | From 2017 | Yes | Calculating the cost of disposal for a particular product would be very difficult given the requirement for the weight of the product, volumes etc and then coverting into a cost per tonne. When comparing similar products in a procurement exercise these costs are unlikely to vary to a significant degree between each product. Where there is a specific idea in which the cost of diposal is deemed to be a variant (eg paper towels or hand dryer) then this should be scoped as a separate project, with input from Finance. In addition we should ensure, through our procurement process, that we are achieving the best value available for our waste disposal contracts. |

**Cover report to the Public Trust Board. Meeting to be held on 29 November 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** | Wednesday, 29 November 2017 |
| **Report Title** | **Audit Committee Terms of Reference** | | |
| **Author** | Sophie Melton Bradley, Deputy Trust Secretary | | |
| **Executive Lead** | Pam Wenger, Trust Secretary | | |
| **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. | ☐ | 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 revised Terms of Reference for the Audit Committee for 2017.

Key issues to note

The Audit Committee reviews its own terms of reference on an annual basis, to ensure that the terms remain fit for purpose, accurate to the committee's function, and in compliance with regulatory requirements and governance best practice.

The Audit Committee reviewed the terms of reference on 30 October 2017 and recommended minor amendments, with input from the Internal and External Auditors and with reference to most recent guidance note from ICSA on best practice for audit committee terms of reference (published in March 2017).

Following review, no major changes to the terms of reference are proposed. The attached terms of reference reflect the revisions agreed by Audit Committee on 30 October 2017, intended to:

a) Clarify existing practice,
b) Ensure the terms of reference reflect ICSA guidance/best practice;
c) Reflect input from the Internal and External Auditors;
d) Reflect input from the Chair of the Committee;
d) Include minor grammatical corrections.

**Recommendations**

Members are asked to:

- **Approve** the Terms of Reference for the Audit Committee 2017-18.

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

| **Board Assurance Framework Risk**<br>**(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**<br>**(please tick any which are impacted on / relevant to this paper)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quality | ☐ | Equality | ☐ | Legal | ☐ | Workforce | ☐ |

| **Impact Upon Corporate Risk** |
|---|
| |

| |
|---|
| n/a |

| Resource Implications<br>(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)** |
| 30 October 2017 | | | | |

University Hospitals Bristol NHS
NHS Foundation Trust

# Terms of Reference – Audit Committee

| Document Data | |
|---|---|
| **Corporate Entity** | Audit Committee |
| **Document Type** | Terms of Reference |
| **Document Status** | Draft |
| **Executive Lead** | Trust Secretary |
| **Document Owner** | Trust Secretary |
| **Approval Authority** | Board of Directors |
| **Review Cycle** | 12 months |
| **Next Review Date** | 15/10/2018 |

| Document Change Control | | | | |
|---|---|---|---|---|
| **Date of Version** | **Version Number** | **Lead for Revisions** | **Type of Revision (Major/Minor)** | **Description of Revisions** |
| 16/02/2011 | 1 | Trust Secretary | Draft | Draft for consideration by the members of the Audit and Assurance Committee |
| 08/03/2011 | 2 | Trust Secretary | Draft | Draft for consideration by the Audit and Assurance Committee |
| 04/05/2011 | 3 | Trust Secretary | Draft | Draft for consideration by the Audit Committee on 09 May 2011 |
| 09/05/2011 | 4 | Trust Secretary | Draft | Revisions by Audit Committee |
| 26/05/2011 | 5 | Trust Secretary | Draft | For Approval by Trust Board of Directors |
| 26/05/2011 | 6 | Trust Secretary | Approved version | Approved by the Trust Board of Directors |
| 01/09/2015 | 7 | Trust Secretary | Major | Revised terms of reference for consideration by the Audit Committee 9th September 2015 |
| 05/10/2016 | 8 | Trust Secretary | Minor | Revised terms of reference for consideration by the Audit Committee 18 October 2016. |
| 10/10/2017 | 9 | Deputy Trust Secretary | Moderate | Revisions to<br>a) Clarify existing practice,<br>b) Ensure terms of reference reflect ICSA guidance/best practice.<br>c) Reflect input from the Internal and External Auditors,<br>d) Reflect input from the Chair [and the members] of the Committee<br>e) Include minor grammatical corrections. |

## Table of Contents

Page No

## 1. Constitution of the Committee

The Audit Committee is a statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the suitability and efficacy of the Trust's provisions for Governance, Risk Management and Internal Control.

