University Hospitals Bristol
NHS Foundation Trust

# Public Trust Board Meeting Papers

Date: 24 May 2018

Time: 11:00 – 13:00

Venue: Conference Room, Trust Headquarters

NHS
University Hospitals Bristol
NHS Foundation Trust

# PUBLIC TRUST BOARD

## Meeting to be held on Thursday 24 May 2018, 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 | Chair | Verbal |
| 2. | Declarations of interest | Information | Chair | Verbal |
| 3. | Patient Story | Information | Chief Executive | 1 |
| 4. | Minutes of the last meeting<br>• **26 April 2018** | Approval | Chair | 4 |
| 5. | Matters arising and action log | Approval | Chair | 22 |
| 6. | Chief Executive's Report | Information | Chief Executive | 25 |
| **Care and Quality** | | | | |
| 7. | Major Incident in BHOC | Assurance | Deputy Chief Executive and Chief Operating Officer | 29 |
| 8. | Quality and Performance Report | Assurance | Deputy Chief Executive and Chief Operating Officer; Chief Nurse; Director of People | To follow |
| 9. | Learning from Deaths Report | Assurance | Acting Medical Director | 33 |
| 10. | Quality and Outcomes Committee - Chair's Report | Assurance | Quality & Outcomes Committee Chair | To be tabled |
| **Organisational and System Strategy and Transformation** | | | | |
| 11. | Embracing Change, Proud to Care – Our 2025 Vision – Strategy | Approval | Director of Strategy and Transformation | 41 |

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| 12. | Operational Plan 2018/19 | Approval | Director of Strategy and Transformation | 53 |
| **Financial Performance** | | | | |
| 13. | Finance Report | Assurance | Director of Finance and Information | 91 |
| 14. | Finance Committee Chair's Report | Assurance | Chair of Finance Committee | To be tabled |
| 15. | Treasury Management Policy | Assurance | Director of Finance and Information | 107 |
| **Governance** | | | | |
| 16. | Emergency Preparedness Annual Report | Assurance | Deputy Chief Executive and Chief Operating Officer | 139 |
| 17. | General Data Protection Regulation Compliance Update | Assurance | Trust Secretary | 154 |
| 18. | Audit Committee Chair's Report | Assurance | Audit Committee Chair | To be tabled |
| 19. | Providers self-certification 2018 | Approval | Trust Secretary | 159 |
| 20. | Terms of Reference for the Quality and Outcomes Committee – Review | Approval | Trust Secretary | 168 |
| **Items for Information** | | | | |
| 21. | Governors' Log of Communications | Assurance | Chief Executive | 179 |
| **Concluding Business** | | | | |
| 22. | Any Other Urgent Business | | Chair | Verbal |
| 23. | Date and time of next meeting<br>• **28 June 2018, Conference Room, THQ** | | Chair | Verbal |

**Cover report to the Public Trust Board. Meeting to be held on 24 May 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 3 |
| **Meeting Title** | Trust Board | **Meeting Date** | Thursday, 24 May 2018 |
| **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 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>

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

UH Bristol is a partner member of the newly formed Bristol Deaf Heath Partnership. Working in collaboration with North Bristol NHS Trust, Bristol Community Health, Avon and Wiltshire Mental Health Partnership NHS Trust, Sirona Care and Health and a range of third sector organisations, the Bristol Deaf Heath Partnership provides a single forum that fosters dialogue; enabling us to work together to understand and improve the experience of Deaf, hard of hearing and deaf blind people across the health community in Bristol. In this video story, Terry talks about his experiences of accessing services at Bristol Community Health and how this makes him feel. The video is designed to stimulate a conversation about the needs of d/Deaf patients and the potential for shared learning across the partner organisations.

At UH Bristol we recognise that a person who is D/deaf or has some hearing loss may require support from a communication professional. This may include a British Sign Language interpreter (BSL), lip speaker, Note Taker or speech-to-text-reporter. Sign Solutions is the Trust's contracted provider of British Sign Language (BSL) interpreting and other communication support needs for deaf patients. Corporate oversight of this work is undertaken by the Trust's Patient Inclusion and Diversity Group, a newly formed sub-group of the Patient Experience Group.

This story is shared with Trust Board in the context of our Patient Experience and Involvement Q1 theme on the D/deaf community and Deaf Health Awareness Week, 14-20th May 2018.

The video can be accessed by following this link: http://bit.ly/deaf_access_healthcare

**Recommendations**

Members are asked to:

- **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 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 | ☐ | 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, | ☐ |

| | | | |
|---|---|---|---|
| the benefit of patients and the NHS. | | transformation and partnership working. | |
| Failure to maintain financial sustainability. | ☐ | | |

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

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

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

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

**Minutes of the Public Trust Board Meeting**

**Held on Thursday 26 April 2018, 11:00-13:00, Conference Room, Trust Headquarters**

**Present**

**Board Members**

| Member Name | Job Title/Position |
|---|---|
| Jeff Farrar | Chair of the Board |
| David Armstrong | Non-Executive Director |
| Paula Clarke | Director of Strategy and Transformation |
| Julian Dennis | Non-Executive Director |
| Sue Evans | Honorary Non-Executive Director |
| Matt Joint | Director of People |
| Paul Mapson | Director of Finance and Information |
| Carolyn Mills | Chief Nurse |
| Mark Smith | Chief Operating Officer and Deputy Chief Executive |
| Martin Sykes | Non-Executive Director |
| Steve West | Non-Executive Director |
| Robert Woolley | Chief Executive |
| Jill Youds | Non-Executive Director |

**In Attendance**

| Name | Job Title/Position |
|---|---|
| Eric Sanders | Trust Secretary |
| Sophie Melton Bradley | Deputy Trust Secretary |
| Nathaniel Hines | Member of the Public (for **Item 3**) |
| Tony Watkin | Staff Member (for **Item 3**) |
| Juliet Cox | Head of Nursing, Division of Surgery |
| Carole Dacombe | Public Governor |
| Clive Hamilton | Member of the Public |
| Anna Horton | Staff Member |
| Mo Phillips | Public Governor |
| Ray Phipps | Patient Governor |
| Rashid Joomum | Patient Governor |
| Jason Roberts | Member of the Public (Cymbio) |
| John Rose | Member of the Public |
| Rhona Thomas | Staff Member |
| Adrian Upex | Staff Member |
| Garry Williams | Patient Governor |
| | |
| Anna Charles | King's Fund Representative |
| Matthew Kershaw | King's Fund Representative |

**Minutes:**

| | |
|---|---|
| Sophie Melton Bradley | Deputy Trust Secretary |

The Chair opened the Meeting at 11.00

| Minute Ref | Item Number | Action |
|---|---|---|
| **Preliminary Business** | | |
| 55/04/2018 | **1. Welcome and Introductions/Apologies for Absence** | |
| | The Chair welcomed everyone to the meeting, including Anna Charles and Matthew Kershaw from the King's Fund, who were observing the meeting, and Sue Evans, who had joined the Board as an Honorary Non-Executive Director through NHS Improvement's NExT programme.<br><br>Apologies were received from Acting Medical Director Mark Callaway, Non-Executive Directors Guy Orpen and Emma Woollett, and Non-Executive Director (Designate) Madhu Bhabuta. | |
| 56/04/2018 | **2. Declarations of Interest** | |
| | There were no declarations of interest. | |
| 57/04/2018 | **3. Patient Story** | |
| | The meeting began with a patient story, introduced by the Chief Nurse, Carolyn Mills.<br><br>• It was noted that the patient who had initially planned to speak at this month's meeting was unfortunately unwell, but hoped to return to a Board meeting later in the year. The Patient Safety Team had therefore at short notice created a video, presented by Patient and Public Involvement Lead Tony Watkin. This covered a range of perspectives from patients, family members, student medics, and other staff members, talking about what patient experience meant to them.<br><br>• The video highlighted the importance to patients and family of receiving prompt and helpful care, and getting good information on what was happening to them: patients noted that coming into hospital could be a frightening experience, but the care they had received from staff had been reassuring and helpful. Staff, including Medical students, noted the importance of providing safe care to the patient experience. Both staff and patients recognised that understanding how people were feeling, and making them feel at ease, was key to the quality of the patient experience.<br><br>• Patient Experience and Involvement Team Manager Paul Lewis also discussed some of the wider aspects of the patient experience work that the team was working on, including work with the Transformation Team on developing the Trust's culture of customer service, and implementation of a rapid time feedback system for patients/families. | |

| Minute Ref | Item Number | Action |
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| | Members of the Board noted the following:<br>• The Chair of the Board emphasised the enormous value these stories brought to the Board's work, particularly in 'bringing to life' the work that the Trust did every day. He expressed appreciation for the Patient Safety Team's presentation, especially given the short notice.<br><br>• Members echoed the Chair's appreciation for the presentation they had seen, and expressed the importance of a positive patient experience in ensuring good quality, compassionate care. They noted it was important not to ask leading questions in putting together videos of this kind, to encourage patients to give their own views. Members suggested that a video of this kind (and perhaps one focussing on things that weren't so positive in terms of patient experience) could be used as a valuable training tool for staff.<br><br>• Patient Governor Garry Williams noted that the speakers on patient safety in the video had been able to articulate their views clearly. It would be important not to lose sight of those patients who might have more difficulty expressing themselves, whose views on the patient experience were also important. Tony Watkin noted that the team had been carrying out some work specifically with patients with cognitive impairments, as part of broader work ensuring that a range of voices were heard.<br><br>• Public Governor Penny Parsons noted that it was encouraging that the student medics in the presentation were clearly motivated, and focusing on the right priorities in terms of patient care/experience.<br><br>**Members RESOLVED to:**<br>• **Receive** the patient story | |
| 58/04/18 | **4. Minutes of the last meeting** | |
| | The minutes of the meeting held on the 28 March 2018 were agreed as a true and accurate record with no amendments.<br><br>• Under <u>Item 10 – The Quality and Outcome Committee Chair's Report</u> third paragraph to be amended as follows: 'The Committee had received a further update on the 'on-hold' patients backlog, and were pleased to note that, thanks to the hard work of Mark Smith and his team, the number of patients on the list was now significantly reduced (from over 80,000 to 49,000), and no significant harm had been identified **to date**.'<br><br>**Members RESOLVED to:**<br>• **Receive** the minutes of the meeting held on the 28 February 2018 | |

| Minute Ref | Item Number | Action |
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| | as a true and accurate record. | |
| 59/04/2018 | **5. Matters arising and Action Log** | |
| | Members received and reviewed the action log.<br><br>**Min reference** 44/03/2018: Quality and Performance Report: *The Acting Medical Director to update the Board on progress to attract candidates to stroke care at UH Bristol.* **As the Acting Medical Director had given his apologies, this action would be carried over to the May 2018 meeting.**<br><br>**Min reference** 53/03/18: Any Other Urgent Business: *The Deputy Chief Executive and Chief Operating Officer to provide a 62-day target remedial action plan to the next meeting of the Quality and Outcomes Committee.* **This action was complete.**<br><br>**Min reference** 06/01/2018: Chief Executive's Report *Update on the Digital Transformation Programme to come to a future Board meeting.* **This item would be covered at a future Board Seminar.**<br><br>**Min reference** 08/01/18: Quality and Performance Report *Acting Medical Director to share the annual report on the genomics project with the Board. –* **The Trust Secretary Eric Sanders would follow up on this with the Acting Medical Director Mark Callaway**.<br><br>**Min reference** 30/02/18: Chief Executive's Report: *Trust Secretariat to Incorporate opportunities for visits to the Sexual Assault Referral Centre into NED visit planning.* **This would be incorporated into the visit planning schedule for Non-Executive Directors.**<br><br>**Members RESOLVED to:**<br>• **Note** the action log, including completed actions. | |
| 60/04/18 | **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>• Following the Trust's successful achievement of the 2017/18 Operational Plan, the Providers Sustainability Funding (PSF) bonus and incentive payment would be shared as additional Capital with the Divisions who had made the achievement possible. It was noted that there had been some revisions to the draft Operational Plan for next year to reflect the revised control total NHS Improvement had now proposed for the Trust in 2018/19, and the Executive Team were recommending that the Board ratify and approve the revised plan. | |

| Minute Ref | Item Number | Action |
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| | • Objectives for 2018/19 for the Trust were clear: particularly the focus on staff well-being and staff development (which was already improving, as indicated by the 2017 National Staff Survey results) and looking at quality objectives including customer service<br><br>• The challenges the Trust had experienced during the winter period should be recognised and responded to. UH Bristol would be taking steps to ensure there was sufficient capacity in place for next winter, not just through additional beds but improved escalation processes and systems to help the Trust best meet winter demands.<br><br>• The Trust had begun a major review of its next Strategic Plan, and there would be a full day Engagement Workshop for senior staff on the new Strategy on the 2 May 2018: an internal staff survey on the strategy had already received 730 responses, and feedback had been gathered from external partners and stakeholders. The Board would receive an update on progress at the Board Seminar on 15 May 2018. Robert Woolley noted that, given the challenges for funding and other issues for NHS in the current climate, it was vital to understand what UH Bristol's strategy was going to be, to address challenges in the 'new world'.<br><br>• Following a number of high-profile security incidents involving NHS Trusts (such as the 2017 WannaCry ransomware attack) the Trust had been undertaking its own internally- and externally-led reviews of its levels of preparedness for such an attack, which remained a significant focus of attention going into the new year.<br><br>• The new Medical Director Dr Bill Oldfield now had an agreed start date with the Trust of 1 August 2018. The new Arts Programme Director, Dr Anna Farthing, would be joining the Trust in May. This was a partnership role with Above and Beyond, who were funding the post for 18 months. Her work would support the Trust's work on staff wellbeing as well as patient experience.<br><br>Members of the Board noted the following:<br>• Members of the Board congratulated the Trust's staff and the Executive Team on managing to land a successful 2017/18 outturn given the challenges faced in-year, and noted it was very important that staff could clearly see the reasons for the level of financial control that had been exercised, and also the benefits of doing so (e.g. creating capacity for investment).<br><br>• Deputy Chief Executive and Chief Operating Officer Mark Smith noted that the Trust had performed strongly all year, but had still not been able to achieve the four key targets (against A&E 4-hour waiting; 18 week referral to treatment; 62 day cancer referral and 6 | |

| Minute Ref | Item Number | Action |
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| | week diagnostic waiting), in part because of an extremely difficult winter. Whilst the Trust was still 'in the middle of the pack' on performance, there needed to be focus on getting trajectories against targets moving in the right direction. It was noted this issue had also been discussed at the Quality and Outcomes Committee meeting on 24 April. Robert Woolley noted that improving and increasing capacity to address the struggles experienced in the last quarter, which would also help the Trust to address performance against the constitutional targets, was a major priority.<br><br>• Patient Governor Garry Williams noted that the challenges presented this year had required the Trust to act decisively in the best interests of patients in difficult circumstances, something it continued to do well.<br><br>**Members RESOLVED to:**<br>• **Receive** the Chief Executive's Report for assurance. | |
| 61/04/18 | **7. Board Assurance Framework – Q4** | |
| | Chief Executive Robert Woolley presented the Board Assurance Framework for Q4.<br><br>• It was noted that this Quarterly Report had been reviewed by the Executive Team, the Senior Leadership Team, and the Audit Committee (on 20 April). The cover paper described the trajectory around risks underpinning the in-year objectives for 2017-18, under the Trust's seven strategic priorities.<br><br>Members of the Board discussed the following:<br>• Non-Executive Director and Chair of the Audit Committee David Armstrong noted that the Audit Committee had agreed to tailor its approach to reviewing the Board Assurance Framework (BAF), based on the outcomes of last year's BAF internal audit. The BAF structure and approach would also be discussed at the Board Seminar on 15 May 2018.<br><br>**Members RESOLVED to:**<br>• **Receive** the Board Assurance Framework – Q4 for assurance. | |
| **Care and Quality** | | |
| 62/04/18 | **8. Quality and Performance Report** | |
| | Mark Smith, Chief Operating Officer and Deputy Chief Executive, presented the Quality and Performance Report.<br><br>It was noted that: | |

| Minute Ref | Item Number | Action |
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| | • There were plans in place to recover the trajectory against the A&E 4 hour wait target. Whilst adult A&E performance had a difficult month in March, for the first time in its history the children's A&E department had achieved the 95% target, which was excellent news.<br><br>• There had been another multi-agency discharge event (MADE), focusing on the Trust's DTOCs position, and the external company Newton Europe had been commissioned to provide support to social care colleagues on improving outflow and DTOCs performance. The Trust was continuing to roll out the Clinical Utilisation Review (CUR) to surface reasons for flow delays.<br><br>• There was presently a significant middle grade staffing shortfall in A&E which would be discussed at the Executive Team meeting to see how this could be addressed urgently. Weston Area NHS Health Trust (WAHT) was still struggling with winter pressures, which put further pressure on UH Bristol.<br><br>• There was a root and branch review taking place on the use of escalation capacity escalation to help understand how the hospital shared and managed the risks around escalation.<br><br>• There had been 121 cancellations of surgery in March due to winter pressures and sever adverse weather periods, but the Trust was focused on recovering the backlog by June (compared to November in 2016/17). Structural changes, including automatic 8.15 theatre starts to support flow, were being explored.<br><br>• The Quality and Outcomes Committee (QoC) had received a presentation on work that had occurred to increase efficiency and throughput of CT scans, which had been very successful, and the same methodology would now be applied to cataract surgery. The committee had also received a presentation on improvement against diagnostic targets in key areas.<br><br>• There would also be a change in the language used, focusing on quality improvement, waste reduction and patient care rather than productivity, to ensure staff were engaged and understood the value of this kind of work.<br><br>Chief Nurse Carolyn Mills noted the following points on Quality:<br>• There was continued good performance on quality and safety, against the backdrop of the challenges noted during the meeting. QoC had reviewed the Quality and Performance Report with a particular focus on sustained non-delivery in KPIs related to stroke and fractured neck of femur (NOF) treatment. There had been some improvements against fractured NOF performance related to a new | |

| Minute Ref | Item Number | Action |
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| | consultant appointment in orthogeriatrics, but it was noted that there were still continuing challenges to the delivery of sustainable performance in these areas.<br><br>• The Quality team had identified an error in the data flows in complaints data, which they were seeking to understand. This meant that the dissatisfied complaint KPI was wrong. It was expected that performance would improve once this error was resolved.<br><br>• The Committee received the Q4 report on Patient Safety Improvement, which showed some sustained improvement against metrics. A final report would be brought to the Board at the end of the programme in the summer.<br><br>**Action:** Chief Nurse Carolyn Mills to provide an update to the Board on Patient Safety Improvement at the end of the programme in September 2018.<br><br>• There had been a good level of response to the Patient Safety Culture Assessment questionnaire, which should help understanding of whether there had been a culture change over the last three years.<br><br>The Director of People Matt Joint noted the following on Workforce and Organisational Development:<br><br>• There was a very positive picture for the month, including on training targets and recruitment rates. A new supporting attendance policy had been launched to help support sickness absence rates.<br><br>• As discussed at QoC, there had been work undertaken to significantly increase exit interview rates, and the team were exploring the data coming out of these. Anecdotally, the cost of living in Bristol (including housing) seemed to be arising as a factor leading to people leaving the area, and Matt Joint was considering what the Trust could do to support people in this respect, e.g. around public transport.<br><br>Members of the Board noted the following:<br>• Non-Executive Director John Moore expressed surprise that housing was being cited as an issue for people leaving the Trust, though it was noted there was no quantified data on this yet – this was just one of the early messages from increased early exit interview data, which needed further exploration. John Moore underlined that a creative approach to shared and flexible working should be a key priority in attracting new staff and encouraging staff to stay with the Trust.<br><br>• Non-Executive Director Steve West asked that if any data became evident demonstrating there were issues around housing or similar | |

| Minute Ref | Item Number | Action |
|---|---|---|
| | issues for key workers, that this could be shared with him in his role as Chair of the Local Enterprise Partnership (LEP) for them to consider. The LEP had mainly focused its efforts on large private employers, but NHS and social care were significant local employers, and the LEP might need to reflect on these issues.<br><br>• It was noted that whilst fractured NOF rates were improving, it would be helpful for the Board to get a progress update on establishing an elderly hip ward, as had previously been discussed.<br><br>**Action:** Mark Smith, Deputy Chief Executive and Chief Operating Officer, and Chief Nurse Carolyn Mills to follow up on progress with establishing an elderly hip ward with the Acting Medical Director Mark Callaway.<br><br>• The Chair of the Quality and Outcomes Committee noted that Head of the HR Service Centre Debbie Tunnell had given a great presentation on recruitment efforts, including proactive efforts to attract back staff who have left the healthcare profession, e.g. for family or other reason.<br><br>• Patient Governor Garry Williams asked whether there were any difficulties with retaining more longstanding or older staff. This was not a particular issue identified for the Trust; however the Executive Team were mindful of the overall age of the workforce, both in terms of retention, and in encouraging back staff who had left the healthcare profession.<br><br>• Public Governor Carole Dacombe asked if there were any workforce issues identified which were specific to junior medical staff (especially in light of the significant middle grade staffing shortfall noted in A&E). This was not a particular identified issue for the Trust: it was noted this particular A&E pressure was related to 'bunching' of maternity leave putting strain on the service, and the Trust would be considering how best to support the service.<br><br>**Members RESOLVED to:**<br>• **Receive** the Quality and Performance Report for assurance. | |
| 63/04/18 | **9. Quality and Outcomes Committee - Chair's Report** | |
| | Members received a written report of the meeting of the Quality and Outcomes Committee on 24 April 2018.<br><br>The meeting had been chaired by the Chair of the Board, Jeff Farrar, who gave the following further update:<br><br>• In addition to updates to the Committee noted under **Item 8** (including CT scanning efficiency improvements, and staff recruitment), the | |

| Minute Ref | Item Number | Action |
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| | Acting Medical Director Mark Callaway had provided a helpful update on the Learning from Deaths Report.<br>• The Director of People Matt Joint had provided an update on the National Staff Survey Results for 2017 – this would be discussed further by the Board under **Item 10**.<br><br>**Members RESOLVED to:**<br>• **Receive** the Report of the Quality and Outcomes Committee for assurance. | |
| 64/04/18 | **10. National Staff Survey Results – 2017** | |
| | Director of People Matt Joint presented the National Staff Survey Results 2017.<br><br>• There had been a 43% response rate to the survey, which was about average for an acute trust. There had been a small but significant increase in the overall engagement score from 3.83 to 3.85, notable at a time when a lot of other Trusts' engagement scores had gone down: UH Bristol was now in the upper quartile against comparator Trusts.<br><br>• There had been poor scores around confidence in management/leadership: a major programme was being implemented to address managerial and leadership training at the moment, and the Trust was confident these scores would improve, and there would be continued focus on leadership development.<br><br>• UH Bristol had had poor scores around appraisals, linked to known issues with the online appraisal system (kallidus) which had now been resolved.<br><br>Members of the Board noted the following:<br>• The Chair of the Board noted that he had asked for the full Staff Survey results to be shared with the Non-Executive Directors as there was some interesting detail in the outcomes. He drew the Board's attention in particular to bullying and harassment scores which, whilst in line with peer Trusts, still seemed high; but also very high performance against the question of whether staff would recommend friends and family were treated by this hospital.<br><br>• Members of the Board noted that there were some interesting contradictions in the data (such as some disparity in the quality indicators responses, and low scores against motivation at work despite high performance against the 'recommending friends and family be treated here' question. There was a lot of interesting detail | |

| Minute Ref | Item Number | Action |
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| | which needed unpacking.<br><br>• Members noted with concern that the Trust's performance had struggled in some areas, reflecting the fact that previous implementation of measures to resolve known issues had not gone as hoped – such as the on-hold patients issue and the appraisals system. This suggested that some problems were arising from not ensuring that software/process implementations were fit for purpose. This was an issue which would be covered under the Digital Transformation discussion at a future Board Seminar.<br><br>• Members agreed that these results should be further considered at the Quality and Outcomes Committee, particularly the bullying and harassment scoring.<br><br>**Action:** Discussion of work responding to the National Staff Survey results 2017, particularly on bullying and harassment scoring, to come back to the Quality and Outcomes Committee.<br><br>• Members noted that addressing a 'problem' area might lead to an improvement in the short term, but long term maintenance to ensure consistent improvement was also important. Matt Joint added that quarterly reviews would be looking at engagement, and also scoring from the 'Happy App', which should help provide more data.<br><br>**Members RESOLVED to:**<br>• **Receive** the National Staff Survey Results - 2017 for assurance. | |
| **Organisational and System Strategy and Transformation** | | |
| 65/04/18 | **11. Operational Plan 2018/19** | |
| | Director of Strategy and Transformation Paula Clarke presented the Operational Plan 2018/19.<br><br>• This plan was the culmination of a lot of cross-divisional work seeking areas to improve the trajectory of performance. The four key priorities for the Trust in 2018/19 previously highlighted by Chief Executive Robert Woolley should be woven through plan.<br><br>• Since the draft plan had come to the Board in March 2018, there had been a number of key changes, namely:<br><br>o The financial plan position had changed.<br>o More detail had been added in around people and workforce planning.<br>o Corporate objectives had been more clearly set out, including | |

| Minute Ref | Item Number | Action |
|---|---|---|
| | their relationship to strategic priorities. There would be a further update to the Board on this at a later date, including the enabling actions against them.<br>o Performance targets had been changed to reflect the retention of the referral to treat waiting list targets at March 2018 levels. The plan also showed the Trust's aim to improve against the constitutional targets, particularly the 62 day cancer treatment target.<br><br>• The Director of Finance and Information noted that the financial position reflected the latest position as of two days previously: since this time a control total had been agreed with NHS Improvement the previous evening, which the Board were being recommended to accept (£18.5million - accepting the control total would also enable the Trust to achieve Provider Sustainability Funding (PSF) funding). The plan would therefore be revised again to reflect the new control total.<br><br>**Action:** The final financial position, reflecting the £18.5million control total proposed by NHS Improvement, would be reflected in an updated version of the Operational Plan, which would be circulated to the Board by the Director of Finance and Information, for the Board's approval.<br><br>Members of the Board noted the following:<br>• Members recognised that, despite the revised control total, there remained real challenges to delivering the Operational Plan and the stretching savings target, but it provided a framework to work within.<br><br>• Members questioned whether some aspects of the plan, such as the alignment of the success criteria with the corporate plan, could be simplified. It was noted that some of the complexity arose from the need to meet regulatory requirements, but the Executive team recognised that it was important that the plan was clear and comprehensive. It was also noted that the Quality Accounts Report would cover quarterly objectives for each of the priority areas identified.<br><br>• The Director of Finance and Information noted that it was difficult to benchmark achievement against the new savings target, but felt there was work to do to achieve the 3.5% savings figure. It was also noted that further improve productivity levels, a key step to achieving this, was likely to help improve patient care and morale as well.<br><br>**Members RESOLVED to:**<br>• **Approve** the Trust's Provider Self-Certification.<br>• **Approve** the submission of the Operational Plan for 2018/19 to NHS | |

| Minute Ref | Item Number | Action |
|---|---|---|
| | Improvement (subject to revision to reflect the acceptance of a control total from NHS Improvement of £18.5million), with the final Plan to be approved at the May 2018 Board. | |
| 66/04/18 | **12. Transforming Care Programme Board Report – Q4** | |
| | The Director of Strategy and Transformation Paula Clarke presented the Transforming Care Programme Board Report – Q4.<br><br>• The report showed there was a clear approach to transformation which was embedded in the organisation. The Quality and Performance Report and other updates at the Board meeting had demonstrated this embedded approach to transformation. The report covered Q4 but was also looking ahead to 2018/19.<br><br>• Over the last six months the Director of Strategy and Transformation had been working closely with the Executive team and the Senior Leadership Team to ensure there was clear alignment between use/implementation of technologies, smarter working initiatives, and continuous productivity improvement. The alignment of technical system rollouts with the human aspects of embedding new systems/processes, in many cases alongside service redesign, had been a key focus. As part of this the transformation and IT teams had been working more closely together, and it was felt this had paid dividends in terms of improvements. 200 staff had now been trained on the bronze programme on Quality Improvement, and there had been enthusiastic feedback from the training teams on the way this was working.<br><br>• The report, in particular the forward look to 2018/19, was being shared with the Board for comments and feedback.<br><br>Members of the Board noted the following:<br>• Members wondered whether it would be helpful to make one of the transforming care priorities (or principles) about focusing on simplifying tools for staff use.<br>• Members also asked whether certain elements of the report could be more explicitly led by the relevant functional managers (e.g. HR colleagues leaving the staff-related elements) to ensure this was culturally driven forward. It was noted that the transformation team had an enabling function, facilitating relevant teams in leading transformation, so it might just be a presentational issue in the report.<br>• Members considered the report to be a helpful overview of what was being done elsewhere, as well as analysing what was happening in the Trust at all levels, and providing assurance on how projects were being aligned with strategic directive. It was suggested that the report could be shorter, and more clearly formatted for comprehension. | |

| Minute Ref | Item Number | Action |
|---|---|---|
| | Members also asked if there could be more specific information in the report on objectives and next steps. The report would be revised and Board members' comments reflected.<br><br>**Action:** Director of Strategy and Transformation to revise the Transforming Care Programme Board Report to reflect Board members' input.<br><br>**Members RESOLVED to:**<br>• **Receive** the Transforming Care Programme Board Report – Q4 for assurance. | |
| **Research and Innovation** | | |
| 67/04/18 | **13. Research and Innovation Report – Q3** | |
| | The Head of Research and Innovation Diana Benton presented the Research and Innovation Report - Q3.<br><br>• There had been good improvements in performance against timescales and other targets for Research and Innovation: the team were delighted to have received a 4% increase in budget from the local clinical research network, partly due to activity improvements but also due to changes in the central allocation formula to make it more market- and local population- based.<br><br>• There was good engagement with Research and Innovation across all the Divisions, with particular work in Medicine to consolidate divisional research so as to reach a break even position by the end of the year. A lot of vaccine work had been successfully carried through from the paediatric to the adult population.<br><br>• Research and Innovation ambitions included the Trust being seen as a centre of excellence across the whole piece, expanding sexual health research, and increasing engagement with non-medical clinicians to give them time to do research.<br><br>• As a specialist Trust UH Bristol was carrying out some quite complicated research e.g. in oncology. The complexity was impacting the Trust's ability to achieve the 70-day performance target (for example, some studies had to be set up over 21 support departments, creating inevitable delays). However, it was anticipated that performance would improve in these areas once set-up studies were able to progress.<br><br>• Key risks to research and innovation included ongoing clinical pressures impacting staff's ability to commit time to carrying out | |

| Minute Ref | Item Number | Action |
|---|---|---|
| | research.<br><br>Members of the Board discussed the following:<br><br>• Members asked what support the Board could offer the Research and Innovation Team in developing a bid for a National Institute for Health Research facility, which was clearly a great opportunity. Diana Benton noted that there had been early conversations on this, and a key issue was finding suitable estate space, as research space across the Trust consisted of a number of small facilities, as well as use of the Crick Institute. The importance of protecting current research space was underlined.<br><br>• Members noted the point about clinical pressures potentially deprioritising research time, and asked if this was significant risk, and what the governance around managing this was. The Chief Executive Robert Woolley emphasised that the Trust would not consciously deprioritise research as it was strategically vital to its role and work, especially as a teaching hospital, but there was more of an incremental risk that individuals might deprioritise research in response to increasing pressures 'on the ground' (it was also noted that where there was local short staffing, staff would be more likely to focus on clinical work). It was noted there was good escalation in place when potential trends of this kind, which might need management intervention, were identified, and good Executive and Board commitment to the Trust's research agenda.<br><br>**Members RESOLVED to:**<br>• **Receive** the Research and Innovation Report Q3 for assurance. | |
| **Financial Performance** | | |
| 68/04/18 | **14. Finance Report** | |
| | The Director of Finance and Information Paul Mapson presented the Finance Report on the 2017/18 financial position to the Board.<br><br>• The original Finance Report presented to the Board had shown a £12.5million surplus for the year. The receipt of winter funding had helped the Trust mitigate the impact of winter pressures. Additionally, funding for Welsh tariffs (the HRG4+ issue, discussed at previous Board meetings) had unexpectedly been released, which meant that the planned income shortfall in this area was no longer the case.<br><br>• Underlying issues remained around medical and nursing pay overspend: although these had been somewhat mitigated this year they would need management to ensure improvement. | |

| Minute Ref | Item Number | Action |
|---|---|---|
| | • As the Finance Committee had been advised at its 23 April 2018 meeting, NHS Improvement had passed money held back because Trusts were failing to meet A&E 4 hour wait targets ('bonus and incentive' funding) to Trusts that had delivered their 2017/18 control total. So this represented an additional £7.3million also not shown in the report. The surplus for 2017/18 would now be £19.9million, significantly higher than expected. This was excellent news for the Trust, and the intention was to spend that additional money on capital schemes in 2018/19.<br><br>**Members RESOLVED to:**<br>• **Receive** the Finance Report for Assurance. | |
| 69/04/18 | **15. Finance Committee Chair's Report** | |
| | Members received a written report of the meeting of the Finance Committee of 25 April 2018.<br><br>Members also received a verbal account of the meetings from Martin Sykes, Non-Executive Director and Chair of the Finance Committee:<br><br>• The Committee was pleased by the successful outturn for 2017/18 (as discussed under **Item 11**).<br><br>• The Committee had received a presentation on the Trust's procurement strategy for next year, and had noted that a large part of next year's savings programme was focussed on procurement, so it would be essential to get this strategy right: the Audit and Finance Committees would need to revisit progress on this later in the year, especially as there had been concerns previously discussed as to the structure, recruitment and embeddedness in the Trust of the procurement function. Director of Finance and Information Paul Mapson would come back to the Committee in six months' time to discuss how the procurement function had been improved and embedded.<br><br>**Members RESOLVED to:**<br>• **Receive** the report of the Finance Committee for assurance. | |
| **Governance** | | |
| 70/04/18 | **16. Audit Committee Chair's Report** | |
| | Members received a written report of the meeting of the Audit Committee of 20 April 2018.<br><br>Members also received a verbal account of the meetings from David | |

| Minute Ref | Item Number | Action |
|---|---|---|
| | Armstrong, Non-Executive Director and Chair of the Audit Committee:<br><br>• As the new Committee Chair, David Armstrong was keen that the Committee refreshed its focus on the internal audit programme for the upcoming year, as well as its oversight of the Board Assurance Framework and Corporate Risk Register. The Committee had requested more granularity as to how the programme was put together and agreed, and would also be aiming to ensure it reflected the reviews of all the Board Committee Chairs.<br><br>• The Committee had reviewed the Accounting Policies for the year, and commented on the Annual General Statement. The Committee recommended to the Board that it adopt the NHS Improvement Self-Certification Licence.<br><br>**Members RESOLVED to:**<br>• **Receive** the report of the Audit Committee for assurance. | |
| 71/04/18 | **17. Annual Review of Directors' Interests** | |
| | • This item was received for **information**. | |
| 72/04/18 | **18. Register of Seals – Q4** | |
| | • This item was received for **information.** | |
| **Items for Information** | | |
| 73/04/18 | **19. Governors' Log of Communications** | |
| | There were no updates on the Governors' Log of Communications.<br><br>**Members RESOLVED to:**<br>• **Receive** the Governors' Log of Communications for Assurance. | |
| **Concluding Business** | | |
| 74/04/18 | **20. Any Other Urgent Business** | |
| | Public Governor John Rose asked whether there were figures available for the pressures on UH Bristol A&E services of patients referred from Weston. These would be shared outside the meeting.<br><br>• **Action:** Deputy Chief Executive and Chief Operating Officer Mark Smith to share the figures on Weston patients referred to UH Bristol's A&E with Public Governor John Rose.<br><br>Public Governor John Rose asked if there had been any progress against | |

| Minute Ref | Item Number | Action |
|---|---|---|
| | Green to Go. Mark Smith advised that Newton Europe, an external agency commissioned by the CCG, were looking at analysing this, and there was a huge amount of work on capacity, particularly outflow from the organisation. | |
| 75/04/18 | **21. Date and time of Next Meeting** | |
| | The date of the next meeting was confirmed as **11.00 – 13.00, 24 May 2018, Conference Room, THQ** | |

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

**Public Trust Board of Directors meeting**
**24 May 2018**
**Action tracker**

| Outstanding actions from the meeting held on 26 April 2018 | | | | | |
|---|---|---|---|---|---|
| **No.** | **Minute reference** | **Detail of action required** | **Responsible officer** | **Completion date** | **Additional comments** |
| 1. | 62/04/18 | **Quality and Performance Report**<br>Chief Nurse Carolyn Mills to provide an update to the Board on Patient Safety Improvement at the end of the programme in September 2018.<br><br>Acting Medical Director Mark Callaway to update Board on progress with establishing an elderly hip ward with the Acting Medical Director Mark Callaway | Chief Nurse<br><br>Acting Medical Director | September 2018<br><br>May 2018 | **Work in Progress**<br>Update to be provided to the Board in September 2018<br><br>Update to be provided to the Board in May 2018 |
| 2. | 65/04/18 | **Operating Plan 2018/19**<br>The final financial position, reflecting the £18.5million control total proposed by NHS Improvement, would be reflected in an updated version of the Operational Plan, which would be circulated to the Board by the Director of Finance and Information, for the Board's approval. | Director of Finance and Information and Director of Strategy and Information | May 2018 | **Complete**<br>Final Operational Plan circulated for Board approval. |
| 3. | 66/04/18 | **Transforming Care Programme Board Report – Q4**<br>Director of Strategy and Transformation to revise the Transforming Care Programme Board Report to reflect Board members' input. | Director of Strategy and Transformation | May 2018 | **Work in Progress**<br>Update to be provided to the May 2018 Board meeting. |

| | | | | | |
|---|---|---|---|---|---|
| 4. | 74/04/18 | **Any Other Urgent Business**<br>Deputy Chief Executive and Chief Operating Officer Mark Smith to share the figures on Weston patients referred to UH Bristol's A&E with Public Governor John Rose | Deputy Chief Executive and Chief Operating Officer | May 2018 | **Work in Progress**<br>Update to be provided to the May 2018 Board meeting. |
| 5. | 44/03/18 | **Quality and Performance Report**<br>The Acting Medical Director to update the Board on progress to attract candidates to stroke care at UH Bristol. | Acting Medical Director | May 2018 | **Work in Progress**<br>Update to be provided to the Board in May 2018 |
| 6. | 06/01/2018 | **Chief Executive's Report**<br>Update on the Digital Transformation Programme to come to a future Board meeting. | Director of Finance and Information | June 2018 | **Work in Progress**<br>The Board would receive an Update on the Digital Transformation Programme at a future meeting. |
| 7. | 08/01/18 | **Quality and Performance Report**<br>Acting Medical Director to share the annual report on the genomics project with the Board. | Acting Medical Director | April 2018 | **Work in Progress**<br>The Acting Medical Director would circulate the final report to the Board when available. |
| 8. | 30/02/18 | **Chief Executive's Report**<br>Trust Secretariat to incorporate opportunities for visits to the Sexual Assault Referral service into NED visit planning. | Trust Secretary and Deputy Trust Secretary | June 2018 | **Work in Progress**<br>This action would be incorporated into NED visit planning later in the year. |
| **Closed actions from the meeting held on 26 April 2018** | | | | | |
| **No.** | **Minute reference** | **Detail of action required** | **Responsible officer** | **Completion date** | **Additional comments** |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 1. | 53/03/18 | **Any Other Urgent Business**<br>The Deputy Chief Executive and Chief Operating Officer to provide a 62-day target remedial action plan to the next meeting of the Quality and Outcomes Committee | Deputy Chief Executive and Chief Operating Officer | April 2018 | **Work in Progress**<br><br>Update to be provided to QoC in April 2018. |
| 2. | | **National Staff Survey Results – 2017**<br><br>Discussion of work responding to the National Staff Survey results 2017, particularly on bullying and harassment scoring, to come back to the Quality and Outcomes Committee. | Director of People | April 2018 | **Work in Progress**<br>Update to be provided to QoC. |

**Cover report to the Public Trust Board. Meeting to be held on 24 May 2018 at 11:00-13:00 in the Conference Room, Trust Headquarters**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 6 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Thursday, 24 May 2018 |
| **Report Title** | **Chief Executive Report** | | |
| **Author** | Mark Smith, Chief Operating Officer/Deputy Chief Executive | | |
| **Executive Lead** | Mark Smith, Chief Operating Officer/Deputy Chief Executive | | |
| **Freedom of Information Status** | | Open | |

| **Strategic Priorities (please choose any which are impacted on / relevant to this paper)** | | | |
|---|---|---|---|
| Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion. | ☐ | 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<br><br>To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team.<br><br>Key issues to note<br><br>The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in May 2018. |
| **Recommendations** |

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

Members are asked to:
**Note** the report.

| **Intended Audience**<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)** |
| | | | | |

# SENIOR LEADERSHIP TEAM

# REPORT TO TRUST BOARD – MAY 2018

## 1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in May 2018

## 2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **received** updates on the financial position for 2018/2019.

## 3. STRATEGY AND BUSINESS PLANNING

The group **approved** sign-off of Divisional Operating Plans for the Divisions of Surgery and Women's and Children's.

The group **approved** the Capital Programme 2018/2019.

The group **approved** the national mandatory contract variation.

The group **approved** the Annual Quality Report 2017/2018 for onward submission to the Audit Committee and Trust Board.

The group received an update on the Strategy Renewal Programme and **approved** the draft strategic priorities and objectives to provide the strategic planning framework for Divisions in phase 3, for onward submission to the Trust Board.

The group **approved** the Outline Business Case for the renewal of the Managed Equipment Service contract in Laboratory Medicine, for progression to issue the OJEU tender.

## 4. RISK, FINANCE AND GOVERNANCE

The group **approved** the Emergency Preparedness Annual Report, which provided an overall position in relation to compliance with the NHS England Core Standards for Emergency Preparedness Resilience and Response and the focus of work for the forthcoming year, for onward submission to the Trust Board.

The group **received** an update on the process and progress to date on the job planning review.

The group **received** a proposal to establish a mechanism for co-ordinating national medical guidelines that were non-National Institute for Clinical Excellence, and agreed further discussion was required.

The group **received** an update on the Trust-wide uninterrupted power supply provision.

The group **received** an update on the General Data Protection Regulation Compliance and Implementation.

The group **received** three Internal Audit Reports with significant assurance in relation to Divisional Review – Diagnostics and Therapies, Information Governance Toolkit and Contract Income.

The group **approved** revised Terms of Reference for the Service Delivery Group and Strategy Steering Group.

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

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

**Mark Smith**
**Deputy Chief Executive/Chief Operating Officer**
**May 2018**

**Cover report to the Public Trust Board. Meeting to be held on 24 May 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 7 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Thursday, 24 May 2018 |
| **Report Title** | **Major Incident – Bristol Haematology and Oncology Centre** | | |
| **Author** | Alison Grooms, Deputy Chief Operating Officer<br>Eric Sanders, Trust Secretary | | |
| **Executive Lead** | Mark Smith, Chief Operating Officer/Deputy Chief Executive | | |
| **Freedom of Information Status** | | Open | |

| **Strategic Priorities** | | | |
|---|---|---|---|
| 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** | | | | | | | |
|---|---|---|---|---|---|---|---|
| For Decision | ☐ | For Assurance | ☒ | For Approval | ☐ | For Information | ☐ |

## Executive Summary


A fire in the Bristol Haematology and Oncology Centre on 10 May 2018 resulted in the need to evacuate 53 patients and staff. No one was harmed during the evacuation and work is now ongoing to ensure that services can be safely and quickly returned to normal.

The response from staff and the wider system has been magnificent and has ensured that patients have been provided high quality care through very difficult circumstances.

The investigation into the fire has commenced and the outcome and any learning will be reported back to the Board in due course.

**This update note** the initial details of the fire, the immediate actions taken and the proposed next steps to fully investigate the fire.

| Recommendations |
|---|
| Members are asked to:<br>• **Note** the update on the Major Incident – Bristol Haematology and Oncology Centre |

| Intended Audience | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Board/Committee Members | ☒ | Regulators | ☒ | Governors | ☒ | Staff | ☒ | Public | ☒ |

| Board Assurance Framework Risk | | | |
|---|---|---|---|
| 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 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quality | ☐ | Equality | ☐ | Legal | ☐ | Workforce | ☐ |

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

| Resource Implications | | | |
|---|---|---|---|
| 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)** |
| | | | | |

## 1. Purpose

1.1. To update Board members on the fire in the Bristol Haematology and Oncology Centre and subsequent actions.

## 2. Background

2.1. A fire broke out in the early hours of Thursday 10 May 2018 in the plant room of the Bristol Haematology and Oncology Centre (BHOC). The detection equipment quickly identified the fire and alerted staff. 53 patients and staff were immediately evacuated to other areas of the Trust.

## 3. Immediate Actions

3.1. To ensure that the evacuated patients could be cared for in other parts of the hospital the following actions were taken:

- Patients were diverted from the adults' Emergency Department
- Planned procedures were cancelled
- Radiotherapy, Chemotherapy and outpatient appointments were cancelled as the building could not be used

3.2. The Trust declared a major incident and subsequently a system-wide major incident was declared. Systems partners all joined together to support the safe and effective care of all patients. Some of the immediate measures included supported discharges, extending hours at Minor Injury Units, and cancellation of planned operations at other hospitals to free up capacity.

3.3. Staff have worked hard since the fire to restore power, clean the building and restart treatments for patients.

3.4. The major incident was stood down on Monday 14 May 2018 following agreement by all system partners.

3.5. Oversight of the programme of works to restore the building, the reprovision of activity in alternative locations, and plans to enable full clinical activities to recommence in the BHOC are being overseen by the BHOC Recovery Board. The Board was established to support the divisions and give oversight to the variouis workstreams and activities required.

3.6. The Director of People has ensured that staff who were immediately involved in evacuating patients and who supported in the immediate aftermath of the incident have been offered support to recognise the potential impact that this may have on their wellbeing. Ongoing support will be offered to all staff.

3.7. The Director of Nursing has also visited all patients who were evacuated to ensure they are being cared for and understand the actions the Trust is taking to ensure they continue to receive high quality care. The clinical psychology teams and clinical nurse specialists have been supporting the patients affected.

3.8. The Trust was able to restart providing urgent radiotherapy over the weekend of 12/13 May and urgent chemotherapy, haematology and outpatient activity was provided in other parts of the Trust and outsourced. Outpatient services returned to BHOC on Wednesday 16 May 2018 and day unit chemotherapy on Thursday 17 May 2018. Work continues to clean and re-open remaining parts of the building.

## 4. Next Steps

4.1. The Trust has instigated an investigation into the source of the fire and learning from the incident which will be used to inform any actions required to prevent a

reoccurrence. The outcome of the investigation will be reported to the Board once completed.

4.2. The Board, staff and members of the public will continue to receive regular updates on progress to fully reopen BHOC though the usual communication channels and via social media.

University Hospitals Bristol
NHS Foundation Trust

**Cover report to the Public Board Meeting to be held on 24 May 2018 at 09.00 – 11.00 in the Board Room, Trust HQ**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | **8** |
| **Meeting Title** | Trust Board | **Meeting Date** | **Thursday, 24 May 2018** |
| **Report Title** | **Quality and Performance Report** | | |
| **Author** | James Rabbitts, Head of Performance Reporting<br>Anne Reader, Head of Quality (Patient Safety)<br>Matt Joint, Director of People | | |
| **Executive Lead** | Overview and Access – Mark Smith, Deputy Chief Executive and Chief Operating Officer<br>Quality – Carolyn Mills, Chief Nurse<br>Workforce – Matt Joint, Director of people | | |
| **Freedom of Information Status** | | Closed | |

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

| Recommendations |
|---|
| Members are asked to:<br><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)** |
| | | 23 May 2018 | | |

University Hospitals Bristol NHS
NHS Foundation Trust

# Quality & Performance Report

**May 2018**

## Executive Summary

**Single Oversight Framework**

- The 62 Day Cancer standard for GP referrals achieved 87.3% for March and 82.4% for Quarter 4. So March achieved the national standard of 85% and the Sustainability and Transformation Fund (STF) target of 82.6%. However the quarter as a whole narrowly missed the STF target.
- The measure for percentage of A&E patients seen in less than 4 hours was 84.0% for April. This did not achieve the 95% national or Sustainability and Transformation Fund (STF) target of 90%. The Children's Hospital has sustained its consistently good performance and continues to meet the STF trajectory each month. The Bristol Royal Infirmary performance had risen to 73.9% in April.
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 88.2% as at end of April. This did not achieve the national 92% standard. The Sustainability and Transformation Fund (STF) target for this measure has been set at 87% so this was achieved. The Trust was 1133 patients away from the national compliance of 92%. Early sight for May is holding at 88%
- The percentage of Diagnostic patients waiting under 6 weeks at end of April was 96.8%, with 311 patients waiting 6+ weeks. This is lower than the national 99% standard. The maximum allowed breaches to achieve 99% was 97.

**Headline Indicators**

Performance against Clostridium difficile Cases and Patient Experience remain consistently above target. The Medicines Omitted Doses measure remains above target this month after a small deterioration in February. Fracture Neck of Femur performance rose in April, with 64% achieving Best Practice Tariff, compared to a 2017/18 average of 35%. Percentage seeing an ortho-geriatrician (one of the key supporting measures) achieved the 90% in April.

Last Minute Cancelled (LMC) Operations remains above the required threshold of 0.8% of admissions, with 84 such cancellations in April, which equated to 1.4% of admissions. Also the 28 day readmission standard of 95% was not achieved in April (13 patients not re-admitted within 28 days).

The number of beddays spent outlying in April was 800 which is a significant reduction from January to March position. Additionally, only 64 outlier beddays were used on the two escalation wards: A512 and A414 Queen's Day Unit.

In the Workforce measures, percentage Agency usage reduced by 17.9 full time equivalents (fte) to 0.9%, which is below the 1.0% trust target for April. The largest reductions were seen in Trust Services. Reductions were also seen in Medicine and Surgery, where usage reduced by 35.7% and 28.6%, respectively.

Sickness absence reduced to 3.5% in April, which is below the 3.6% Trust target, with reductions in all Divisions. The largest staff group reduction was seen in Unregistered Nursing. Stress/Anxiety continues to be the cause for the most of amount of sickness.

Overall vacancies remained static at 5.4%. The largest reduction across the bed-holding divisions was in Women's & Children's, where it was down by 20.0%. Turnover increased to 14.2% in April, with increases across all divisions except Diagnostics & Therapies and Trust Services. The largest increase in staff group was seen in Registered Nursing (1.1 percentage points).

# 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

| Access Key Performance Indicator | | Quarter 3 2017/18 | | | Quarter 4 2017/18 | | | Quarter 1 2018/19 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Oct 17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 |
| **A&E 4-hours** | Actual | 90.1% | 90.3% | 85.3% | 82.7% | 83.2% | 78.9% | 84.0% | | |
| | Trust "Footprint" | 92.8% | | | 86.1% | | | | | |
| | STF trajectory | 90% | 90% | 90% | 90% | 92% | 95% | 90% | 90% | 90% |
| **62-day GP cancer** | Actual (Monthly) | 84.1% | 88.6% | 82.9% | 78.4% | 81.3% | 87.3% | | | |
| | Actual (Quarterly) | 85.4% | | | 82.4% | | | | | |
| | STF trajectory | 82.5% | 82.5% | 82.5% | 82.6% | 82.6% | 82.6% | 81% | 83% | 83% |
| **Referral to Treatment Time** | Actual | 90.0% | 88.9% | 88.3% | 88.1% | 88.4% | 87.0% | 88.2% | | |
| | STF trajectory | 92% | 92% | 92% | 92% | 92% | 92% | 87% | | |
| **6-week wait diagnostic** | Actual | 98.2% | 98.3% | 97.6% | 97.8% | 99.2% | 98.5% | 96.8% | | |
| | STF trajectory | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% |

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved
RED rating = national standard not achieved, the STF trajectory not achieved

Note on A&E Trust "Footprint":
In agreement with NHS England and NHS Improvement, each Acute Trust was apportioned activity from Walk In Centres and Minor Injury Units in their region. For UHBristol this was the Bristol, North Somerset and South Gloucestershire (BNSSG) region. The result of this apportionment was carried out and published by NHS England as "Acute Trust Footprint" data. This data is being used to assess whether a Trust achieved the STF target for Quarter 3 and 4. The above table shows the Trust achieved the required level, after apportionment, in Quarter 3 but not in Quarter 4.

## Summary Scorecard

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


Key changes in indicators in the period:

RED to AMBER
Dissatisfied Complaints
Referral to Treatment
Staff Turnover

AMBER to GREEN
Outpatient Cancellations
Cancer 62 Day Wait
Staff Sickness

RED to GREEN
Medication Errors
Outliers
Agency Usage

GREEN to RED
Diagnostic Waits

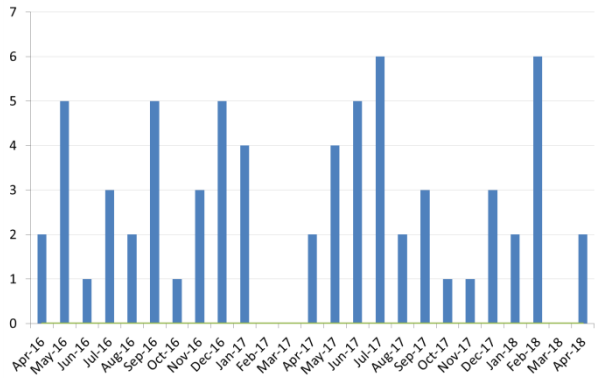
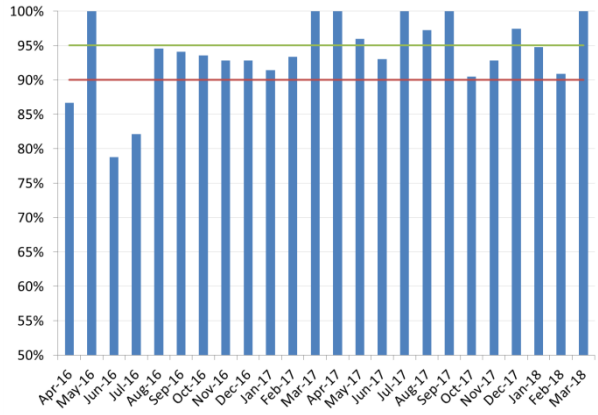
## Overview – Successes, Priorities, Opportunities, Risks and Threats

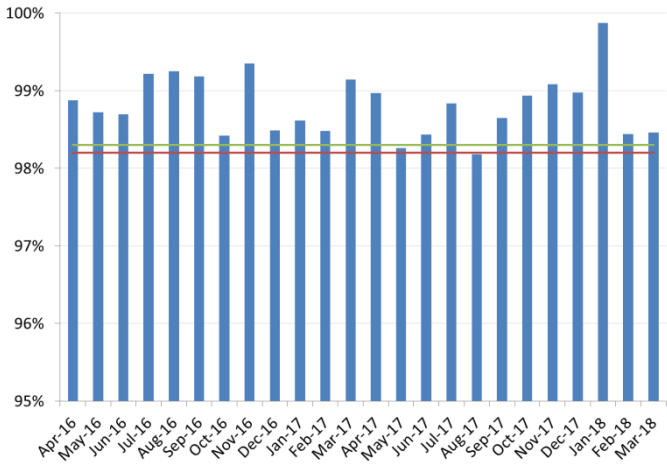
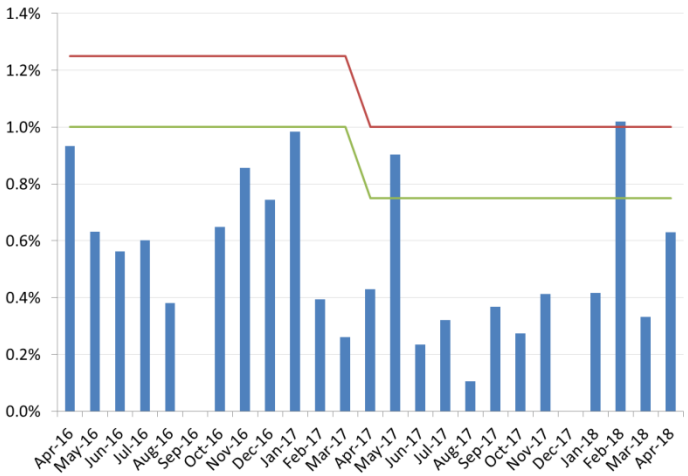
| | Successes | Priorities |
|---|---|---|
| ACCESS Emergency | • When the Trust's A&E 4 hour performance is uplifted by the apportionment of local Walk In Centres (as published by NHS England), the Trust achieved 92.8% for Quarter 3 and so achieved the Sustainability & Transformation Funds (STF) target of 90%. Performance without this apportionment was 88.64%.<br>• The Children's Hospital continues to meet the STF trajectory for 4hr performance and met the 95% standard in March.<br>• The BRI particularly has seen improved flow and a reduction in occupancy levels enabled performance to improve. There are still peak times when the BRI ED struggles with high volumes of attendances and ongoing work within the division continues | • Continue to recover the 4 hour performance particularly at the Bristol Royal Infirmary.<br>• Early recovery of performance and re-focus on improvements as we start to move into summer |
| ACCESS Planned Care | • The Trust is beginning to see reductions in the volume of on hold pathways being added, which is a major step forward.<br>• There are now five on-hold reasons within our Patient Administration System ("Medway PAS") that are selectable at the point of recording the outcome of the patient appointment and a further two on-hold reasons which are system generated. Previously there were 23 selectable on-hold reasons within Medway PAS.<br>• The weekly performance meetings continues with a focus on RTT performance, diagnostic 6-week standard, on-hold status flags in Medway, overdue partial bookings undated 40+ week waiting patients. More recently Cancer Performance is now incorporated into this overall Performance meeting. | • Continue to hold steady state on Referral To Treatment (RTT) performance with a plan to restore achievement of the 92% Referral to Treatment national standard as an aggregate position at end of August 2018<br>• The sampling process for all cohorts identified as part of the "on hold "patient pathways, has now been completed, to either full validation, or to the expected standard identified by the IST of 10% of all pathways. Results of this sampling need to be collated and reviewed.<br>• Focus continues on clearing of long waiting breaches and clearing in the Referral to Treatment backlog, particularly in Pediatric Services and Dentistry services.<br>• Ensure Diagnostic Wait target achieves national standard of 99% or more of patients waiting under 6 weeks. Particular focus needed on Cardiac Echos and Ultrasound. |
| ACCESS Cancer Waits | • Recovery trajectory and national standard for 62 day GP performance were met in March, and recovery trajectory for quarter narrowly missed (by 0.06 percentage points).<br>• Subsequent chemotherapy and radiotherapy standards and two week wait first appointment standard achieved for the quarter<br>• 62 day GP referred standard achieved in quarter 3, for the first time a quarter has been achieved since 2012.<br>• Good recovery from cancellations each time these have occurred. | • Minimise surgical cancellations of cancer patients and take actions to recover quickly when cancellations occur.<br>• Recover from the impact of the Bristol Haematology and Oncology Centre fire on performance. Extent of impact is not known at the time of writing.<br>• Recover the 85% standard by July at the latest and maintain this.<br>• Continue work with other providers to reduce late referrals/minimise their impact<br>• Prepare for the changes to performance reporting rules from July 2018 – cancer register upgrade scheduled for May and full programme of work in place |

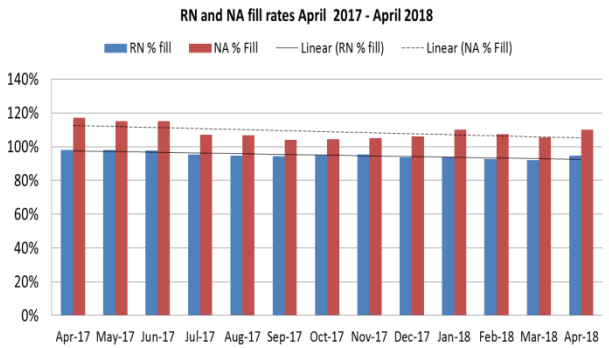
| | Successes | Priorities |
|---|---|---|
| QUALITY | • The number of outliers for April 2018 was 800 beddays, providing a positive impact on the quality of care received by patients. This was a significant reduction from 1377 outlier bed days in March. | • Complaints responded to within timeframe was 83.1% for April and has not been achieved in 2017/18 as a whole. It is a quality priority for 2018/19 to achieve the 95% target for this indicator. |
| WORKFORCE | • Review of the Exit Questionnaire process has improved response rates from 17% in December 2018 to 52% in April 2018, against a target of 50%.<br>• The Trust has run it's first 'You said…We did together' week to launch the staff survey results and engage staff with changes taking place in their local area as result of last year's engagement plans.<br>• The average waiting time for Occupation Health Counselling provision has reduced from 18 to 10 working days following triage within 48 hours of referral.<br>• Staff member and line manager guidance disseminated following further communications on BREXIT.<br>• New Recruitment Toolkit launched for appointing managers. | • Maintain focus on proactive management of sickness absence in hotspots around the Trust, with a particular emphasis on coaching managers to support staff with mental health issues.<br>• Doctors in Training (DiT) streamlining project for the pass-porting of pre-employment checks being piloted by Resourcing. |

| | Opportunities | Risks & Threats |
|---|---|---|
| ACCESS Emergency | • Re-focus of work with Bristol City Council (BCC) around DTOC reduction –a mini MADE event was held at the end of March in response to Bristol position.<br>• Development of joint plan with BCC to recover DTOC position<br>• Learning from winter plans and review of particular days performance will inform future resilience plans | • Quarter 1 performance at risk with continued pressure on adult services<br>• Continued operational pressure on the hospital through Easter into April presents a risk to RTT recovery plans |
| ACCESS Planned Care | • System C (our Patient Administration System supplier) has made us aware of additional functionality that can be used to reduce the risk of patients not being added to the waiting list following a decision to list at outpatients. The ability to use this functionality and the suitability to this Trust is being reviewed with both Trust HQ Performance Team and the IM&T department.<br>• A review meeting has been arranged on 16th May (previously arranged for 10th May) with our local commissioners to review the access policy. The policy requires further clarity to be included on the number of times patients can exercise their right to cancel or postpone their treatment for social reasons.<br>• Further enhancements to the PTL (patient tracking list) for waiting patients are underway. The final result is for the Trust to have one PTL that is Trustwide and includes RTT patients, non-RTT patients, Planned patients, Cancer patients and those waiting for a diagnostic test. | • Focused review of the on-hold patients will continue and will be expanded as the risks identified during the process are likely to increase.<br>• Although the new functionality in our Patient Administration System allows better management of the on-hold status flags this does not remove the on-hold backlog. This will be monitored and addressed on a weekly basis at the RTT Performance meeting to prevent a further backlog being created.<br>• At end of April there were 15 Referral to Treatment (RTT) patients waiting 52+ weeks, 10 of which are dated to be treated in May. We are still affected by patient choice when soonest dates are being offered and patients are exercising their right to wait for social reasons.<br>• Loss of diagnostic capacity in Echos and Ultrasound poses a risk to delivery of the 99% target. |
| ACCESS Cancer Waits | • Avoiding cancellation is the single most important high impact action for the Trust to improve and sustain performance against the cancer standards.<br>• A 'virtual PTL' (waiting list meeting) with referring providers is continuing to develop, with focus at present on Taunton and North Bristol. Yeovil and Bath are also starting to participate.<br>• Incorporation of cancer into a cross-standards performance meeting gives new opportunities to discuss performance issues, particularly those not specific to cancer. Focus is currently on diagnostic tests and 'getting it right first time' with early results encouraging | • Late referrals from other providers continue to impact on achievement of the 62-day GP cancer waiting times standard. The new standards may provide an opportunity to mitigate this but the new rules are complex and this is not yet a certain benefit.<br>• Surgical cancellations are a high risk to achievement of several cancer standards as well as to patient experience and quality. Levels have dropped in April and May (apart from after the fire) but the impact of previous cancellations is still affecting capacity in the complex surgical services.<br>• Dermatology transfer not taking place until 2019, meaning the Trust's challenging casemix remains an issue |

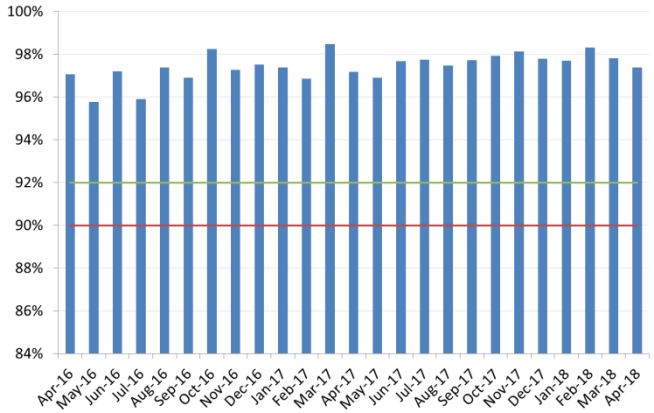
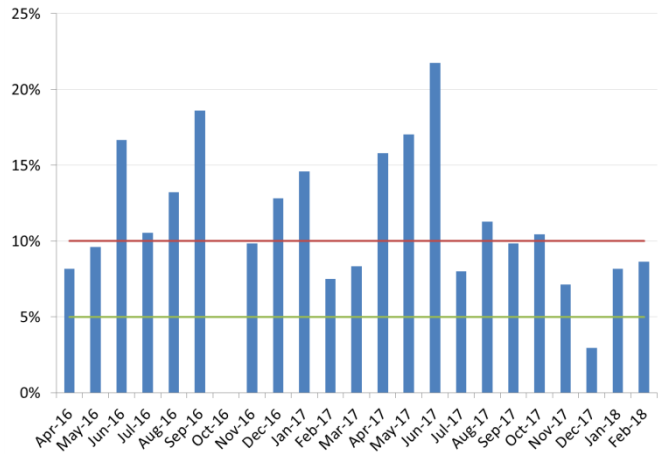
| | Opportunities | Risks & Threats |
|---|---|---|
| QUALITY | • Although there was one MSSA case for April 2018, we remained below the annual limit of 28 cases in 2017/18. There is particular continued focus on intravenous line care to reduce incidence of line related MSSA and an opportunity to improve the visibility of the venous infusion phlebitis assessment (VIPA) score for staff in the e observations system. | • There were two grade 3 pressure ulcers on two different patients' heels reported in April 2018 both of which are currently under investigation.<br>• Fractured neck of femur best practice tariff improved in April 2018 to 63.6% but remains below the 90% target, mainly due to need to prioritise urgent trauma according to clinical need. |
| WORKFORCE | • Alignment with the SW Streamlining /MaST (Mandatory and Statutory) 2018 Programme continues, with an aim to streamline corporate induction by August 2018.<br>• Significant increase in exit data available allows closer scrutiny of the reasons why staff are leaving, to better inform recruitment and retention strategies.<br>• Using the Diversity week in May to further understand the experience of our staff within the protected characteristics. | • To align with Streamlining/MaST standards, the refresher periods for two core skills programmes; Resus and Infection Prevention and Control (IPC), must change from 2-yearly and 3-yearly, respectively, to annual updates. |

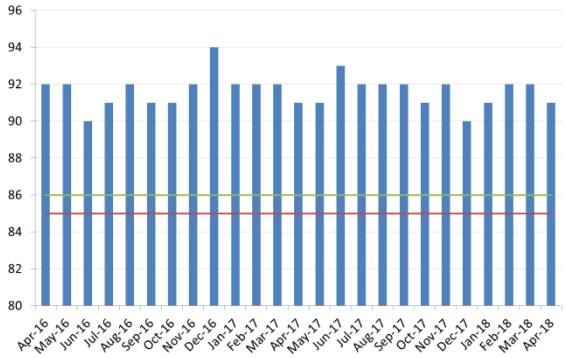
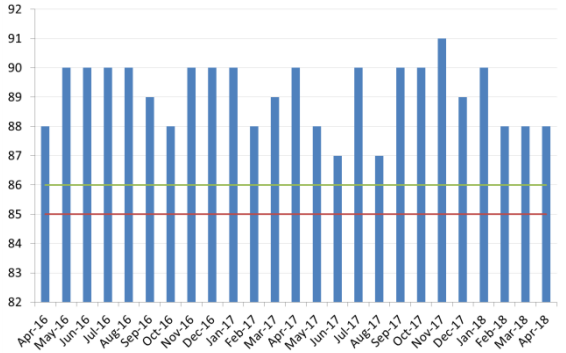
| Description | Current Performance | Trend | Comments |
|---|---|---|---|
| **Infection control**<br>The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16). | Performance in Trust acquired Clostridium *difficile* (C. diff) is good with low numbers of cases in relation to the limits set.<br>There were two cases of C. diff currently attributed to the Trust in April 2018, however these are awaiting a decision by the CCG<br>To date, this year, we have had no hospital apportioned avoidable cases of clostridium difficile assigned as a result of a lapse in care. | **Total number of C. diff cases**<br>  | Alternate monthly meetings between the infection control team and Clinical Commissioning Group (CCG) aim to review all cases of clostridium difficile and apportion these appropriately. There is a time delay and therefore Trust attributed cases may not be agreed for some time after the infection was identified. |
| **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%. | There is a gap in processing the previous data flows for this measure with a plan to switch to obtaining data from the e observations/Care Flow system when fully implemented. In the meantime incident reporting and investigation for occasions when NEWS was not acted upon in accordance with the escalation protocol continues and monthly spot check audits continue. | **Percentage of early warning scores acted upon**<br>  | |

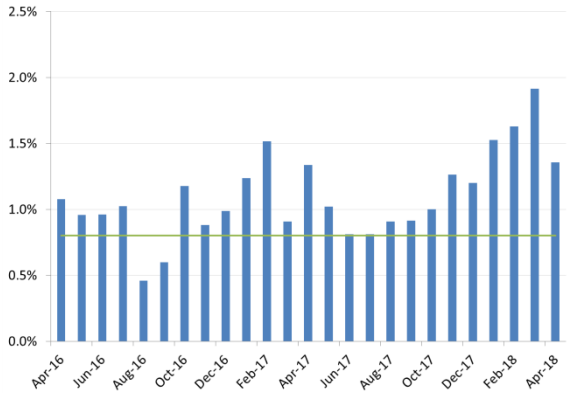
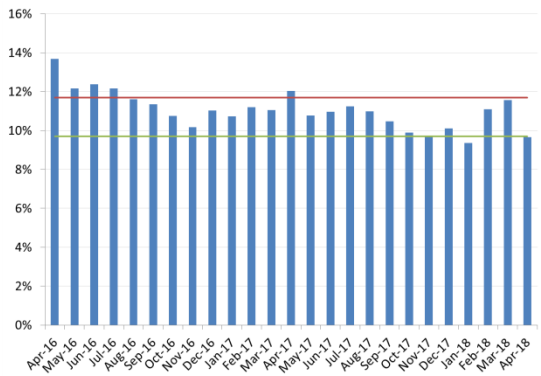
| Description | Current Performance | Trend | Comments |
|---|---|---|---|
| **Safety Thermometer – No new harm.** The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital | There is a gap in processing the previous data flows for this measure which is taken from a monthly point prevalence audit. We will continue to obtain assurance from incident reporting and investigation of all falls and pressure ulcers and VTE and monthly spot check audits continue of all elements which make up the no new harms measure. | **The percentage of patients surveyed showing No New Harm each month**<br>  | |
| **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 April 2018, 0.63% (4 out of the 636 patients) reviewed had one or more omitted critical medications in the past three days. The target for omitted doses is no more than 0.75%. The 0.63 % for April 2018 is a slight deterioration from the March 2018 figure of 0.33% (2 out of 605). | **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%). |

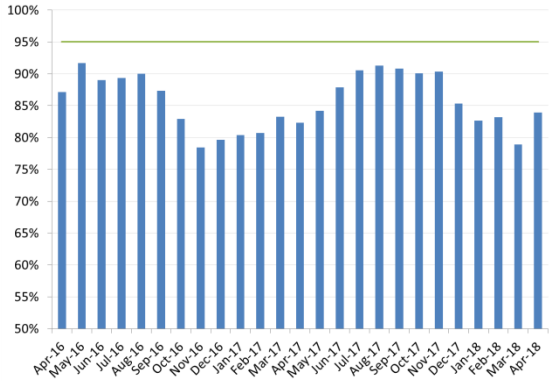
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Overall compliance reduced to 89% compared with last month (excluding Child Protection Level 3). Compliance with each of the reporting categories is provided below.
<table>
<tr><th>April 2018</th><th>UH Bristol</th></tr>
<tr><td>Total</td><td>89%</td></tr>
<tr><td>Three Yearly (14 topics)</td><td>90%</td></tr>
<tr><td>Annual (Fire)</td><td>88%</td></tr>
<tr><td>Annual (IG)</td><td>84%</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>87%</td></tr>
<tr><td>Safeguarding</td><td>89%</td></tr>
</table>
</td>
<td>Although 89% is a 1% reduction in compliance from February and March, this is due to a shifted focus on only the 11 ‘Core Skills’ of the nationally-recognised Core Skills Training Framework (CSTF).<br><br>The report continues to list any other Essential Training (those still considered as mandatory, but outside the 11 Core Skills titles). Compliance for these topics is 92% overall.<br><br>If all programmes were combined and averaged, using the previous reporting format the resulting compliance would be 90%.</td>
<td>See Section 3 in the Improvement Plans 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 April 2018 the trust had rostered 231,373 expected nursing, midwifery and nursing assistants’ hours, with the number of actual hours worked recorded on the system was 229,021.
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>65047</td><td>60594</td><td>4452</td></tr>
<tr><td>Specialised Services</td><td>40152</td><td>39476</td><td>675</td></tr>
<tr><td>Surgery</td><td>44396</td><td>43797</td><td>599</td></tr>
<tr><td>Women’s and Children</td><td>79426</td><td>87506</td><td>-8079</td></tr>
<tr><td>Trust - overall</td><td>229021</td><td>231373</td><td>-2352</td></tr>
</table>
</td>
<td>The percentage overall staffing fill rate by month<br> 

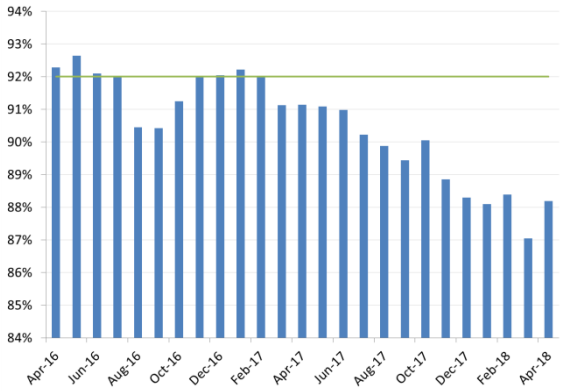
</td>
<td>Overall for the month of April 2018, the trust had 94% cover for RN’s on days and 96% RN cover for nights. The unregistered level of 103% for days and 119% for nights reflects the activity seen in March 2018. This was due primarily to NA specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night.</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 April 2018 was 97.4%. 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 February 2018.<br><br>As of 16 May 2018, 5 of the 58 responses sent out in February had resulted in dissatisfied replies (8.6% 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 (measured in May each year and published in our annual Quality Report).<br>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 (Section 5 in Improvement Plans section) |

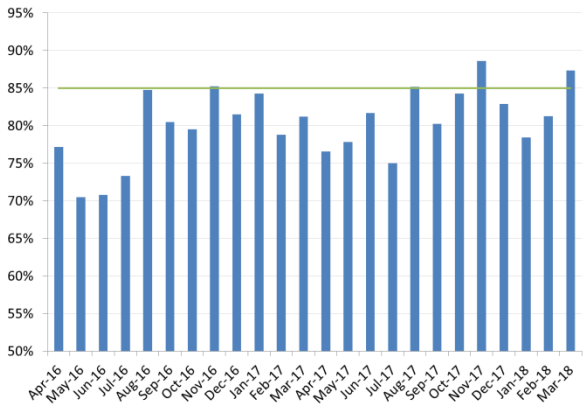
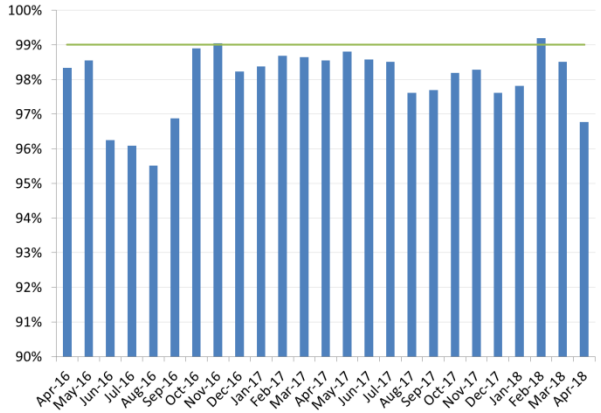
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as “key drivers” of patient satisfaction via analysis and focus groups.</td>
<td>For the month of April 2018, 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>Q4 2017/18</th><th>Q1 2018/19</th></tr>
<tr><td>Trust</td><td>92</td><td>91</td></tr>
<tr><td>Medicine</td><td>89</td><td>91</td></tr>
<tr><td>Surgery</td><td>92</td><td>91</td></tr>
<tr><td>Specialised Services</td><td>92</td><td>90</td></tr>
<tr><td>Women's & Children's (Children’s Hospital)</td><td>92</td><td>90</td></tr>
<tr><td>Women's & Children's Division (Postnatal wards)</td><td>92</td><td>90</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 88 in April 2018 (out of score of 100). Divisional scores for quarter 1 are provided as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful.
<table>
<tr><th></th><th>Q4 2017/18</th><th>Q1 2018/19</th></tr>
<tr><td>Trust</td><td>89</td><td>89</td></tr>
<tr><td>Medicine</td><td>91</td><td>88</td></tr>
<tr><td>Specialised Services</td><td>84</td><td>85</td></tr>
<tr><td>Surgery</td><td>89</td><td>88</td></tr>
<tr><td>Women's & Children's (Children’s Hospital)</td><td>89</td><td>86</td></tr>
<tr><td>Diagnostics & Therapies</td><td>92</td><td>92</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 – alerting the Trust Board and senior management that remedial action is required. In the year to date the Trust score remains green. Divisional scores are examined in detail in the Trust’s Quarterly Patient Experience Report.</td>
</tr>
</table>

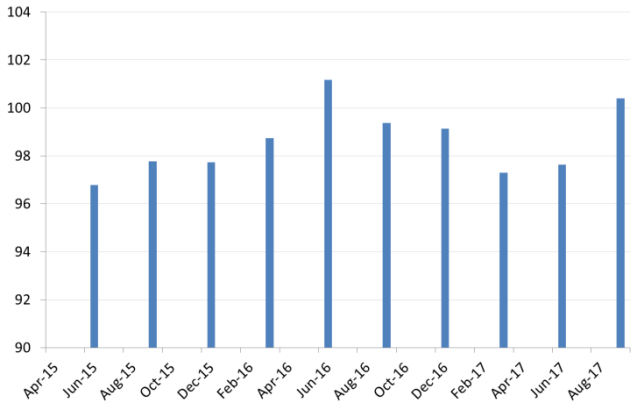
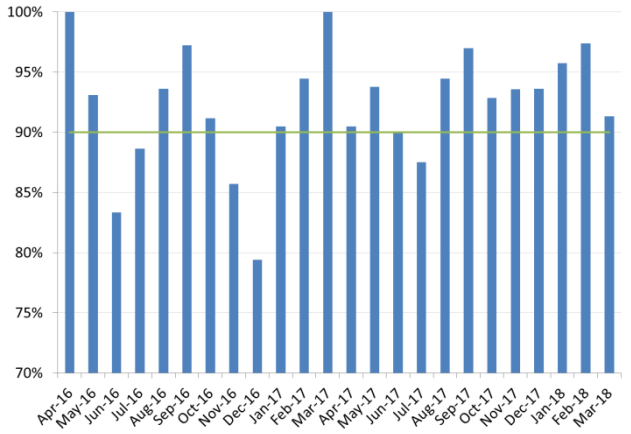
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In April the Trust cancelled 84 (1.36%) of operations at last-minute for non-clinical reasons. The top five reasons for the cancellations are shown below:
<table>
<tr><th>Cancellation reason</th><th>Number</th></tr>
<tr><td>Other emergency patient prioritised/list over run</td><td>26</td></tr>
<tr><td>Staff unavailable</td><td>21</td></tr>
<tr><td>No beds available</td><td>17</td></tr>
<tr><td>AM list over-ran</td><td>7</td></tr>
<tr><td>Other</td><td>7</td></tr>
<tr><td>No HDU/ICU beds</td><td>6</td></tr>
</table>
Of the 121 patients cancelled in March, 13 were not readmitted within 28 days. Meaning 89.3% were re-admitted within 28 days, so the Trust just missed the former national standard of 95%.</td>
<td>Percentage of operations cancelled at last-minute<br> 
</td>
<td>Some improvement in performance across the month, our best since December 17 but issues remain particularly in relation to scheduling and activity lost due to emergency demand.<br><br>See Section 6 in the Improvement Plans section for more 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 April 9.65% of outpatient appointments were cancelled by the hospital, which is below the Green threshold of 9.7%. This is a decrease from last month’s cancellation percentage of 11.6%.</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.<br><br>See Section 7 in the Improvement Plans section for more details.</td>
</tr>
</table>

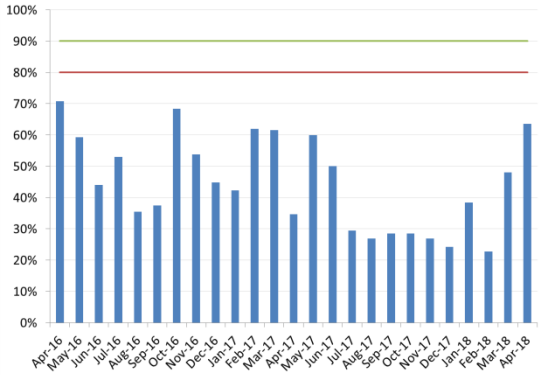
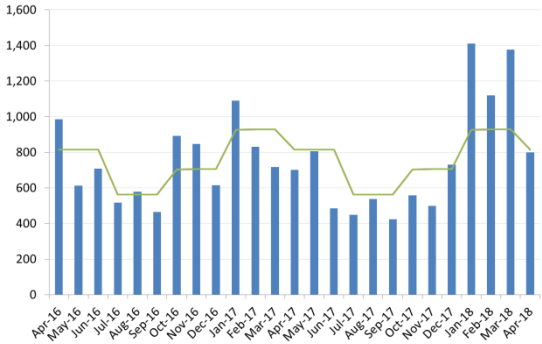
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The Trust achieved 83.95% in April which is below both the national standard (95%) and the recovery trajectory (90%). Performance and activity levels for the last three months are shown below.<br><br>
<table>
<tr><th></th><th>Feb 2018</th><th>Mar 2018</th><th>Apr 2018</th></tr>
<tr><td>Attendances</td><td>10383</td><td>11346</td><td>11605</td></tr>
<tr><td>Patients managed < 4 hours</td><td>8639<br>83.2%</td><td>8951<br>78.9%</td><td>9743<br>83.95%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments<br> 

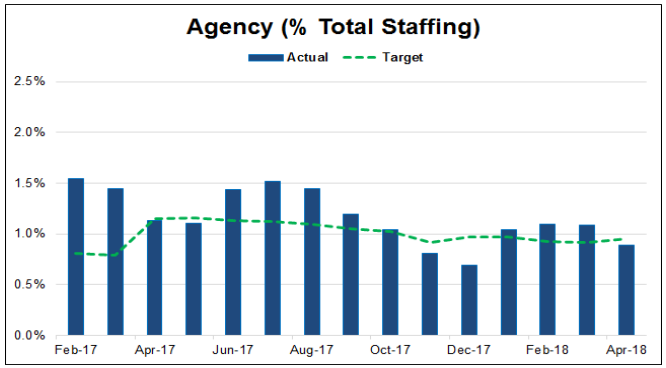
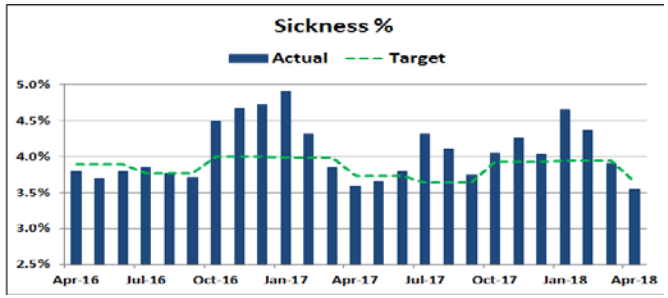
</td>
<td>Some improvement in April particularly at the BRI. Pressures remain in BRHC with increased demand but the team have been able to maintain good performance.<br><br>Updated urgent care recovery plan aligned to trajectory in place</td>
</tr>
<tr>
<td>Referral to Treatment (RTT) is a measure of 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 April, with performance reported at 88.2%. However, this was above the Sustainability and Transformation Fund (STF) recovery target of 87%.<br><br>The 52 week trajectory resulted in 18 remaining waiters at the end of March.<br><br>
<table>
<tr><th></th><th>Feb</th><th>Mar</th><th>Apr</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>148</td><td>164</td><td>154</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>15</td><td>18</td><td>15</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month<br> 

</td>
<td>Performance against the RTT standard is currently at 88.2%. This indicates we are 1133 patients away from the national compliance of 92%.<br><br>Early sight for May is holding at 88%.</td>
</tr>
</table>

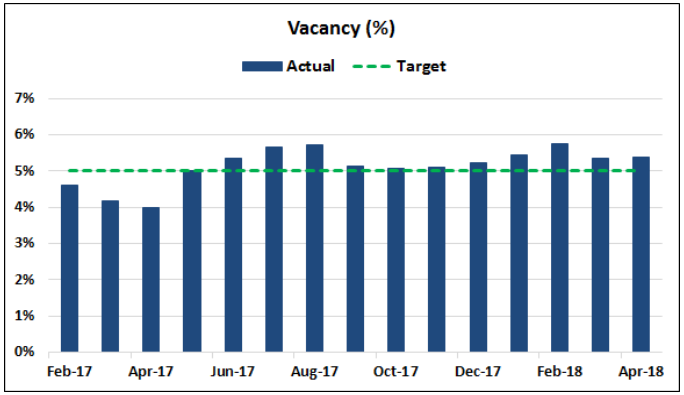
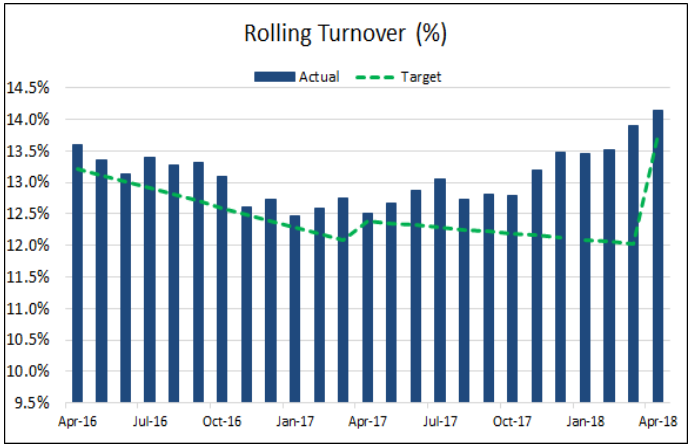
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. The 62 day GP referred standard is the one referred to here</td>
<td>March performance of 87.3%, exceeding the national target and recovery trajectory. April forecast to meet the recovery trajectory of 81% (drop from March due to impact of earlier cancellations, and patient choice over Easter).</td>
<td>Percentage of patients treated within 62 days of GP Referral<br> 
</td>
<td>Performance has been affected by winter pressures and the heavy snowfall on two occasions in March. There are some ongoing capacity issues as a result which are still being resolved. Avoiding cancellations and recovering rapidly from those that do occur remains the key action for the Trust, as well as continuing to develop a virtual PTL (waiting list meeting) with other providers to reduce late referrals. The recent fire in Bristol Haematology and Oncology Centre will also impact on performance, the extent of this is not yet known, but every possible action is being taken to mitigate this and avoid incurring delays. See Actions 10A-10J 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 96.8% at end of April, which is below the 99% national standard. The number of over 6-week waiters at month-end is:
<table>
<tr><th>Diagnostic test</th><th>Mar</th><th>Apr</th></tr>
<tr><td>MRI</td><td>44</td><td>65</td></tr>
<tr><td>Sleep</td><td>41</td><td>24</td></tr>
<tr><td>Endoscopies</td><td>7</td><td>6</td></tr>
<tr><td>CT</td><td>13</td><td>21</td></tr>
<tr><td>Echo</td><td>15</td><td>109</td></tr>
<tr><td>Ultrasound</td><td>21</td><td>82</td></tr>
<tr><td>Other</td><td>1</td><td>4</td></tr>
<tr><td>TOTAL</td><td>142</td><td>311</td></tr>
<tr><td>Percentage</td><td>98.5%</td><td>96.8%</td></tr>
</table></td>
<td>Percentage of patients waiting under 6 weeks at month-end<br> 
</td>
<td>The standard was missed at end of April. Maximum allowed breaches to achieve 99% was 97, against actual number of breaches of 311.<br><br>See Actions 11A-11D in Improvement Plans section for more details.</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 the 12 months to September 2017 was 100.4 The Trust remains in the "as expected" category for SHMI.<br>This statistical approach estimates that there were 7 more actual deaths than expected deaths in the 12-month period up to September 2017. | **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 a given 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 March, 21 out of 23 patients (91.3%) 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 finished at 93.2%. | **Percentage of patients with a Door to Balloon Time < 90 minutes by month**<br>  | There was a slight dip in performance in March but year to date remains above the 90% target and performance recovered to above 90% from August. |