## 2. Purpose and function

The purpose and function of the Committee is to:

2.1 Monitor the integrity of the financial statements of the Trust, any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them;

2.2 Assist the Board of Directors with its oversight responsibilities and independently and objectively monitor, review and report to the Board on the adequacy of the processes for governance, assurance, and risk management, and where appropriate, facilitate and support through its independence, the attainment of effective processes;

2.3 Review the effectiveness of the Trust's internal audit and external audit function; and

2.4 In discharging its role and function, the Committee shall provide assurance to the Board of Directors that an appropriate system of internal control is in place to ensure that business is conducted in accordance with the law and proper standards, and affairs are managed to secure economic, efficient and effective use of resource with particular regard to value for money; and

2.5 Report to the Board as to how it is discharging its responsibilities as a Committee (e.g. via the annual report).

## 3. Authority

The Committee is:

3.1 Authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any officer of the Trust and to call any employee to be questioned at a meeting of the Committee as and when required;

3.2 Authorised to obtain whatever professional advice it requires (as advised by the Trust Secretary); and

3.3 A Non-executive Committee of the Trust Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

## 4. Membership and attendance

4.1 Members of the Committee shall be appointed by the Board of Directors and shall be made up of at least four members. All members of the Committee shall be independent Non-executive Directors at least one of whom shall have recent and relevant financial experience. The Chair of the Finance Committee, the

Chair of the Quality and Outcomes Committee, and the Senior Independent Director, shall be members of the Audit Committee.

4.2 The Chairman of the Board of Directors shall not be a member of the Committee.

4.4 Only members of the Committee have the right to attend Committee meetings. Other non-committee members may be invited to attend and assist the committee from time to time, according to particular items being considered and discussed.

4.5 The Chair of the Committee shall not be the Senior Independent Director of the Board of Directors.

4.6 In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

4.7 External Audit and Internal Audit representatives shall be invited to attend all meetings of the Committee. At least once a year the Committee should meet privately with the External and Internal Auditors.

4.8
The Director of Finance shall normally attend meetings.

4.9 The Chief Executive and other Executive Directors should be invited to attend as appropriate. The Chief Executive should be required to attend, at least annually, to discuss the process for assurance that supports the Annual Governance Statement.

4.10 The Committee Secretary shall be the Trust Secretary. The Trust Secretary or the Deputy Trust Secretary shall attend all meetings of the Committee.

## 5. Quorum

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

5.2 [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.]

## 6. Duties

The Committee shall undertake the duties detailed in the NHS Audit Committee Handbook and shall have regard to the Audit Code for NHS Foundation Trusts. The Committee should carry out the duties below for the Foundation Trust and major subsidiary undertakings as a whole, as appropriate. These duties shall include:

### 6.1 Financial Reporting

The Committee shall:

6.1.1 Ensure the integrity of the annual report and financial statements of the Trust, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and judgements which they contain;

6.1.2 Review summary financial statements, significant financial returns to regulators and any financial information contained in other official documents, including the Annual Governance Statement;

6.1.3 Review the consistency of, and changes to, accounting policies both on a year on year basis and across the Trust and its subsidiary undertakings;

6.1.4 Review the methods used to account for significant or unusual transactions where different approaches are possible (including unadjusted mis-statements in the financial statements);

6.1.5 Review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the External Auditor; and

6.1.6 Review the clarity of disclosure in the Trust's financial reports and the context in which statements are made.

6.1.7 The committee Chair shall report formally to the board on its proceedings after each meeting on all matters within its duties and responsibilities

6.1.8 The committee shall make whatever recommendations to the board it deems appropriate on any area within its remit where action or improvement is needed.

## 6.2 Governance, Risk Management and Internal Control

The Committee shall

6.2.1 Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

6.2.2 Review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

6.2.3 Review the Board Assurance Framework and processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

6.2.4 Review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications, and work

related to counter fraud and security as required by the NHS Counter Fraud Authority;

6.2.5 Receive assurance from Internal Audit, External Audit, directors and managers, including evidence of compliance with systems of governance, risk management and internal control, together with indicators of their effectiveness.