<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 April 2018 performance was 63.6% (21/ 33 patients) for overall Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 72.7% (24/33 patients).<br><br>
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number of patients</th></tr>
<tr><td>Other urgent trauma patients prioritised.</td><td>5</td></tr>
<tr><td>Patient required medical optimisation before proceeding to surgery.</td><td>4</td></tr>
</table>
</td>
<td>Percentage of patients with fracture neck of femur who met best practice tariff<br> 
</td>
<td>One patient also did not receive any ortho-geriatrician review due to annual leave, and clinician having to provide cover for 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 in the Improvement Plans section).</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 April 2018 there were 800 outlier bed-days against a target of 814 outlier bed-days.<br><br>
<table>
<tr><th>Outlier bed-days</th><th>March</th></tr>
<tr><td>Medicine</td><td>380</td></tr>
<tr><td>Surgery</td><td>256</td></tr>
<tr><td>Specialised Services</td><td>126</td></tr>
<tr><td>Women's & Children's</td><td>12</td></tr>
<tr><td>Diagnostics and Therapies</td><td>26</td></tr>
<tr><td>Total</td><td>800</td></tr>
</table>
<br>Note: 64 outlier beddays were used on the two escalation wards in April: A512 and A414 Queen’s Day Unit.</td>
<td>Number of days patients spent outlying from their specialty wards<br> 
</td>
<td>The quarter one target has been set at 814 and this was met in month following an improvement in flow across the BRI.</td>
</tr>
</table>

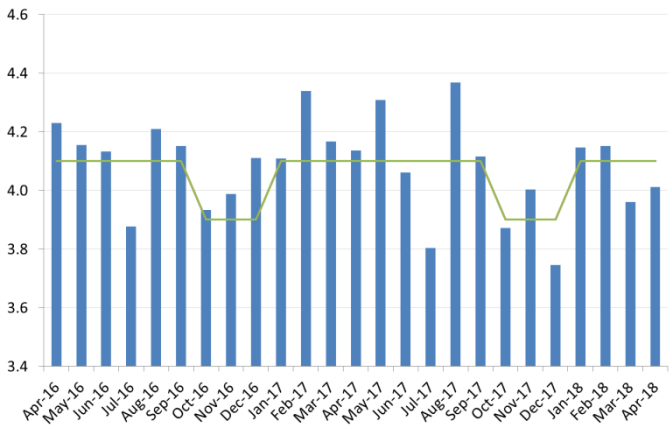
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Agency usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2015/16. The red threshold is 10% over the monthly target.</td>
<td>Agency usage reduced by 17.9 FTE, with the largest reduction seen in Trust Services. Significant reductions also seen in Medicine and Surgery, where usage reduced by 35.7% and 28.6%, respectively. Usage in Nursing & Midwifery has reduced this month, falling by 21.5% (16.8 FTE).
<table>
<tr><th>April 2018</th><th>FTE</th><th>Actual %</th><th>KPI</th></tr>
<tr><td>UH Bristol</td><td>76.3</td><td>0.9%</td><td>1.0%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>4.3</td><td>0.4%</td><td>1.1%</td></tr>
<tr><td>Medicine</td><td>21.7</td><td>1.7%</td><td>2.0%</td></tr>
<tr><td>Specialised Services</td><td>8.7</td><td>0.9%</td><td>0.9%</td></tr>
<tr><td>Surgery</td><td>10.6</td><td>0.6%</td><td>0.9%</td></tr>
<tr><td>Women’s & Children’s</td><td>24.2</td><td>1.2%</td><td>0.7%</td></tr>
<tr><td>Trust Services</td><td>1.9</td><td>0.2%</td><td>0.3%</td></tr>
<tr><td>Facilities & Estates</td><td>4.9</td><td>0.7%</td><td>0.4%</td></tr>
</table>
</td>
<td>Agency usage as a percentage of total staffing by month.<br> 
</td>
<td>See section 14 in the Improvement Plans section for more details.</td>
</tr>
<tr>
<td>Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2015/16. The red threshold is 0.5% over the monthly target. *</td>
<td>Sickness absence reduced from 3.9% to 3.5%, with reductions in all Divisions. The largest staff group reduction was seen in Unregistered Nursing. Stress/Anxiety continues to be the cause for the most of amount of sickness, although days lost has reduced by 9.8% compared with last month.
<table>
<tr><th>April 2018</th><th>Actual</th><th>KPI</th></tr>
<tr><td>UH Bristol</td><td>3.5%</td><td>3.6%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>2.7%</td><td>3.0%</td></tr>
<tr><td>Medicine</td><td>4.4%</td><td>3.5%</td></tr>
<tr><td>Specialised Services</td><td>2.5%</td><td>3.3%</td></tr>
<tr><td>Surgery</td><td>3.4%</td><td>3.6%</td></tr>
<tr><td>Women's & Children's</td><td>4.0%</td><td>3.6%</td></tr>
<tr><td>Trust Services</td><td>2.3%</td><td>2.9%</td></tr>
<tr><td>Facilities & Estates</td><td>5.3%</td><td>6.2%</td></tr>
</table>
</td>
<td>Sickness absence as a percentage of full time equivalents by month<br> 

<br>Please note: Sickness data is refreshed retrospectively to capture late data entry, and to ensure the data is consistent with the Trust’s final submission for national publication.</td>
<td>See section 15 in the Improvement Plans section for more details.</td>
</tr>
</table>

| Description | Current Performance | Trend | Comments |
|---|---|---|---|
| **Vacancies** - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%. | Overall vacancies remained static at 5.4%. Nursing vacancies increased by 3.7 FTE in month to 214.6 (6.7%). The largest reduction across the bed-holding divisions was in Women's & Children's, where it was down by 20.0% (6.6 FTE) compared with last month. | **Vacancies rate by month**   | See section 16 in the Improvement Plans section for more details. |
| **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 12.0% by the end of 2017/18. The red threshold is 10% above monthly trajectory**.** | Turnover increased to 14.2% from 13.9% last month, with increases across all divisions except Diagnostics & Therapies and Trust Services. The largest increase in staff group was seen in Registered Nursing (1.1 percentage points), followed by Estates & Ancillary, where turnover rose by 0.8 percentage points. | **Staff turnover rate by month**   | See section 17 in the Improvement Plans section for more details. |

| April 2018 | Actual | KPI |
|---|---|---|
| **UH Bristol** | **5.4%** | **5.0%** |
| Diagnostics & Therapies | 6.6% | 5.0% |
| Medicine | 6.4% | 5.0% |
| Specialised Services | 7.3% | 5.0% |
| Surgery | 6.1% | 5.0% |
| Women's & Children's | -0.1% | 5.0% |
| Trust Services | 6.2% | 5.0% |
| Facilities & Estates | 10.5% | 5.0% |

| April 2018 | Actual | KPI |
|---|---|---|
| **UH Bristol** | **14.2%** | **13.8%** |
| Diagnostics & Therapies | 11.3% | 11.5% |
| Medicine | 14.8% | 14.4% |
| Specialised Services | 16.1% | 15.3% |
| Surgery | 13.6% | 12.7% |
| Women's & Children's | 11.8% | 11.7% |
| Trust Services | 16.4% | 16.4% |
| Facilities & Estates | 19.2% | 18.3% |

<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 April the average length of stay for inpatients was 4.01 days, which is just below the RED threshold of 4.10 days.<br>Number of patients in hospital at month-end with a “long” Length of Stay is below:
<table>
<tr><th></th><th>Feb-18</th><th>Mar-18</th><th>Apr-18</th></tr>
<tr><td>7+ Days</td><td>381</td><td>366</td><td>357</td></tr>
<tr><td>14+ Days</td><td>252</td><td>238</td><td>234</td></tr>
<tr><td>21+ Days</td><td>174</td><td>161</td><td>164</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 77 as at end of April.</td>
</tr>
</table>

## Improvement Plans

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| **SAFE – Deteriorating Patient, National Early Warning Scores (NEWS) Acted Upon** | | | | |
| 1A | | | | |
| **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 |
| **SAFE – Essential Training** | | | | |
| 3A | • April 2018 compliance for mandatory/statutory training is 89%. This figure reflects the new focus on the 11 'Core Skills' of the nationally-recognised Core Skills Training Framework (CSTF).<br>• Alignment with the South West Streamlining/MaST (Mandatory and Statutory) 2018 Programme continues, with an aim to streamline corporate induction by August 2018. | 31 August 2018 | Divisional Performance Review meetings<br>Oversight of training compliance by the Education Board and SLT | The Streamlining/MaST focus also lends to a methodical analysis of any Core Skills programmes that have yet to achieve their individual 90% compliance target.<br>In May, the first to be examined for improvements to provision (and resulting compliance) is *Moving and Handling,* which is currently at 82% compliance. |
| **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 | Current complaints training is being reviewed to incorporate learning from exchange visit with Sheffield Teaching Trust. | March 2018 | Improvement under development | Achieve and maintain a green RAG rating for this indicator. |
| 5B | The Trust has established a new complaints review panel as a pilot in 2017. | Panels have taken place in Medicine and Diagnostics and Therapies and Surgery. | Evidence that the panel is in place and learning identified and shared with Divisions | Achieve and maintain a green RAG rating for this indicator |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| **CARING – Cancelled Operations** | | | | |
| 6A | Continued focus on recruitment and retention of staff to enable all adult BRI Critical Care beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited and in post.<br>Division working in planes to keep open the 21st bed as consistently as possible. | Ongoing<br><br>Ongoing | Monthly Divisional Review Meetings; | Sustained reduction in critical care related cancellations in 2017/18.<br><br>As above. |
| 6B | Specialty specific actions to reduce the likelihood of cancellations. | Ongoing | Monthly review of plan with Deputy Chief Operating Officer | As above. |
| **CARING – Hospital Cancelled Outpatient Appointments** | | | | |
| 7A | Explore option of increasing required notice of annual leave from six to eight weeks to reduce the number of cancelled clinics | Agreed in principle. Process of how to communicate this out and enact it being worked through | Workforce and Organisational Delivery group | Discussed and supported at March meeting, Director of People to work through process |
| 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")<br><br>Detailed plan to stop paper referrals on 4th June. |
| 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. | Outpatient Steering Group | Linked in to eRS plan. Outpatients Operating Model developed which clearly identifies levels of responsibility and action between divisions, corporate team and IM&T |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 7D | 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 monitored through Outpatient Steering Group | Outpatient Steering Group | Ongoing work with divisions to identify specialities to support the reduction in follow-up work at Clinical Commissioning Group (CCG) level. |
| 7E | 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 outpatient team to support the divisions to do re-build. | Outpatient Steering Group | Recruitment underway |
| 7F | On the 14th August clinic cancellation codes were 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 | Re-audit after change to consultant leave |
| **RESPONSIVE – A&E 4 Hour Wait** | | | | |
| 8A | Refreshed Urgent Care Steering Group (UCSG) Improvement plan for the BRI. It focusses 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. 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 achieve trajectory for 18-19 against revised urgent care improvement plan |
| 8B | Increased support from NHS Improvement's Emergency Care Improvement Programme (ECIP) has commenced; focussing on support Integrated Discharge work and implementing trusted assessor | Ongoing | Progress tracked through Urgent Care Steering Group | |

| 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 longest waiting patients through new weekly Performance meeting.<br><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 at the RTT weekly performance meeting. Routine weekly 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. | For April 2018 we plan to deliver compliance of the 92% standard, which will be updated as we progress across the winter pressure period. |
| 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 the detail of the 9 remaining 52 week waiters who exercised their right to patient choice. | Achieve zero 52 week waiters by End of December 2017 excluding those patients who have decided to take a dates beyond that time line (patient choice) |
| 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 | Complete | Fortnightly meetings between Divisions and Associate Director of Performance, and Access Improvement Manager | RTT weekly performance meeting have been implemented. |
| 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 | |
| 9E | Chronological booking report to be developed to challenge inefficient booking practices for outpatients and elective procedures. | Complete | Sign-off of report by Chief Operating Officer completed | |
| 9F | Implementation of chronological booking report. | Ongoing | 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. | Incorporate into the weekly performance meetings as of 20th December 2017 |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 9G | Dental administrative management improvement plan to be developed. | Complete | Signed-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. | Complete | 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. | Complete | 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 2019 | As above | As above |
| 10D | Undertake necessary work for Trust to become lead provider for adult dermatology in Taunton. | End March 2019 | 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. | Complete | As above | As above |
| 10G | Reduce delays in the colorectal pathway due to capacity and pathway management issues. | Complete | As above | As above |
| 10H | Reduce delays for radiological diagnostics, in particular CT colonography, head and neck ultrasound. | End November 2017 (completed) | As above | As above |
| 10I | Work with partners to reduce late referrals. | Ongoing | As above | As above |
| 10J | Resolve capacity shortfall in gynaecology following staff sickness. | End October 2017 (resolved) | As above (resolved) | As above (achieved as planned) |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| **RESPONSIVE – Diagnostic Waits** | | | | |
| 11A | Corporate PTL (Patient Tracking List) weekly meeting established with Divisions. Divisions will review weekly, with central Performance team, the Referral to Treatment (RTT) and Diagnostic waiting lists. It will review by sub-speciality and cover performance monitoring, target setting and forecasting | Commenced December 2017 | Delivery of 99% performance beyond June 2018 | Delivery of 99% performance beyond June 2018 |
| 11B | A Trust-wide Patient Tracking List (PTL) has been developed to give a single data set for this area of performance; rather than relying on local spreadsheets. Sign-off and validation is being delivered through Divisional Analysts, working closely with operational leads. | From mid-May 2018 | Weekly PTL Meeting | Delivery of sustainable performance |
| 11C | Specialised Services to implement a Recovery Plan to significantly reduce Cardiac Echos waiting 6+ weeks | From May 2018 | Weekly PTL Meeting | Delivery of sustainable performance for the service |
| 11D | Ultrasound recruiting 1 new sonographer, to start in July, with extra agency cover to help with the backlog in the interim | New staff starts July | Weekly PTL Meeting | Delivery of sustainable performance for the service |
| **EFFECTIVE – Fracture Neck of Femur** | | | | |
| 12A | Consultant orthogeriatric capacity – there are currently vacancies within the Care of the Elderly service that is impacting on the capacity of the orthogeriatric service. The Division of Medicine has two Care of the Elderly consultant vacancies. One of is being covered by two clinical fellows. It is not anticipated that this will provide any additional capacity for the orthogeriatric service. A new consultant has now started. This will release the two consultants from Care of the Elderly sessions; 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. | A middle grade orthogeriatrician commenced in January 2018 to provide improvements in cover. | Improvements in dashboard measures.<br>Update reports to the Quality and Outcomes Committee | Improvements in time to review by an orthogeriatrician. |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 12B | Establishment of an elderly trauma and hip fracture ward – to cohort frail elderly trauma patients on A604, to facilitate direct admission from ED to ring-fenced fractured neck of femurs beds. There also needs to be sufficient capacity to maintain ring fenced hip fracture admission beds and medical ward capacity for step-down patients. The Deputy Chief Operating Officer will lead the planning process to establish the elderly trauma and hip fracture ward. The proposed ward staffing enhancements at the weekend has been included in the Division of Surgery 2018/19 OPP as a cost pressure. | This is contingent upon amending care pathways and admission protocols. | Improvements in dashboard measures.<br>Update reports to the Quality and Outcomes Committee | Improvements to the quality and coordination of patient care. |
| 12C | Physiotherapy the day after surgery – to ensure that there is physiotherapy support available to the orthopaedic wards on Sundays<br>There are potential benefits associated with reduction in patient length of stay with earlier mobilisation. | The physio consultation has now ended and staff have been given contractual notice to allow us to rota them to work Sundays.<br>There will now be a three month lead time which will end in May 2018 | Improvements in dashboard measures.<br>Update reports to the Quality and Outcomes Committee | Improvements against the new quality standard measure of therapy review the day after surgery. |
| 12D | Time to surgery – to improve trauma throughput and to expedite the surgery of fractured neck of femur 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. | Automatic sending commenced on the 8th December and the plan is to review at the end of January.<br>An audit has been commenced to understand the number of patients on trauma board awaiting surgery in the hospital and at home. | Improvements against time to theatre standard |
| **EFFECTIVE – Outliers** | | | | |
| 13A | Ward processes to increase early utilisation of discharge lounge to facilitate patients from Acute Medical Unit getting into the correct speciality at point of first transfer. Ward required across other specialties to embed good board round practices and support criteria led discharge | Ongoing | Developing new reporting through Clinical Utilisation Review (CUR) | Linked to increased and timely use of discharge lounge plan |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| **EFFICIENT – Agency Usage** | | | | |
| 14A | **Effective rostering**:<br>"Health-roster" - implemented with KPIs in place. The new Safe Staffing module has now been 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 | Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings |
| 14B | **Controls and efficiency:**<br>• Trust agency rules continue to drive down high cost non-framework agency spend.<br>• Neutral Vendor contract for nurse agency supply is now imbedded across the BNSSG area, helping to support an improved achievement with the national agency price caps.<br>• Operating plan agency trajectories monitored by divisional reviews. | Ongoing<br><br>Ongoing<br><br>Monthly/ quarterly reviews | Nursing agency: oversight by Savings Board and Nursing Agency Controls Group.<br>Medical agency: oversight through the Medical Efficiencies Group | |
| 14C | **Enhancing bank provision:**<br>• Bank recruitment and marketing plans for all staff groups developed for 2018/19.<br>• Employee On-Line access (for Bank-only RNs, 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 rolled out on a phased approach commencing with children's nurses. | Ongoing<br><br>May 2018 | Performance against target for Bank recruitment is monitored by the Recruitment Sub Group | |
| **EFFICIENT – Staff Sickness** | | | | |
| 15A | **Supporting Attendance Policy**<br>A 6-month review of the Policy will be undertaken in September as agreed with Staff-Side. Skills training is also being developed for managers that will go beyond the basic training of applying the policy. | September 2018 | Oversight by Workforce and Organisational Development (OD) Board | Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings. Where |

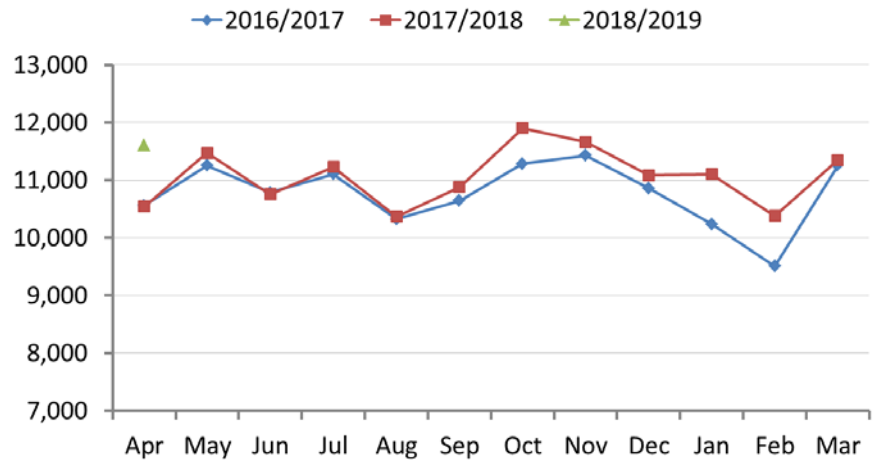
| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 15B | **Supporting Attendance Surgeries**<br>Ongoing to expedite individual cases. Monthly deep dives continue to support areas where exception reporting is required. | Ongoing | | divisions are above target an extensive deep dive into the data with a recovery plan |
| 15C | **Occupational Health**<br>Counselling appointments reduced from 18 to 10 days from point of enquiry. Triage service in place to offer signposts to sources of support within 48 hours of referral. | Ongoing | | |
| 15D | **Manual Handling:**<br>Two Safety Briefings disseminated; Digital Eye Strain and Safe Use of Portable Display Screen Devices, to support clinical staff with the new technology. | Date To Be Confirmed | Oversight by Workforce and Organisational Development (OD) Board via the Workplace Wellbeing Sub Group<br>Workplace Wellbeing Steering Group (quarterly) /CQUIN Assurance Group | |
| 15E | **Psychological wellbeing:**<br>Job Description for post of Workplace Mental Wellbeing Lead drafted. Awaiting stakeholder feedback prior to advertising.<br><br>"Building Resilience to Stress" one-off workshop courtesy of Spiral Wellbeing planned to coincide with May's Mental Health Awareness Week. | May 2018<br><br>May 2018 | | |
| 15F | **General wellbeing**<br>Dedicated "Money Advice" on HR Web updated following research evidence illustrating how poor financial wellbeing impacts on psychological wellbeing, high stress and anxiety levels, and lower levels of good health. | May 2018 | | |
| **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><br>Divisional Performance |

| Number | Action | Timescale | Assurance | Improvement trajectory |
|---|---|---|---|---|
| 16B | **Marketing and advertising:**<br>• Recruitment and marketing plans for Nursing, Radiology and Domestic Assistants have been in place for 2017/18 and are now being developed for 2018/19.<br>• New series of nurse recruitment videos under design and development. Launch scheduled for National Nursing Day in May 2018.<br>• Following a mixed review a final "Head-hunter" agency approach is being tested across 3 hard to recruit to areas in the children's hospital. Alternative options are being reviewed as contingency.<br>• Recruitment approaches to Care of the Elderly are being reviewed to target an increasingly hard to fill area across both the nursing and medical workforce | Ongoing<br><br>May 2018<br><br>From February 2018<br><br>May 2018 | Divisional Performance & Operational Review Meetings and the Recruitment Sub Group | against plan is monitored at monthly and quarterly Divisional Performance review meetings |
| **EFFICIENT – Turnover** | | | | |
| 17A | Improving Staff Experience plans remain in place and local initiatives are undertaken in hot spot areas as identified in the staff survey. Corporate programs of work include;<br>• E-Appraisal<br>• Leadership behaviours<br>• Dignity at work<br>• Staff recognition framework | Ongoing | Workforce and Organisational Development (OD) Group | Divisional performance is monitored monthly at Performance and Operational Reviews |
| 17B | Revised improving staff experience plans will be developed during May and June following on from the Trust's 'You said… We did' week | June 2018 | | |

## 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.

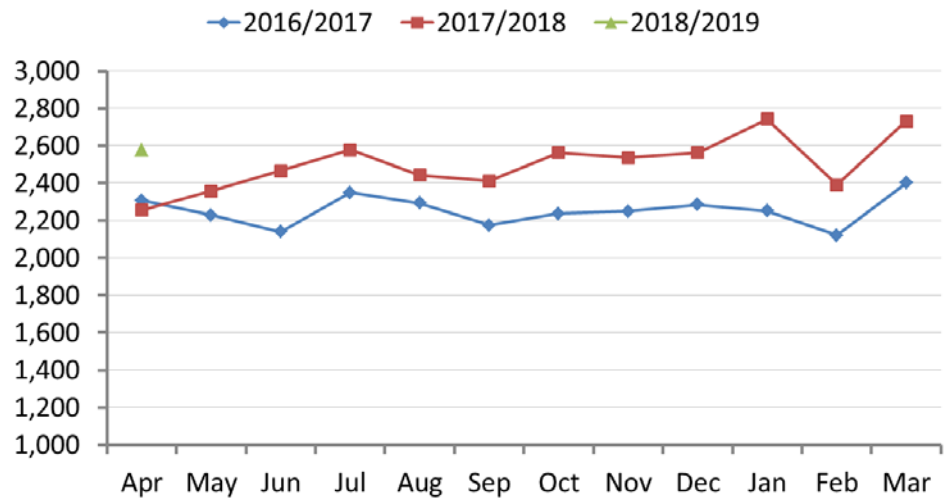
**Emergency Department (ED) attendances**



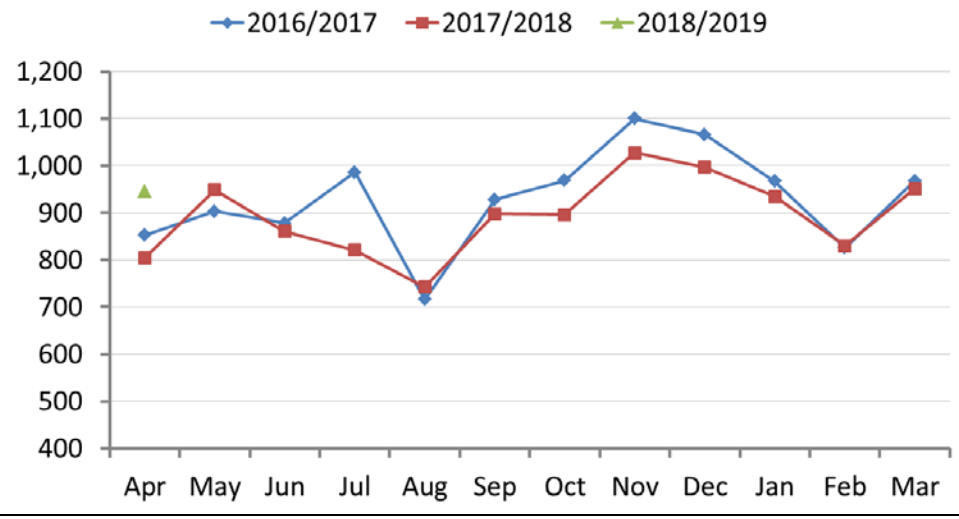

**Summary points:**

- Emergency Department attendances for April are above April levels in previous years,
- Total number of emergency admissions into the Bristol Royal Infirmary has remained consistently above levels in previous years.
- Elective admissions (Trust level) and New Outpatient attendances for April are above levels in previous Aprils.
- With only 1 month of the new year delivered, seasonal trends are not apparent yet.

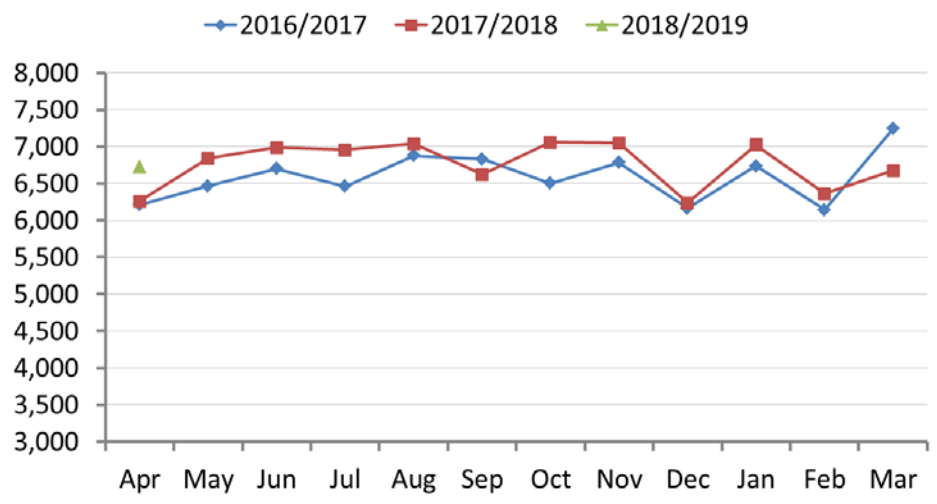
**Emergency Inpatient Activity (BRI Discharges)**



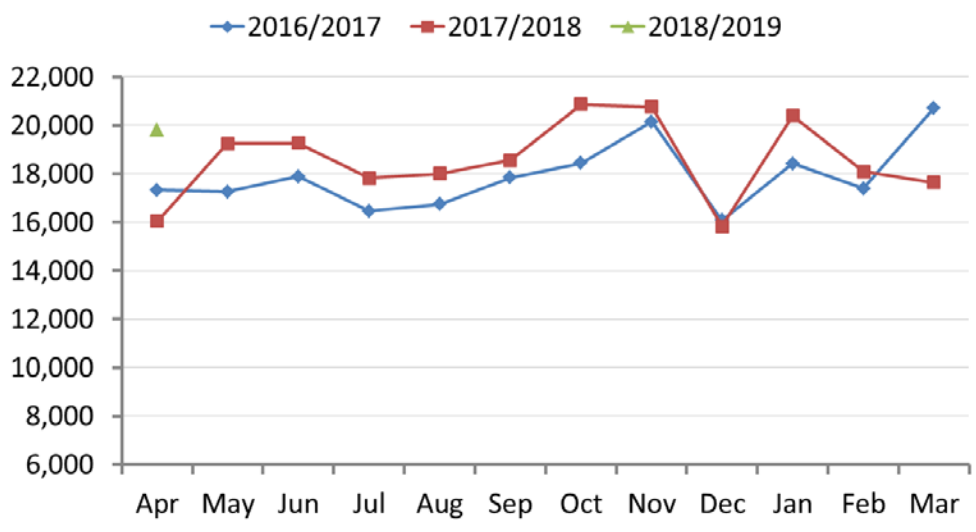

**Emergency Inpatient Activity (BCH Discharges)**



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



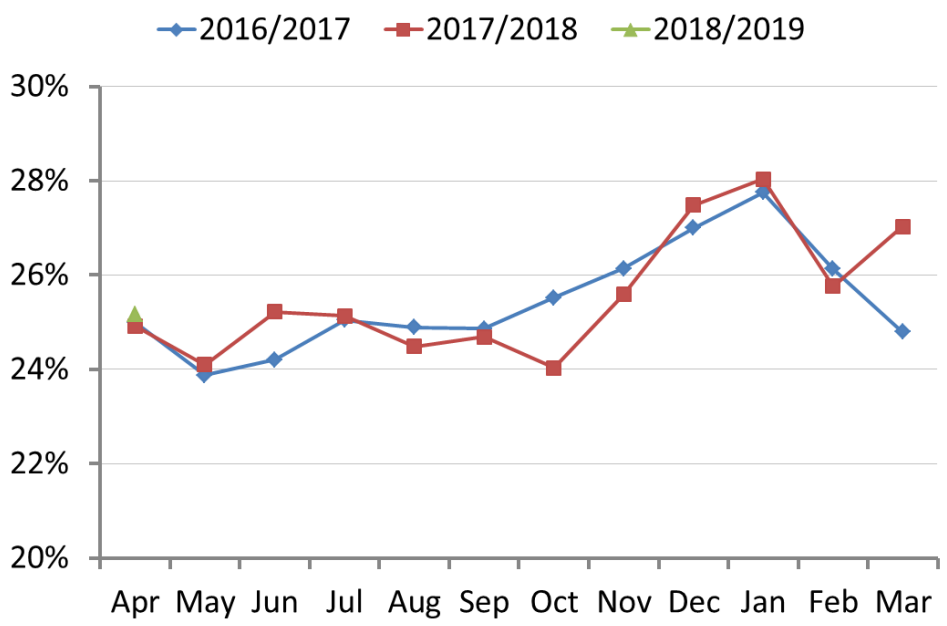

**New outpatient attendances**



## Assurance and Leading Indicators

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

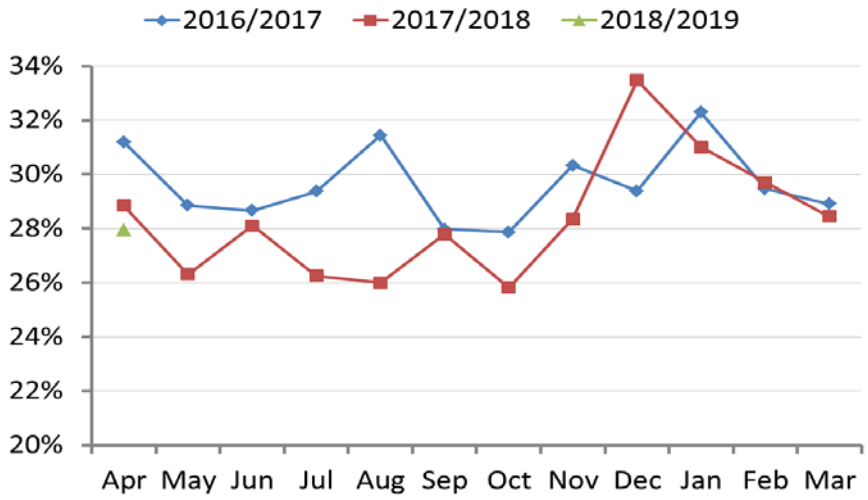
**Percentage ED attendances resulting in admission**



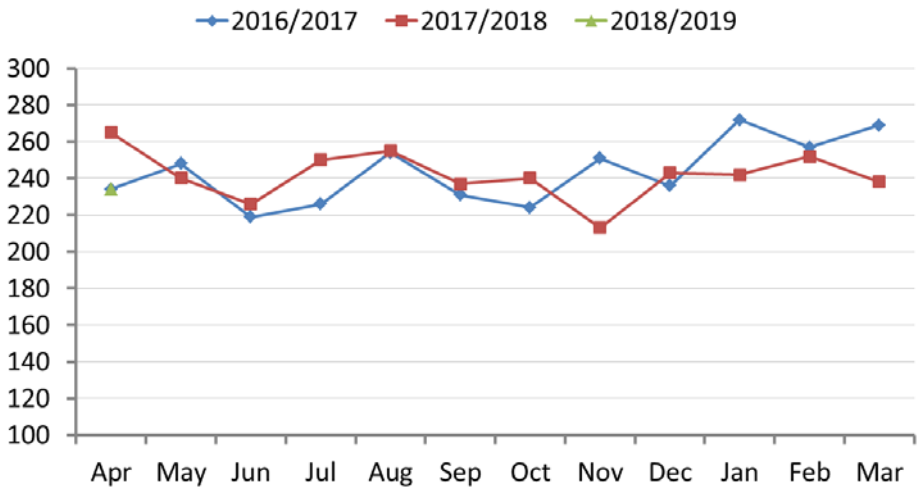

**Summary points:**

- The percentage of patients arriving in our Emergency Departments and converting to an admission remains consistent with previous years.
- Number of patients in hospital for 14+ days at month-end has remained around 240 at each month-end
- Number of Delayed Transfer of Care (DToC) patients fell in March (month-end position) but number of beddays consumed by DToC patients remained similar to previous months.
- Bristol Royal Infirmary (including the Heart Institute) bed occupancy remained fell just below 100% in April
- The number of patients referred by their GP with a suspected cancer (2-week waits) has remained above 2016/17 levels all year, except for March 2018.

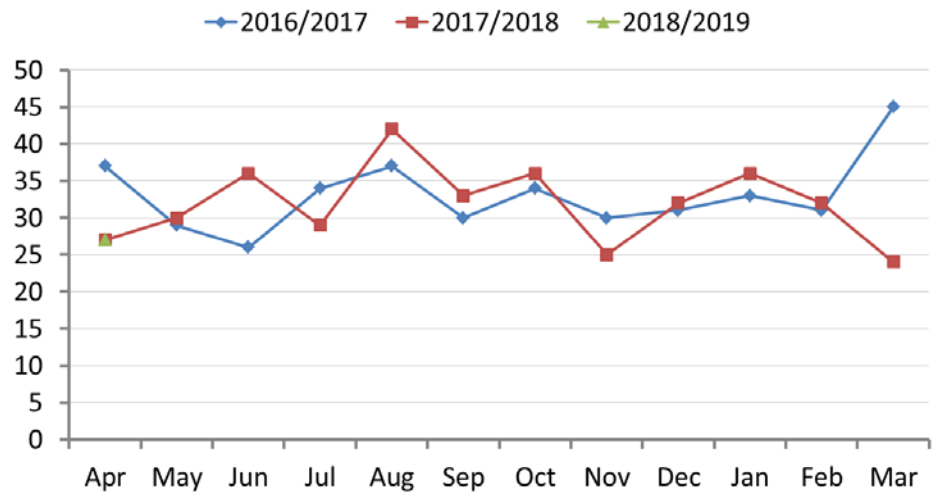
**Percentage of Emergency BRI spells patients aged 75 years and over**



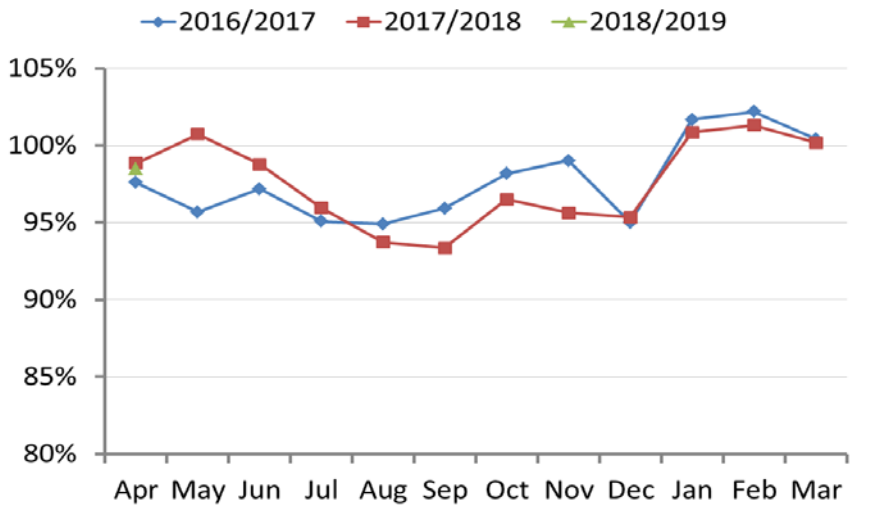

**Over 14 day stays , at month-end**



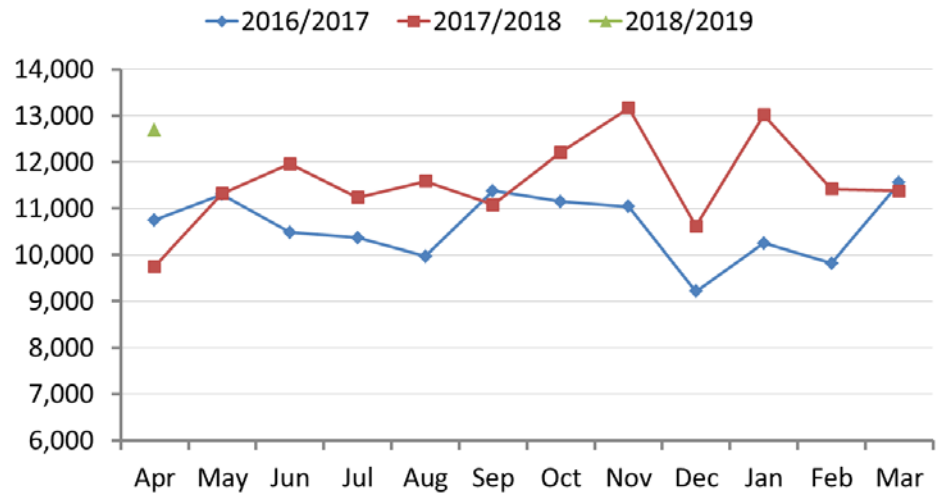
**Delayed Transfers of Care (Number of patients at month-end)**



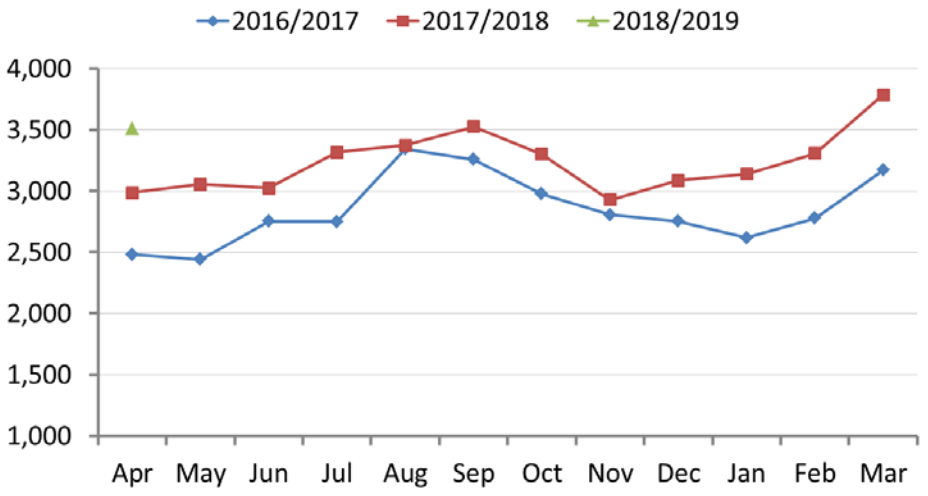

**BRI Bed Occupancy (Overnight)**



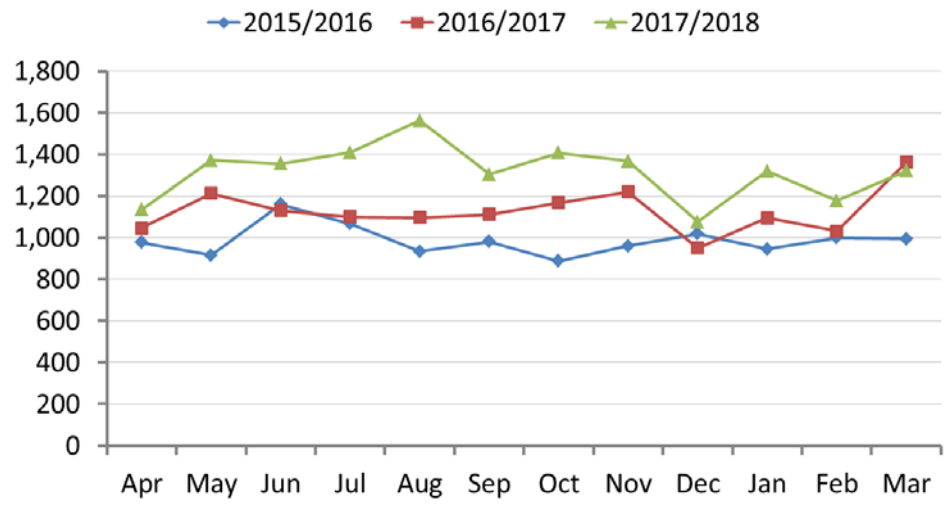

**Number of RTT pathways stopped (i.e. treatments)**



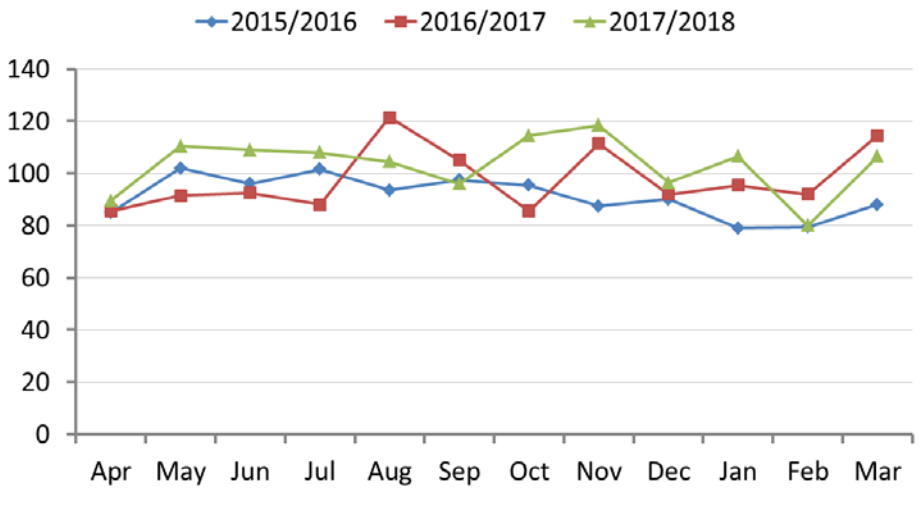

**Number of RTT pathways over 18 weeks**



**Cancer 2-week wait – urgent GP – referrals seen**




**Cancer 62-day GP referred treatments**



# Trust Scorecards

## SAFE, CARING & EFFECTIVE

| | | | Annual | | Monthly Totals | | | | | | | | | | | | Quarterly Totals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Topic | ID | Title | 17/18 | 18/19 YTD | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | 17/18 Q2 | 17/18 Q3 | 17/18 Q4 | 18/19 Q1 |
| **Patient Safety** | | | | | | | | | | | | | | | | | | | | |
| Infections | DA01 | MRSA Trust Apportioned Cases | 4 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 2 | 1 | 1 |
| | DA02 | MSSA Trust Apportioned Cases | 25 | 3 | 1 | 3 | 0 | 3 | 0 | 5 | 4 | 1 | 2 | 3 | 3 | 3 | 3 | 10 | 8 | 3 |
| | DA03 | CDiff Trust Apportioned Cases | 35 | 2 | 4 | 5 | 6 | 2 | 3 | 1 | 1 | 3 | 2 | 6 | 0 | 2 | 11 | 5 | 8 | 2 |
| C.Diff "Avoidables" | DA03B | CDiff Trust Apportioned Cases - Lapse in Care | - | - | 2 | 1 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 0 | 0 | 0 |
| | DA03D | CDiff Trust Apportioned Cases - Still Under Review | 12 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 3 | 2 | 6 | 0 | 2 | 0 | 4 | 8 | 2 |
| Infection Checklists | DB01 | Hand Hygiene Audit Compliance | 97.6% | 96.8% | 98.1% | 98.4% | 97.2% | 97.7% | 96.3% | 96.4% | 97.6% | 97.3% | 98.4% | 98.2% | 96.9% | 96.8% | 97% | 97.1% | 97.8% | 96.8% |
| | DB02 | Antibiotic Compliance | 86.4% | - | 89.6% | 87.4% | 87.8% | 81.3% | 84.4% | 85.1% | 89.1% | 85.4% | 85.2% | 89.6% | 85.3% | - | 84.3% | 86.4% | 86.6% | - |
| Cleanliness Monitoring | DC01 | Cleanliness Monitoring - Overall Score | - | - | 96% | 96% | 96% | 97% | 97% | 96% | 96% | 95% | 98% | 94% | 95% | 95% | - | - | - | - |
| | DC02 | Cleanliness Monitoring - Very High Risk Areas | - | - | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 96% | 97% | 98% | 97% | - | - | - | - |
| | DC03 | Cleanliness Monitoring - High Risk Areas | - | - | 96% | 97% | 97% | 97% | 97% | 96% | 97% | 96% | 93% | 96% | 96% | 96% | - | - | - | - |
| Serious Incidents | S02 | Number of Serious Incidents Reported | 57 | 3 | 7 | 6 | 5 | 3 | 9 | 2 | 4 | 4 | 6 | 2 | 7 | 3 | 17 | 10 | 15 | 3 |
| | S02a | Number of Confirmed Serious Incidents | 44 | - | 6 | 6 | 5 | 3 | 9 | 1 | 2 | 4 | 6 | - | - | - | 17 | 7 | 6 | - |
| | S02b | Number of Serious Incidents Still Open | 11 | 3 | - | - | - | - | - | 1 | 1 | 0 | 0 | 2 | 7 | 3 | - | 2 | 9 | 3 |
| | S03 | Serious Incidents Reported Within 48 Hours | 100% | 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 | 94.7% | 100% | 100% | 83.3% | 100% | 100% | 100% | 100% | 50% | 100% | 100% | 100% | 100% | 100% | 100% | 80% | 100% | 100% |
| | S04 | Serious Incident Investigations Completed Within Timescale | 96.1% | 100% | 75% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 80% | 100% | 100% | 100% | 100% | 100% | 92.3% | 100% |
| | S04a | Overdue Exec Commissioned Non-SI Investigations | 19 | 2 | 2 | 2 | 1 | 1 | 2 | 1 | 1 | 3 | 3 | 1 | 1 | 2 | 4 | 5 | 5 | 2 |
| Never Events | S01 | Total Never Events | 9 | 0 | 1 | 2 | 1 | 0 | 0 | 2 | 0 | 0 | 2 | 0 | 1 | 0 | 1 | 2 | 3 | 0 |
| Patient Safety Incidents | S06 | Number of Patient Safety Incidents Reported | 15656 | 1428 | 1315 | 1330 | 1288 | 1249 | 1229 | 1311 | 1332 | 1193 | 1347 | 1379 | 1480 | 1428 | 3766 | 3836 | 4206 | 1428 |
| | S06b | Patient Safety Incidents Per 1000 Beddays | 50.86 | 55.84 | 49.94 | 53.99 | 49.49 | 48.38 | 49.91 | 50.19 | 52.96 | 46.38 | 50.04 | 57.11 | 55.29 | 55.84 | 49.25 | 49.82 | 54.04 | 55.84 |
| | S07 | Number of Patient Safety Incidents - Severe Harm | 92 | 6 | 11 | 8 | 6 | 7 | 7 | 4 | 9 | 9 | 10 | 7 | 7 | 6 | 20 | 22 | 24 | 6 |
| Patient Falls | AB01 | Falls Per 1,000 Beddays | 4.59 | 3.79 | 3.91 | 4.91 | 4.53 | 4.76 | 5.04 | 4.48 | 3.78 | 4.51 | 4.61 | 4.68 | 5.04 | 3.79 | 4.77 | 4.26 | 4.78 | 3.79 |
| | AB06a | Total Number of Patient Falls Resulting in Harm | 25 | 2 | 3 | 4 | 0 | 0 | 3 | 2 | 2 | 5 | 2 | 0 | 2 | 2 | 3 | 9 | 4 | 2 |
| Pressure Ulcers Developed in the Trust | DE01 | Pressure Ulcers Per 1,000 Beddays | 0.162 | 0.156 | 0.076 | 0.203 | 0.154 | 0.155 | 0.203 | 0.038 | 0.159 | 0.156 | 0.372 | 0.207 | 0.149 | 0.156 | 0.17 | 0.117 | 0.244 | 0.156 |
| | DE02 | Pressure Ulcers - Grade 2 | 45 | 2 | 1 | 5 | 2 | 4 | 4 | 1 | 4 | 4 | 10 | 5 | 4 | 2 | 10 | 9 | 19 | 2 |
| | DE04A | Pressure Ulcers - Grade 3 or 4 | 5 | 2 | 1 | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 3 | 0 | 0 | 2 |
| Venous Thrombo-embolism (VTE) | N01 | Adult Inpatients who Received a VTE Risk Assessment | 98.4% | 98.1% | 98.9% | 98.7% | 98.8% | 97.4% | 98.3% | 98.4% | 98.2% | 98% | 98% | 98.3% | 98.3% | 98.1% | 98.2% | 98.2% | 98.2% | 98.1% |
| | N02 | Percentage of Adult Inpatients who Received Thrombo-prophylaxis | 95% | 93.8% | 97.6% | 97% | 97.4% | 94.9% | 92.3% | 97.1% | 94% | 92.3% | 91.4% | 94.4% | 97.1% | 93.8% | 94.7% | 94.5% | 94.1% | 93.8% |
| | N04 | Number of Hospital Associated VTEs | 42 | - | 3 | 5 | 4 | 2 | 3 | 6 | 1 | 4 | 9 | - | - | - | 9 | 11 | 9 | - |
| | N04A | Number of Potentially Avoidable Hospital Associated VTEs | 2 | - | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | - | - | - | 0 | 1 | 0 | - |
| | N04B | Number of Hospital Associated VTEs - Report Not Received To Date | 7 | - | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 3 | - | - | - | 0 | 4 | 3 | - |
| Nutrition | WB03 | Nutrition: 72 Hour Food Chart Review | 92.1% | - | 87.7% | 91.5% | 96.2% | 94.6% | 92.6% | 91% | 95.2% | 88.8% | 95% | 91% | 93.7% | - | 94.5% | 91.3% | 93% | - |
| Nutrition Audit | WB10 | Fully and Accurately Completed Screening within 24 Hours | 89.9% | - | - | 92.2% | - | - | 92% | - | - | 88.9% | - | - | 86.3% | - | 92% | 88.9% | 86.3% | - |
| Safety | Y01 | WHO Surgical Checklist Compliance | 99.7% | 99.9% | 99.7% | 99.8% | 99.8% | 99.8% | 99.9% | 99.8% | 99.2% | 99.8% | 100% | 99.8% | 99.6% | 99.9% | 99.8% | 99.6% | 99.8% | 99.9% |

## SAFE, CARING & EFFECTIVE (continued)

| | | | Annual | | Monthly Totals | | | | | | | | | | | | Quarterly Totals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Topic | ID | Title | 17/18 | 18/19 YTD | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | 17/18 Q2 | 17/18 Q3 | 17/18 Q4 | 18/19 Q1 |
| Medicines | WA01 | Medication Incidents Resulting in Harm | 0.55% | - | 0.44% | 0% | 1.35% | 0.51% | 0% | 1.97% | 0.47% | 0.5% | 0.49% | 0% | 0% | - | 0.64% | 0.97% | 0.15% | - |
| | WA03 | Non-Purposeful Omitted Doses of the Listed Critical Medication | 0.4% | 0.63% | 0.9% | 0.24% | 0.32% | 0.11% | 0.37% | 0.27% | 0.41% | 0% | 0.42% | 1.02% | 0.33% | 0.63% | 0.25% | 0.24% | 0.57% | 0.63% |
| Safety Thermometer | AK03 | Safety Thermometer - Harm Free Care | 97.9% | - | 97.3% | 97.9% | 97.7% | 96.9% | 97.7% | 97.5% | 98.8% | 98.3% | 98.8% | 98.2% | 98.2% | - | 97.4% | 98.2% | 98.4% | - |
| | AK04 | Safety Thermometer - No New Harms | 98.8% | - | 98.3% | 98.4% | 98.8% | 98.2% | 98.7% | 98.9% | 99.1% | 99% | 99.9% | 98.4% | 98.5% | - | 98.6% | 99% | 98.9% | - |
| Deteriorating Patient | AR03 | National Early Warning Scores (NEWS) Acted Upon | 96% | - | 96% | 93% | 100% | 97% | 100% | 90% | 93% | 97% | 95% | 91% | 100% | - | 99% | 94% | 95% | - |
| Out of Hours | TD05 | Out of Hours Discharges (8pm-7am) | 8.7% | 10.2% | 7% | 6.7% | 8.4% | 10.9% | 9.7% | 9.1% | 9.4% | 9.1% | 8.7% | 8.2% | 9% | 10.2% | 9.7% | 9.2% | 8.6% | 10.2% |
| Timely Discharges | TD03 | Percentage of Patients With Timely Discharge (7am-12Noon) | 22.4% | 20.3% | 22.6% | 23.3% | 22.9% | 21.9% | 24% | 24.2% | 24% | 20.8% | 20.5% | 20.9% | 21.9% | 20.3% | 22.9% | 23% | 21.1% | 20.3% |
| | TD03D | Number of Patients With Timely Discharge (7am-12Noon) | 11138 | 834 | 950 | 944 | 962 | 909 | 983 | 1024 | 1010 | 863 | 867 | 814 | 945 | 834 | 2854 | 2897 | 2626 | 834 |
| Staffing Levels | RP01 | Staffing Fill Rate - Combined | 98.9% | 99% | 102.6% | 102.4% | 98.6% | 98% | 97.1% | 97.5% | 98.1% | 97.2% | 98.5% | 96.8% | 95.7% | 99% | 97.9% | 97.6% | 97% | 99% |
| **Clinical Effectiveness** | | | | | | | | | | | | | | | | | | | | |
| Mortality | X04 | Summary Hospital Mortality Indicator (SHMI) - National Data | 99 | - | - | 97.6 | - | - | 100.4 | - | - | - | - | - | - | - | 100.4 | - | - | - |
| | X02 | Hospital Standardised Mortality Ratio (HSMR) | 92.5 | - | 79.7 | 94.2 | 82.2 | 76.4 | 105.8 | 98.8 | 101.3 | 107.5 | 95.5 | 84.7 | - | - | 87.4 | 103 | 90.8 | - |
| Readmissions | C01 | Emergency Readmissions Percentage | 3.28% | - | 3.77% | 3.57% | 3.33% | 3.51% | 3.76% | 3.43% | 3.66% | 3.57% | 3.5% | 2.17% | 2.07% | - | 3.53% | 3.55% | 2.6% | - |
| Sepsis (Inpatients) | AG02a | Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients) | 51.1% | - | 37.5% | 38.1% | 21.1% | 50% | 16.7% | 20% | 33.3% | 46.7% | 64.7% | 87% | 83.3% | - | 29.7% | 35.5% | 79.7% | - |
| | AG03a | Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatient | 77.4% | - | 50% | 62.5% | 66.7% | 100% | 100% | 50% | - | 100% | - | 100% | 50% | - | 88.9% | 75% | 75% | - |
| | AG04a | Sepsis Patients Percentage with a 72 Hour Review (Inpatients) | 93.3% | - | 100% | 100% | 100% | 100% | 100% | 66.7% | - | 75% | - | 100% | - | - | 100% | 71.4% | 100% | - |
| Sepsis (Emergency Department) | AG02b | Percentage of Patients Meeting Criteria Screened for Sepsis (ED) | 83.4% | - | 76.9% | 78.3% | 93.8% | 95% | 92.9% | 91.7% | 76% | 68% | 86% | 88% | 88% | - | 94% | 75.8% | 87.3% | - |
| | AG03b | Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (ED) | 85.5% | - | 63.6% | 77.8% | 84.6% | 88.2% | 100% | 94.1% | 86.2% | 91.7% | 90% | 74.2% | 94.1% | - | 90% | 90% | 83.8% | - |
| | AG04b | Sepsis Patients Percentage with a 72 Hour Review (ED) | 93.1% | - | 100% | 100% | 100% | 100% | 100% | 88.9% | 84% | 90.9% | 100% | 82.1% | 100% | - | 100% | 87.7% | 91.2% | - |
| Maternity | G01 | Percentage of Low Weight Babies | 2.5% | 3.2% | 3.5% | 0.5% | 1.5% | 3.3% | 3.4% | 0.9% | 2% | 4.6% | 3.2% | 2% | 3.2% | 3.2% | 2.7% | 2.5% | 2.8% | 3.2% |
| | G01A | Number of Low Weight Babies | 119 | 12 | 15 | 2 | 6 | 13 | 13 | 4 | 7 | 18 | 13 | 7 | 12 | 12 | 32 | 29 | 32 | 12 |
| Fracture Neck of Femur | U02 | Fracture Neck of Femur Patients Treated Within 36 Hours | 64.2% | 72.7% | 86.7% | 85% | 67.6% | 84.6% | 85.7% | 61.9% | 34.6% | 48.5% | 57.7% | 45.5% | 60% | 72.7% | 77.8% | 47.5% | 54.8% | 72.7% |
| | U03 | Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours | 61.6% | 97% | 73.3% | 60% | 47.1% | 34.6% | 33.3% | 47.6% | 69.2% | 60.6% | 69.2% | 77.3% | 92% | 97% | 39.5% | 60% | 79.5% | 97% |
| | U04 | Fracture Neck of Femur Patients Achieving Best Practice Tariff | 34.8% | 63.6% | 60% | 50% | 29.4% | 26.9% | 28.6% | 28.6% | 26.9% | 24.2% | 38.5% | 22.7% | 48% | 63.6% | 28.4% | 26.3% | 37% | 63.6% |
| | U05 | Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours) | - | - | 38 | 37.1 | 45.9 | 43.8 | 37.1 | 53.3 | 75.9 | 58.6 | 64.8 | 65.7 | 81.5 | 48.7 | - | - | - | - |
| Stroke Care | O01 | Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour | 62.6% | - | 51.4% | 66.7% | 72.9% | 61.9% | 70% | 60.7% | 55.6% | 60.9% | 57.9% | 61.3% | 54.3% | - | 68.5% | 59.1% | 57.4% | - |
| | O02 | Stroke Care: Percentage Spending 90%+ Time On Stroke Unit | 85.8% | - | 80.6% | 81.8% | 83.3% | 81% | 92.5% | 96.4% | 83.3% | 87% | 84.2% | 93.5% | 80.4% | - | 85.4% | 88.2% | 85.2% | - |
| | O03 | High Risk TIA Patients Starting Treatment Within 24 Hours | 54.6% | 15.4% | 50% | 77.3% | 27.3% | 66.7% | 75% | 66.7% | 70% | 42.9% | 50% | 36.4% | 20% | 15.4% | 55.9% | 62.9% | 34.2% | 15.4% |
| Dementia | AC01 | Dementia - FAIR Question 1 - Case Finding Applied | 89.3% | 87.3% | 88.3% | 89.4% | 91.1% | 89.9% | 93.5% | 87.7% | 93.7% | 87.9% | 90.7% | 87.3% | 86.3% | 87.3% | 91.5% | 89.6% | 88.2% | 87.3% |
| | AC02 | Dementia - FAIR Question 2 - Appropriately Assessed | 96.2% | 95% | 97.6% | 100% | 100% | 97.7% | 97.9% | 94% | 97.4% | 100% | 93.8% | 86% | 96.5% | 95% | 98.6% | 96.9% | 92% | 95% |
| | AC03 | Dementia - FAIR Question 3 - Referred for Follow Up | 92.9% | - | 66.7% | 100% | 100% | 100% | 100% | 75% | 100% | 100% | 100% | - | 100% | - | 100% | 87.5% | 100% | - |
| | AC04 | Percentage of Dementia Carers Feeling Supported | 60% | - | - | 100% | - | - | - | - | - | - | 100% | - | 33.3% | - | - | - | 50% | - |
| Outliers | J05 | Ward Outliers - Beddays Spent Outlying. | 9098 | 800 | 807 | 485 | 448 | 537 | 424 | 558 | 499 | 730 | 1411 | 1120 | 1377 | 800 | 1409 | 1787 | 3908 | 800 |

## SAFE, CARING & EFFECTIVE (continued)

| Topic | ID | Title | Annual | | Monthly Totals | | | | | | | | | | | | Quarterly Totals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 17/18 | 18/19 YTD | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | 17/18 Q2 | 17/18 Q3 | 17/18 Q4 | 18/19 Q1 |
| **Patient Experience** | | | | | | | | | | | | | | | | | | | | |
| Monthly Patient Surveys | P01d | Patient Survey - Patient Experience Tracker Score | - | - | 91 | 93 | 92 | 92 | 92 | 91 | 92 | 90 | 91 | 92 | 92 | 91 | 92 | 91 | 92 | 91 |
| | P01g | Patient Survey - Kindness and Understanding | - | - | 95 | 97 | 96 | 94 | 96 | 95 | 95 | 95 | 96 | 95 | 95 | 97 | 95 | 95 | 96 | 97 |
| | P01h | Patient Survey - Outpatient Tracker Score | - | - | 88 | 87 | 90 | 87 | 90 | 90 | 91 | 89 | 90 | 88 | 88 | 88 | 89 | 90 | 89 | 88 |
| Friends and Family Test Coverage | P03a | Friends and Family Test Inpatient Coverage | 35% | 40.7% | 38.3% | 37.4% | 35.8% | 35.1% | 35.3% | 39.5% | 33.2% | 28.4% | 34.9% | 36.2% | 30.3% | 40.7% | 35.4% | 33.9% | 33.7% | 40.7% |
| | P03b | Friends and Family Test ED Coverage | 17.3% | 17.3% | 16.1% | 20.9% | 17.2% | 18.5% | 18.3% | 17.9% | 17.9% | 14.6% | 17.8% | 17.4% | 15.2% | 17.3% | 18% | 16.9% | 16.8% | 17.3% |
| | P03c | Friends and Family Test MAT Coverage | 19% | 19.8% | 17.1% | 21.8% | 20% | 17.3% | 18.3% | 21% | 12.4% | 23.1% | 17.5% | 17.7% | 18.2% | 19.8% | 18.6% | 19% | 17.8% | 19.8% |
| Friends and Family Test Score | P04a | Friends and Family Test Score - Inpatients | 97.7% | 97.4% | 96.9% | 97.7% | 97.7% | 97.5% | 97.7% | 97.9% | 98.1% | 97.8% | 97.7% | 98.3% | 97.8% | 97.4% | 97.6% | 98% | 97.9% | 97.4% |
| | P04b | Friends and Family Test Score - ED | 81% | 80.1% | 77% | 84.4% | 77.4% | 81.9% | 83.5% | 83.3% | 80.3% | 77% | 81.8% | 83.2% | 77.7% | 80.1% | 81% | 80.5% | 81% | 80.1% |
| | P04c | Friends and Family Test Score - Maternity | 96.9% | 94.6% | 95.8% | 96.9% | 94.9% | 96.5% | 99.2% | 98% | 97.5% | 98.1% | 94.6% | 96.8% | 97.1% | 94.6% | 96.8% | 98% | 96.1% | 94.6% |
| Patient Complaints | T01 | Number of Patient Complaints | 1815 | 149 | 158 | 150 | 146 | 146 | 138 | 154 | 155 | 98 | 143 | 121 | 159 | 149 | 430 | 407 | 423 | 149 |
| | T01a | Patient Complaints as a Proportion of Activity | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| | T03a | Complaints Responded To Within Trust Timeframe | 83% | 83.1% | 83% | 80.4% | 82% | 87.3% | 78.7% | 85.1% | 87.1% | 83.8% | 87.8% | 82.8% | 77.9% | 83.1% | 83% | 85.4% | 82.3% | 83.1% |
| | T03b | Complaints Responded To Within Divisional Timeframe | 83.8% | 85.9% | 83% | 78.3% | 90% | 81.7% | 86.9% | 83.6% | 90% | 82.4% | 91.8% | 82.8% | 77.9% | 85.9% | 85.7% | 85.4% | 83.4% | 85.9% |
| | T04c | Percentage of Responses where Complainant is Dissatisfied | 10.4% | - | 17.02% | 21.74% | 8% | 11.27% | 9.84% | 10.45% | 7.14% | 2.94% | 8.16% | 8.62% | - | - | 9.89% | 6.83% | 8.41% | - |
| Cancelled Operations | F01q | Percentage of Last Minute Cancelled Operations (Quality Objective) | 1.19% | 1.36% | 1.02% | 0.81% | 0.81% | 0.91% | 0.91% | 1% | 1.26% | 1.2% | 1.53% | 1.63% | 1.92% | 1.36% | 0.88% | 1.15% | 1.69% | 1.36% |
| | F01a | Number of Last Minute Cancelled Operations | 919 | 84 | 67 | 54 | 54 | 61 | 58 | 68 | 85 | 71 | 102 | 98 | 121 | 84 | 173 | 224 | 321 | 84 |

## RESPONSIVE

| | | | Annual Target | | Annual | | Monthly Totals | | | | | | | | | | | | Quarterly Totals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Topic | ID | Title | Green | Red | 17/18 | 18/19 YTD | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | 17/18 Q2 | 17/18 Q3 | 17/18 Q4 | 18/19 Q1 |
| Referral to Treatment (RTT) Performance | A03 | Referral To Treatment Ongoing Pathways Under 18 Weeks | 92% | 92% | 89.6% | 88.2% | 91.1% | 91% | 90.2% | 89.9% | 89.4% | 90% | 88.9% | 88.3% | 88.1% | 88.4% | 87% | 88.2% | 89.8% | 89.1% | 87.8% | 88.2% |
| | A03a | Referral To Treatment Number of Ongoing Pathways Over 18 Weeks | - | - | - | - | 3056 | 3023 | 3317 | 3372 | 3524 | 3300 | 2927 | 3085 | 3138 | 3308 | 3783 | 3510 | - | - | - | - |
| Referral to Treatment (RTT) Wait Times | A06 | Referral To Treatment Ongoing Pathways Over 52 Weeks | 0 | 1 | 209 | 15 | 11 | 46 | 30 | 32 | 19 | 10 | 13 | 9 | 1 | 15 | 18 | 15 | 81 | 32 | 34 | 15 |
| | A07 | Referral To Treatment Ongoing Pathways 40+ Weeks | - | - | - | - | 165 | 193 | 198 | 240 | 182 | 155 | 136 | 158 | 160 | 148 | 164 | 154 | - | - | - | - |
| Cancer (2 Week Wait) | E01a | Cancer - Urgent Referrals Seen In Under 2 Weeks | 93% | 93% | 94.3% | - | 95.6% | 94.3% | 93.4% | 93.2% | 94.6% | 94.6% | 95.5% | 94.8% | 92.2% | 96.9% | 92.1% | - | 93.7% | 95% | 93.6% | - |
| | E01c | Cancer - Urgent Referrals Stretch Target | 80% | 80% | 58.9% | - | 55.4% | 62.2% | 63.6% | 62.4% | 59.9% | 64.2% | 57.6% | 54.4% | 58.8% | 59.6% | 54.6% | - | 62% | 59% | 57.7% | - |
| Cancer (31 Day) | E02a | Cancer - 31 Day Diagnosis To Treatment (First Treatments) | 96% | 96% | 95.8% | - | 96.6% | 95.1% | 97% | 97.9% | 96.9% | 95.4% | 98.1% | 96.7% | 92.9% | 95.1% | 95.8% | - | 97.3% | 96.7% | 94.5% | - |
| | E02b | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug) | 98% | 98% | 98.6% | - | 97.5% | 98.7% | 98.6% | 98.6% | 98.5% | 99.3% | 98.7% | 98.9% | 98.7% | 98.6% | 98.4% | - | 98.6% | 99% | 98.6% | - |
| | E02c | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) | 94% | 94% | 92% | - | 92.2% | 93.2% | 91.7% | 96.3% | 94.7% | 95.7% | 96.8% | 93% | 96.6% | 87.7% | 79.5% | - | 94.3% | 95.2% | 89% | - |
| | E02d | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) | 94% | 94% | 96.3% | - | 96.6% | 95.9% | 93.9% | 97.3% | 98% | 96.4% | 96.1% | 97.6% | 92.9% | 97.9% | 96.4% | - | 96.3% | 96.6% | 95.6% | - |
| Cancer (62 Day) | E03a | Cancer 62 Day Referral To Treatment (Urgent GP Referral) | 85% | 85% | 81.7% | - | 77.8% | 81.7% | 75% | 85.2% | 80.2% | 84.3% | 88.6% | 82.9% | 78.4% | 81.3% | 87.3% | - | 80.1% | 85.4% | 82.4% | - |
| | E03b | Cancer 62 Day Referral To Treatment (Screenings) | 90% | 90% | 74.8% | - | 44.4% | 100% | 87.5% | 100% | 100% | 66.7% | 76.5% | 71.4% | 100% | 58.3% | 28.6% | - | 96.3% | 73.3% | 61.5% | - |
| | E03c | Cancer 62 Day Referral To Treatment (Upgrades) | 85% | 85% | 85.4% | - | 77.7% | 87% | 78.6% | 84.8% | 90.7% | 74.7% | 88.5% | 85.7% | 88.7% | 83.9% | 90.9% | - | 84.6% | 83% | 87.9% | - |
| | E03f | Cancer Urgent GP Referrals - Numbers Treated after Day 103 | - | - | 47.5 | - | 5 | 5 | 8 | 5 | 3 | 3.5 | 2 | 4.5 | 3 | 2.5 | 2 | - | 16 | 10 | 7.5 | - |
| Cancelled Operations | F01 | Last Minute Cancelled Operations - Percentage of Admissions | 0.8% | 0.8% | 1.19% | 1.36% | 1.02% | 0.81% | 0.81% | 0.91% | 0.91% | 1% | 1.26% | 1.2% | 1.53% | 1.63% | 1.92% | 1.36% | 0.88% | 1.15% | 1.69% | 1.36% |
| | F01a | Number of Last Minute Cancelled Operations | - | - | 919 | 84 | 67 | 54 | 54 | 61 | 58 | 68 | 85 | 71 | 102 | 98 | 121 | 84 | 173 | 224 | 321 | 84 |
| | F02 | Cancelled Operations Re-admitted Within 28 Days | 95% | 85% | 94.2% | 89.3% | 92.5% | 97% | 100% | 98.1% | 95.1% | 96.6% | 91.2% | 94.1% | 88.7% | 94.1% | 92.9% | 89.3% | 97.6% | 93.8% | 92.3% | 89.3% |
| Admissions Cancelled Day Before | F07 | Percentage of Admissions Cancelled Day Before | - | - | 1.61% | 2.26% | 1.86% | 1.82% | 1.2% | 0.88% | 1.73% | 1.28% | 1.9% | 1.38% | 1.81% | 2.08% | 2.31% | 2.26% | 1.26% | 1.53% | 2.06% | 2.26% |
| | F07a | Number of Admissions Cancelled Day Before | - | - | 1244 | 140 | 122 | 121 | 80 | 59 | 110 | 87 | 128 | 82 | 121 | 125 | 146 | 140 | 249 | 297 | 392 | 140 |
| Primary PCI | H02 | Primary PCI - 150 Minutes Call to Balloon Time | 90% | 70% | 76.1% | - | 78.1% | 77.5% | 75% | 80.6% | 84.8% | 73.8% | 77.4% | 63.8% | 80.9% | 71.1% | 65.2% | - | 80.2% | 70.8% | 74.1% | - |
| | H03a | Primary PCI - 90 Minutes Door to Balloon Time | 90% | 90% | 93.2% | - | 93.8% | 90% | 87.5% | 94.4% | 97% | 92.9% | 93.5% | 93.6% | 95.7% | 97.4% | 91.3% | - | 93.1% | 93.3% | 95.4% | - |
| Diagnostic Waits | A05 | Diagnostics 6 Week Wait (15 Key Tests) | 99% | 99% | 98.29% | 96.8% | 98.8% | 98.58% | 98.52% | 97.61% | 97.7% | 98.19% | 98.28% | 97.62% | 97.81% | 99.19% | 98.51% | 96.8% | 97.94% | 98.03% | 98.53% | 96.8% |
| Outpatients | R03 | Outpatient Hospital Cancellation Rate | 9.7% | 11.7% | 10.7% | 9.7% | 10.8% | 11% | 11.2% | 11% | 10.5% | 9.9% | 9.7% | 10.1% | 9.4% | 11.1% | 11.6% | 9.7% | 10.9% | 9.9% | 10.6% | 9.7% |
| | R05 | Outpatient DNA Rate | 5% | 10% | 7.2% | 6.4% | 7.2% | 7.5% | 7.4% | 7.2% | 7.4% | 7.1% | 7.1% | 7.6% | 6.8% | 6.4% | 7.3% | 6.4% | 7.4% | 7.2% | 6.8% | 6.4% |
| Outpatient Ratio | R01 | Follow-Up To New Ratio | 2.03 | 2.03 | 2.19 | 2.06 | 2.25 | 2.23 | 2.25 | 2.26 | 2.16 | 2.1 | 2.15 | 2.2 | 2.22 | 2.17 | 2.1 | 2.06 | 2.22 | 2.15 | 2.16 | 2.06 |
| ERS | BC01 | ERS - Available Slot Issues Percentage | - | - | 20.7% | - | 24% | 21.7% | 18.8% | 16.8% | 15.8% | 20.2% | 22.3% | 20.8% | 20.8% | 22.6% | - | - | 17.1% | 21.1% | 21.6% | - |

## RESPONSIVE (continued)

| Topic | ID | Title | Annual Target Green | Annual Target Red | Annual 17/18 | Annual 18/19 YTD | Monthly Totals May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | Quarterly Totals 17/18 Q2 | 17/18 Q3 | 17/18 Q4 | 18/19 Q1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Delayed Discharges | Q01A | Acute Delayed Transfers of Care - Patients | - | - | 279 | 22 | 24 | 30 | 18 | 31 | 22 | 26 | 17 | 23 | 27 | 23 | 19 | 22 | 71 | 66 | 69 | 22 |
| | Q02A | Non-Acute Delayed Transfers of Care - Patients | - | - | 103 | 5 | 6 | 6 | 11 | 11 | 11 | 10 | 8 | 9 | 9 | 9 | 5 | 5 | 33 | 27 | 23 | 5 |
| | Q01B | Acute Delayed Transfers of Care - Beddays | - | - | 8466 | 576 | 604 | 577 | 745 | 647 | 757 | 774 | 854 | 606 | 836 | 715 | 696 | 576 | 2149 | 2234 | 2247 | 576 |
| | Q02B | Non-Acute Delayed Transfers of Care - Beddays | - | - | 3106 | 291 | 145 | 259 | 278 | 374 | 243 | 315 | 273 | 255 | 272 | 182 | 204 | 291 | 895 | 843 | 658 | 291 |
| Green To Go List | AQ06A | Green To Go List - Number of Patients (Acute) | - | - | - | - | 42 | 43 | 46 | 51 | 36 | 46 | 44 | 47 | 53 | 54 | 52 | 59 | - | - | - | - |
| | AQ06B | Green To Go List - Number of Patients (Non Acute) | - | - | - | - | 13 | 11 | 15 | 17 | 22 | 22 | 11 | 13 | 15 | 26 | 17 | 18 | - | - | - | - |
| | AQ07A | Green To Go List - Beddays (Acute) | - | - | - | - | 1371 | 1403 | 1430 | 1580 | 1502 | 1461 | 1555 | 1532 | 1757 | 1652 | 1989 | 1832 | - | - | - | - |
| | AQ07B | Green To Go List - Beddays (Non-Acute) | - | - | - | - | 383 | 419 | 401 | 572 | 515 | 671 | 451 | 479 | 593 | 453 | 501 | 614 | - | - | - | - |
| Length of Stay | J03 | Average Length of Stay (Spell) | - | - | 4.05 | 4.01 | 4.31 | 4.06 | 3.8 | 4.37 | 4.12 | 3.87 | 4 | 3.74 | 4.15 | 4.15 | 3.96 | 4.01 | 4.09 | 3.87 | 4.08 | 4.01 |
| | J04D | Percentage Length of Stay 14+ Days | - | - | 6.8% | 6.5% | 7.8% | 6.7% | 6.2% | 7% | 6.8% | 6.8% | 6.9% | 6% | 6.6% | 6.9% | 7.1% | 6.5% | 6.7% | 6.5% | 6.9% | 6.5% |
| 14 Day LOS Patients | C07 | Number of 14+ Day Length of Stay Patients at Month End | - | - | - | - | 240 | 226 | 250 | 255 | 237 | 240 | 213 | 243 | 242 | 252 | 238 | 234 | - | - | - | - |
| AMU | J35 | Percentage of Cardiac AMU Wardstays | - | - | 4.2% | 7% | 3.9% | 5.2% | 4.2% | 4.3% | 4.2% | 4.9% | 6.4% | 5.6% | 2.5% | 4.2% | 3.4% | 7% | 4.2% | 5.6% | 3.3% | 7% |
| | J35A | Percentage of Cardiac AMU Wardstays Under 24 Hours | - | - | 47% | 31% | 61.3% | 37.2% | 39.5% | 50% | 32.4% | 44.2% | 60% | 38.8% | 61.9% | 61.3% | 29.6% | 31% | 40.9% | 48.3% | 50.6% | 31% |
| **Emergency Department Indicators** | | | | | | | | | | | | | | | | | | | | | | |
| ED - Time In Department | B01 | ED Total Time in Department - Under 4 Hours | 95% | 95% | 86.48% | 83.95% | 84.21% | 87.89% | 90.53% | 91.26% | 90.84% | 90.06% | 90.33% | 85.33% | 82.69% | 83.2% | 78.89% | 83.95% | 90.87% | 88.64% | 81.54% | 83.95% |
| | *This is measured against the national standard of 95%* | | | | | | | | | | | | | | | | | | | | | |
| ED - Time in Department (Differentials) | BB14 | ED Total Time in Department - Under 4 Hours (STP) | - | - | 86.48% | 83.95% | 84.21% | 87.89% | 90.53% | 91.26% | 90.84% | 90.06% | 90.33% | 85.33% | 82.69% | 83.2% | 78.89% | 83.95% | 90.87% | 88.64% | 81.54% | 83.95% |
| | BB07 | BRI ED - Percentage Within 4 Hours | - | - | 78.35% | 73.92% | 73.76% | 79.01% | 85.11% | 86.82% | 86.53% | 84.11% | 88.22% | 77.24% | 71.39% | 73.24% | 65.06% | 73.92% | 86.14% | 83.2% | 69.78% | 73.92% |
| | BB03 | BCH ED - Percentage Within 4 Hours | - | - | 94.89% | 94.45% | 94.05% | 97.14% | 96.62% | 96.35% | 94.99% | 96.34% | 91.54% | 92.56% | 93.91% | 94.5% | 95.08% | 94.45% | 95.97% | 93.42% | 94.49% | 94.45% |
| | BB04 | BEH ED - Percentage Within 4 Hours | 99.5% | 99.5% | 96.26% | 94.4% | 96.57% | 97.9% | 96.58% | 97.04% | 96.58% | 97.43% | 94.21% | 98.34% | 96.63% | 94.35% | 92.9% | 94.4% | 96.74% | 96.59% | 94.62% | 94.4% |
| | *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 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 3 | 0 | 0 | 0 | 0 | 5 | 3 | 0 |
| Time to Initial Assessment | B02c | ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH) | 95% | 95% | 97.9% | 96.8% | 96.3% | 98.3% | 98.5% | 99.3% | 97.8% | 98.8% | 98.6% | 98.2% | 97.6% | 96.5% | 96.3% | 96.8% | 98.5% | 98.5% | 96.8% | 96.8% |
| | B02b | ED Time to Initial Assessment - Data Completness | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Time to Start of Treatment | B03 | ED Time to Start of Treatment - Under 60 Minutes | 50% | 50% | 52.2% | 49.5% | 52.3% | 52.8% | 54% | 55.4% | 54.1% | 53.2% | 48.4% | 51% | 54.4% | 52.4% | 48% | 49.5% | 54.5% | 50.8% | 51.6% | 49.5% |
| | B03b | ED Time to Start of Treatment - Data Completeness | 95% | 95% | 97.4% | 96.5% | 97.2% | 97.1% | 97.4% | 97.3% | 97.5% | 97.1% | 97.8% | 98% | 98% | 97.6% | 96.5% | 96.5% | 97.4% | 97.6% | 97.4% | 96.5% |
| Others | B04 | ED Unplanned Re-attendance Rate | 5% | 5% | 2.8% | 3% | 2.6% | 2.7% | 2.7% | 1.9% | 2.3% | 2.9% | 3.3% | 3.3% | 3.1% | 2.9% | 2.9% | 3% | 2.3% | 3.2% | 3% | 3% |
| | B05 | ED Left Without Being Seen Rate | 5% | 5% | 1.9% | 1.4% | 2.6% | 2.5% | 2% | 2.1% | 3.7% | 1.1% | 1.1% | 1% | 1% | 1.1% | 1.5% | 1.4% | 2.6% | 1.1% | 1.2% | 1.4% |
| Ambulance Handovers | BA09 | Ambulance Handovers - Over 30 Minutes | - | - | 840 | 75 | 82 | 84 | 46 | 54 | 44 | 63 | 63 | 87 | 62 | 59 | 85 | 75 | 144 | 213 | 206 | 75 |
| Acute Medical Unit (AMU) | J35 | Percentage of Cardiac AMU Wardstays | - | - | 4.2% | 7% | 3.9% | 5.2% | 4.2% | 4.3% | 4.2% | 4.9% | 6.4% | 5.6% | 2.5% | 4.2% | 3.4% | 7% | 4.2% | 5.6% | 3.3% | 7% |
| | J35a | Percentage of Cardiac AMU Wardstays Under 24 Hours | - | - | 47% | 31% | 61.3% | 37.2% | 39.5% | 50% | 32.4% | 44.2% | 60% | 38.8% | 61.9% | 61.3% | 29.6% | 31% | 40.9% | 48.3% | 50.6% | 31% |

## EFFICIENT

| Topic | ID | Title | Monthly Totals | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
| Sickness | AF02 | Sickness Rate | 3.7% | 3.8% | 4.3% | 4.1% | 3.7% | 4.1% | 4.2% | 4% | 4.7% | 4.3% | 3.9% | 3.5% |
| | | *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 | 8479.3 | 8491.6 | 8499.7 | 8547.6 | 8557.9 | 8599.7 | 8665.5 | 8648.5 | 8679.5 | 8679.4 | 8677.6 | 8617.4 |
| | AF09A | Actual Staff FTE (Including Bank & Agency) | 8546.3 | 8584.7 | 8602.5 | 8641.4 | 8642 | 8665.1 | 8679 | 8602.9 | 8710.4 | 8676.8 | 8675.7 | 8562 |
| | AF13 | Percentage Over Funded Establishment | 0.8% | 1.1% | 1.2% | 1.1% | 1% | 0.8% | 0.2% | -0.5% | 0.4% | -0% | -0% | -0.6% |
| | | *Green is below 0.5%. Amber is 0.5% to below 1% and Red is 1% or above* | | | | | | | | | | | | |
| Bank Usage | AF04 | Workforce Bank Usage | 476.6 | 501.8 | 531 | 536.4 | 503.4 | 495.3 | 481.4 | 432.4 | 517.3 | 503.8 | 461.4 | 413.3 |
| | AF11A | Percentage Bank Usage | 5.58% | 5.85% | 6.17% | 6.21% | 5.83% | 5.72% | 5.55% | 5.03% | 5.94% | 5.81% | 5.32% | 4.83% |
| | | *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 | 94.1 | 123.4 | 130.6 | 125.3 | 102.9 | 90.4 | 70 | 59.6 | 91.1 | 95.5 | 94.2 | 76.3 |
| | AF11B | Percentage Agency Usage | 1.1% | 1.44% | 1.52% | 1.45% | 1.19% | 1.04% | 0.81% | 0.69% | 1.05% | 1.1% | 1.09% | 0.89% |
| | | *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) | 420.4 | 451 | 477.3 | 483.8 | 434.4 | 431.3 | 436.1 | 446.8 | 468 | 494.1 | 459.8 | 459.8 |
| | AF07 | Vacancy Rate (Vacancy FTE as Percent of Funded FTE) | 5% | 5.4% | 5.7% | 5.7% | 5.1% | 5.1% | 5.1% | 5.2% | 5.5% | 5.8% | 5.4% | 5.4% |
| | | *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) | 174 | 148 | 189 | 370 | 230 | 138 | 195 | 184 | 330 | 190 | 212 | 163 |
| | AF10 | Workforce Turnover Rate | 12.7% | 12.9% | 13.1% | 12.7% | 12.8% | 12.8% | 13.2% | 13.5% | 13.5% | 13.5% | 13.9% | 14.2% |
| | | *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) | 89% | 89% | 88% | 86% | 87% | 87% | 87% | 87% | 88% | 90% | 90% | - |
| | AF21b | Essential Training Compliance - Annual Training (Fire & IG) | - | - | - | - | - | - | - | - | - | - | - | - |
| | AF21f | Essential Training Compliance - Fire Safety | 84% | 84% | 86% | 87% | 87% | 87% | 87% | 87% | 88% | 88% | 88% | - |
| | AF21g | Essential Training Compliance - Information Governance | 75% | 75% | 80% | 82% | 82% | 82% | 82% | 82% | 84% | 85% | 84% | - |
| | AF21c | Essential Training Compliance - Induction | 98% | 98% | 98% | 98% | 98% | 98% | 97% | 97% | 98% | 98% | 98% | - |
| | AF21d | Essential Training Compliance - Resuscitation Training | 71% | 71% | 77% | 80% | 81% | 83% | 84% | 84% | 85% | 87% | 87% | - |
| | AF21e | Essential Training Compliance - Safeguarding Training | 90% | 90% | 89% | 87% | 87% | 87% | 87% | 87% | 89% | 90% | 89% | - |
| | | *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 APRIL 2018:**