### 6.3 Internal Audit and Counter Fraud

The Committee shall:

6.3.1 Ensure that there is an effective Internal Audit function that meets the *Public Sector Internal Audit Standards* and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors;

6.3.2 Consider and approve the Internal Audit strategy and annual plan and ensure it has adequate resources and access to information, including the Board Assurance Framework, to enable it to perform its function effectively and in accordance with the relevant professional standards. The Committee shall also ensure the function has adequate standing and is free from management or other restrictions;

6.3.3 Review promptly all reports on the Trust from the Internal and External Auditors, review and monitor the Executive Management's responsiveness to the findings and recommendations of reports, and ensure coordination between Internal and External Auditors to optimise use of audit resource;

6.3.4 Meet the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out. The Head of Internal Audit shall be given the right of direct access to the Chair of the Committee, Chief Executive, Board of Directors and to the Committee;

6.3.5 Conduct a review of the effectiveness of Internal Audit and Counter Fraud services once every five years; and

6.3.6 Satisfy itself that the Trust has adequate arrangements in place for counter fraud and security that meets the required NHS Counter Fraud Authority standards and shall review the outcomes of work in these areas.

### 6.4 External Audit

The Committee shall:

6.4.1 Consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor;

6.4.2 Work with the Council of Governor to manage the selection process for new auditors and, if an auditor resigns, the Committee shall investigate the issues leading to this, and make any associated recommendations to the Council of Governors;

6.4.3 Receive assurance of External Auditor compliance with the Audit Code for NHS

Foundation Trusts;

6.4.4 Approve the External Auditor's remuneration and terms of engagement including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted;

6.4.5 Agree and review the policy regarding the supply of non-audit services by the External Auditor and monitor that service, taking into account relevant ethical guidance;

6.4.6 Review and monitor the External Auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work;

6.4.7 Meet the external auditor at least once a year, without management being present; to discuss their remit and any issues arising from the audit;

6.4.8 Discuss and agree with the External Auditors, before the audit commences, the nature and scope of the audit, as set out in the annual plan;

6.4.9 Discuss with the External Auditors their evaluation of audit risks and assessment of the Trust, and the impact on the audit fee; and

6.4.10 Review all External Audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses;

## 6.5 Other Board Assurance Functions

6.5.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications to the governance of the Trust. These will include, but not be limited to, any reviews undertaken by the Department of Health Arms-Length Bodies, Regulators, and professional bodies with responsibility for the performance of staff or functions.

6.5.2 The Committee shall review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work and in relation to matters of quality affecting the Board Assurance Framework, including the Quality and Outcomes Committee and the Finance Committee.

## 6.6 Annual Report and Annual Members Meeting

6.6.1 The annual report should include a statement referring to any non-audit services provided by the external auditors, and if so, how auditor objectivity and independence is safeguarded;

6.6.2 The annual report should include details of the full auditor appointment process, and where the Council of Governors decide not to accept the recommendations of the Committee, a statement setting out (a) an explanation of the Committee's recommendation in relation to the appointment, reappointment or removal of the external auditor and (b) the reasons the Council of Governors has chosen not to accept those reasons.

6.6.3 Where the external auditor's contract is terminated in disputed circumstances, the annual report should include detail on the removal process and the underlying reasons for removal.

6.6.4 The annual report should include a section outlining how the committee is discharging its responsibilities.

6.6.5 The Annual Report of the Audit Committee should be signed by the Chair of the Audit Committee.

6.6.6 The Committee Chair shall attend the Annual Members Meeting/Annual General Meeting and prepared to respond to any stakeholder questions on the Committee's activities.

### 6.7 Clinical Audit

6.7.1 The Committee shall review issues around clinical risk management and satisfy itself on the assurance that can be gained from the Clinical Audit function.

6.7.2 The Committee will receive the Clinical Audit Annual Plan and Annual Report and receive regular updates on progress made by clinical audit throughout the year.

### 6.8 Speaking Out Policy and Fraud

6.8.1 The Committee shall monitor and receive assurance on compliance with the Trust's Speaking Out Policy, and ensure that the policy allows for proportionate and independent investigation of such matters and appropriate follow-up action.

## 7. Reporting and Accountability

7.1 The Committee Chair shall report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, and make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

7.2 The Committee shall report to the Trust Board annually on its work in support of the Annual Governance Statement.

7.3 The Committee shall make necessary recommendations to the Council of Governors on areas relating to the appointment, re-appointment and removal of External Auditors, the level of remuneration and terms of engagement as it deems appropriate.

7.4 The Chair of the Committee shall write to the Independent Regulator of NHS Foundation Trusts (NHS Improvement) in those instances where the services of the External Auditor are terminated in disputed circumstances.

7.5 Where exceptional, serious and improper activities have been revealed by the Committee, the Chair of the Committee shall write to NHS Improvement, if insufficient action has been taken by the Board of Directors after being informed of the situation.

7.6 The Committee shall produce a statement to be included in the Trust's Annual Report which describes how the Committee has fulfilled its terms of reference and discharged its responsibilities throughout the previous year.