**All Essential Training**

| | UH Bristol | Diagnostic & Therapies | Facilities & Estates | Medicine | Specialised Services | Surgery | Trust Services | Women's & Children's |
|---|---|---|---|---|---|---|---|---|
| Three Yearly | 90% | 92% | 90% | 90% | 91% | 90% | 91% | 88% |
| Annual Fire | 88% | 88% | 94% | 87% | 89% | 86% | 91% | 86% |
| Annual IG | 84% | 85% | 87% | 85% | 86% | 83% | 89% | 79% |
| Induction & Orientation | 98% | 99% | 99% | 98% | 98% | 98% | 98% | 98% |
| Medical & Dental Induction | 54% | 75% | N/A | 43% | 50% | 60% | N/A | 52% |
| Resuscitation | 87% | 87% | N/A | 87% | 88% | 90% | 81% | 85% |
| Safeguarding | 89% | 90% | 87% | 91% | 87% | 89% | 91% | 90% |

**Timeline of Trust Essential Training Compliance:**

| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| Compliance | 87% | 89% | 89% | 89% | 88% | 89% | 89% | 88% | 89% | 89% | 90% | 90% | 89% |

**Safeguarding Adults and Children**

| | UH Bristol | Diagnostics & Therapies | Facilities & Estates | Medicine | Specialised Services | Surgery | Trust Services | Women's & Children's |
|---|---|---|---|---|---|---|---|---|
| Safeguarding Adults L1 | 88% | 87% | 85% | 92% | 86% | 87% | 91% | 94% |
| Safeguarding Adults L2 | 90% | 92% | 83% | 91% | 89% | 91% | 86% | 89% |
| Safeguarding Adults L3 | 88% | 100% | N/A | 83% | 92% | 93% | 89% | 100% |
| Safeguarding Children L1 | 93% | 94% | 94% | 96% | 94% | 90% | 94% | N/A |
| Safeguarding Children L2 | 86% | 85% | 78% | 89% | 85% | 87% | 78% | 92% |

**Child Protection Level 3**

| | UH Bristol | Diagnostic & Therapies | Medicine | Specialised Services | Surgery | Trust Services | Women`s & Children`s |
|---|---|---|---|---|---|---|---|
| Core | 78% | 92% | 68% | 63% | 75% | 100% | 79% |
| Specialist | 82% | N/A | 100% | N/A | N/A | 100% | 82% |

# Appendix 3

## Access standards – further breakdown of figures

**A) 62-day GP standard** – performance against the 85% standard, the Sustainability and Transformation Partnership Trajectory, and the recovery trajectory

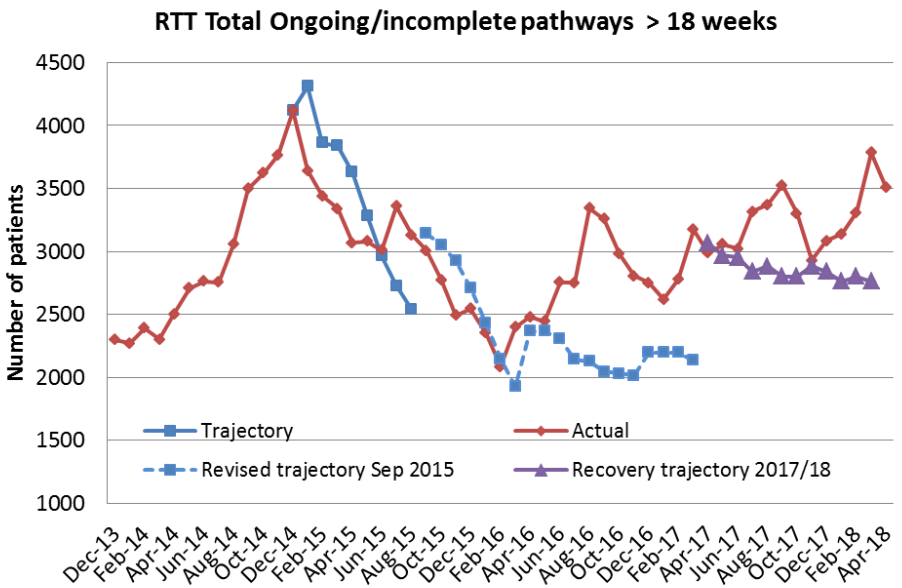
| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual 62-day GP performance | 76.7% | 78.0% | 81.7% | 75.0% | 85.2% | 80.2% | 84.1% | 88.4% | 83.0% | 78.0% | 81.3% | 87.3% |
| STP trajectory | 81.0% | 81.0% | 81.0% | 83.6% | 83.6% | 83.6% | 82.5% | 82.5% | 82.5% | 82.6% | 82.6% | 82.6% |
| Recovery trajectory | - | - | - | - | 81.0% | 80.0% | 80.5% | 79.0% | 80.6% | 81.4% | 81.6% | 85.0% |
| Quarter performance recovery trajectory | - | | | 79.0% | | | 80.0% | | | 82.5% | | |
| Quarter performance STF trajectory | 81.0% | | | 83.6% | | | 82.5% | | | 82.6% | | |
| Quarter performance actual | 78.8% | | | 80.1% | | | 85.4% | | | 82.4% | | |

## 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 February 2018**

| RTT Specialty | Ongoing Over 18 Weeks | Ongoing Pathways | Ongoing Performance |
|---|---|---|---|
| Cardiology | 396 | 2,059 | 80.8% |
| Cardiothoracic Surgery | 62 | 311 | 80.1% |
| Dermatology | 105 | 2,179 | 95.2% |
| E.N.T. | 101 | 2,082 | 95.1% |
| Gastroenterology | 14 | 686 | 98.0% |
| General Medicine | 0 | 8 | 100% |
| Geriatric Medicine | 0 | 66 | 100% |
| Gynaecology | 142 | 1,279 | 88.9% |
| Neurology | 158 | 487 | 67.6% |
| Ophthalmology | 509 | 4,089 | 87.6% |
| Oral Surgery | 247 | 2,594 | 90.5% |
| Other | 1,657 | 12,081 | 86.3% |
| Rheumatology | 26 | 505 | 94.9% |
| Thoracic Medicine | 8 | 565 | 98.6% |
| Trauma & Orthopaedics | 85 | 721 | 88.2% |
| **Grand Total** | **3,510** | **29,712** | **88.2%** |

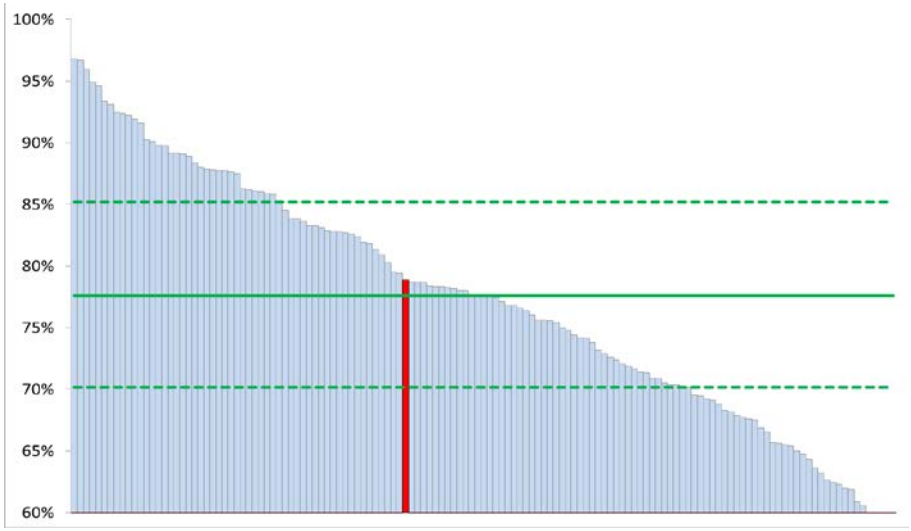



| | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|
| Non-admitted pathways > 18 weeks | 2107 | 2221 | 1962 | 1711 | 1783 | 1865 | 1956 | 2121 | 1960 |
| Admitted pathways > 18 weeks | 1265 | 1303 | 1338 | 1216 | 1302 | 1273 | 1352 | 1662 | 1550 |
| Total pathways > 18 weeks | 3372 | 3524 | 3300 | 2927 | 3085 | 3138 | 3308 | 3783 | 3510 |
| Actual % incomplete < 18 weeks | 89.9% | 89.4% | 90.0% | 89.5% | 88.3% | 88.1% | 88.4% | 87.0% | 88.2% |
| Recovery forecast | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 87% |

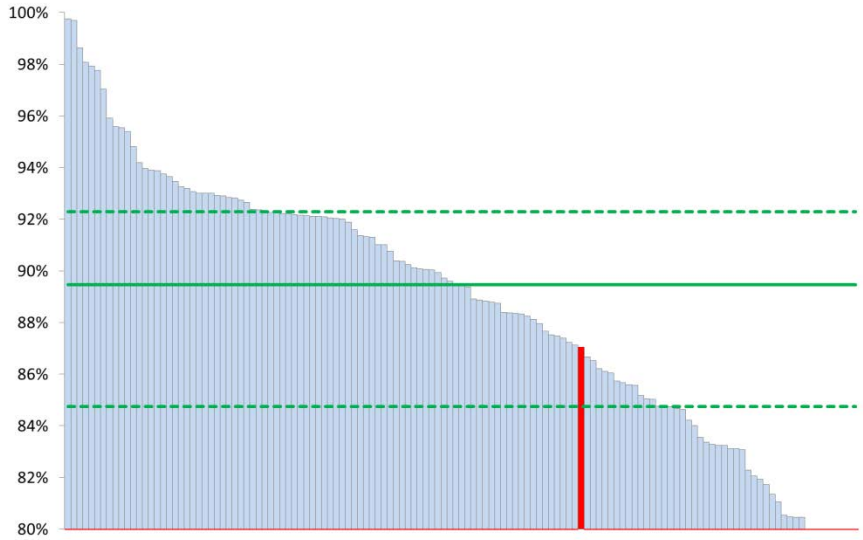
## Appendix 4

### Benchmarking Reports

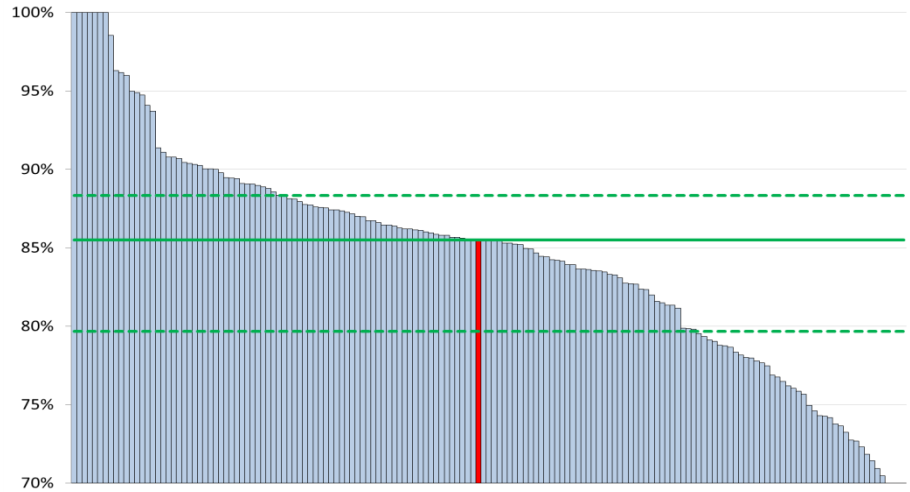
**A&E 4-hours – Type 1 Departments (Quarter 4 – Oct to Dec 2017)**




**Referral to Treatment Time Ongoing Pathways (March 2018)**




**62-day GP cancer (Quarter 3 2017/18)**

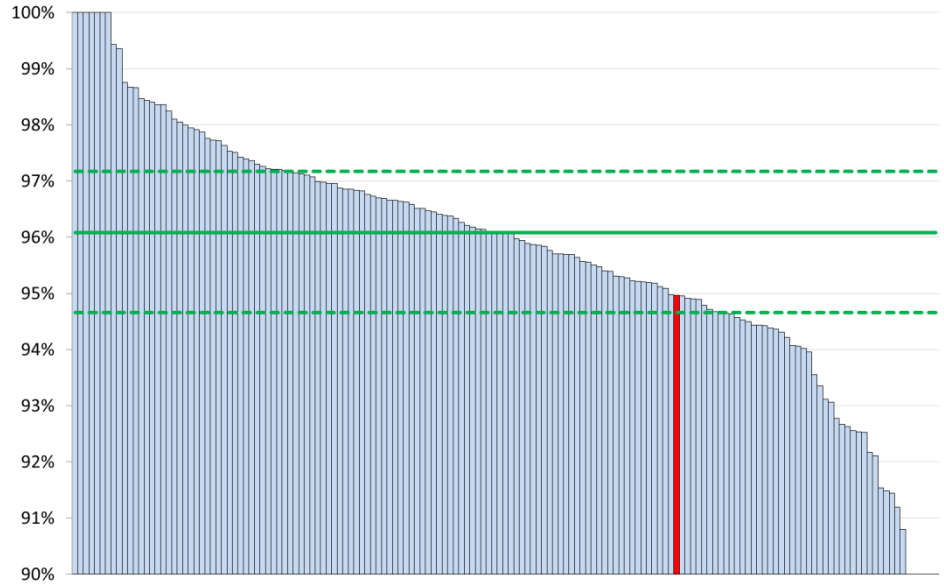



**6-week diagnostic (End of March 2018)**

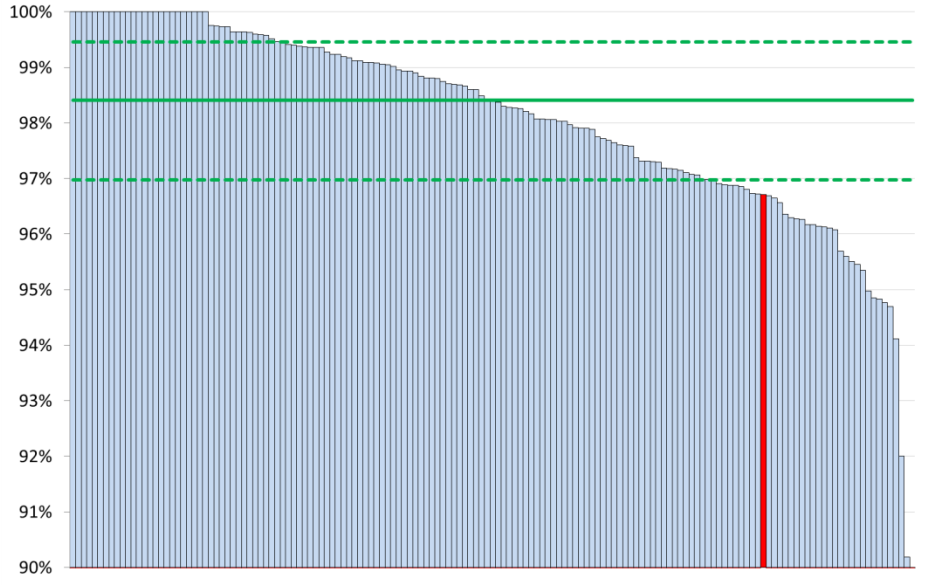
## Appendix 4 (continued)

### Benchmarking Reports

**Cancer 2-Week wait (Quarter 3 2017/18)**




**31-day first definitive cancer (Quarter 3 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 Public Trust Board. Meeting to be held on 24 May 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 9 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Thursday, 24 May 2018 |
| **Report Title** | **Learning from Deaths** | | |
| **Author** | Mark Callway, Acting Medical Director | | |
| **Executive Lead** | Mark Callaway, Acting Medical Director | | |
| **Freedom of Information Status** | | Open | |

| **Strategic Priorities (please choose any which are impacted on / relevant to this paper)** | | | |
|---|---|---|---|
| Strategic Priority 1 :We will consistently deliver high quality individual care, delivered with compassion. | ☒ | 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 report on the first 3 quarters learning from death process<br><br><u>Key issues to note</u><br><br>1. All adult in patient deaths have been screened<br>2. A Structured case note review occurs in between 20-30%<br>3. The majority of care provided when reviewed is good<br>4. 1 death has been identified as potentially avoidable |
| **Recommendations** |
| The board are asked to approve the report |

Members are asked to:

- **Approve 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)** |
| | | **24 April 2018** | | |

# Quarter 3 Learning from Death Report

# Mortality Surveillance group for QOC

**M Callaway**

**Introduction**

The learning deaths process was established in UH Bristol on 1st April 2017. This report represents the first three quarters from this process with the data presented at the mortality surveillance group.

All inpatient deaths were reviewed by the mortality screening nurse.

Deaths which could be identified as for further assessment are subjected to a case note review.

This process is summarised in the mortality review process summary attached.

All inpatient deaths following an out of hospital cardiac arrest are excluded from this process and deaths with in the intensive care unit are reviewed in parallel with the process for collecting data for the ITU database.

| | Quarter 1 (Apr – Jun 17) | Quarter 2 (July – Sept 17) | Quarter 3 (Oct – Dec 17) | Totals |
|---|---|---|---|---|
| **Total deaths** | 301 | 277 | 374 | **952** |
| **OOHCA** | 26 | 35 | 38 | 99 |
| **Total excluding OOHCA** | 275 | 242 | 336 | **853** |
| **ITU deaths** | - | - | 34 | |
| **Total SCNR identified** | 59 | 56 | 97 | **212** |
| **Medicine** | **36** | **32** | **72** | **140** |
| complete | 34 | 26 | 30 | 90 |
| pending | 2 | 6 | 42 | 50 |
| **Surgery** | 9 | 9 | 9 | **27** |
| complete | 6 | 4 | 3 | 13 |
| pending | 3 | 5 | 6 | 14 |
| **Specialised Services** | 14 | 14 | 14 | **42** |
| complete | 12 | 10 | 6 | 28 |
| pending | 2 | 4 | 8 | 14 |
| **Obstetric** | 0 | 0 | 1 | **1** |
| **Number triggering MDO Review** | 4 | **1** | **0** | **5** |
| **Number of SUI reports related to patient death** | 8 | **2** | **4** | **14** |
| **Number of avoidable deaths** | 1 | **0** | **0** | **1** |
| **Number of Learning Difficulty Deaths** | 4 | **7** | **2** | **13** |
| **Death within 30 days of discharge** *(From 20th November 2017)* | - | **-** | | **127** |

**Quarter 3 Report**

The current data shows that between 20-30% of all deaths are subjected to a structured case note review (SCNR). The majority of these deaths are within the division of medicine.

Only a small number of deaths within this group have triggered a medical director office second review and to date there has only been one potentially avoidable death. This number is smaller than we had first anticipated but reflects the overall standard of care that is being identified by the SCNR.

This data is being feedback to the Division and there is a planned meeting of the mortality team to discuss the performance from the first year and to set the parameters for the team going forward into 2018/2019 given this is a new process. There are outstanding reviews for this period, but the majority of these have been allocated and are waiting completion. Ina addition measures have been put in place to accommodate these reviews including recruiting more reviewers, including all the matrons in the Division of Medicine. This training has been completed.

In addition priority has been given to the six mandatory groups required in the initial learning for death guidance. Some issues with the patients notes and Evolve have been identified and these have been fed back to the Evolve team via the CICO's

In the first 3 quarters 14 deaths that were subject to structured case note review have also been subject to a SUI report. Both reports worked in tandem with clear collaboration between the two processes, often with the SUI looking at a specific area of acre whilst the SCNR reviewers the whole episode of the inpatient process.

A method for involving family and friends has been developed with a new paragraph inserted into the bereavement leaflet given to all bereaved families via patient bereavement office. Any concerns raised via this route will lead to a SCNR, currently this process triggers 3.5% of the reviews undertaken and no serious failings in care have been identified via this route. Most concerns raised are regarding communication and the management of the patients end of life pathway.

The number of deaths in patients with a history of learning difficulty or mental health within the first three quarters p was 13, there were no areas of concern identified. A meeting with the Lederer team has taken place to fully integrate the approach between these two teams going forward.

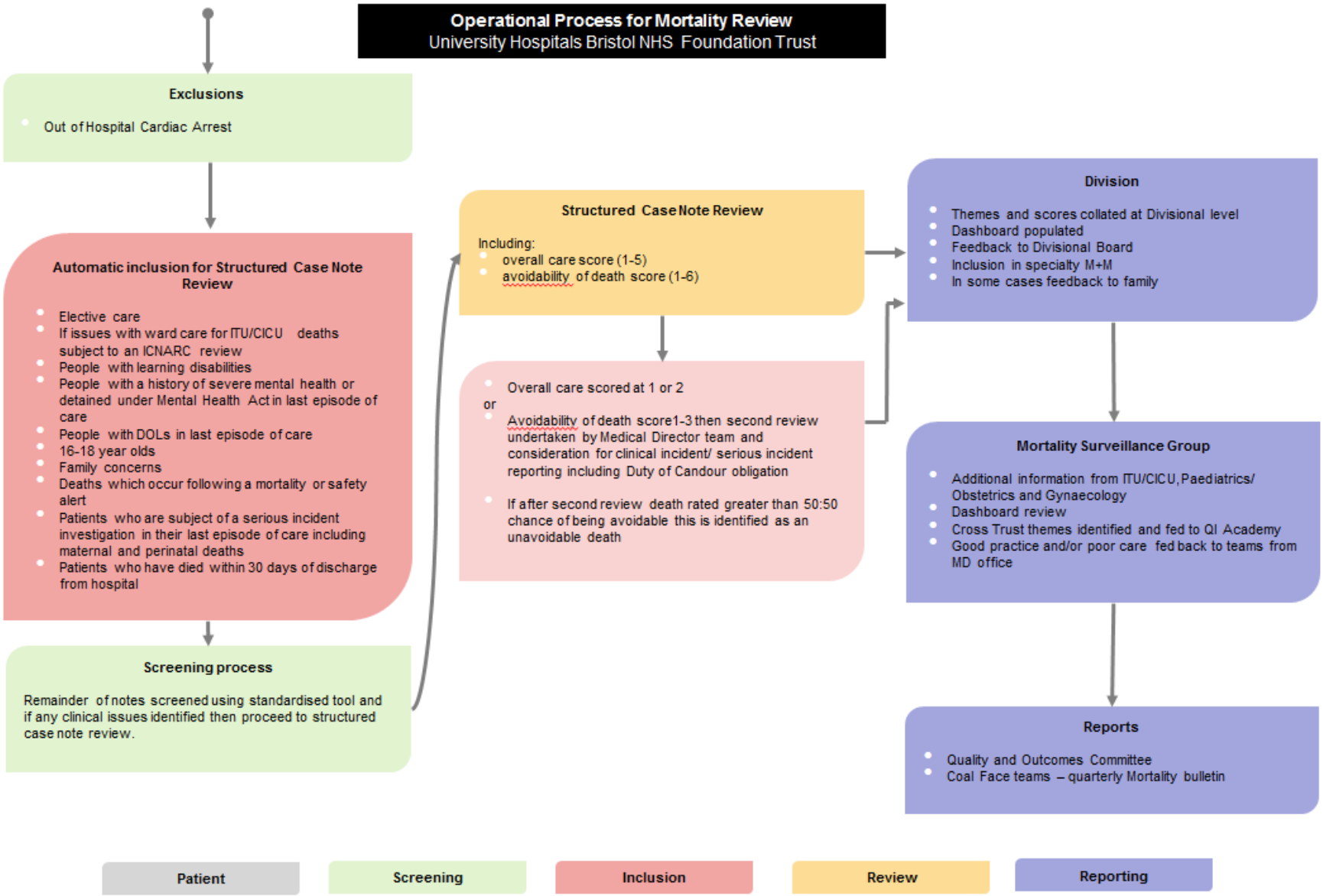
Since the 20th Nov we have also been reviewing deaths in patients who have died within 30 days of admission to this organisation. The number of deaths within this group is 127. This is a requirement from the learning from deaths document we are one of the only centres in the UK to have achieved this assessment. We have performed an initial review of this data and have identified 16 patients in whom the deaths were unpredicted or unexpected following admission, this group is being reviewed and we are working with partners in the AHSN to broaden the potential learning from this group.

The two major themes associated with this patients subject to SCNR in all Divisions were the instigation of the end of life pathway, and the early involvement of senior decision making to adopt this pathway. The instigation of the end of life pathway is a major cross divisional issue and has now formed the basis of an active and ongoing project within the Quality Improvement Academy for the year 2018/19.

This project will assess the integration of the End Of Life pathway in the overall management of patients within the institution. The HOSI triggered data is a year behind and as such will start to impact on data collection from the new year 2018/19.

As part of the ASHN collaborative we feed back all our results and the themes from learning from deaths and these are the common areas for learning from all the Hospitals within the region.

We are instigating the plan to improve the number of reviewers and are having an annual review in May of the process following the completion of the first year. Following this meeting the group will produce an Annual report to disseminate throughout the organisation.


Operational Process for Mortality Review
University Hospitals Bristol NHS Foundation Trust
Exclusions
Out of Hospital Cardiac Arrest
Automatic inclusion for Structured Case Note Review
Elective care
If issues with ward care for ITU/CICU deaths subject to an ICNARC review
People with learning disabilities
People with a history of severe mental health or detained under Mental Health Act in last episode of care
People with DOLs in last episode of care
16-18 year olds
Family concerns
Deaths which occur following a mortality or safety alert
Patients who are subject of a serious incident investigation in their last episode of care including maternal and perinatal deaths
Patients who have died within 30 days of discharge from hospital
Screening process
Remainder of notes screened using standardised tool and if any clinical issues identified then proceed to structured case note review.
Structured Case Note Review
Including:
overall care score (1-5)
avoidability of death score (1-6)
Overall care scored at 1 or 2
or
Avoidability of death score1-3 then second review undertaken by Medical Director team and consideration for clinical incident/ serious incident reporting including Duty of Candour obligation
If after second review death rated greater than 50:50 chance of being avoidable this is identified as an unavoidable death
Division
Themes and scores collated at Divisional level
Dashboard populated
Feedback to Divisional Board
Inclusion in specialty M+M
In some cases feedback to family
Mortality Surveillance Group
Additional information from ITU/CICU, Paediatrics/ Obstetrics and Gynaecology
Dashboard review
Cross Trust themes identified and fed to QI Academy
Good practice and/or poor care fed back to teams from MD office
Reports
Quality and Outcomes Committee
Coal Face teams – quarterly Mortality bulletin
Patient
Screening
Inclusion
Review
Reporting

**Cover report to the Public Trust Board. Meeting to be held on 24 May 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 11 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | 24 May 2018 |
| **Report Title** | **Embracing Change, Proud to Care – Renewing our Trust Strategy** | | |
| **Author** | Paula Clarke - Director of Strategy and Transformation<br>Sarah Nadin – Associate Director of Strategy and Business Planning | | |
| **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**

Purpose

In January 2018, Trust Board noted and supported the proposed approach to delivering a renewed and integrated organisational strategy and long-term ambition for the period from 2019-2025, structured through a four phase programme.

The purpose of this paper is to;

- Provide an update on work completed in phases 1 and 2 of the programme, which included the development of the strategic context & case for change and the completion of a range of engagement activities engagement activities.
- Seek approval of the draft strategic priorities and objectives to provide a working strategic planning framework for divisions in phase 3.
- Provide an overview of Phase 3 and the next steps.

Key issues to note

Trust Board are asked to note the following issues;

- Phases 1 and 2 of the programme have now been completed, involving the development of the strategic case for change and engagement within and outside of the organisation.
- The engagement phase included engagement internally through a staff survey and through roadshows and attendance at key meetings and the external engagement included a stakeholder survey and targeted events with key stakeholders, including primary care and Members and the public.
- A senior leaders' event was held on the 2nd April to help develop a new set of strategic priorities and objectives to inform our 2025 strategy. It is intended that these draft priorities and objectives will form the basis of the strategic framework provided to divisions as part of phase 3 of the programme.
- These draft strategic priorities and objectives were revised following feedback at the event and were discussed at Board Seminar on the 15th May 2018 and were further revised following input.
- Senior Leadership Team considered and supported the draft priorities and objectives on the 16th May 2018.
- The next phase of the programme will focus on divisions responding to the strategic framework, to describe the detail of how the priorities will be delivered, within clinical services, teaching, learning and education and research. This will also integrate and align enabling strategies such as workforce, estates, financial planning and digital.
- The overall intention is to publish the new Trust strategy, Embracing Change, Proud to Care – Our 2025 Vision in quarter 4 2019.

**Recommendations**

Trust Board is asked to:

- **Review** and **approve** the draft strategic priorities and objectives to provide a strategic planning framework for Divisions in phase 3 of the programme.

It should be noted that Trust Board is asked to approve these as **draft priorities and objectives** for the purposes of planning during phase 3 of the programme only. Amendments will be made as required, based on on-going engagement and the outputs of phase 3, and will form part of the final sign off and approval of the overall strategy in quarter 4 2018.

| 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)** |
| | | | | |

## Embracing Change, Proud to Care – Our Strategy Renewal Programme

### 1. Introduction

In January 2018, Trust Board noted and supported the proposed approach to delivering a renewed and integrated organisational strategy and long-term ambition for the period from 2019-2025.

The purpose of this paper is to;

- Provide an update on work completed in phases 1 and 2 of the programme, which included the development of the strategic context and case for change and the completion of a range of engagement activities engagement activities.
- Seek approval of the draft strategic priorities and objectives to provide a working strategic planning framework for divisions in phase 3.
- Provide an overview of Phase 3 and the next steps.

### 2. Background

The objective of the programme is to set the strategic direction for the Trust from 2019-2025, setting out a clear position on what we want to achieve and how we will do this and ensuring our organisational vision remains fit for purpose.

This is a 12-18 month programme of working with the following key aims;

- To understand and pro-actively manage our responses to our significantly changed and changing national and local environment.
- To provide a framework for securing the ongoing success of the organisation and, where needed, to think radically about our approach to achieve this.
- To make explicit, evidence-based choices about maximising our opportunities and addressing our increasing challenges to delivering our stated strategic intent.
- To use the process of developing our strategy to further grow staff, patient and wider stakeholder engagement.
- To secure ownership and understanding of the final outputs and delivery actions.
- To have learned from and built upon the success and gaps in our current strategy.

A full overview of the programme is outlined in Appendix 1.

### 3. Progress to date

The following key activities have been completed since the start of the programme.

- The programme structure has been established.
- The strategic case for change has been produced and discussed at Senior Leadership Team (SLT), identifying key drivers for change.
- There has been SLT review and sign off of Trust-wide SWOT (Strengths, Weaknesses, Opportunities and Threats) and PESTLE (Political, Economic, Social, Technological, Legal, Environmental), assessments for clinical services, Research, Teaching and Education.
- Extensive engagement has been completed with staff, Governors, Members and external stakeholders and engagement will continue throughout the programme. This concluded with a strategy engagement event for 80 leaders across the Trust on 2nd May.

### 3.1 Completion of Phase 1: The case for change

**Key activities:**

This phase contained the following activities;

- A desktop review of our current position and of the contextual factors which will influence the Trust over the period of the strategy.
- Development of a Trust level SWOT and PESTLE analysis.

- Evaluation of the successes and learning from our last strategy to inform the design of the programme and outputs.
- Development of a detailed project plan and communications and engagement plan for the programme.

**Phase 1 Outputs:**
The outputs of this phase were;
- Conclusions produced from the review of current Trust strategy and from the desktop contextual review, including an inventory of contextual factors and external influences which have been considered.
- Findings and conclusions produced from the review of the current Trust position, including quality diagnosis, revenue and cost driver analysis, workforce and operations.
- Summary of our performance against key indicators, including a description of the basis for the assessment and the current position and trends.
- Themes and drivers produced and taken into the engagement phase.
- Examples of possible strategic aims produced to generate debate on what specific actions we could consider across our clinical service, research and teaching portfolios.
- Word document capturing all of the work completed.
- Slide pack of all information and analysis completed, to be provided to divisions for Phase 3.

## 3.2 Completion of Phase 2: Internal and External Engagement

### 3.2 Key activities

**The following activities have been undertaken as part of the engagement phase of the programme.**
- Internal staff survey
- External survey
- Roadshows across all Trust sites
- Public Engagement Event involving our Members.
- Governor Engagement Event
- GP Engagement Event
- Attendance at divisional meetings and staff forums
- Development and publication of a video and leaflet for staff about our strategy development.
- 2nd May leadership event

### 3.3 Phase 2 output:
In addition to undertaking the above engagement activities, the following outputs have been produced through Phase 2 of the programme.
- Analysis of internal and external surveys, with key themes and views identified.
- Increased awareness from staff across the organisation of the intention to renew our strategy.
- Senior leadership consultation on draft strategic aims and objectives.
- Updated **draft strategic priorities and objectives** produced, to be approved by SLT and Trust Board at the end of May. The intention is that this will form the basis of the strategic framework for divisions to respond to in Phase 3.
- Views gained on whether our current Trust vision requires updating in the context of our revised strategy.
- Outline design of Phase 3 of the programme.

### 3.4 Summary of the learning from our engagement phase

**Response Rates**
The figures below outline that 734 responses were received to the internal survey and 50 to the external survey.

All workforce groups were well represented in the responses, with 57% from clinical members of staff. Of the 50 responses from external stakeholders, 19 were from primary and community care and 21 were from the voluntary and charitable sector.

Figure 1. Range of responses from the internal staff survey.

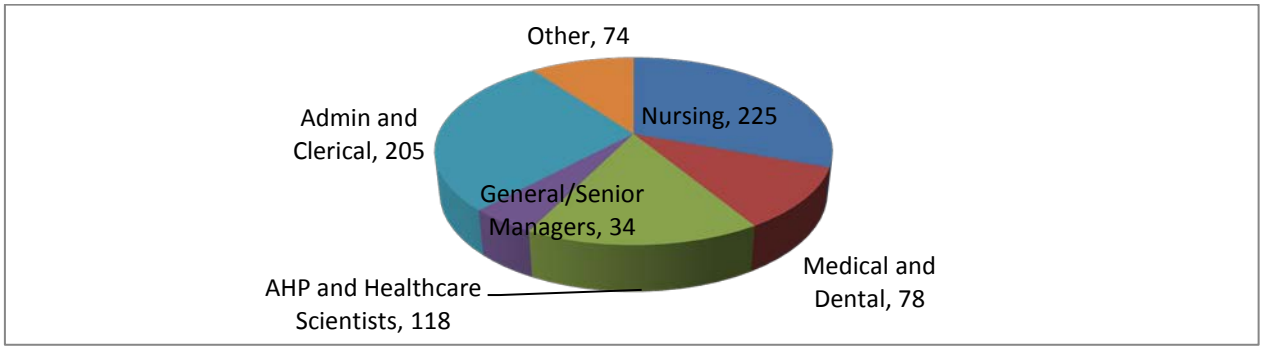
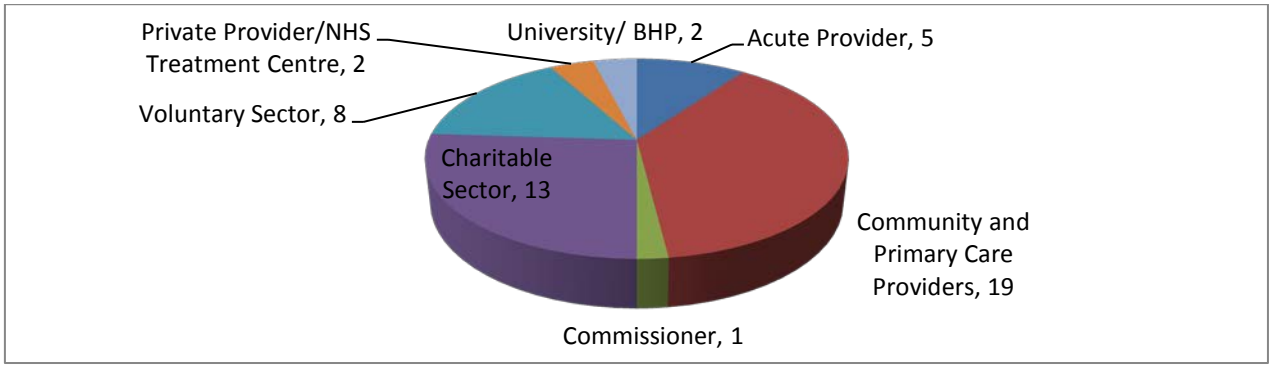



Figure 2. Range of responses from the external stakeholder survey




**Key themes from internal engagement**
The following four key themes were identified from the various internally focussed engagement activities.

- There is a real sense of pride in working for the organisation and an ambition to think creatively about the future.
- Value was placed on innovation, improvement and research and how this will develop in the future.
- The criticality of supporting and developing our staff and the environment they work in, was a core theme.
- The need to manage the pressures our teams face and secure more effective patient flow was highlighted with recognition of the benefits of working collaboratively with our partners and a focus on out of hospital solutions.

**Key themes from external engagement**
The following six key themes were identified from the externally focussed engagement activities.

- Recognition of the leadership role played by the Trust in the local system with a challenge that our focus can be predominantly inwardly directed.
- Stakeholders clearly signalling a desire for more collaboration and more outreach provision of acute teams into community settings.

- There was a theme of increased acute care collaboration and the need to contribute to making pathways less complex and making Bristol and Bristol, North Somerset and South Gloucestershire a consistently outstanding place to receive care for patients.
- It was clear that primary care as provider partners are keen to work with us to develop the future of services.
- Recognition that technology across the system is a real enabler for rapid and radical change.

## 4. Strategic Priorities and Objectives

The combined output of phases 1 and 2 was used to develop a set of new **draft strategic priorities and supporting objectives** for the organisation to provide direction for the Trust to 2025.

These strategic priorities and objectives were developed through the analysis completed in phase 1 and the views and feedback secured in phase 2. They were also tested with our Senior Leadership Team and Divisional Boards at a leadership event attended by 80 of our clinical, professional and managerial leaders on the 2nd May 2018.

Appendix 2 outlines the full details of the proposed priorities and objectives, which are also summarised below.

| **Draft Strategic Priorities** |
|---|
| Excel in consistent delivery of **high quality**, patient centred care, delivered with compassion. |
| Invest in **our staff** and their wellbeing, supporting them to care with pride and skill, **educating and developing** the workforce for the future |
| Consolidate and **grow our specialist clinical services** and **improve how we manage demand for our general acute services**, focussing on core areas of excellence and pursuing appropriate, effective out of hospital solutions |
| L**ead, collaborate and co-create sustainable integrated models of care** with our partners to improve the health of the communities we serve |
| Be at the leading edge of **research and transformation** that is translated rapidly into exceptional clinical care and embrace **innovation** |
| Deliver **financial sustainability for the Trust** and contribute to the **financial recovery of our health system** to safeguard the quality of our services for the future |

Trust Board is asked to approve these as **draft priorities and objectives** for the purposes of planning during phase 3 of the programme. If amendments are required based on the outputs of phase 3, these will be proposed during phase 4 and will form part of the final sign off and approval of the overall strategy.

## 5. Phase 3 – Development of service level plans

The request from SLT at the start of the process was to provide divisions with a clear direction from the Board on what the priorities are for the next 5 years to provide the basis to develop service level strategic and operational plans.

In phase 3, divisions will be required to develop detailed plans addressing what the key implications and actions are for achieving our agreed strategic ambitions. This will include the following considerations;

- What does implementation of these strategic priorities and objectives mean for
  a) clinical services (our general acute and our specialist, tertiary services),
  b) divisional research and education and teaching plans.
- How will these be delivered within the divisions?
- What is required from our enabling strategies to support this delivery?
- How will these actions be translated into annual divisional and team plans?

Phase 3 will also include the alignment of our enabling strategies to ensure they are effectively integrated into divisional plans and are clearly focussed on delivering the overall Trust priorities.

A standardised format for all clinical service, core and supporting strategy outputs will be provided. This will be developed with divisional representatives before the end of May and will be provided to divisions for the start of June.

## 6. Next Steps

The timetable below summarises the high level next steps in the programme.

| Date | Action |
|---|---|
| May 2018 | SLT and Trust Board to finalise and approve draft strategic priorities and objectives along with draft outline of Phase 3 process. |
| June 2018 | Divisions provided with strategic framework and outline of Phase 3 process.<br>Refresh of enabling strategies begins. |
| October 2018 | Completion of Phase 3 – Core service delivery plans and enabling strategies. |
| Quarter 4 2019 | Publication of 2025 Trust Strategy. |

## 7. Recommendation

Trust Board is asked to review and **approve** the draft strategic priorities and objectives to provide strategic planning framework for Divisions in phase 3 of the programme.

It should be noted that Trust Board is asked to approve these as **draft priorities and objectives** for the purposes of planning during phase 3 of the programme only. Amendments will be made, based on the outputs of phase 3, during phase 4 and will form part of the final sign off and approval of the overall strategy in quarter 4 2018.

## Appendix 1 - Overview of the Programme

This figure below outlines at a high level the outputs and approach to be adopted in our 4 phases of strategy development against the high level timeframe outlined below:

**Phase 1:**
**Agree the Strategic Context and Drivers (A Case for Change)**

- Set out the strategic context and case for change which our new strategy must respond to
- Understand our past and current performance and productivity
- Trust SWOT/PESTLE
- Identify key drivers (importance/impact)
    - Identify initial set of possible strategic responses (choices) to key strategic drivers

**Complete by: February 2018**

**Phase 2:**
**Renew our Vision and Strategic aims**

- Engage with a broad range of internal and external stakeholders on the context and drivers
- Wide range of engagement approaches to secure views on our possible responses and key strategic choices
- Identify key points which staff would wish to see in our vision
    - Strategic analysis/financial assumptions
    - **Output = renewed vision & draft strategic aims to direct work in phase 3**

**Complete by: May 2018**

**Phase 3:**
**Develop core service delivery and supporting strategies**

- Develop service and enabling strategies that respond to the drivers, context, vision and draft strategic aims
- Focus on key areas of change we will have to make and how we plan to achieve
- Ensure we have an integrated and consistent set of plans to inform the final Trust strategy
- Support alignment of early actions into the 2019/20 OPP. (embed ownership)

**Complete by: October 2018**

**Phase 4:**
**Finalise and launch our Integrated Strategy**

- Finalise strategic aims and actions to deliver over the strategic period
- Develop an integrated strategy document
- Consult on this for a limited period
- Launch an agreed communications plan
- Deliver, monitor and flex

**Complete by: January 2019**

Throughout the process continue to adapt to and influence emerging drivers and system plans

**Appendix 2 - OUR STRATEGIC FRAMEWORK**

**15th May 2018**

| **Our Strategic Priorities** – ***We will….*** | **Our Strategic Objectives** – ***Which means that we will….*** |
|---|---|
| Excel in consistent delivery of **high quality**, patient centred care, delivered with compassion. | • Sustain our outstanding CQC rating.<br>• Achieve all constitutional access standards, through the delivery of agreed in year trajectories. Ensure patients have access to the right care when they need it and are discharged as soon as they are medically fit.<br>• Deliver our quality objectives outlined in our Quality Strategy (Ensuring timely access to services; Improving patient and staff experience; Improving outcomes and reducing mortality; Delivering safe and reliable care).<br>• Continue to develop our estate and provide a modern environment for staff and patients.<br>• Drive improvements in staff engagement and wellbeing to support them to deliver excellent care.<br>• Engage more effectively with our patients and our partners.<br>• Actively seek opportunities to collaborate with out of hospital partners, redesigning pathways to improve the quality of care we deliver. |
| Invest in **our staff** and their wellbeing, supporting them to care with pride and skill, **educating and developing** the workforce for the future | • Pursue a new strategic workforce development approach and redefine how we recruit and retain staff as an organisation and as a local healthcare system.<br>- Continuing to market all vacancies with innovative, cost effective solutions, utilising the strong employer brand Love Life Love Bristol to deliver a highly skilled and productive workforce that is as diverse as the community that we serve.<br>- Developing a clear plan for what new roles we will need and how we will fund and grow these roles effectively. Over the next five years, focussing on alternative roles in hard to recruit to areas.<br>- Use our reputation for excellence in clinical services, research, education and teaching to lever worldwide recruitment opportunities.<br>• Place staff health and wellbeing at the centre of planning the future of our services, with a focus on creating a positive work/life balance for our staff.<br>• Focus on the diversity of our workforce and the equality of how we support access to roles.<br>• Develop our teaching and education offer in conjunction with our academic partners to create innovative workforce solutions and train the workforce of the future.<br>• Develop our Leadership and Management Capability through delivery of a comprehensive programme of leadership and management training and development.<br>• Transform and optimise workforce efficiency.<br>• Support and enable staff to work more closely with teams in partner organisations and across multiple settings.<br>• Access and use staff feedback to inform targeted actions to improve the day to day experience of our staff. |
| Consolidate and **grow our specialist clinical services** and **improve how we manage demand for our general acute services**, focussing on core areas of excellence and pursuing appropriate, effective out of hospital solutions | • Make choices on our core areas of excellence and target investment to support growth in our very specialised services to provide expert treatment for people across the south-west region, Wales and beyond.<br>• Ensure the reputation of our specialist services is as strong as possible to encourage growth in regional referrals.<br>• Actively support excellence and innovation across our range of general services to ensure the local population we serve have access to the best possible care.<br>• Critically evaluate services which are clinically or financially unsustainable and make active decisions regarding their strategic direction.<br>• Mandate our teams to support delivery of appropriate care out of hospital (default to out of hospital first).<br>• Resolve internal patient flow challenges currently impacting on the effective delivery of general and specialist care – develop an internal operating model that delivers both.<br>• Use technology to improve the safety and effectiveness of our services and be able to offer greater accessibility in and out of our hospitals.<br>• Develop our provider to provider relationships with Primary Care, with an expectation that our teams will actively seek new ways of working together for the benefit of pathways and patients. |

| | |
|---|---|
| **Lead, collaborate and co-create sustainable integrated models of care** with our partners to improve the health of the communities we serve | • Build our leadership role in the BNSSG Healthier Together Partnership, supporting steps towards an integrated care system with the aim of making BNSSG Outstanding.<br>• Use our digital and research excellence and academic expertise to maximise the implementation of evidenced based clinical pathways across hospital, primary and community provision.<br>• Continue to develop our partnerships with Weston Area Health Trust and North Bristol Trust to support our collective clinical and financial sustainability.<br>• Overtly address with NBT the difficult questions about the remaining duplication of acute services across Bristol<br>• Develop our role in leading, with NHSE the future of Specialised Services for the region.<br>• Continue to maximise the opportunities associated with our regional and tertiary provider status and develop and lead clinical networks across the region.<br>• Work more closely with patients, families and other healthcare partners to co-design more joined up care that takes account of the whole person not just their immediate health issues.<br>• Promote healthy lifestyles, helping to prevent ill health and improve mental and physical well-being through all of our activities.<br>• Actively pursue opportunities to work more effectively and creatively with our voluntary sector and charitable partners.<br>• Support staff to be advocates for collaboration with our partners and to develop relationships and opportunities to work together at a specialty and divisional level. |
| Be at the leading edge of **research and transformation** that is translated rapidly into exceptional clinical care and embrace **innovation** | • Build our reputation as a world class leader in population health and biomedical research, maximising the potential of the Biomedical Research Centre to undertake cutting edge studies that will improve care and treatment into the future.<br>• Use our digital capabilities to transform where and how we deliver care, education and research (Digitally enabled transformation) and maximise the opportunity provided by our successful appointment as a National Digital Exemplar site.<br>• Provide our staff with improvement skills and capabilities through our Quality Improvement (QI) Academy.<br>• Create an environment that makes it easy to innovate within organisation through our QI Hub and continue to develop a culture in which individuals and teams are encouraged to innovate.<br>• Remain agile, using evidence to excel in getting it right first time.<br>• Sustain and improve our performance in initiating and delivering high quality clinical research trials, through actively supporting clinical staff to engage with research and through embedding it within clinical practice. |
| Deliver **financial sustainability for the Trust** and contribute to the **financial recovery of our health system** to safeguard the quality of our services for the future | • Working smarter not harder, by eliminating waste and ensuring we add value from every action we take, however small, to maintain our financial health in the context of severe local and national financial pressures.<br>• We will achieve upper quartile productivity benchmarks across all measures.<br>• We will actively implement the GIRFT recommendations across our services.<br>• We will evaluate the financial sustainability of all clinical services with the aim of improving the RCI position of services to the best possible position.<br>• We will secure contracts with commissioners which reflect demand and work with partners to reduce costs across the system through pathway redesign.<br>• We will not allow financial mechanisms to be the reason we do not do the right thing within our system and will look for ways to lead new ways of working to drive change.<br>• We will work with partners to build trust, through encouraging staff to build productive relationships at a service and divisional level and through trialling small changes to build confidence.<br>• We will increase our income through innovative commercial approaches, whilst ensuring focus remains on the delivery of our core services.<br>• We will engage more effectively with staff on the benefits of financial sustainability and improve our communications relating to the financial position of the Trust and how this relates to investment within clinical services. |

**Cover report to the Public Trust Board. Meeting to be held on 24 May 2018 at 11.00 – 13.00 in the Conference Room, Trust HQ**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 12 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Thursday, 24 May 2018 |
| **Report Title** | **Operating Plan 2018/19 - Final** | | |
| **Author** | **Paula Clarke, Director of Strategy and Transformation** | | |
| **Executive Lead** | Paula Clarke, Director of Strategy and Transformation | | |
| **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

The Board is being presented with the final version of the Operating Plan 2018/19, previously discussed at the March and April 2018 Board meetings, for formal adoption.

Key issues to note

At the April 2018 Public Board, it was confirmed that the Trust's final financial plan for 2018/19, reflecting the £18.5million control total proposed by NHS Improvement, would be included in the updated version of the Operational Plan (which the Board approved in principle and by circulation).

The Operating Plan 2018/19, including the final financial position, was submitted to NHS Improvement on 30 April 2018, and has now been published on the UH Bristol website

| Click the link below to view the Operational Plan 2018/19:<br>Operational Plan 2018/19 |
|---|
| **Recommendations** |
| The Board is being asked to formally note the final Operating Plan 2018/19.<br><br>Members are asked to:<br><br>• **Note** the Operating Plan 2018/19 for information. |

| **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)** |
| | | | | |

Operational Plan 2017/2018 to 2018/2019 (Year Two Refresh) – supporting narrative

## 1. Context for Operational Plan

Trust Board approved the two year Operational Plan for 2017-2019 on 22nd December 2016, which was subsequently submitted to NHS Improvement (NHSI) on 23rd December 2016. This 2018/19 Plan therefore reflects a refresh of that two year plan setting out the Trust's approach and position on activity, quality, workforce and financial planning for the period. The current draft position is based on a robust and integrated approach to operational planning within the Trust and alignment with the aspirations and relevant specific actions of the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan (BNSSG STP *Healthier Together*). The Trust fully appreciates the financial challenges in the NHS overall and our track record evidences our commitment and ability to deliver affordable, quality care sustainably. Our leadership role within the STP *Healthier Together* footprint seeks to extend this experience into the system and we have supported the adoption of an open book approach through the local System Delivery Oversight Group and through our negotiation of any required changes to year two of the two year contract signed on 23rd December 2016.

Our plan reflects the following position at 24th April 2018;

- Acceptance of the proposed NHS Improvement Control Total offer of a £18.5 surplus. This will enable the Trust to reserve £15.5 of Provider Sustainability Funding (PSF) and obviate the need to pay core performance fines.
- Service Level Agreement (SLA) proposals have been agreed with Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCGs) and associates and NHS England (Specialised and Non-Specialised).
- Clarity and ownership of stretching quality priorities delivered through enabling quality improvement frameworks - our 2018/19 quality priorities are being finalised and will be approved by the Board in our Quality Accounts in May 2018.
- Workforce plans aligned to finance, activity and quality and addressing robust accountability for managing agency and locum expenditure
- Commitment to deliver sustained or improved performance in core access and NHS Constitution standards aligned to NHSI/NHSE guidance.

## 2. Strategic Backdrop

Our 2017/19 Operational Plan has been written in the context of the longer term direction set out in our existing five year strategic plan and also within the context of the developing BNSSG STP *Healthier Together*. Our current Trust Strategy ("Rising to the Challenge 2020") states that as an organisation, our key challenge is to maintain and develop the quality of our services, whilst managing within the finite available resources with our focus being on "affordable excellence". We are also clear that we operate as part of a wider health and care community and our strategic intent sets out our position with regard to how we optimise our collective resources to deliver sustainable quality care into the future.

Our Vision is *for Bristol and our hospitals, to be among the best and safest places in the country to receive care* and our strategic intent is to provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services.

We are committed to addressing the aspects of care that matter most to our patients and during 2018/19, we will ensure our strategy remains dynamic to the changing needs of our patients and ongoing changes within both the national and local planning environment. In 2016/17, we undertook a review to prioritise and stratify our clinical strategy and established a clear governance framework within which to drive strategic decision-making and support implementation plans and in 2017/18, we have focussed on progressing the development of our core areas of clinical strategy, along with key enabling strategies, such as our digital agenda. In 2018/19 we are working to renew our current 2014-2019 Trust strategy and are engaging staff, patients and external partners to develop a strategy to 2025 that will enable us to maintain outstanding care in the context of the challenges we face. This is a major strategic project in 2018/19 and will be key in setting our future direction as an organisation.

A key aim in developing our own internal strategic programme and future strategy is to align with the new processes, pathways and structures developing as part of the local *Healthier Together* and the changing national context. These new approaches provide us with a significant opportunity to progress our strategic priorities at pace and to work together with our partners to resolve some of the system-wide challenges we face. The decision made at the Trust Board in January 2018 to pursue an organistional merger via acquisition with Weston Area Health Trust, represents significant progress in this approach and we will develop plans for the partnership and service specific alignment during 2018/19.

The Trust has a clear governance route through which to identify, assess and manage significant risks that may threaten the achievement of our strategic objectives. We reviewed these processes in 2016/17 and agreed a new Board Assurance Framework (BAF) with the Trust Board considering the BAF on a quarterly basis and this governance process will remain through 2018/19.

## 3. Link to the local Sustainability and Transformation Partnership *Healthier Together*

We remain clear that system leadership and collaborative working are essential for system sustainability and our two year Operational Plan is set firmly within the context of our local BNSSG STP *Healthier Together*. The *Healthier Together* programme has developed five key strands to its' ambition and vision that will enable the footprint to develop and implement a sustainable health and care system for our local population, these are outlined below;

- *We want individuals to be at the centre of their own health and care. People will be inspired and supported to care for themselves.*
- *Services will be more joined up, easy to access and as close to home as possible.*
- *We want access to our leading-edge hospital and specialist services to be simplified and to continue to serve a population well beyond the BNSSG area with excellent life-saving services.*
- *We want to focus more on improving the way we provide care with greater emphasis on delivering care in the community – because it's best. We will also focus more on mental health, urgent care, hospital services and prevention.*
- *We recognise bold action is needed over the coming years to meet increasing demand, but this is evolution – not revolution. There isn't going to be one big single plan that solves all of the problems.*

Our two year Operational Plan has been developed in the context of these ambitions and there is clear alignment with our operational priorities. A transformational programme of change is being established through the *Healthier Together* partnership, structured via nine strategic priorities. These are:

| | | | |
|---|---|---|---|
| System Productivity | Integrated Care | Effective Planned care | Children's & Maternity services |
| Healthy Weston | Acute Care Collaboration | Mental Health & Learning disabilities | Prevention & Early Intervention |
| Primary Care reform (GPFV) | | | |

Through our Operational Plan, we are clear that we play a key role in both leading and contributing to *Healthier Together* programmes of work. Delivery of our quality, performance and financial operating plan intent is predicated on both organisational and system actions. The *Healthier Together* programme clearly identifies its ambitious but equally pragmatic vision, wherein the impact of a new model of care and specific transformational service delivery changes are agreed by all partners, but which remain to be developed to the stage that we can confidently reflect the impact in our contracts and our operational delivery projections. As the *Healthier Together* plans mature, we will incorporate material changes in our 2018-19 contracts via variations and in the dynamic approach we adopt to our two year Operating Plan projections.

Improved productivity and effectiveness is a key focus of the developing projects within the *Healthier Together* programme and within our organisation, with specific emphasis placed on the need to maximise the use of acute facilities and resources, reducing costs, duplication and variation where possible and potentially reconfiguring or redistributing services between the three acute providers if this provides greater opportunity for services to develop and thrive. The Trust has already worked with other providers to deliver major change to the benefit of patients on a wide range of services and we are committed to develop the next phase of acute care collaboration based on shared leadership models.

During 2018-19, we will continue to lead and enable translation of the acute care collaboration principles into delivery through a smaller number of high impact projects to both realise 'quick wins' in closing the gaps and establish and build confidence in new ways of working and collaborating as a system. The priority projects identified are;

| | |
|---|---|
| • Stroke pathways | • Trauma and Orthopaedic and Musculoskeletal services |
| • Pathology model of care | • Medicines optimisation |
| • Corporate overheads reduction | • Weston sustainability |

In parallel, we will scope and implement projects in Neonatal Intensive Care; Interventional Radiology and Optimising outpatients.

## 4. Local and National Commissioning Context 2018/19

As outlined above, the planning assumptions within the Trust Operational Plan for 2018-19 have been developed in such a way that takes into account both the national priorities highlighted in the planning guidance "Refreshing NHS Plans for 2018/19 and the local priorities for the BNSSG Healthier Together Sustainability and Transformation Plan (STP).

In 2018/19 we have set our activity levels and performance trajectories to accommodate the national activity growth assumptions and the constitutional standards requirements for:

- Waiting list maintenance at March 2018 levels for all commissioners, predicted to be 3,240 patients (based on 27,000 pathways at March 2019) and 52 week waits only on an exceptional basis where patient choice has been exercised; and
- Delivery of the other constitutional standards including cancer 2 week waits, cancer 62 day urgent referral to treatment and diagnostic waiting times.

With respect to the Accident and Emergency 4 hour performance standard, the national requirement is for aggregate performance above 90% for the month of September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019, and that the NHS returns to 95% overall performance within the course of 2019. Based on our analysis of actions to improve performance alongside a realistic assessment of the lead time for system actions to fully impact, we have set our trajectory for A&E at 90% by September 2018 and maintenance to March 2019

Locally we have also agreed with commissioners a threshold for RTT performance between 87-90% during the course of 2018-19. On the basis that the Trust will accept a control total for 2018/19, the Trust will be exempt from contractual fines and penalties as defined within the NHS Standard Contract and will also pursue opportunities for securing income for advice and guidance services which are recommended nationally as part of local tariff reform.

The operational challenges and opportunities for the Trust are set within a local context in which our *Healthier Together* STP continues to mature and develop closer provider and commissioner relationships to address the BNSSG system financial deficit. In the short term, task and finish groups have been set up to review all existing projects and identify potential activity reductions for 2018/19 including areas such as urgent and same day emergency care; bed optimisation to affect length of stay; referral management and outpatient activity and mental health activity as part of CCG requirements to eliminate out of area activity and deliver a new Mental Health Investment Standard. We are working closely with these task and finish groups to maximise the benefit for UH Bristol and the wider system.

We also have commitment from Specialised Commissioners in the South Region to work more closely with our STP in implementing these plans, which will include a review of adult and paediatric critical care, neonatal critical care and rehabilitation pathways for brain injuries and neurological injuries and increasing Children and Adolescent Mental Health (CAMHs) placements.

From a future Trust planning perspective we are fully committed to the system way of working and supporting our STP to mature into a fully integrated care system. In 2018/19 we are particularly interested in supporting CCGs to fulfil their new statutory responsibility for delegated commissioning of Primary Care Medical Services and the associated new clinical pathways for integrated out of hospital care. For example, we are already supporting initiatives to review clinical pathways such as Respiratory, Musculoskeletal, Stroke, Frailty and Diabetes across BNSSG and we are also engaging on plans for a new model of adult Audiology provision and clinical pathways for Deep Vein Thrombosis.

Finally, within the next financial year the Trust also expect to be clearer about the outcomes of the North Somerset Sustainability Programme and the future of Weston Area Health Trust as part of a joint review with CCGs, NHS England and NHS Improvement. This in turn may lead to further in depth reviews for out of hospital model of care affecting Trust services, including but not limited to South Bristol Community Hospital.

5. Organisational Strategy 2018-19 Focus

Our 2017/18 NHSI Operational Plan outlined our organisational commitment to the development of the BNSSG STP *Healthier Together* and how, as year one of our two year plan, our 2017/18 priority was to contribute to developing and implementing plans to address the identified system gaps in Care and Quality, Health and Wellbeing and Finance and Efficiency. This commitment remains in 2018/19, with the focus of our strategic and operational plans over year two of our two year plan directed at the following Corporate Objectives:

| Strategic Priority | Corporate Objective 2018/19 |
|---|---|
| We will consistently deliver high quality individual care, delivered with compassion. | • Ensure patients have access to the right care when they need it and are discharged as soon as they are medically fit.<br>• Improve performance against access standards and delivery of our performance trajectories in the four core standards.<br>• Improve patient and staff experience<br>• Improve outcomes and reduce mortality<br>• Improve patient safety |
| We will ensure a safe, friendly and modern environment for our patients and our staff. | • Develop the Estates and capital strategy during 2018-19 to continue to align the modernisation and development of our estate to our evolving clinical strategy and support delivery of the emerging system wide new models of care.<br>• Maximise the productivity and utilisation of our estate and facilities. |
| We will strive to employ the best and help all our staff fulfil their individual potential | • Develop our Leadership and Management Capability through delivery of a comprehensive programme of leadership and management training and development.<br>• Continue to improve staff engagement and experience.<br>• Recruiting and Retaining the Best. Continue to market all vacancies with innovative, cost effective solutions, utilising the strong employer brand Love Life Love Bristol to deliver a highly skilled and productive workforce that is as diverse as the community that we serve.<br>• Reward and Performance Management: Improve the quality and application of staff appraisal.<br>• Transform and optimise workforce efficiency: control agency and locum costs, review the Strategic Workforce Plan for the Trust and, in collaboration with BNSSG Workforce Advisory Board, support the strategic workforce activity of the Healthier Together programme. |
| We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation. | • Maximise the opportunity provided by our successful appointment as a National Digital Exemplar site to continue to deliver a programme to support the long-term vision of the Trust's Clinical Systems Strategy - *that every member of our staff will have access to the information they need, when they need it, without having to look for a piece of paper, wait to use a computer or ask the patient yet again.*<br>• Maintain performance in initiating and delivering high quality clinical trials, demonstrated by remaining within the upper quartile of trusts within our league (as reported to Department of Health via NIHR); maintain our performance in initiating research and remain the top recruiting trust within the West of England Clinical Research Network and within the top 10% of Trusts nationally (published annually by NIHR).<br>• Maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR).<br>• Continue to develop our research capacity and capability building on the significant grant secured from the National Institute for Health Research to fund a Biomedical Research Centre undertaking cutting edge studies that will improve care and treatment in the future.<br>• Deliver our Transforming Care Programme focussing on working smarter, eliminating waste and transforming the way in which we deliver quality care through service and workforce redesign enabled through digital transformation. |
| We will provide leadership to the networks we are part of, for the benefit of the region and people we serve | • Lead and collaborate through the BNSSG Healthier Together partnership to make our services fit for the future.<br>• Continue to develop our partnerships with Weston Area Health Trust and North Bristol Trust to support our collective clinical and financial sustainability<br>• Play an active part in the research and innovation landscape through our contribution to Bristol Health |

| | |
|---|---|
| | Partners, West of England Academic Health Science Network and Collaborative for Leadership and Applied Research and HealthCare (CLARHC).<br>• Effectively host the Networks that we are responsible for including Operational Delivery Networks, the CLARHC and Clinical Research Network. |
| 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. | • Deliver agreed financial plan for 2018/19.<br>• Deliver minimum cash balance.<br>• Deliver the annual Cost Improvement Plan (CIP) programme.<br>• Implement an Executive led productivity programme to eliminate waste and add value from :<br>• Out patients; Length of stay; Theatres; Consultant productivity; and Diagnostics. |
| We will ensure we are soundly governed and are compliant with the requirements of our regulators. | • Recommit to and renew our Trust Strategy, setting the strategic direction for the Trust from 2019-2025, and ensure we integrate our clinical, teaching and research capabilities to maximise the benefit for the people we serve<br>• Implement General Data Protection Regulations.<br>• Ensure all principles of good governance are embedded in practice and policy.<br>• Achieve regulatory compliance against CQC fundamental standards. |

## 6. Quality planning

### 6.1 Approach to quality planning

The Trust is committed to delivering excellent health services that meet the needs of our patients and their families and provides the highest quality standards. The Board and Senior Leadership Team of UH Bristol have a critical role in leading a culture which promotes the delivery of high quality services. This requires both vision and action to ensure all efforts are focussed on creating an environment for change and continuous improvement. The Trust's annual quality delivery plans and quality strategy (2016-2020) set out the actions we will take to ensure that this is achieved.

We do have much to be proud of. The Trust's quality improvement programme led by the Chief Nurse, Medical Director and Chief Operating Officer continues to show us what is possible when we have a relentless focus on quality improvement. In our last strategy, we recognised that access to services is integral to patient experience and that great patient experience happens when staff feel valued, supported and motivated. In our revised strategy, we have now made this wider view of quality integral to our definition. Our quality strategy and quality improvement work is therefore structured around four core quality themes:

| | |
|---|---|
| • Ensuring timely access to services<br>• Delivering safe and reliable care | • Improving patient and staff experience<br>• Improving outcomes and reducing mortality |

Running through each of these are the threads of research, innovation and quality improvement. Our quality improvement priorities are underpinned by our commitment to address the aspects of care that matter most to our patients in collaboration with our strategic partners. They also take into account national quality and commissioning priorities, our quality performance during 2017/18 feedback from our public and staff consultations and are supported by our organisational values – respecting everyone, working together, embracing change and recognising success. We are committed to the continued focus on delivering our quality strategy, through our quality improvement plan and particularly focussing on areas highlighted in our recent CQC inspection as requiring improvement. We will also be focussing in 2018/19 on ensuring we continue to build on the outstanding practice recognised by the CQC and on maintaining our overall rating of Outstanding as a Trust.

### 6.2 Summary of our quality improvement plan and focus for 2017-2019

In summary, our quality improvement plan will mean that we:

- Cancel fewer operations.
- Reduce patient waiting times.
- Improve the safety of patients by reducing avoidable harm.
- Strengthen our patient safety culture.
- Create new opportunities for patients, families and staff to give us feedback about their experiences, and in a way which enables concerns to be addressed in real-time.
- Develop a customer service mind set across the organisation, including how we handle and respond to complaints.
- Take a lead role in the development of a new national system of rapid peer review of unexpected patient deaths, implementing learning about the causes of preventable deaths.
- Significantly improve staff satisfaction, making UH Bristol an employer of choice.
- Address the issues relating to 'on-hold' patients on RTT pathways and mitigating actions are now in place to prevent the risk of it happening again.
- Reduce the number of 'Never Events' occurring within the Trust.

Our plans will be built on a foundation of:

- The patient-centred principle of "nothing about me without me".
- Partnership working.
- Evidence-based treatment and care derived from high-class research – some of it led by us.
- Effective teamwork.
- Systematic benchmarking of our practice and performance against the best.
- Learning when things go wrong.
- Intelligent use of clinical audit and quality improvement activities.

- Learning from internal and external review.

Table 1: Our key quality improvement priorities for 2018/19

| *Ensuring timely access to services* | *Improving patient and staff experience* | *Improving outcomes and reducing mortality* | *Delivering safe and reliable care* |
|---|---|---|---|
| • Deliver the four national access standards<br>• Reduce the number of cancelled operations – particularly at the last minute<br>• Reduce the number of cancelled clinics and delays in clinic when attending an outpatient appointment<br>• Work with partners to ensure that when patients are identified as requiring onward specialist mental healthcare, we minimise the delays and maintain the patient's safety while they await their transfer. | • Create new opportunities for patient and public involvement<br>• Introduce a system to support people to give feedback, where possible in real-time, at the point of care.<br>• Achieve Friends and Family Test scores and response rates which are consistently in the national upper quartile<br>• Improve our handling and resolving complaints effectively from the perspective of our service users<br>• To achieve year-on-year improvements in the Friends and Family Test (whether staff would recommend UH Bristol as a place to work) and staff engagement survey scores<br>• Be upper quartile performers in all national patient surveys<br>• Develop a customer service mind-set in all our dealings with patients, and introduce a programme of mystery shopping to support this | • Implement evidence-based clinical guidance, supported by a comprehensive programme of local clinical audit, and by working in partnership with our regional academic partners to facilitate research into practice and evidenced based care/commissioning<br>• Use benchmarking intelligence to understand variation in outcomes<br>• Ensure learning from unexpected hospital deaths<br>• Deliver programmes of targeted activity in response to this learning | • Develop our safety culture to help embed safety and quality improvement in everything thing we do<br>• Improve early recognition and escalation of deteriorating patients to include early recognition and management of sepsis and Acute Kidney Injury (AKI)<br>• Improve medicines safety including at the point transfer of care (medicines optimisation)<br>• Eliminate peri-procedure "never events"<br>• Delivering national CQUINs |

Despite our quality strategy and work to improve our patient flow, we continue to identify ongoing risks in relation to access and patient flow. The challenges we face in delivery of our performance standards are outlined in section 7. In recognising the impact that limited access to services and particularly the cancellation of planned surgery or outpatient appointments places on the quality of care we provide for our patients, our actions to address these through our Transforming Care Programme and productivity and performance improvement plans will remain a key priority for the next year.

### 6.3 Approach to quality improvement

The Trust's objectives, values and quality strategy provide a clear message that high quality services and excellent patient experience are the first priority for the Trust. In the context of the responsibilities of individual NHS bodies to live within the funding available, we are clear that the commitments we make in our quality strategy also need to be financially deliverable and our relentless focus on quality must be accompanied by an equally relentless focus on efficiency. The message underpinning our approach to quality improvement is "affordable excellence".

We plan to achieve this by securing continued ownership and accountability for delivery of our quality priorities through our five clinical Divisions. All Divisions have specific, measurable quality goals as part of their annual Operating Plans, with progress against these plans monitored by Divisional Boards and by the Executive Team through monthly Divisional Performance Reviews.

We specifically aim to ensure that clinical care is delivered in accordance with patients' preferences and in line with the best available clinical evidence including NICE[1] standards, Royal College guidelines and recommendations arising from national confidential inquiries. By understanding our current position in relation to national guidance (for example through clinical audit) and by working with our regional academic partners (including through Bristol Health Partners and The National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care West) to facilitate research into practice and evidenced based care/commissioning, we can work towards minimising any variations in practice.

UH Bristol has developed regional and national influence in the field of clinical audit practice over a period of more than 15 years. Over the next year, we will continue to develop the way we use participation in local clinical audit to drive improvement in clinical services and ensure;

- All clinical services (at sub-specialty level) will participate regularly in clinical audit (measured by registered clinical audit activity).
- 95% of relevant published NICE guidance[2] will be formally reviewed by the Trust within 90 days of publication.
- We will develop and implement new internal systems for identifying and monitoring compliance with national guidance other than those for which systems already exist (NICE and NCEPOD[3]).

We recognise that we need to support our staff in continuous improvement and we plan to achieve this through "Transforming Care" - our overarching programme of transformational change designed to address specific priorities for improvement across all aspects of our services. Our transformation improvement priorities for 2018/19 will continue to be structured around the six "pillars" of delivering best care, improving patient flow, delivering best value, renewing our hospitals, building capability and leading in partnership.

[1] The National Institute for Health and Care Excellence
[2] i.e. clinical guidelines, quality standards and technology appraisal guidance
[3] The National Confidential Enquiry into Patient Outcome and Death

Within our Innovation and Improvement Framework, the Trust has developed a QI (Quality Improvement) Academy to align and develop QI training, development and support opportunities for frontline staff, with the aim of increasing capability and capacity within and across frontline teams from awareness to practitioner to expert. We will continue to grow the Academy in 2018/19 increasing our silver level programmes and developing a gold level, QI expert programme.

Our governors engage with the quality agenda via their Strategy Focus Group and Quality Focus Group. Each quarter, the Board and its sub-committees receive the Board Assurance Framework and the Trust's Risk Register which report high level progress against each of the Trust's corporate objectives (including quality objectives) and any associated risks to their achievement. Additionally, the Board's Audit Committee works with the Trust's Clinical Audit and Effectiveness team to consider evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives.

### 6.4 Quality impact assessment process

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes and unfunded cost pressures and commissioner proposals on the quality of services. This includes a formal Quality Impact Assessment (QIA) for all Cost Improvement Plans (CIP) with a financial impact of greater than £50k and any scheme that eliminates a post involved in frontline service delivery.

The Trust's QIA process involves a structured risk assessment, using our standardised risk assessment framework, which includes assessment against the risk domains of safety, quality and workforce. The QIA provides details of mitigating actions and asks for performance or quality measures which will allow the impact of the scheme or proposal to be monitored. The QIA sign off process provides review and challenge through Divisional quality governance mechanisms to ensure senior oversight of any risks to quality of the plans. The Medical Director and Chief Nurse are responsible for assuring themselves and the Board that CIPs and unfunded cost pressures and commissioner proposals, will not have an adverse impact on quality. Any QIA that has a risk to quality score over a set threshold which the Trust wants to proceed with is presented to the Quality and Outcomes Committee (a sub-Committee of the Trust Board). This ensures Board oversight of the QIA process.

The Trust's overall processes for monitoring quality and triangulating information provide a framework within which to monitor the impact of schemes. For any schemes or proposals where there are potential risks to quality, we plan to strengthen our processes to ensure transparency of scheme-specific Key Performance Indicators (KPIs) and how these are robustly monitored via divisional and Trust governance structures.

### 6.5 Triangulation of Quality, Workforce and Finance

Our internal business planning and associated monitoring processes underpin the triangulation of our quality, workforce and finance objectives. Our Operating Plans are developed through the five clinical and Trust Services corporate Divisions with monthly and quarterly Divisional Reviews conducted with the Executive team. These reviews include detailed information on workforce KPI's and any workforce risks, which support cross-referencing of quality and workforce performance. The Trust's Clinical Quality Group monitors compliance with CQC Fundamental Standards on an ongoing basis and our Quality and Outcomes Committee monitors performance against a range of performance standards.

The NHS national staffing return compares expected and actual staffing levels on wards for each day and night. This information is also triangulated with the Trust quality performance dashboard to assess whether the overall standard of patient care was of good quality. This forms part of the monthly report to the Quality and Outcomes Committee and each ward receives its own RAG-rated quality performance dashboard including workforce KPIs on a monthly basis. This enables the triangulation of workforce and quality data at a ward, Divisional and Trust-wide level and is further supported by a six monthly staffing report to the Board, which takes an overview of significant changes in workforce numbers, national guidance or requirements, and progress on agreed actions. There are also annual Divisional staffing reviews of inpatient areas led by the Chief Nurse and includes Finance Leads and Divisional Senior Nurses, to ensure that staffing levels and skill mix are appropriate, affordable and provide quality care as measured by our quality KPIs. In addition, there are agreed criteria laid out in our six monthly Board report to prompt an ad hoc review of establishment and skill mix as required.

- Through the independent review against Monitor's 'Well-led framework for governance' completed in 2015/16, the Trust Board was provided with assurance that systems and process were in place to ensure that the Board and Senior Leadership Team had good oversight of care, quality, operations and finances. The actions identified to further improve the governance systems in the Trust as a result of the review have all been completed. During 2018/19 we plan to complete an externally facilitated Well-Led Review to ensure that we maintain good governance standards and identify areas for further improvement.

### 6.6 Seven day working

We regularly assess ourselves against the standards for seven day working using standard six monthly audits against the core clinical standards (2, 5, 6 and 8). This has helped us target our work on specific areas in developing our plans to provide seven day services. Within the nine 'must do's' for 2017-19 is the requirement to meet the four priority standards for seven day hospital services for all urgent care network specialist services by November 2017 (this includes vascular, stroke, major trauma, heart attack and children's critical care services) and progress towards the 4 standards for all non-urgent care network services by 2020. The most recent completed audit in the spring of this year showed the progress achieved but also highlights where compliance gaps remain.

We can confirm we achieved compliance against the November 2017 requirement for urgent care network specialist services for paediatric major trauma, heart attack and children's critical care services and we are not the local provider for major trauma or vascular services. We have however, identified that further service developments are required to meet the standards for stroke services and within our Interventional Radiology service, which contributes to the vascular network standards. These plans are summarised below alongside our plans to achieve the 2020 goal for the broader roll out of seven day services to all relevant specialties. It is also of note that a review of the model for stroke services is currently a priority project within the BNSSG STP *Healthier Together* and the affordable provision of seven day services within this urgent care specialist service may be provided through a cross system solution. Outline plans to address identified gaps in seven day services against the 2017 and 2020 standards include:

- Standard 2: Time to consultant Review: Additional consultant capacity within general surgery, trauma & orthopaedics and gynaecology services to ensure full compliance with the standard.

- Standard 5: Access to Diagnostics: Formalisation of Interventional Radiology arrangements with North Bristol NHS Trust.
- Standard 6: Access to Consultant-directed interventions: Investment in consultant capacity to allow for the delivery of two additional weekend endoscopy lists, to address the gap in our service for lower gastrointestinal endoscopy
- Standard 8: On-going Review: Proposals under standard 2 will provide capacity to close gaps in capability in the surgical areas specified.

We have recently reviewed our current practice to maximise our ability to deliver Standard 2 but despite changes, potential challenges to the delivery of Standard 2 remain. Service development proposals to address the gaps in seven day coverage were discussed with Commissioners through the contract negotiations in 2017/18 and 2018/19. Commissioners indicated that the proposed investments were not affordable within the 2017/18 – 2018/19 planning round and accepted that the Trust may not be able to meet all the standards until opportunities to improve compliance through service reconfiguration / commissioners re-prioritisation are assessed, despite the mitigation and service redesign being undertaken. We have agreed derogation of the standards in our contract with our commissioners due to the commissioner decision that plans to address these gaps in service are not affordable within the two year planning cycle.

## 7. Activity, Capacity and Performance

### 7.1 Activity and Capacity Planning

The Trust approach to capacity and demand planning for 2018-19 builds on our experience in using the capacity planning tools provided by the Interim Management and Support Team (IMAS) and the methodology used in the last two years to agree contract volumes with commissioners. Each specialty used the IMAS models to estimate the level of capacity required to hold a stable position of 87% to 90% from March 2018 to March 2019 as per NHS Planning Guidance and to make progress to improve where possible. Following the seasonal decrease in performance, our aim will be to maintain a stabilised position and across the full year, plan in a more structured way to allow for seasonal variation. Demographic growth forms the basis for growing the 2017/18 recurrent activity baseline however, where modelling indicates annual growth in excess of demographic changes, a three-year analysis has been used to estimate recurrent growth.

The Trust Service Level Agreement (SLA) proposals have been built-up from this modelling. The level of planned activity for 2018/19 also takes account of the impact of any planned service transfers, service developments and other known planned changes to activity levels. The current status of contracts with our main commissioners is as follows; Contacts are agreed with all commissioners however there has been further discussions regarding contract volumes and value to be agreed through Variation Orders to assure alignment between plans. NHSE Specialised South West contract value has been agreed and the contract signed, BNSSG CCG contract value has been agreed and signed, along with Associate Commissioner contract values at the end of April.

Within the context of the *Healthier Together* programme, the Trust is working with commissioners to particularly identify areas of exceptional growth and agree shared approaches to demand management. The focus of this joint planning is in outpatients, urgent and emergency care and developing out of hospital models to maximise the utilisation of acute beds, including the reduction of delayed transfers of care.

The schedule of planned day-case and inpatient activity for 2018/19 is used to assess the number of beds required in the Trust. Baseline bed requirements have been estimated from the forecast specialty and work-type level spell volumes and current length of stay. Planned bed-days savings from improvements are being focussed in a number of areas, including Length of Stay reduction through internal efficiencies and productivity at a specialty level, day of surgery admissions for elective patients and exploring opportunities to redistribute activity across our main and peripheral sites to maximise the use of facilities. Seasonality has also been applied to planning the use of beds and theatres to account for necessary phasing of elective and emergency work through the year. Trust capacity plans also include winter planning resilience measures based on continuous learning from our current winter plans and actions to manage prolonged periods of higher demand in the winter months.

The Trust will continue to focus on reducing reliance on waiting list initiatives to deliver core capacity however, it is acknowledged that this will be required to clear the backlog following the winter period. To support financial sustainability and responsiveness to heightened periods of demand, a cross-Trust seasonality planning forum has been developed to ensure a collective plan is owned and defined. The majority of required activity to meet contract levels will be delivered "in-house" with a small amount of outsourcing, to maintain flexibility where demand is more volatile. The Trust will continue to use proactive systems for identifying rising demand and mobilise waiting list initiatives and other ad hoc sources of capacity as it has in previous years to manage such situations.

### 7.2 Non-Financial performance Improvement trajectories

The Trust continued to have challenges in consistently meeting all of the core national access standards in 2017/18, including those that now sit within the NHS Improvement Single Oversight Framework. The following provides analysis of performance during 2017/18 to date as context to the approach the Trust is taking to hold a stabilised position from March to March during 2018/19 and beyond. The Trust will also seek to take an early view on how it is performing against the anticipated holistic measures of urgent and emergency care system health and identify actions that need to be taken by the Trust and the wider system, once these measures have been published.

#### 7.2.1 Referral to Treatment Times (RTT)

The last time the Trust achieved 92% was February 2017. From October 2017 to the current position, as of January 2018, the month end position has fluctuated with a variance of 2%-3% between November 2017 and January 2018 month end. The deterioration is due in part to the implementation of the new business rules in RTT4 which required a greater intensity in validation and an instantaneous application of validation.

Overall growth in referrals was up 3% in quarter one but down 2% in quarter two 2017/18, relative to the same period last year, highlighting the need for the Trust to have the ability to flex operational capacity to meet changing levels of demand. Specialties showing persistent increases in demand include Cardiology, Dermatology, Neurology, Pain Relief and a number of Paediatric specialties. The Trust is continuing to work with commissioners on ways of managing and smoothing demand, with active programmes of work across the community underway for Neurology and Dermatology in particular, but also other projects involving more directed use of independent providers and advice & guidance services.

The capacity and demand modelling undertaken for 2017/18 has built in appropriate levels of recurrent growth to enable services to invest in adequate levels of capacity to support the maintenance of RTT waiting list sizes, and in some areas, to address residual backlogs through non-recurrent activity where this is considered required and deliverable. The expectation is, therefore, that the current waiting list and performance position against RTT, measured as the number of patients on an incomplete pathway, will be no higher in March 2019 than in March 2018 and reduced where possible . The baseline for performance has been submitted at 87% to allow for the reverse pacing of elective activity from April to July18 and the significant impact of winter pressures on elective cancellations. Focus will also be placed on continuing to sustain and further improve reductions in the number of patients waiting over 52 weeks as indicated in the national guidance where the current level of potential 52 Week waiting patients should as a minimum, be reduced by half.

### 7.2.2 Cancer standards

The Trust continued to perform well against the majority of the national cancer standards, including achievement of the 62 day GP standard in quarter 3 following implementation of a remedial action plan. The predominant cause of breaches continued to be delays at other providers (38%) with a further 21% of breaches resulting from periods of medical deferral and/or clinical complexity, and 9% due to patient choice. Collaborative work on improving shared pathways continues with a 'virtual PTL' (waiting list meeting) being piloted from February 2018. All other providers in the region have agreed to participate. The 62 day standard is potentially more achievable for the Trust in 2018/19 but is still at risk from external factors. The Trust expects to achieve the two week wait and all 31 day standards in each quarter of 2018/19. The current trajectory for 62day compliance against the national standard is indicating July as the first point of delivery for 18/19.

Surgical cancellations, particularly related to availability of critical care beds, remain a challenge for the Trust and the largest single internal threat to achievement of the cancer standards. Quarter 4 has seen an impact on a number of standards as a result. Capacity across the two intensive care units is being reviewed, alongside work with commissioners on managing emergency critical care demand – particularly from outside the area.

2017/18 saw continuing growth in demand. The table below shows the growth in numbers of patients first seen/treated under the cancer standards during Q1-Q3 2017/18 compared to the same period in 2016/17.

Table 2: Growth in numbers of patients first seen / treated under the cancer standards

| Patients per standard | 2 week wait (first seen) | First treatment | Subsequent treatment |
|---|---|---|---|
| Growth | 1949<br>(19%) | 117<br>(5.7%) | 389<br>(35%) |

In addition, preparations are in place for shadow reporting of the new cancer standards through 2018/19 and the Trust is working with the South West Cancer Alliance and lead commissioners to ensure the relevant elements of Cancer Transformation initiatives are in place within the Trust for 2018/19.

### 7.2.3 Diagnostic waiting times standards

Performance against the 99% standard was only achieved in February 18 for the 2017/18 year. Performance ranged from 97.6% to 98.8% and the areas that experienced most breaches were: Sleep Studies, Non-obstetric ultrasound, MRI and Cardiac CT. There was an increase in demand experienced by Sleep Studies, Cardiac MRI, Cardiac CT and Paediatric MRI. Staffing issues and reduced capacity were also a factor for Non-obstetric ultrasound, Cardiac CT and Paediatric MRI. The Trust now has a recovery trajectory that aims to deliver 99% performance by the end of May 2018, against a backdrop of a significant shortfall in sonographers, which will increase in July and August of 2018. Plans are currently underway for overseas recruitment, whilst in the interim, using bank and agency staff where applicable.

### 7.2.4 A&E 4-hour standard

Achievement of the A&E 4-hour standard continued to be a challenge in 2017/18 with the Trust achieving its recovery trajectory between May and November 2017, but struggling thereafter with the start of the seasonal rise in demand. This still represents a significant improvement year on year in the achievement of the A&E 4hr standard, and was particularly well sustained in the Bristol Royal Hospital for Children, who achieved their STF target to date and met the national 95% target for the first 5 months of the year. Levels of emergency admissions during the first half of 2017/18 were 4.6% higher than the same period in 2016/17, exceeding last year's planning assumptions. Delayed discharges in adult services remain the primary cause of the Trust's inability to meet a maximum 4-hour wait. The Trust has refreshed its approach to Urgent Care Improvement, developing the executive-led response group from last winter into a well-embedded Urgent Care Steering Group. Working with Emergency Care Improvement Programme from NHSI the Trust has reinvigorated the recovery plan across all divisions, including improvements in areas of: discharge planning process, targeted reductions in length of stay and supporting partner organisations within the *Healthier Together* programme to reduce delayed discharges and avoid admissions. Based on assessment of the impact and lead time for these actions our aim is to achieve performance against the 4 hour standard of 90% by September 2018 and maintenance to March 2019

### 7.2.5 Winter Planning

We are current working closely with BNSSG CCG to submit a combined winter plan for 2018/19. Internally learning has been taken from initiatives which were successful in supporting winter demand in 2017/18 and are being consolidated into organisational and divisional plans for 2018/19. These include actions to increase escalation bed capacity; longer term planning for our bed base; and additional staff in key areas, such as deep cleaning, as well as productivity measure, such as more effective use of our catheter labs.

### 7.2.6 Length of Stay (LOS) Plans

Through 2017/18 we have implemented a new programme to drive productivity across a range of indicators, including LOS. Although we benchmark well against LOS in a number of areas, we also recognise that we have significant opportunities to drive efficiency and bed day savings. Through this programme, our divisional teams have outlined LOS reduction plans in their annual Operating plans, which include actions such as increased access to diagnostics and reporting and continued implementation of enhanced recovery pathways after surgery, improved access to CAHMs services for children and adolescents and increased dates of day of surgery admission for cardiac surgery. As well as these internal measures, we

are also working closely with our partners through the urgent care and optimising beds task and finish group and *Healthier Together* to identify system wide solutions to support discharge and optimise the use of our acute bed base. We have run a number of Multi-Agency Discharge Events (MADE) since January 2018, which have proved effective in the short term in supporting the discharge of patients, but also in taking system wide learning with our partners to inform the work of the task and finish groups.

## 8. Workforce

### 8.1 Strategic Context and *Healthier Together Programme*.

Our Workforce and Organisational Development Strategy 2014/15 to 2019/20 was formulated through engagement with Divisions and trade union colleagues. This recognised the importance of recruitment to key staff groups in a tight labour market, maintaining and developing the quality of services with fewer available resources and aligning our staffing levels with the capacity demands and financial resource to ensure safe and effective staffing levels. We continue to develop our strategy in response to our changing environment, increasingly focussing on transformational change to release productivity savings, engaging staff in the process, as described in the Carter (February 2016) report and subsequent Model Hospital work and aligning our objectives with the *Healthier Together* programme.