7.7 Outside of the written reporting mechanism, the Committee Chair should attend the Annual Members Meeting and be prepared to respond to any questions on the Committee's area of responsibility.

7.8 The Committee shall review its own terms of reference annually.

## 8. Administration

8.1 The Trust Secretary shall provide secretariat services to the Committee and shall provide appropriate support to the Chair and Committee members as required.

8.2 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee Chair. The Board of Directors, Chief Executive, External Auditors or Head of Internal Audit may request an additional meeting if they consider it necessary.

8.3 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, no less than five working days before the date of the meeting. Supporting papers shall be made available no later than three working days before the date of the meeting.

8.4 The secretary shall minute the proceedings of all Committee meetings, and draft minutes of Committee meetings shall be made available promptly to all members of the Committee.

8.5 The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.

## 9. Notice and minuting of meetings

9.1 Meetings of the Committee shall be convened by the Committee Secretary, at the request of any of its members or at the request of the external audit lead partner or head of internal audit, if they consider it necessary.

9.2 Unless otherwise agreed by the Committee, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the committee no later than five working days

before the date of the meeting. Wherever possible, supporting papers shall be sent to committee members at the same time.

9.4 Committee papers shall include an outline of their purpose and key points, and make clear what actions are expected of the Committee.

9.3 Notices, agendas and supporting papers will be sent in electronic form as standard, except the recipient has specifically agreed to receive documents in paper format.

9.4 The secretary shall minute the proceedings and decisions of all meetings of the committee, including recording the names of those present and in attendance.

9.5 Draft minutes of committee meetings shall be agreed with the committee Chair and then circulated promptly to all members of the committee, unless it would be inappropriate to do so in the opinion of the committee Chair.

## 10. Frequency of Meetings

10.1 The Committee shall meet a minimum of four times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require to allow the Committee to discharge all of its responsibilities.

## 11. Review of Terms of Reference

11.1 The Committee shall, at least once a year, review its own performance to ensure it is operating at maximum effectiveness. The Committee shall use the Audit Committee Self-assessment Checklist for this purpose.

**Cover report to the Public Trust Board. Meeting to be held on 29 November 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 14 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Wednesday, 29 November 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**<br>**(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. | ☐ | 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**<br>**(please select any which are relevant to this paper)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| For Decision | ☐ | For Assurance | ☒ | For Approval | ☐ | For Information | ☐ |

| **Executive Summary** |
|---|
| <u>Purpose</u><br><br>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.<br><br>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:<br><br>• **Note** the Report. |
|---|

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

| **Board Assurance Framework Risk**<br>**(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**<br>**(please tick any which are impacted on / relevant to this paper)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quality | ☐ | Equality | ☐ | Legal | ☐ | Workforce | ☐ |

| **Impact Upon Corporate Risk** |
|---|
| |

| **Resource Implications**<br>**(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** **31/10/2017**

The NHS guidance regarding the recording of the sexual orientation of patients over 16 was published on 5 October 2017. The Trust would wish to adopt this guidance following the implementation suggested in the accompanying Implementation guidance.

It is recommend that sexual orientation monitoring occurs at every face to face contact with the patient, where no record of this data already exists.

The Trust is reviewing the position from an IT perspective, as it is recommended that organisations should take a phased approach to implementation and make any necessary changes to IT systems as part of broader system updates.

The data collected will follow the standard data set as recommended in the full specification documentation so our dataset is consistent with the data collected in partner organisations. This implementation has to be completed by 31 March 2018.

***Status:*** *Awaiting Governor Response*

| ID | Governor Name | | |
|---|---|---|---|
| 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:*** *Director of Finance* ***Response requested:*** 17/10/2017

**Response** **17/11/2017**

The NHS contract target for clinical correspondence turnaround is 10 days since April 2017, which will reduce to 7 days from April 2018.

The number of letters completed for the Trust in October 2017 was 28,455 out of which 73% were compliant, six months after the introduction of the target. This compares to compliance of 44% against 25,951 letters in October 2016. We are aiming to reach 80% compliance within 7 days by April 2018. The remaining letters outside of the 80% compliance target will, in the main, be letters awaiting test results.

Workshops are being held with medical secretary teams across the Trust to investigate and implement ways in which the process can be improved. For example, in the Division of Medicine the introduction of process improvements has resulted in medical secretaries turning their letters around within 24 hours of receipt from clinicians. The challenge now is to introduce this way of working across all divisions.

***Status:*** *Closed*