The Trust is a member of the BNSSG Workforce Advisory Board (WAB) providing the opportunity to address workforce transformation in support of the *Healthier Together* programme in partnership with other healthcare providers, commissioners, and local authorities. The BNSSG WAB has identified key priorities for the STP footprint which are supported through the Health Education England South West Investment Plan. These include:

- Developing a common vision and purpose to support recruitment and retention, with staff engagement events, up-skilling staff to deliver continuous improvement and Organisational Development facilitation;
- Improved staff health and wellbeing, building on organisations' work to achieve CQUINS, achieving a minimum standard across the health community;
- Mental health training for staff to improve their ability to provide psychologically informed interventions;
- A recruitment "passport" to reduce recruitment time and costs when staff move between local health organisations;
- A system-wide approach to support increased collaboration on apprenticeships;
- Implementation of a neutral vendor approach to nurse agency controls and spend.

The Trust continues with its implementation of a Trust-wide apprenticeship programme in line with the Government levy and workforce target. Models of delivery are currently under review, including an option for *Healthier Together* programme-wide approach. For existing staff, development needs are reviewed as part of the annual appraisal, and in addition, the Trust has focussed enhanced staff development opportunities on difficult to recruit and high turnover areas, such as Care of the Elderly, Theatres and Intensive Care. Collaborative working with the University of the West of England has supported the allocation of continuing professional development modules for nursing and allied health professional staff. This new partnership approach in decision making and strategic discussion will ensure that education for nurses and allied healthcare professionals in UH Bristol is aligned to meeting workforce development needs and supporting service delivery changes required by the transformation agenda.

### 8.2 Workforce Planning Approach – Operating Plans

The annual workforce planning process at UH Bristol forms an integral part of the annual Operational Plan cycle. Each Division is required to provide a detailed workforce plan aligned to finance, activity and quality plans. An assessment of workforce demand is linked to commissioning plans reflecting service changes, developments, CQUINS, service transfers and cost improvement plans. The IMAS capacity planning tool is used to identify workforce requirements associated with capacity changes. We have agreed nurse to patient ratios which are reflected in the plans. Workforce supply plans include an assessment of workforce age profiles, turnover, sickness absence and the impact these will have on vacancy levels and the need for temporary staff. Divisional plans are developed by appropriate service leads and clinicians, directed by the Clinical Chair and Divisional Director, and are subject to Executive Director panel review prior to submission to Trust Board. Throughout the course of the year, actual performance against the Operating Plan, including workforce numbers, costs and detailed workforce KPIs are reviewed through Quarterly Divisional Performance reviews held with the Executive team.

The impact of changes which may affect the supply of staff from Europe and beyond and changes to the NHS nursing and allied health professional bursaries are factored into planning and our Workforce and Organisational Development Group has a role in regularly reviewing the impact of such changes and ensuring that appropriate plans are put in place if required.

### 8.3 Managing agency and locum use

Our underpinning strategy to manage agency and locum use is focussed on managing both demand and supply. The underpinning approach to manage the demand for temporary staffing is to focus on the drivers of demand, which include sickness absence, vacancies and turnover through a range of actions which are reported monthly to Quality and Outcomes Committee. Direct actions to manage demand for agency include increased efficiency and effectiveness of rostering by fully implementing a different nursing and midwifery e-rostering system from April 2017 and an electronic acuity and dependency tool from April 2017, continuing to monitor and challenge rostering and operating plan KPIs through the monthly Nursing Controls Group, robustly escalate requests for agency usage and focus on demand for enhanced observation through recruiting to the designated funded establishment. Implementing an e-rostering system for medical staff is planned for 2018 to mirror the efficiencies seen in nursing. Actions to manage supply include improving the ratio of bank fill to agency by external and internal marketing campaigns, incentive payments, and the establishment of a locum bank in 2018. Through close collaborative working with NHS partners across BNSSG, a neutral vendor approach to the management of nurse agency supply was implemented in November 2017. This has been driven by the need to improve control of unnecessary agency spend, achieve greater compliance with the national price caps, increase fill rates and improve quality of service provision.

With the increasing drive to promote transparency, improve data requirements and embed strong accountability to Boards, the Trust is meeting the reporting requirements laid out by NHS Improvement. This includes analyses of the highest earning agency staff, long term agency usage, high costing shift activity, framework and agency cap rate overrides, and more recently bank usage. This is combined with enhanced controls in relation to escalation to ensure there is appropriate sign-off and control at Executive level.

Good progress has been made on reducing agency spend over the past 3 year, as outlined in the table below;

Table 3. Trust agency spend 2016/17 actual to 2018/19 plan

| | 2016/17 £000 | 2017/18 FOT £000 | 2018/19 Plan £000 |
|---|---|---|---|
| Nursing staff | 8,069 | 6,712 | 3,404 |
| Medical staff | 1,014 | 716 | 460 |
| Other | 1,967 | 1,366 | 1,304 |
| Total | 11,050 | 8,794 | 5,168 |
| Agency Ceiling | 12,793 | 12,793 | 11,779 |

8.4 Workforce Numbers

The anticipated workforce plan, derived from the operating planning process described above, expressed in whole-time equivalents (wte) for 2018/19 and how this compares to the previous year is set out in the table below.

The Supply table below reflects planned staffing as shown in the WTE tab of the Workforce templates.

Table 4. Workforce Demand and Supply

| DEMAND (Changes in Funded establishment) Staff Group | Funded Establishment 2017/18 Forecast Outturn wte | Service Developments wte | Savings Programme wte | Activity /Capacity Changes wte | Funded Establishment March 2019 wte | Change wte |
|---|---|---|---|---|---|---|
| Medical and Dental | 1,290 | 0 | (0.3) | 15 | 1,305 | 15 |
| Qualified Nursing and Midwifery staff | 2,565 | 9 | (2) | 15 | 2,588 | 22 |
| Qualified Scientific and Professional Staff | 1,132 | 5 | 0 | 21 | 1,158 | 26 |
| Support to clinical staff | 2,562 | 1 | 0 | 12 | 2,576 | 13 |
| NHS Infrastructure Support (Admin and Estates) | 1,120 | 20 | (8) | 9 | 1,141 | 21 |
| Total | 8,670 | 36 | (11) | 72 | 8,768 | 97 |

| SUPPLY Change | March 2018 Forecast Outturn | | | March 2018 | Changes March 2018 to March 2019 | | | 2018/19 | March 2019 Planned Outturn | | | March 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff Group | Employed wte | Bank wte | Agency wte | wte | Employed wte | Bank wte | Agency wte | Total Changes wte | Employed wte | Bank wte | Agency wte | Planned Total Staffing wte |
| Medical and Dental | 1,266 | | 6 | 1,271 | 37 | | (3) | 34 | 1,303 | | 3 | 1,305 |
| Qualified Nursing & Midwifery staff | 2,350 | 120 | 63 | 2,532 | 114 | (34) | (24) | 55 | 2,464 | 85 | 38 | 2,588 |
| Qualified Scientific and Professional Staff | 1,090 | 14 | 9 | 1,112 | 49 | (4) | 1 | 46 | 1,138 | 9 | 10 | 1,158 |
| Support to clinical staff | 2,318 | 237 | 12 | 2,566 | 50 | (39) | (2) | 9 | 2,368 | 198 | 10 | 2,576 |
| NHS Infrastructure Support (Admin and Estates) | 1,045 | 72 | 9 | 1,126 | 38 | (19) | (4) | 15 | 1,083 | 53 | 5 | 1,141 |
| Total | 8,069 | 442 | 98 | 8,608 | 287 | (97) | (31) | 159 | 8,356 | 345 | 67 | 8,768 |

The workforce plan summarised in the table shown above aligns with the NHS Improvement templates, reflecting the overall strategy to increase our ratio of substantive staffing relative to agency and bank usage through increased recruitment, decreased turnover, and reduced sickness absence.

## 8.5 Transformation and productivity programmes

We will engage and involve staff in solutions which will require different ways of working, such as clinical teams joining up to deliver pathways of care, new roles, changes in skill mix, and development of new competences, in support of *Healthier Together* programme, with a greater likelihood of posts bridging the primary care / acute interface. We will follow up the work started in 2017/18 on Strategic Workforce Planning, with a strategic workforce review. This will involve examining our services, using benchmarking and model hospital information to review the structure and skill-mix of our workforce and ensure that it is fit for purpose both in the present and for the future. Scoping apprenticeships across all Agenda for Change roles is also key to the year ahead.

Examples of plans for workforce transformation include the following:

### Medical:

- The Trust is a 'fast follower' in the *NHS Streamlining Doctors in Training Programme.* Through this, testing and trialling a transformational way of managing rotations is being undertaken. Key efficiencies from August 2018 will include a reduction in the repetition of pre-employment checks and a reduction in time spent in a face to face induction. Benefits will also be realised through a reduction in re-work across the region, improved accuracy of pay protection arrangements and significantly improved workforce data. A framework to meet the 2016 Contract KPI's will also be established.
- Alternative staffing models are being explored to provide sustainable longer term solutions for Junior Doctor rotas i.e. consideration of re-opening the Associate Specialist role to aid recruitment and retention in some specialties.
- Key areas within Children's Services have been identified as appropriate settings for Physician's Assistants and the Division is working with University of the West of England to support a cohort of PAs with their placements (April 2019) and eventually have a commitment to employ 4/5 at the end of their training (August 2020).
- Productivity gains in Children's Theatres through focussed timely starts will affect the MDT in Theatres.
- Teaching and Education fellow in Cardiology, Oncology and Haematology.
- The *Healthier Together* programme Trauma and Orthopaedics Transformation Project includes service redesign options. Gaps in service provision across specialities including Trauma and Orthopaedics, Care of the Elderly and Emergency Department are being filled by new clinical fellow posts which combine elements of research/education/training, and in some cases, expeditions with clinical work which are more attractive to applicants.
- Remaining gaps will be covered within Trauma and Orthopaedics by Physician Associates whilst the Emergency Department is developing options to extend the use of Emergency Nurse Practitioner roles and develop Advanced Nurse Practitioner roles.

### Nursing

- Development of the Advanced Clinical Practitioner (ACP) in areas such as Emergency Care, Care of the Elderly and Paediatric Surgery to provide career progression, respond to gaps in medical capacity, and improve retention;
- Recruitment to a relatively small number of adult nurses within paediatric settings such as Cardiac Cath Lab, PICU and ED.
- Reviews of skill mix following recommendations contained in the "safe and sustainable" paper (staff / patient ratios from 1:3 across all age groups for ward patients, to 1:3 for less than 2 years of age, and 1:4 for patients over the age of 2 years, which affects a number of the Children's Hospital wards).
- Changes to theatre skill mix to improve recruitment and retention with development opportunities.
- Exploring further options for Assistant Practitioner and Nurse Associate roles.

### Scientific, Professional and Technical

- In the context of a strategic workforce review, examination of skill mix within all diagnostic and therapy services will be undertaken, including a review of the impact of digital transformation on roles, and the opportunity to release clinical capacity by developing A&C/technical/assistant support roles.
- Work with education providers to develop apprenticeships in all allied health, scientific and technical professions at all levels, integrated into our career structures.
- Development of Consultant and advanced practice AHP, Pharmacy and Healthcare Scientific posts to provide clinical services and cost effective solutions to help mitigate the risk of medical staff shortages.
- Increase cohort of Pharmacy prescribers.

### Administrative and Clerical staff

- Our administrative and clerical staff programme is focussed on common processes, quality approach to recruitment, training and standards for our ward clerks and booking clerks, standardisation of job descriptions, efficiencies in the administrative and clerical Bank, with the aim to improve support and the quality and efficiency of our clinical services and support enhanced professionalism across our administrative and clinical teams.

### Estates & Facilities staff

- Development of apprenticeships linked to career pathways will be undertaken in order to attract and retain staff and support high quality patient care.

## 8.6 Workforce KPIs

Our workforce KPIs are set at a Divisional and staff group level, taking account of historic performance and comparable benchmarks and helping to drive continuous improvement in making best use of our people.

**Staff Turnover Rate** A target for 2018/19 has been set to reduce from 13.4% to 12.3 % and to 12.1% in 2019/20.

**Vacancy Percentage** Recruiting to vacancies, particularly hard to recruit and specialist areas which are covered by high cost agency workers, remains an important element in our agency reduction plan. The UH Bristol vacancy rate for 2016/17 was 4.2%, and the average year to date vacancy rate (October 2017) of 5.1% compares favourably with other Teaching Trusts. Our internal target is to sustain 5% through 2018/19 and 2019/20.

Sickness Absence We are aiming for a year on year improvement in our sickness absence rates, with a forecast out turn of 4.0% in 2017/18, reducing to 3.8% in 2018/19.

### 8.7 Junior Doctor Contract

The Junior Doctors Contract 2016 has been fully implemented for all 54 rotas. The Contract Implementation Group continues to meet monthly to ensure compliance for each rota is maintained, to oversee exception reports and to develop longer term workforce strategies to manage staffing shortages with certain specialties. The Trust plans to implement e-rostering to provide more effective management of rotas and to more easily facilitate the accumulative calculation of junior doctors' hours.

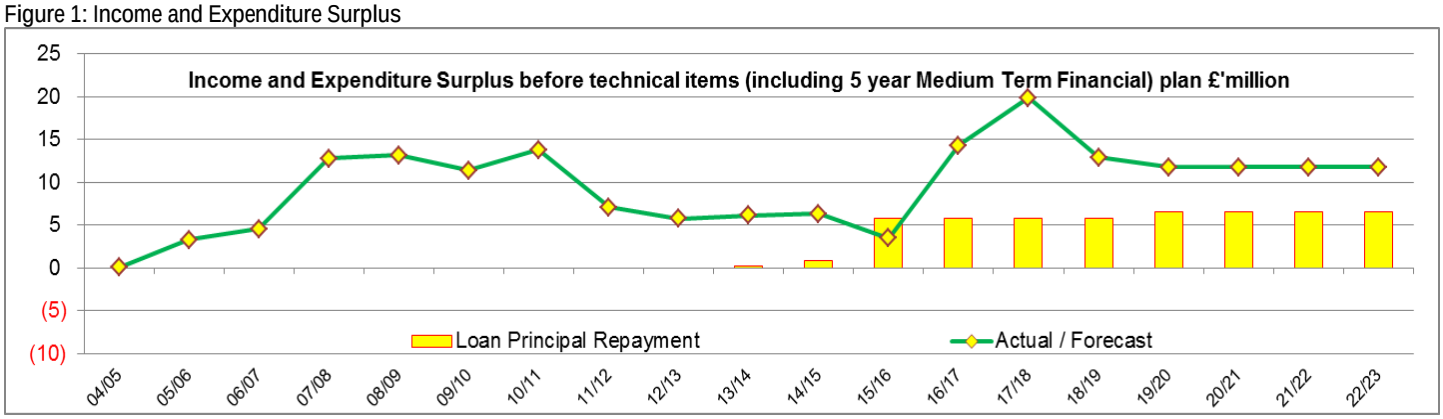
## 9.0 Financial Planning

### 9.1 2017/18 Actual Outturn

#### 9.1.1 Net surplus

The Trust achieved a 2017/18 net income & expenditure surplus of £19.9m, which is a £7.0m favourable variance against the accepted control total surplus of £12.9m. The variance was due to loss of Sustainability performance funding for quarters 1 and 4 (£1.7m) offset by NHS Improvement support received to offset income losses (£1.3m) plus a late share of incentive & bonus funding from NHS Improvement (£7.3m). This will be the Trust's 15th year of break-even or better. A summary of the Trust's financial position, including the historical performance, is provided below in figure 1.

Figure 1: Income and Expenditure Surplus




The Trust remains one of the best performing Acute Trusts in terms of financial performance. To achieve this, however, non-recurrent measures of over £7.3m were required to deliver the Control Total in 2017/18 (along with the receipt of Winter funding). Of these measures c.£6m are non-repeatable hence additional recurrent CIPs are required to restore this position in 2018/19.

#### 9.1.2 Savings

The Trust's 2017/18 savings requirement was £11.5m. Savings of £12.1m were delivered in the year. Of these £8.8m were recurrent. The Divisions' underlying deficits from 2017/18 of £6.1m will be carried forward into the 2018/19 savings requirement.

#### 9.1.3 Capital expenditure

The Trust's capital expenditure was £25.4m for 2017/18 against an NHS Improvement plan of £47.9m due to scheme slippage, primarily within the Trust's strategic programme. The Trust's gross carry-forward commitments into 2018/19 are £31.9m.

#### 9.1.4 Use of Resources Rating

The Trust's Use of Resources Rating (UORR) of 1, is the highest rating. The Trust has strong liquidity with a working capital balance of £43.0m at the 31st March 2018 and achieved 24.9 liquidity days and a liquidity metric of one. The Trust's revenue available for capital service was £53.7m delivers capital service cover of 3.0 times and a metric of one. The Trust's net income and expenditure margin was 2.9% and achieves a metric of one. The adverse I&E margin variance achieves a metric of 1 and the forecast agency expenditure metric scores a rating of one. The position is summarised below.

Table 5: 2017/18 Use of Resources Rating

| | Metric | Rating |
|---|---|---|
| Liquidity | 24.9 days | 1 |
| Capital service cover | 3.03 times | 1 |
| Net I&E margin | 2.91% | 1 |
| I&E margin variance | 0.94% | 1 |
| Agency expenditure variance against ceiling | 34.3% | 1 |
| Overall UORR rounded | 1 | 1 |

| Rating 1 | Rating 2 | Rating 3 | Rating 4 |
|---|---|---|---|
| 0 days | -7 days | -14 days | <-14 days |
| 2.5 times | 1.75 times | 1.25 times | <1.25 times |
| >1% | >0% | <-1% | >-1% |
| =>0% | <-1% | <-2% | >-2% |
| <0% | <25% | <50% | >=50% |

## 9.2 2018/19 Financial Plan

### 9.2.1 Introduction

The 2018/19 plan is based on the following key drivers;

- Acceptance of the NHS Improvement proposed control total of a £18.5m surplus. This includes receipt of £15.5m Provider Sustainability Funding (PSF) and obviates the need to pay core performance fines.
- The Trust's savings target is set at 5.1% of recurrent budgets generating £25.5m (5.1%)
- The stretch to the proposed control of £18.5m beyond the 2017/18 plan is £3.4m which is included in the savings target.
- The plan still carries a risk around the unresolved issue of Wales HRG4+ tariffs (valued at £1.5m) which is assumed to be received as income in year.
- A gross inflation uplift of 2.1% (plus the CNST tariff uplift) includes a 1% pay award and incremental drift together valued at £5.2m, the balance to full year impact of the new Junior Doctors contract at £0.8m, pensions auto-enrolment at £0.8m, an increase in the cost of Clinical Negligence Scheme for Trusts (CNST) premiums at £2.9m and non-pay inflation at 3% or £2.2m. The 2.1% uplift is considered just about adequate but makes no allowance for other cost pressures;
- Net activity growth of £10.0m, additional high cost drugs of £12.6m, Research & Development growth of £3.5m, CEA Awards of £0.4m and a loss of £1.5m relating to HRG4+ Wales income;
- Service Level Agreement (SLA) proposals have been agreed with Commissioners. This included Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCGs) and associates and NHS England (Specialised and Non-Specialised);
- The Divisional 2017/18 over-spending of £7.2m has been covered by non-recurrent measures in 2017/18. Of these measures c.£6m are non-repeatable in 2018/19 hence the underlying shortfall requires recurrent CIPs to be delivered to prevent this going to the bottom line. The derivation of the £7.2m is from accumulated cost pressures (mainly Nursing and Medical Pay) and unachieved prior year savings targets.

The Trust believes the plan continues to describe an excellent level of financial performance. A surplus plan has been delivered for the 15 years up to 2017/18 and 2018/19 will be the 16th year. The Trust is proud of this track record which it has used to underpin its achievements in terms of capital infrastructure and quality improvement.

### 9.2.2 Financial Plan

The 2018/19 financial plan of a £20.6m surplus is summarised below

Table 6. Summary of the 2018/19 financial plan

| Surplus / (Deficit) | £m | |
|---|---|---|
| Underlying position brought forward | (0.4) | Position excludes £13.3m PSF |
| National Tariff efficiency requirement | (10.1) | 2.0% deflator included in the 2018/19 National Tariff |
| Divisional underlying deficit from 2017/18 | (6.1) | |
| Savings programme | 25.5 | |
| Cost pressures | | |
| Divisional clinical cost pressures | (0.7) | Increase offset in part by Tariff. |
| Capital Charges volume growth | (1.2) | Volume growth. |
| Medical and Dental SIFT | (0.7) | Estimated HEE impacts |
| Corporate risk prioritised cost pressures | (0.5) | Unavoidable recurrent costs only. |
| Pharmacy out-sourcing costs | (0.3) | Unavoidable recurrent costs only. |
| CEA awards | (0.4) | Not fully funded |
| Other cost pressures | (0.2) | |
| Tariff Loss | (0.1) | Tariff Adjustment |
| 2018/19 Underlying position | 4.8 | |
| Non-recurrent | | |
| Provider Sustainability Funding | 15.5 | |
| Change costs / spend to save | (0.3) | To fund schemes generating recurring savings. |
| Corporate risk prioritised cost pressures | (0.5) | Unavoidable non-recurrent costs only. |
| Transition costs for strategic schemes | (0.3) | In support of strategic capital schemes. |
| Clinical IT programme | (0.7) | Funds the IT Programme support costs. |
| Net I&E Surplus / (Deficit) exc. PSF & technical items | 18.5 | Definition used for Control Total purposes. |
| Donated asset depreciation | (1.5) | |
| Donated asset income | 3.0 | |
| Net impairments | 0.6 | |
| Net I&E Surplus / (Deficit) inc. technical items | 20.6 | |

### 9.2.3 Income

The Trust's total income is £690.2m and is summarised below.

Table 7: 2018/19 Income build up

| | | £m | £m |
|---|---|---|---|
| Rollover Income | Recurrent income from 2017/18 | | 653.5 |
| Tariff | Gross inflation including CNST | 13.2 | |
| | Efficiency | (10.1) | |
| | | | 3.1 |
| Impact of Guidance | Tariff impact | (0.1) | |
| | | | (0.1) |
| Activity / SLA Changes | Service transfers | 0.9 | |
| | Recurrent activity (including undelivered QIPP) | 6.3 | |
| | Non-recurrent activity (including undelivered QIPP) | 2.0 | |
| | Remove prior year non-recurring activity | (4.3) | |
| | Non RTT activity changes | 5.0 | |
| | Revenue Developments (ERPs) | 0.2 | 10.0 |
| Provider Sustainability Funding | | | 2.2 |
| Other | High cost drug / devices assessment (including NICE) | 12.6 | |
| | Research & Development growth | 3.5 | |
| | CQUINs | 0.5 | |
| | Other | 4.9 | |
| | | | 21.5 |
| | Total 2018/19 Income (Including Donation Income of £3m) | | 690.2 |

### 9.2.4 Costs

The 2018/19 level of cost pressures for the Trust is very challenging and should be considered in the context of operational pressures on spending, the full delivery of savings plans and transformation initiatives. Firm control will continue to be required to avoid the Trust's medium term plans being undermined beyond 2018/19. The main assumptions included in the Trust's cost projections are:

- Inflation costs of £13.2m;
- Agency costs of £5.8m;
- Savings requirement of £25.5m;
- Recurrent unavoidable cost pressures of £4.1m;
- Non Recurrent unavoidable cost pressures of £1.8m;
- Payment of loan interest at £2.7m;
- Depreciation of £25.9m; and
- Capital charges volume growth of £1.2m.
- Stretch to deliver control total surplus of £3.4m (0.7%)

### 9.2.5 Cost Improvement Plans

The Trust sets CIP targets for 2018/19 to include the following requirements:

- Commissioner efficiency requirement of £10.1m (2.0%);
- Divisional underlying deficits of £6.1m (1.2%);
- Unavoidable recurrent cost pressures of £4.1m (0.9%); and
- Unavoidable non-recurrent cost pressures of £1.8m (0.3%).
- Stretch to deliver control total surplus of £3.4m (0.7%)

This represents a CIP requirement of £25.5m or 5.1% of operational budgets.

The Trust has an established process for generating CIPs operated under the established Transforming Care programme. There is an increased focus in 2018/19 on delivering savings from productivity hence the Trust has established a series of targeted programmes led by executive directors directed at delivering productivity from:

- Out patients;
- Length of stay;
- Theatres;
- Consultant productivity; and
- Diagnostics.

These programmes are using all available benchmarking in order to identify areas for improvement and develop actions plans to ensure delivery. The Trust also has a series of programmes focussing on increased and robust controls including in the areas of non-pay, drugs and pay areas particularly medical staffing and nursing. Further work streams dedicated to delivering transactional CIPs have also been established, for example:

- Improving purchasing and efficient usage of non-pay including drugs and blood;

- Ensuring best value in the use of the Trust's Estates and Facilities. This includes a review of the delivery of specific services, and further improvements in energy efficiencies;
- Ensuring best use of technology to improve efficiency, linking productivity improvement with the introduction of new tools in clinical records management and patient administration;
- Addressing and reducing expenditure on premium payments including agency spend; and
- Focussing on reducing any requirement to outsource activity to non-NHS bodies.

The Trust's risk assessed CIP plan is summarised below. The total of unidentified savings is currently £2.4m.

| Workstreams | £m |
|---|---|
| Allied Healthcare Professionals Productivity | 0.9 |
| Medical Staff Efficiencies Productivity | 0.6 |
| Nursing & Midwifery Productivity | 1.1 |
| Diagnostic testing | 0.2 |
| Reducing and Controlling Non Pay | 4.9 |
| Medicines savings (Drugs) | 0.8 |
| Trust Services efficiencies | 0.6 |
| HR Pay and productivity | 0.1 |
| Estates and Facilities productivity | 0.7 |
| Productivity | 3.1 |
| Other | 6.7 |
| Subtotal – savings identified | 19.7 |
| Unidentified savings | 5.8 |
| Total – savings requirement | 25.5 |

### 9.2.7 Capital expenditure

The Trust has a significant capital expenditure programme investing £613m from April 2007 until March 2023 in the development of its estate. In 2018/19, the Trust's planned capital expenditure totals £47.0m, after estimated £22.5m slippage into 2019/20 which will be reviewed later in the year when the position is firmed up. The net 2018/19 capital expenditure plan is summarised below:

Table 8: Source and applications of capital

| Source of funds | 2018/19 Plan £m | Application of funds | 2018/19 Plan £m |
|---|---|---|---|
| Cash balances | 7.6 | Carry forward schemes – Phase 5 | 15.8 |
| Depreciation | 24.3 | Carry forward schemes – Other | 16.1 |
| Loan – Car Park Scheme * | 3.2 | IM&T | 4.1 |
| Donations | 3.0 | Medical equipment | 8.9 |
| Public Dividend Capital | 1.6 | Operational capital | 6.2 |
| 2017/18 Incentive STF Funds | 7.3 | Estates replacement | 2.5 |
| | | MSCP | 3.2 |
| | | Phase 5 | 5.4 |
| | | Additional Capital Investment (unallocated) | 7.3 |
| | | Net slippage estimated | (22.5) |
| Total | 47.0 | Total | 47.0 |

The Trust completed a loan application in support of University Hospital's Bristol Marlborough Hill Car Park Scheme for £19.1m. This was submitted to the Independent Trust Financing Facility (ITFF) in March 2017 and the ITFF recommended the application.

### 9.2.8 Use of Resources Rating

The planned net surplus of £22.0 and acceptance of the proposed 2018/19 control total of £22.0m is the driver behind the Trust's overall Use of Resources Rating (UORR) of 1. The position is summarised below:

Table 9: 2018/19 Use of Resources Rating

| | Metric | Rating |
|---|---|---|
| Liquidity | 22.9 days | 1 |
| Capital service cover | 3.0 times | 1 |
| Net I&E margin | 2.7% | 1 |
| I&E margin variance | 0% | 1 |
| Agency expenditure variance against ceiling | 56.1% | 1 |
| Overall UORR rounded | 1 | 1 |

| Rating 1 | Rating 2 | Rating 3 | Rating 4 |
|---|---|---|---|
| 0 days | -7 days | -14 days | <-14 days |
| 2.5 times | 1.75 times | 1.25 times | <1.25 times |
| >1% | >0% | <-1% | >-1% |
| =>0% | <-1% | <-2% | >-2% |
| <0% | <25% | <50% | >=50% |

9.2.9 Summary Statement of Comprehensive Income

The 2018/19 Statement of Comprehensive Income (SoCI) and closing cash balance is summarised below:

Table 10: SoCI and closing cash balance

| | 2018/19 Plan £m |
|---|---|
| Income (Excluding Donations) | 687.2 |
| Operating expenditure | (631.7) |
| EBITDA (excluding donation income) | 55.5 |
| Non-operating expenditure | (37.0) |
| Net surplus / (deficit) excluding technical items | 18.5 |
| Net impairments | 0.6 |
| Donation income | 3.0 |
| Donated asset depreciation | (1.5) |
| Net surplus / (deficit) including technical items | 20.6 |
| Year-end cash | 80.0 |

9.3 Financial Risks

The main risks to the delivery of the 2018/19 plan include:

- CQUIN schemes are not earnable and may cost more to deliver;
- Cost pressures exceed that budgeted for – particular concern exists over the cost of the new Junior Doctors contract and the proposed Agenda for Change contract
- Delivery of the Trust's new savings programme is considered high risk;
- Planned activity is not delivered hence compromising the Trust's Operational Plan including the potential need to use premium cost delivery methods; and
- Growth in emergency activity cannot be managed within planned capacity or there is a failure to invest in Community and Primary Care schemes to support this demand – leading to loss of elective activity and premium rate solutions.

9.4 Changes from the 2018/19 Operating Plan included as year two in the 2017/18 – 2018/19 Operating Plan Submission

The original two year control total of £24.642m was rejected so sustainability funding was not included. For the final plan this forms a major reason for the increase to the £690.2m income plan. The full reconciliation is shown below:

The planned level of income is higher – as follows:

| | £m |
|---|---|
| • Original 2018/19 plan | 649.5 |
| • Tariff inflation | 0.7 |
| • Net activity changes | 7.0 |
| • High cost drugs | 9.6 |
| • Loss of CQUINs | (1.6) |
| • R&D increases | 3.5 |
| • HEE Reductions | (0.7) |
| • Donations | 3.0 |
| • Service Transfer | 0.9 |
| • Other net changes | 2.8 |
| • Provider Sustainability Funding | 15.5 |
| • Total | 690.2 (Including Donation Income of £3.0m) |

9. Membership and elections

10.1 Governor elections in the previous years and plans for the coming 12 months

In 2017, 14 governor roles were available for election, across seven constituencies, including public, patient and staff members. We received 29 nominations in total. One candidate was elected unopposed and the other six constituencies went forward to election. Turnout was largely in line with previous elections.

The staff governor representing the medical and dental constituency stepped down on 31 October 2017 and a by-election for this seat will be held in spring 2018. The next elections are due to be held in 2019.

10.2 Governor recruitment, training and development and member engagement activities

Governors are provided with a comprehensive programme of training and development that begins upon appointment with an induction seminar. The induction seminar is one of four governor development seminars each year; the content of the seminars now focuses on either core skills, updates and/or training. The governor development sessions are useful mechanisms to ensure that the Council of Governors builds understanding of the workings of the Trust alongside the governor role and statutory duties. In addition to the development sessions the governors hold regular focus group meetings on Trust strategy, quality and performance, and constitution, which are attended by Executive Directors/senior managers and a Non-executive Director.

In terms of member engagement, at the start of 2017, the membership team agreed with governors a set of priorities around membership engagement for each quarter of the year, focusing first on the election campaign, then on governor induction. In the last three months of 2017, there was a review of membership engagement methods and practices, with a full programme of activities in place for 2018. The membership team has continued with regular membership engagement activities with governor support, including a monthly e-newsletter, Health Matters events (health talks for members/members of the public) and a members' page in the Trust's 'Voices' magazine which is sent to every member twice a year.

### 10.3 Membership strategy – plans for next 12 months

A renewed focus on engagement for 2017-18 has seen the membership team put in place a full events programme: increasing Health Matters events from quarterly events to near monthly; introducing monthly hospital 'Meet and Greet' stalls to enable governors to meet their constituents; undertaking an online membership survey (to assess the benefits and impact of membership) and a postal mailshot inviting feedback. Over the coming months, the membership office will be assessing the activities undertaken and formulating a new strategy to ensure membership remains fit for purpose to 2020 and beyond, with support from governors through the governor-led Constitution Focus Group.

## 10. Conclusion

This Operational Plan reflects significant work across the Trust and has been built up from detailed and integrated Divisional plans. While this provides assurance on achievability, we will continue to develop the plan to enhance our confidence in its delivery and to reflect continuing work within our system as part of *Healthier Together.*

**Operational Plan 2017/2018 to 2018/2019 (Year Two Refresh) – supporting narrative**

University Hospitals Bristol NHS Foundation Trust

## 1. Context for Operational Plan

Trust Board approved the two year Operational Plan for 2017-2019 on 22nd December 2016, which was subsequently submitted to NHS Improvement (NHSI) on 23rd December 2016. This 2018/19 Plan therefore reflects a refresh of that two year plan setting out the Trust's approach and position on activity, quality, workforce and financial planning for the period. The current draft position is based on a robust and integrated approach to operational planning within the Trust and alignment with the aspirations and relevant specific actions of the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan (BNSSG STP *Healthier Together*). The Trust fully appreciates the financial challenges in the NHS overall and our track record evidences our commitment and ability to deliver affordable, quality care sustainably. Our leadership role within the STP *Healthier Together* footprint seeks to extend this experience into the system and we have supported the adoption of an open book approach through the local System Delivery Oversight Group and through our negotiation of any required changes to year two of the two year contract signed on 23rd December 2016.

**Our plan reflects the following position at 24th April 2018;**

- Acceptance of the proposed NHS Improvement Control Total offer of a £18.5 surplus. This will enable the Trust to reserve £15.5 of Provider Sustainability Funding (PSF) and obviate the need to pay core performance fines.
- Service Level Agreement (SLA) proposals have been agreed with Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCGs) and associates and NHS England (Specialised and Non-Specialised).
- Clarity and ownership of stretching quality priorities delivered through enabling quality improvement frameworks - our 2018/19 quality priorities are being finalised and will be approved by the Board in our Quality Accounts in May 2018.
- Workforce plans aligned to finance, activity and quality and addressing robust accountability for managing agency and locum expenditure
- Commitment to deliver sustained or improved performance in core access and NHS Constitution standards aligned to NHSI/NHSE guidance.

## 2. Strategic Backdrop

Our 2017/19 Operational Plan has been written in the context of the longer term direction set out in our existing five year strategic plan and also within the context of the developing BNSSG STP *Healthier Together*. Our current Trust Strategy ("Rising to the Challenge 2020") states that as an organisation, our key challenge is to maintain and develop the quality of our services, whilst managing within the finite available resources with our focus being on "affordable excellence". We are also clear that we operate as part of a wider health and care community and our strategic intent sets out our position with regard to how we optimise our collective resources to deliver sustainable quality care into the future.

**Our Vision is *for Bristol and our hospitals, to be among the best and safest places in the country to receive care* and our strategic intent is to provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services**.

We are committed to addressing the aspects of care that matter most to our patients and during 2018/19, we will ensure our strategy remains dynamic to the changing needs of our patients and ongoing changes within both the national and local planning environment. In 2016/17, we undertook a review to prioritise and stratify our clinical strategy and established a clear governance framework within which to drive strategic decision-making and support implementation plans and in 2017/18, we have focussed on progressing the development of our core areas of clinical strategy, along with key enabling strategies, such as our digital agenda. In 2018/19 we are working to renew our current 2014-2019 Trust strategy and are engaging staff, patients and external partners to develop a strategy to 2025 that will enable us to maintain outstanding care in the context of the challenges we face. This is a major strategic project in 2018/19 and will be key in setting our future direction as an organisation.

A key aim in developing our own internal strategic programme and future strategy is to align with the new processes, pathways and structures developing as part of the local *Healthier Together* and the changing national context. These new approaches provide us with a significant opportunity to progress our strategic priorities at pace and to work together with our partners to resolve some of the system-wide challenges we face. The decision made at the Trust Board in January 2018 to pursue an organistional merger via acquisition with Weston Area Health Trust, represents significant progress in this approach and we will develop plans for the partnership and service specific alignment during 2018/19.

The Trust has a clear governance route through which to identify, assess and manage significant risks that may threaten the achievement of our strategic objectives. We reviewed these processes in 2016/17 and agreed a new Board Assurance Framework (BAF) with the Trust Board considering the BAF on a quarterly basis and this governance process will remain through 2018/19.

## 3. Link to the local Sustainability and Transformation Partnership *Healthier Together*

We remain clear that system leadership and collaborative working are essential for system sustainability and our two year Operational Plan is set firmly within the context of our local BNSSG STP *Healthier Together*. The *Healthier Together* programme has developed five key strands to its' ambition and vision that will enable the footprint to develop and implement a sustainable health and care system for our local population, these are outlined below;

- *We want individuals to be at the centre of their own health and care. People will be inspired and supported to care for themselves.*
- *Services will be more joined up, easy to access and as close to home as possible.*
- *We want access to our leading-edge hospital and specialist services to be simplified and to continue to serve a population well beyond the BNSSG area with excellent life-saving services.*
- *We want to focus more on improving the way we provide care with greater emphasis on delivering care in the community – because it's best. We will also focus more on mental health, urgent care, hospital services and prevention.*
- *We recognise bold action is needed over the coming years to meet increasing demand, but this is evolution – not revolution. There isn't going to be one big single plan that solves all of the problems.*

Our two year Operational Plan has been developed in the context of these ambitions and there is clear alignment with our operational priorities. A transformational programme of change is being established through the *Healthier Together* partnership, structured via nine strategic priorities. These are:

| | | | |
|---|---|---|---|
| System Productivity | Integrated Care | Effective Planned care | Children's & Maternity services |
| Healthy Weston | Acute Care Collaboration | Mental Health & Learning disabilities | Prevention & Early Intervention |
| Primary Care reform (GPFV) | | | |

Through our Operational Plan, we are clear that we play a key role in both leading and contributing to *Healthier Together* programmes of work. Delivery of our quality, performance and financial operating plan intent is predicated on both organisational and system actions. The *Healthier Together* programme clearly identifies its ambitious but equally pragmatic vision, wherein the impact of a new model of care and specific transformational service delivery changes are agreed by all partners, but which remain to be developed to the stage that we can confidently reflect the impact in our contracts and our operational delivery projections. As the *Healthier Together* plans mature, we will incorporate material changes in our 2018-19 contracts via variations and in the dynamic approach we adopt to our two year Operating Plan projections.

Improved productivity and effectiveness is a key focus of the developing projects within the *Healthier Together* programme and within our organisation, with specific emphasis placed on the need to maximise the use of acute facilities and resources, reducing costs, duplication and variation where possible and potentially reconfiguring or redistributing services between the three acute providers if this provides greater opportunity for services to develop and thrive. The Trust has already worked with other providers to deliver major change to the benefit of patients on a wide range of services and we are committed to develop the next phase of acute care collaboration based on shared leadership models.

During 2018-19, we will continue to lead and enable translation of the acute care collaboration principles into delivery through a smaller number of high impact projects to both realise 'quick wins' in closing the gaps and establish and build confidence in new ways of working and collaborating as a system. The priority projects identified are;

| | |
|---|---|
| • Stroke pathways | • Trauma and Orthopaedic and Musculoskeletal services |
| • Pathology model of care | • Medicines optimisation |
| • Corporate overheads reduction | • Weston sustainability |

In parallel, we will scope and implement projects in Neonatal Intensive Care; Interventional Radiology and Optimising outpatients.

**4. Local and National Commissioning Context 2018/19**

As outlined above, the planning assumptions within the Trust Operational Plan for 2018-19 have been developed in such a way that takes into account both the national priorities highlighted in the planning guidance "Refreshing NHS Plans for 2018/19 and the local priorities for the BNSSG Healthier Together Sustainability and Transformation Plan (STP).

In 2018/19 we have set our activity levels and performance trajectories to accommodate the national activity growth assumptions and the constitutional standards requirements for:

- Waiting list maintenance at March 2018 levels for all commissioners, predicted to be 3,240 patients (based on 27,000 pathways at March 2019) and 52 week waits only on an exceptional basis where patient choice has been exercised; and
- Delivery of the other constitutional standards including cancer 2 week waits, cancer 62 day urgent referral to treatment and diagnostic waiting times.

With respect to the Accident and Emergency 4 hour performance standard, the national requirement is for aggregate performance above 90% for the month of September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019, and that the NHS returns to 95% overall performance within the course of 2019. Based on our analysis of actions to improve performance alongside a realistic assessment of the lead time for system actions to fully impact, we have set our trajectory for A&E at 90% by September 2018 and maintenance to March 2019

Locally we have also agreed with commissioners a threshold for RTT performance between 87-90% during the course of 2018-19. On the basis that the Trust will accept a control total for 2018/19, the Trust will be exempt from contractual fines and penalties as defined within the NHS Standard Contract and will also pursue opportunities for securing income for advice and guidance services which are recommended nationally as part of local tariff reform.

The operational challenges and opportunities for the Trust are set within a local context in which our *Healthier Together* STP continues to mature and develop closer provider and commissioner relationships to address the BNSSG system financial deficit. In the short term, task and finish groups have been set up to review all existing projects and identify potential activity reductions for 2018/19 including areas such as urgent and same day emergency care; bed optimisation to affect length of stay; referral management and outpatient activity and mental health activity as part of CCG requirements to eliminate out of area activity and deliver a new Mental Health Investment Standard. We are working closely with these task and finish groups to maximise the benefit for UH Bristol and the wider system.

We also have commitment from Specialised Commissioners in the South Region to work more closely with our STP in implementing these plans, which will include a review of adult and paediatric critical care, neonatal critical care and rehabilitation pathways for brain injuries and neurological injuries and increasing Children and Adolescent Mental Health (CAMHs) placements.

From a future Trust planning perspective we are fully committed to the system way of working and supporting our STP to mature into a fully integrated care system. In 2018/19 we are particularly interested in supporting CCGs to fulfil their new statutory responsibility for delegated commissioning of Primary Care Medical Services and the associated new clinical pathways for integrated out of hospital care. For example, we are already supporting initiatives to review clinical pathways such as Respiratory, Musculoskeletal, Stroke, Frailty and Diabetes across BNSSG and we are also engaging on plans for a new model of adult Audiology provision and clinical pathways for Deep Vein Thrombosis.

Finally, within the next financial year the Trust also expect to be clearer about the outcomes of the North Somerset Sustainability Programme and the future of Weston Area Health Trust as part of a joint review with CCGs, NHS England and NHS Improvement. This in turn may lead to further in depth reviews for out of hospital model of care affecting Trust services, including but not limited to South Bristol Community Hospital.

**5. Organisational Strategy 2018-19 Focus**

Our 2017/18 NHSI Operational Plan outlined our organisational commitment to the development of the BNSSG STP *Healthier Together* and how, as year one of our two year plan, our 2017/18 priority was to contribute to developing and implementing plans to address the identified system gaps in Care and Quality, Health and Wellbeing and Finance and Efficiency. This commitment remains in 2018/19, with the focus of our strategic and operational plans over year two of our two year plan directed at the following Corporate Objectives:

| Strategic Priority | Corporate Objective 2018/19 |
|---|---|
| **We will consistently deliver high quality individual care, delivered with compassion.** | • Ensure patients have access to the right care when they need it and are discharged as soon as they are medically fit.<br>• Improve performance against access standards and delivery of our performance trajectories in the four core standards.<br>• Improve patient and staff experience<br>• Improve outcomes and reduce mortality<br>• Improve patient safety |
| **We will ensure a safe, friendly and modern environment for our patients and our staff.** | • Develop the Estates and capital strategy during 2018-19 to continue to align the modernisation and development of our estate to our evolving clinical strategy and support delivery of the emerging system wide new models of care.<br>• Maximise the productivity and utilisation of our estate and facilities. |
| **We will strive to employ the best and help all our staff fulfil their individual potential** | • Develop our Leadership and Management Capability through delivery of a comprehensive programme of leadership and management training and development.<br>• Continue to improve staff engagement and experience.<br>• Recruiting and Retaining the Best. Continue to market all vacancies with innovative, cost effective solutions, utilising the strong employer brand Love Life Love Bristol to deliver a highly skilled and productive workforce that is as diverse as the community that we serve.<br>• Reward and Performance Management: Improve the quality and application of staff appraisal.<br>• Transform and optimise workforce efficiency: control agency and locum costs, review the Strategic Workforce Plan for the Trust and, in collaboration with BNSSG Workforce Advisory Board, support the strategic workforce activity of the Healthier Together programme. |
| **We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.** | • Maximise the opportunity provided by our successful appointment as a National Digital Exemplar site to continue to deliver a programme to support the long-term vision of the Trust's Clinical Systems Strategy - *that every member of our staff will have access to the information they need, when they need it, without having to look for a piece of paper, wait to use a computer or ask the patient yet again.*<br>• Maintain performance in initiating and delivering high quality clinical trials, demonstrated by remaining within the upper quartile of trusts within our league (as reported to Department of Health via NIHR); maintain our performance in initiating research and remain the top recruiting trust within the West of England Clinical Research Network and within the top 10% of Trusts nationally (published annually by NIHR).<br>• Maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR).<br>• Continue to develop our research capacity and capability building on the significant grant secured from the National Institute for Health Research to fund a Biomedical Research Centre undertaking cutting edge studies that will improve care and treatment in the future.<br>• Deliver our Transforming Care Programme focussing on working smarter, eliminating waste and transforming the way in which we deliver quality care through service and workforce redesign enabled through digital transformation. |
| **We will provide leadership to the networks we are part of, for the benefit of the region and people we serve** | • Lead and collaborate through the BNSSG Healthier Together partnership to make our services fit for the future.<br>• Continue to develop our partnerships with Weston Area Health Trust and North Bristol Trust to support our collective clinical and financial sustainability<br>• Play an active part in the research and innovation landscape through our contribution to Bristol Health |

| | |
|---|---|
| | Partners, West of England Academic Health Science Network and Collaborative for Leadership and Applied Research and HealthCare (CLARHC).<br>• Effectively host the Networks that we are responsible for including Operational Delivery Networks, the CLARHC and Clinical Research Network. |
| **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.** | • Deliver agreed financial plan for 2018/19.<br>• Deliver minimum cash balance.<br>• Deliver the annual Cost Improvement Plan (CIP) programme.<br>• Implement an Executive led productivity programme to eliminate waste and add value from :<br>• Out patients; Length of stay; Theatres; Consultant productivity; and Diagnostics. |
| **We will ensure we are soundly governed and are compliant with the requirements of our regulators.** | • Recommit to and renew our Trust Strategy, setting the strategic direction for the Trust from 2019-2025, and ensure we integrate our clinical, teaching and research capabilities to maximise the benefit for the people we serve<br>• Implement General Data Protection Regulations.<br>• Ensure all principles of good governance are embedded in practice and policy.<br>• Achieve regulatory compliance against CQC fundamental standards. |

## 6. Quality planning

### 6.1 Approach to quality planning

The Trust is committed to delivering excellent health services that meet the needs of our patients and their families and provides the highest quality standards. The Board and Senior Leadership Team of UH Bristol have a critical role in leading a culture which promotes the delivery of high quality services. This requires both vision and action to ensure all efforts are focussed on creating an environment for change and continuous improvement. The Trust's annual quality delivery plans and quality strategy (2016-2020) set out the actions we will take to ensure that this is achieved.

We do have much to be proud of. The Trust's quality improvement programme led by the Chief Nurse, Medical Director and Chief Operating Officer continues to show us what is possible when we have a relentless focus on quality improvement. In our last strategy, we recognised that access to services is integral to patient experience and that great patient experience happens when staff feel valued, supported and motivated. In our revised strategy, we have now made this wider view of quality integral to our definition. Our quality strategy and quality improvement work is therefore structured around four core quality themes:

| | |
|---|---|
| • Ensuring timely access to services<br>• Delivering safe and reliable care | • Improving patient and staff experience<br>• Improving outcomes and reducing mortality |

Running through each of these are the threads of research, innovation and quality improvement. Our quality improvement priorities are underpinned by our commitment to address the aspects of care that matter most to our patients in collaboration with our strategic partners. They also take into account national quality and commissioning priorities, our quality performance during 2017/18 feedback from our public and staff consultations and are supported by our organisational values – respecting everyone, working together, embracing change and recognising success. We are committed to the continued focus on delivering our quality strategy, through our quality improvement plan and particularly focussing on areas highlighted in our recent CQC inspection as requiring improvement. We will also be focussing in 2018/19 on ensuring we continue to build on the outstanding practice recognised by the CQC and on maintaining our overall rating of Outstanding as a Trust.

### 6.2 Summary of our quality improvement plan and focus for 2017-2019

In summary, our quality improvement plan will mean that we:

- Cancel fewer operations.
- Reduce patient waiting times.
- Improve the safety of patients by reducing avoidable harm.
- Strengthen our patient safety culture.
- Create new opportunities for patients, families and staff to give us feedback about their experiences, and in a way which enables concerns to be addressed in real-time.
- Develop a customer service mind set across the organisation, including how we handle and respond to complaints.
- Take a lead role in the development of a new national system of rapid peer review of unexpected patient deaths, implementing learning about the causes of preventable deaths.
- Significantly improve staff satisfaction, making UH Bristol an employer of choice.
- Address the issues relating to 'on-hold' patients on RTT pathways and mitigating actions are now in place to prevent the risk of it happening again.
- Reduce the number of 'Never Events' occurring within the Trust.

Our plans will be built on a foundation of:

- The patient-centred principle of "nothing about me without me".
- Partnership working.
- Evidence-based treatment and care derived from high-class research – some of it led by us.
- Effective teamwork.
- Systematic benchmarking of our practice and performance against the best.
- Learning when things go wrong.
- Intelligent use of clinical audit and quality improvement activities.

- Learning from internal and external review.

**Table 1: Our key quality improvement priorities for 2018/19**

| *Ensuring timely access to services* | *Improving patient and staff experience* | *Improving outcomes and reducing mortality* | *Delivering safe and reliable care* |
|---|---|---|---|
| • Deliver the four national access standards<br>• Reduce the number of cancelled operations – particularly at the last minute<br>• Reduce the number of cancelled clinics and delays in clinic when attending an outpatient appointment<br>• Work with partners to ensure that when patients are identified as requiring onward specialist mental healthcare, we minimise the delays and maintain the patient's safety while they await their transfer. | • Create new opportunities for patient and public involvement<br>• Introduce a system to support people to give feedback, where possible in real-time, at the point of care.<br>• Achieve Friends and Family Test scores and response rates which are consistently in the national upper quartile<br>• Improve our handling and resolving complaints effectively from the perspective of our service users<br>• To achieve year-on-year improvements in the Friends and Family Test (whether staff would recommend UH Bristol as a place to work) and staff engagement survey scores<br>• Be upper quartile performers in all national patient surveys<br>• Develop a customer service mind-set in all our dealings with patients, and introduce a programme of mystery shopping to support this | • Implement evidence-based clinical guidance, supported by a comprehensive programme of local clinical audit, and by working in partnership with our regional academic partners to facilitate research into practice and evidenced based care/commissioning<br>• Use benchmarking intelligence to understand variation in outcomes<br>• Ensure learning from unexpected hospital deaths<br>• Deliver programmes of targeted activity in response to this learning | • Develop our safety culture to help embed safety and quality improvement in everything thing we do<br>• Improve early recognition and escalation of deteriorating patients to include early recognition and management of sepsis and Acute Kidney Injury (AKI)<br>• Improve medicines safety including at the point transfer of care (medicines optimisation)<br>• Eliminate peri-procedure "never events"<br>• Delivering national CQUINs |

Despite our quality strategy and work to improve our patient flow, we continue to identify ongoing risks in relation to access and patient flow. The challenges we face in delivery of our performance standards are outlined in section 7. In recognising the impact that limited access to services and particularly the cancellation of planned surgery or outpatient appointments places on the quality of care we provide for our patients, our actions to address these through our Transforming Care Programme and productivity and performance improvement plans will remain a key priority for the next year.

### 6.3 Approach to quality improvement

The Trust's objectives, values and quality strategy provide a clear message that high quality services and excellent patient experience are the first priority for the Trust. In the context of the responsibilities of individual NHS bodies to live within the funding available, we are clear that the commitments we make in our quality strategy also need to be financially deliverable and our relentless focus on quality must be accompanied by an equally relentless focus on efficiency. The message underpinning our approach to quality improvement is "affordable excellence".

We plan to achieve this by securing continued ownership and accountability for delivery of our quality priorities through our five clinical Divisions. All Divisions have specific, measurable quality goals as part of their annual Operating Plans, with progress against these plans monitored by Divisional Boards and by the Executive Team through monthly Divisional Performance Reviews.

We specifically aim to ensure that clinical care is delivered in accordance with patients' preferences and in line with the best available clinical evidence including NICE[1] standards, Royal College guidelines and recommendations arising from national confidential inquiries. By understanding our current position in relation to national guidance (for example through clinical audit) and by working with our regional academic partners (including through Bristol Health Partners and The National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care West) to facilitate research into practice and evidenced based care/commissioning, we can work towards minimising any variations in practice.

UH Bristol has developed regional and national influence in the field of clinical audit practice over a period of more than 15 years. Over the next year, we will continue to develop the way we use participation in local clinical audit to drive improvement in clinical services and ensure;

- All clinical services (at sub-specialty level) will participate regularly in clinical audit (measured by registered clinical audit activity).
- 95% of relevant published NICE guidance[2] will be formally reviewed by the Trust within 90 days of publication.
- We will develop and implement new internal systems for identifying and monitoring compliance with national guidance other than those for which systems already exist (NICE and NCEPOD[3]).

We recognise that we need to support our staff in continuous improvement and we plan to achieve this through "Transforming Care" - our overarching programme of transformational change designed to address specific priorities for improvement across all aspects of our services. Our transformation improvement priorities for 2018/19 will continue to be structured around the six "pillars" of delivering best care, improving patient flow, delivering best value, renewing our hospitals, building capability and leading in partnership.

[1] The National Institute for Health and Care Excellence
[2] i.e. clinical guidelines, quality standards and technology appraisal guidance
[3] The National Confidential Enquiry into Patient Outcome and Death

Within our Innovation and Improvement Framework, the Trust has developed a QI (Quality Improvement) Academy to align and develop QI training, development and support opportunities for frontline staff, with the aim of increasing capability and capacity within and across frontline teams from awareness to practitioner to expert. We will continue to grow the Academy in 2018/19 increasing our silver level programmes and developing a gold level, QI expert programme.

Our governors engage with the quality agenda via their Strategy Focus Group and Quality Focus Group. Each quarter, the Board and its sub-committees receive the Board Assurance Framework and the Trust's Risk Register which report high level progress against each of the Trust's corporate objectives (including quality objectives) and any associated risks to their achievement. Additionally, the Board's Audit Committee works with the Trust's Clinical Audit and Effectiveness team to consider evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives.

**6.4 Quality impact assessment process**

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes and unfunded cost pressures and commissioner proposals on the quality of services. This includes a formal Quality Impact Assessment (QIA) for all Cost Improvement Plans (CIP) with a financial impact of greater than £50k and any scheme that eliminates a post involved in frontline service delivery.

The Trust's QIA process involves a structured risk assessment, using our standardised risk assessment framework, which includes assessment against the risk domains of safety, quality and workforce. The QIA provides details of mitigating actions and asks for performance or quality measures which will allow the impact of the scheme or proposal to be monitored. The QIA sign off process provides review and challenge through Divisional quality governance mechanisms to ensure senior oversight of any risks to quality of the plans. The Medical Director and Chief Nurse are responsible for assuring themselves and the Board that CIPs and unfunded cost pressures and commissioner proposals, will not have an adverse impact on quality. Any QIA that has a risk to quality score over a set threshold which the Trust wants to proceed with is presented to the Quality and Outcomes Committee (a sub-Committee of the Trust Board). This ensures Board oversight of the QIA process.

The Trust's overall processes for monitoring quality and triangulating information provide a framework within which to monitor the impact of schemes. For any schemes or proposals where there are potential risks to quality, we plan to strengthen our processes to ensure transparency of scheme-specific Key Performance Indicators (KPIs) and how these are robustly monitored via divisional and Trust governance structures.

**6.5 Triangulation of Quality, Workforce and Finance**

Our internal business planning and associated monitoring processes underpin the triangulation of our quality, workforce and finance objectives. Our Operating Plans are developed through the five clinical and Trust Services corporate Divisions with monthly and quarterly Divisional Reviews conducted with the Executive team. These reviews include detailed information on workforce KPI's and any workforce risks, which support cross-referencing of quality and workforce performance. The Trust's Clinical Quality Group monitors compliance with CQC Fundamental Standards on an ongoing basis and our Quality and Outcomes Committee monitors performance against a range of performance standards.

The NHS national staffing return compares expected and actual staffing levels on wards for each day and night. This information is also triangulated with the Trust quality performance dashboard to assess whether the overall standard of patient care was of good quality. This forms part of the monthly report to the Quality and Outcomes Committee and each ward receives its own RAG-rated quality performance dashboard including workforce KPIs on a monthly basis. This enables the triangulation of workforce and quality data at a ward, Divisional and Trust-wide level and is further supported by a six monthly staffing report to the Board, which takes an overview of significant changes in workforce numbers, national guidance or requirements, and progress on agreed actions. There are also annual Divisional staffing reviews of inpatient areas led by the Chief Nurse and includes Finance Leads and Divisional Senior Nurses, to ensure that staffing levels and skill mix are appropriate, affordable and provide quality care as measured by our quality KPIs. In addition, there are agreed criteria laid out in our six monthly Board report to prompt an ad hoc review of establishment and skill mix as required.

- Through the independent review against Monitor's 'Well-led framework for governance' completed in 2015/16, the Trust Board was provided with assurance that systems and process were in place to ensure that the Board and Senior Leadership Team had good oversight of care, quality, operations and finances. The actions identified to further improve the governance systems in the Trust as a result of the review have all been completed. During 2018/19 we plan to complete an externally facilitated Well-Led Review to ensure that we maintain good governance standards and identify areas for further improvement.

**6.6 Seven day working**

We regularly assess ourselves against the standards for seven day working using standard six monthly audits against the core clinical standards (2, 5, 6 and 8). This has helped us target our work on specific areas in developing our plans to provide seven day services. Within the nine 'must do's' for 2017-19 is the requirement to meet the four priority standards for seven day hospital services for all urgent care network specialist services by November 2017 (this includes vascular, stroke, major trauma, heart attack and children's critical care services) and progress towards the 4 standards for all non-urgent care network services by 2020. The most recent completed audit in the spring of this year showed the progress achieved but also highlights where compliance gaps remain.

We can confirm we achieved compliance against the November 2017 requirement for urgent care network specialist services for paediatric major trauma, heart attack and children's critical care services and we are not the local provider for major trauma or vascular services. We have however, identified that further service developments are required to meet the standards for stroke services and within our Interventional Radiology service, which contributes to the vascular network standards. These plans are summarised below alongside our plans to achieve the 2020 goal for the broader roll out of seven day services to all relevant specialties. It is also of note that a review of the model for stroke services is currently a priority project within the BNSSG STP *Healthier Together* and the affordable provision of seven day services within this urgent care specialist service may be provided through a cross system solution. Outline plans to address identified gaps in seven day services against the 2017 and 2020 standards include:

- Standard 2: Time to consultant Review: Additional consultant capacity within general surgery, trauma & orthopaedics and gynaecology services to ensure full compliance with the standard.

- Standard 5: Access to Diagnostics: Formalisation of Interventional Radiology arrangements with North Bristol NHS Trust.
- Standard 6: Access to Consultant-directed interventions: Investment in consultant capacity to allow for the delivery of two additional weekend endoscopy lists, to address the gap in our service for lower gastrointestinal endoscopy
- Standard 8: On-going Review: Proposals under standard 2 will provide capacity to close gaps in capability in the surgical areas specified.

We have recently reviewed our current practice to maximise our ability to deliver Standard 2 but despite changes, potential challenges to the delivery of Standard 2 remain. Service development proposals to address the gaps in seven day coverage were discussed with Commissioners through the contract negotiations in 2017/18 and 2018/19. Commissioners indicated that the proposed investments were not affordable within the 2017/18 – 2018/19 planning round and accepted that the Trust may not be able to meet all the standards until opportunities to improve compliance through service reconfiguration / commissioners re-prioritisation are assessed, despite the mitigation and service redesign being undertaken. We have agreed derogation of the standards in our contract with our commissioners due to the commissioner decision that plans to address these gaps in service are not affordable within the two year planning cycle.

## 7. Activity, Capacity and Performance

### 7.1 Activity and Capacity Planning

The Trust approach to capacity and demand planning for 2018-19 builds on our experience in using the capacity planning tools provided by the Interim Management and Support Team (IMAS) and the methodology used in the last two years to agree contract volumes with commissioners. Each specialty used the IMAS models to estimate the level of capacity required to hold a stable position of 87% to 90% from March 2018 to March 2019 as per NHS Planning Guidance and to make progress to improve where possible. Following the seasonal decrease in performance, our aim will be to maintain a stabilised position and across the full year, plan in a more structured way to allow for seasonal variation. Demographic growth forms the basis for growing the 2017/18 recurrent activity baseline however, where modelling indicates annual growth in excess of demographic changes, a three-year analysis has been used to estimate recurrent growth.

The Trust Service Level Agreement (SLA) proposals have been built-up from this modelling. The level of planned activity for 2018/19 also takes account of the impact of any planned service transfers, service developments and other known planned changes to activity levels. The current status of contracts with our main commissioners is as follows; Contacts are agreed with all commissioners however there has been further discussions regarding contract volumes and value to be agreed through Variation Orders to assure alignment between plans. NHSE Specialised South West contract value has been agreed and the contract signed, BNSSG CCG contract value has been agreed and signed, along with Associate Commissioner contract values at the end of April.

Within the context of the *Healthier Together* programme, the Trust is working with commissioners to particularly identify areas of exceptional growth and agree shared approaches to demand management. The focus of this joint planning is in outpatients, urgent and emergency care and developing out of hospital models to maximise the utilisation of acute beds, including the reduction of delayed transfers of care.

The schedule of planned day-case and inpatient activity for 2018/19 is used to assess the number of beds required in the Trust. Baseline bed requirements have been estimated from the forecast specialty and work-type level spell volumes and current length of stay. Planned bed-days savings from improvements are being focussed in a number of areas, including Length of Stay reduction through internal efficiencies and productivity at a specialty level, day of surgery admissions for elective patients and exploring opportunities to redistribute activity across our main and peripheral sites to maximise the use of facilities. Seasonality has also been applied to planning the use of beds and theatres to account for necessary phasing of elective and emergency work through the year. Trust capacity plans also include winter planning resilience measures based on continuous learning from our current winter plans and actions to manage prolonged periods of higher demand in the winter months.

The Trust will continue to focus on reducing reliance on waiting list initiatives to deliver core capacity however, it is acknowledged that this will be required to clear the backlog following the winter period. To support financial sustainability and responsiveness to heightened periods of demand, a cross-Trust seasonality planning forum has been developed to ensure a collective plan is owned and defined. The majority of required activity to meet contract levels will be delivered “in-house” with a small amount of outsourcing, to maintain flexibility where demand is more volatile. The Trust will continue to use proactive systems for identifying rising demand and mobilise waiting list initiatives and other ad hoc sources of capacity as it has in previous years to manage such situations.

### 7.2 Non-Financial performance Improvement trajectories

The Trust continued to have challenges in consistently meeting all of the core national access standards in 2017/18, including those that now sit within the NHS Improvement Single Oversight Framework. The following provides analysis of performance during 2017/18 to date as context to the approach the Trust is taking to hold a stabilised position from March to March during 2018/19 and beyond. The Trust will also seek to take an early view on how it is performing against the anticipated holistic measures of urgent and emergency care system health and identify actions that need to be taken by the Trust and the wider system, once these measures have been published.

#### 7.2.1 Referral to Treatment Times (RTT)

The last time the Trust achieved 92% was February 2017. From October 2017 to the current position, as of January 2018, the month end position has fluctuated with a variance of 2%-3% between November 2017 and January 2018 month end. The deterioration is due in part to the implementation of the new business rules in RTT4 which required a greater intensity in validation and an instantaneous application of validation.

Overall growth in referrals was up 3% in quarter one but down 2% in quarter two 2017/18, relative to the same period last year, highlighting the need for the Trust to have the ability to flex operational capacity to meet changing levels of demand. Specialties showing persistent increases in demand include Cardiology, Dermatology, Neurology, Pain Relief and a number of Paediatric specialties. The Trust is continuing to work with commissioners on ways of managing and smoothing demand, with active programmes of work across the community underway for Neurology and Dermatology in particular, but also other projects involving more directed use of independent providers and advice & guidance services.

The capacity and demand modelling undertaken for 2017/18 has built in appropriate levels of recurrent growth to enable services to invest in adequate levels of capacity to support the maintenance of RTT waiting list sizes, and in some areas, to address residual backlogs through non-recurrent activity where this is considered required and deliverable. The expectation is, therefore, that the current waiting list and performance position against RTT, measured as the number of patients on an incomplete pathway, will be no higher in March 2019 than in March 2018 and reduced where possible . The baseline for performance has been submitted at 87% to allow for the reverse pacing of elective activity from April to July18 and the significant impact of winter pressures on elective cancellations. Focus will also be placed on continuing to sustain and further improve reductions in the number of patients waiting over 52 weeks as indicated in the national guidance where the current level of potential 52 Week waiting patients should as a minimum, be reduced by half.

**7.2.2 Cancer standards**

The Trust continued to perform well against the majority of the national cancer standards, including achievement of the 62 day GP standard in quarter 3 following implementation of a remedial action plan. The predominant cause of breaches continued to be delays at other providers (38%) with a further 21% of breaches resulting from periods of medical deferral and/or clinical complexity, and 9% due to patient choice. Collaborative work on improving shared pathways continues with a 'virtual PTL' (waiting list meeting) being piloted from February 2018. All other providers in the region have agreed to participate. The 62 day standard is potentially more achievable for the Trust in 2018/19 but is still at risk from external factors. The Trust expects to achieve the two week wait and all 31 day standards in each quarter of 2018/19. The current trajectory for 62day compliance against the national standard is indicating July as the first point of delivery for 18/19.

Surgical cancellations, particularly related to availability of critical care beds, remain a challenge for the Trust and the largest single internal threat to achievement of the cancer standards. Quarter 4 has seen an impact on a number of standards as a result. Capacity across the two intensive care units is being reviewed, alongside work with commissioners on managing emergency critical care demand – particularly from outside the area.

2017/18 saw continuing growth in demand. The table below shows the growth in numbers of patients first seen/treated under the cancer standards during Q1-Q3 2017/18 compared to the same period in 2016/17.

**Table 2: Growth in numbers of patients first seen / treated under the cancer standards**

| Patients per standard | 2 week wait (first seen) | First treatment | Subsequent treatment |
|---|---|---|---|
| **Growth** | 1949<br>(19%) | 117<br>(5.7%) | 389<br>(35%) |

In addition, preparations are in place for shadow reporting of the new cancer standards through 2018/19 and the Trust is working with the South West Cancer Alliance and lead commissioners to ensure the relevant elements of Cancer Transformation initiatives are in place within the Trust for 2018/19.

**7.2.3 Diagnostic waiting times standards**

Performance against the 99% standard was only achieved in February 18 for the 2017/18 year. Performance ranged from 97.6% to 98.8% and the areas that experienced most breaches were: Sleep Studies, Non-obstetric ultrasound, MRI and Cardiac CT. There was an increase in demand experienced by Sleep Studies, Cardiac MRI, Cardiac CT and Paediatric MRI. Staffing issues and reduced capacity were also a factor for Non-obstetric ultrasound, Cardiac CT and Paediatric MRI. The Trust now has a recovery trajectory that aims to deliver 99% performance by the end of May 2018, against a backdrop of a significant shortfall in sonographers, which will increase in July and August of 2018. Plans are currently underway for overseas recruitment, whilst in the interim, using bank and agency staff where applicable.

**7.2.4 A&E 4-hour standard**

Achievement of the A&E 4-hour standard continued to be a challenge in 2017/18 with the Trust achieving its recovery trajectory between May and November 2017, but struggling thereafter with the start of the seasonal rise in demand. This still represents a significant improvement year on year in the achievement of the A&E 4hr standard, and was particularly well sustained in the Bristol Royal Hospital for Children, who achieved their STF target to date and met the national 95% target for the first 5 months of the year. Levels of emergency admissions during the first half of 2017/18 were 4.6% higher than the same period in 2016/17, exceeding last year's planning assumptions. Delayed discharges in adult services remain the primary cause of the Trust's inability to meet a maximum 4-hour wait. The Trust has refreshed its approach to Urgent Care Improvement, developing the executive-led response group from last winter into a well-embedded Urgent Care Steering Group. Working with Emergency Care Improvement Programme from NHSI the Trust has reinvigorated the recovery plan across all divisions, including improvements in areas of: discharge planning process, targeted reductions in length of stay and supporting partner organisations within the *Healthier Together* programme to reduce delayed discharges and avoid admissions. Based on assessment of the impact and lead time for these actions our aim is to achieve performance against the 4 hour standard of 90% by September 2018 and maintenance to March 2019

**7.2.5 Winter Planning**

We are current working closely with BNSSG CCG to submit a combined winter plan for 2018/19. Internally learning has been taken from initiatives which were successful in supporting winter demand in 2017/18 and are being consolidated into organisational and divisional plans for 2018/19. These include actions to increase escalation bed capacity; longer term planning for our bed base; and additional staff in key areas, such as deep cleaning, as well as productivity measure, such as more effective use of our catheter labs.

**7.2.6 Length of Stay (LOS) Plans**

Through 2017/18 we have implemented a new programme to drive productivity across a range of indicators, including LOS. Although we benchmark well against LOS in a number of areas, we also recognise that we have significant opportunities to drive efficiency and bed day savings. Through this programme, our divisional teams have outlined LOS reduction plans in their annual Operating plans, which include actions such as increased access to diagnostics and reporting and continued implementation of enhanced recovery pathways after surgery, improved access to CAHMs services for children and adolescents and increased dates of day of surgery admission for cardiac surgery. As well as these internal measures, we

are also working closely with our partners through the urgent care and optimising beds task and finish group and *Healthier Together* to identify system wide solutions to support discharge and optimise the use of our acute bed base. We have run a number of Multi-Agency Discharge Events (MADE) since January 2018, which have proved effective in the short term in supporting the discharge of patients, but also in taking system wide learning with our partners to inform the work of the task and finish groups.

## 8. Workforce

### 8.1 Strategic Context and *Healthier Together Programme*.

Our Workforce and Organisational Development Strategy 2014/15 to 2019/20 was formulated through engagement with Divisions and trade union colleagues. This recognised the importance of recruitment to key staff groups in a tight labour market, maintaining and developing the quality of services with fewer available resources and aligning our staffing levels with the capacity demands and financial resource to ensure safe and effective staffing levels. We continue to develop our strategy in response to our changing environment, increasingly focussing on transformational change to release productivity savings, engaging staff in the process, as described in the Carter (February 2016) report and subsequent Model Hospital work and aligning our objectives with the *Healthier Together* programme.

The Trust is a member of the BNSSG Workforce Advisory Board (WAB) providing the opportunity to address workforce transformation in support of the *Healthier Together* programme in partnership with other healthcare providers, commissioners, and local authorities. The BNSSG WAB has identified key priorities for the STP footprint which are supported through the Health Education England South West Investment Plan. These include:

- Developing a common vision and purpose to support recruitment and retention, with staff engagement events, up-skilling staff to deliver continuous improvement and Organisational Development facilitation;
- Improved staff health and wellbeing, building on organisations' work to achieve CQUINS, achieving a minimum standard across the health community;
- Mental health training for staff to improve their ability to provide psychologically informed interventions;
- A recruitment "passport" to reduce recruitment time and costs when staff move between local health organisations;
- A system-wide approach to support increased collaboration on apprenticeships;
- Implementation of a neutral vendor approach to nurse agency controls and spend.

The Trust continues with its implementation of a Trust-wide apprenticeship programme in line with the Government levy and workforce target. Models of delivery are currently under review, including an option for *Healthier Together* programme-wide approach. For existing staff, development needs are reviewed as part of the annual appraisal, and in addition, the Trust has focussed enhanced staff development opportunities on difficult to recruit and high turnover areas, such as Care of the Elderly, Theatres and Intensive Care. Collaborative working with the University of the West of England has supported the allocation of continuing professional development modules for nursing and allied health professional staff. This new partnership approach in decision making and strategic discussion will ensure that education for nurses and allied healthcare professionals in UH Bristol is aligned to meeting workforce development needs and supporting service delivery changes required by the transformation agenda.

### 8.2 Workforce Planning Approach – Operating Plans

The annual workforce planning process at UH Bristol forms an integral part of the annual Operational Plan cycle. Each Division is required to provide a detailed workforce plan aligned to finance, activity and quality plans. An assessment of workforce demand is linked to commissioning plans reflecting service changes, developments, CQUINS, service transfers and cost improvement plans. The IMAS capacity planning tool is used to identify workforce requirements associated with capacity changes. We have agreed nurse to patient ratios which are reflected in the plans. Workforce supply plans include an assessment of workforce age profiles, turnover, sickness absence and the impact these will have on vacancy levels and the need for temporary staff. Divisional plans are developed by appropriate service leads and clinicians, directed by the Clinical Chair and Divisional Director, and are subject to Executive Director panel review prior to submission to Trust Board. Throughout the course of the year, actual performance against the Operating Plan, including workforce numbers, costs and detailed workforce KPIs are reviewed through Quarterly Divisional Performance reviews held with the Executive team.

The impact of changes which may affect the supply of staff from Europe and beyond and changes to the NHS nursing and allied health professional bursaries are factored into planning and our Workforce and Organisational Development Group has a role in regularly reviewing the impact of such changes and ensuring that appropriate plans are put in place if required.

### 8.3 Managing agency and locum use

Our underpinning strategy to manage agency and locum use is focussed on managing both demand and supply. The underpinning approach to manage the demand for temporary staffing is to focus on the drivers of demand, which include sickness absence, vacancies and turnover through a range of actions which are reported monthly to Quality and Outcomes Committee. Direct actions to manage demand for agency include increased efficiency and effectiveness of rostering by fully implementing a different nursing and midwifery e-rostering system from April 2017 and an electronic acuity and dependency tool from April 2017, continuing to monitor and challenge rostering and operating plan KPIs through the monthly Nursing Controls Group, robustly escalate requests for agency usage and focus on demand for enhanced observation through recruiting to the designated funded establishment. Implementing an e-rostering system for medical staff is planned for 2018 to mirror the efficiencies seen in nursing. Actions to manage supply include improving the ratio of bank fill to agency by external and internal marketing campaigns, incentive payments, and the establishment of a locum bank in 2018. Through close collaborative working with NHS partners across BNSSG, a neutral vendor approach to the management of nurse agency supply was implemented in November 2017. This has been driven by the need to improve control of unnecessary agency spend, achieve greater compliance with the national price caps, increase fill rates and improve quality of service provision.

With the increasing drive to promote transparency, improve data requirements and embed strong accountability to Boards, the Trust is meeting the reporting requirements laid out by NHS Improvement. This includes analyses of the highest earning agency staff, long term agency usage, high costing shift activity, framework and agency cap rate overrides, and more recently bank usage. This is combined with enhanced controls in relation to escalation to ensure there is appropriate sign-off and control at Executive level.

Good progress has been made on reducing agency spend over the past 3 year, as outlined in the table below;

**Table 3. Trust agency spend 2016/17 actual to 2018/19 plan**

| | 2016/17 £000 | 2017/18 FOT £000 | 2018/19 Plan £000 |
|---|---|---|---|
| **Nursing staff** | 8,069 | 6,712 | 3,404 |
| **Medical staff** | 1,014 | 716 | 460 |
| **Other** | 1,967 | 1,366 | 1,304 |
| **Total** | 11,050 | 8,794 | 5,168 |
| **Agency Ceiling** | 12,793 | 12,793 | 11,779 |

### 8.4 Workforce Numbers

The anticipated workforce plan, derived from the operating planning process described above, expressed in whole-time equivalents (wte) for 2018/19 and how this compares to the previous year is set out in the table below.

The Supply table below reflects planned staffing as shown in the WTE tab of the Workforce templates.

**Table 4. Workforce Demand and Supply**

| DEMAND (Changes in Funded establishment) Staff Group | Funded Establishment 2017/18 Forecast Outturn wte | Service Developments wte | Savings Programme wte | Activity /Capacity Changes wte | Funded Establishment March 2019 wte | Change wte |
|---|---|---|---|---|---|---|
| Medical and Dental | 1,290 | 0 | (0.3) | 15 | 1,305 | 15 |
| Qualified Nursing and Midwifery staff | 2,565 | 9 | (2) | 15 | 2,588 | 22 |
| Qualified Scientific and Professional Staff | 1,132 | 5 | 0 | 21 | 1,158 | 26 |
| Support to clinical staff | 2,562 | 1 | 0 | 12 | 2,576 | 13 |
| NHS Infrastructure Support (Admin and Estates) | 1,120 | 20 | (8) | 9 | 1,141 | 21 |
| **Total** | **8,670** | **36** | **(11)** | **72** | **8,768** | **97** |

| SUPPLY Change | March 2018 Forecast Outturn | | | March 2018 | Changes March 2018 to March 2019 | | | 2018/19 | March 2019 Planned Outturn | | | March 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff Group | Employed wte | Bank wte | Agency wte | wte | Employed wte | Bank wte | Agency wte | Total Changes wte | Employed wte | Bank wte | Agency wte | Planned Total Staffing wte |
| Medical and Dental | 1,266 | | 6 | 1,271 | 37 | | (3) | 34 | 1,303 | | 3 | 1,305 |
| Qualified Nursing & Midwifery staff | 2,350 | 120 | 63 | 2,532 | 114 | (34) | (24) | 55 | 2,464 | 85 | 38 | 2,588 |
| Qualified Scientific and Professional Staff | 1,090 | 14 | 9 | 1,112 | 49 | (4) | 1 | 46 | 1,138 | 9 | 10 | 1,158 |
| Support to clinical staff | 2,318 | 237 | 12 | 2,566 | 50 | (39) | (2) | 9 | 2,368 | 198 | 10 | 2,576 |
| NHS Infrastructure Support (Admin and Estates) | 1,045 | 72 | 9 | 1,126 | 38 | (19) | (4) | 15 | 1,083 | 53 | 5 | 1,141 |
| **Total** | **8,069** | **442** | **98** | **8,608** | **287** | **(97)** | **(31)** | **159** | **8,356** | **345** | **67** | **8,768** |

The workforce plan summarised in the table shown above aligns with the NHS Improvement templates, reflecting the overall strategy to increase our ratio of substantive staffing relative to agency and bank usage through increased recruitment, decreased turnover, and reduced sickness absence.

### 8.5 Transformation and productivity programmes

We will engage and involve staff in solutions which will require different ways of working, such as clinical teams joining up to deliver pathways of care, new roles, changes in skill mix, and development of new competences, in support of *Healthier Together* programme, with a greater likelihood of posts bridging the primary care / acute interface. We will follow up the work started in 2017/18 on Strategic Workforce Planning, with a strategic workforce review. This will involve examining our services, using benchmarking and model hospital information to review the structure and skill-mix of our workforce and ensure that it is fit for purpose both in the present and for the future. Scoping apprenticeships across all Agenda for Change roles is also key to the year ahead.

Examples of plans for workforce transformation include the following:

**Medical:**

- The Trust is a 'fast follower' in the *NHS Streamlining Doctors in Training Programme.* Through this, testing and trialling a transformational way of managing rotations is being undertaken. Key efficiencies from August 2018 will include a reduction in the repetition of pre-employment checks and a reduction in time spent in a face to face induction. Benefits will also be realised through a reduction in re-work across the region, improved accuracy of pay protection arrangements and significantly improved workforce data. A framework to meet the 2016 Contract KPI's will also be established.
- Alternative staffing models are being explored to provide sustainable longer term solutions for Junior Doctor rotas i.e. consideration of re-opening the Associate Specialist role to aid recruitment and retention in some specialties.
- Key areas within Children's Services have been identified as appropriate settings for Physician's Assistants and the Division is working with University of the West of England to support a cohort of PAs with their placements (April 2019) and eventually have a commitment to employ 4/5 at the end of their training (August 2020).
- Productivity gains in Children's Theatres through focussed timely starts will affect the MDT in Theatres.
- Teaching and Education fellow in Cardiology, Oncology and Haematology.
- The *Healthier Together* programme Trauma and Orthopaedics Transformation Project includes service redesign options. Gaps in service provision across specialities including Trauma and Orthopaedics, Care of the Elderly and Emergency Department are being filled by new clinical fellow posts which combine elements of research/education/training, and in some cases, expeditions with clinical work which are more attractive to applicants.
- Remaining gaps will be covered within Trauma and Orthopaedics by Physician Associates whilst the Emergency Department is developing options to extend the use of Emergency Nurse Practitioner roles and develop Advanced Nurse Practitioner roles.

**Nursing**

- Development of the Advanced Clinical Practitioner (ACP) in areas such as Emergency Care, Care of the Elderly and Paediatric Surgery to provide career progression, respond to gaps in medical capacity, and improve retention;
- Recruitment to a relatively small number of adult nurses within paediatric settings such as Cardiac Cath Lab, PICU and ED.
- Reviews of skill mix following recommendations contained in the "safe and sustainable" paper (staff / patient ratios from 1:3 across all age groups for ward patients, to 1:3 for less than 2 years of age, and 1:4 for patients over the age of 2 years, which affects a number of the Children's Hospital wards).
- Changes to theatre skill mix to improve recruitment and retention with development opportunities.
- Exploring further options for Assistant Practitioner and Nurse Associate roles.

**Scientific, Professional and Technical**

- In the context of a strategic workforce review, examination of skill mix within all diagnostic and therapy services will be undertaken, including a review of the impact of digital transformation on roles, and the opportunity to release clinical capacity by developing A&C/technical/assistant support roles.
- Work with education providers to develop apprenticeships in all allied health, scientific and technical professions at all levels, integrated into our career structures.
- Development of Consultant and advanced practice AHP, Pharmacy and Healthcare Scientific posts to provide clinical services and cost effective solutions to help mitigate the risk of medical staff shortages.
- Increase cohort of Pharmacy prescribers.

**Administrative and Clerical staff**

- Our administrative and clerical staff programme is focussed on common processes, quality approach to recruitment, training and standards for our ward clerks and booking clerks, standardisation of job descriptions, efficiencies in the administrative and clerical Bank, with the aim to improve support and the quality and efficiency of our clinical services and support enhanced professionalism across our administrative and clinical teams.

**Estates & Facilities staff**

- Development of apprenticeships linked to career pathways will be undertaken in order to attract and retain staff and support high quality patient care.

### 8.6 Workforce KPIs

Our workforce KPIs are set at a Divisional and staff group level, taking account of historic performance and comparable benchmarks and helping to drive continuous improvement in making best use of our people.

**Staff Turnover Rate** A target for 2018/19 has been set to reduce from 13.4% to 12.3 % and to 12.1% in 2019/20.

**Vacancy Percentage** Recruiting to vacancies, particularly hard to recruit and specialist areas which are covered by high cost agency workers, remains an important element in our agency reduction plan. The UH Bristol vacancy rate for 2016/17 was 4.2%, and the average year to date vacancy rate (October 2017) of 5.1% compares favourably with other Teaching Trusts. Our internal target is to sustain 5% through 2018/19 and 2019/20.

**Sickness Absence** We are aiming for a year on year improvement in our sickness absence rates, with a forecast out turn of 4.0% in 2017/18, reducing to 3.8% in 2018/19.

### 8.7 Junior Doctor Contract

The Junior Doctors Contract 2016 has been fully implemented for all 54 rotas. The Contract Implementation Group continues to meet monthly to ensure compliance for each rota is maintained, to oversee exception reports and to develop longer term workforce strategies to manage staffing shortages with certain specialties. The Trust plans to implement e-rostering to provide more effective management of rotas and to more easily facilitate the accumulative calculation of junior doctors' hours.

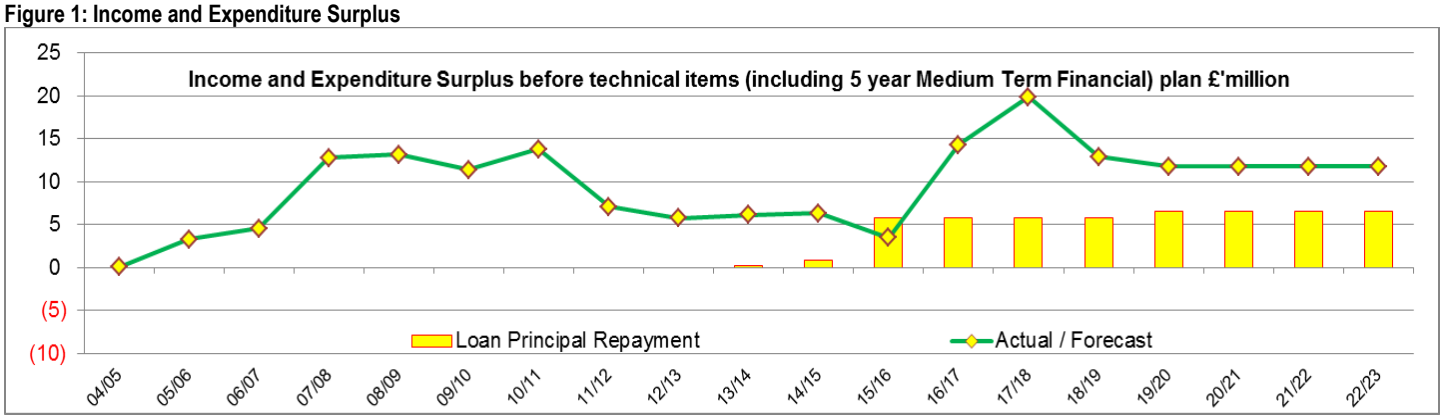
## 9.0 Financial Planning

### 9.1 2017/18 Actual Outturn

#### 9.1.1 Net surplus

The Trust achieved a 2017/18 net income & expenditure surplus of £19.9m, which is a £7.0m favourable variance against the accepted control total surplus of £12.9m. The variance was due to loss of Sustainability performance funding for quarters 1 and 4 (£1.7m) offset by NHS Improvement support received to offset income losses (£1.3m) plus a late share of incentive & bonus funding from NHS Improvement (£7.3m). This will be the Trust's 15th year of break-even or better. A summary of the Trust's financial position, including the historical performance, is provided below in figure 1.

**Figure 1: Income and Expenditure Surplus**




The Trust remains one of the best performing Acute Trusts in terms of financial performance. To achieve this, however, non-recurrent measures of over £7.3m were required to deliver the Control Total in 2017/18 (along with the receipt of Winter funding). Of these measures c.£6m are non-repeatable hence additional recurrent CIPs are required to restore this position in 2018/19.

#### 9.1.2 Savings

The Trust's 2017/18 savings requirement was £11.5m. Savings of £12.1m were delivered in the year. Of these £8.8m were recurrent. The Divisions' underlying deficits from 2017/18 of £6.1m will be carried forward into the 2018/19 savings requirement.

#### 9.1.3 Capital expenditure

The Trust's capital expenditure was £25.4m for 2017/18 against an NHS Improvement plan of £47.9m due to scheme slippage, primarily within the Trust's strategic programme. The Trust's gross carry-forward commitments into 2018/19 are £31.9m.

#### 9.1.4 Use of Resources Rating

The Trust's Use of Resources Rating (UORR) of 1, is the highest rating. The Trust has strong liquidity with a working capital balance of £43.0m at the 31st March 2018 and achieved 24.9 liquidity days and a liquidity metric of one. The Trust's revenue available for capital service was £53.7m delivers capital service cover of 3.0 times and a metric of one. The Trust's net income and expenditure margin was 2.9% and achieves a metric of one. The adverse I&E margin variance achieves a metric of 1 and the forecast agency expenditure metric scores a rating of one. The position is summarised below.

**Table 5: 2017/18 Use of Resources Rating**

| | Metric | Rating |
|---|---|---|
| Liquidity | 24.9 days | 1 |
| Capital service cover | 3.03 times | 1 |
| Net I&E margin | 2.91% | 1 |
| I&E margin variance | 0.94% | 1 |
| Agency expenditure variance against ceiling | 34.3% | 1 |
| **Overall UORR rounded** | **1** | **1** |

| Rating 1 | Rating 2 | Rating 3 | Rating 4 |
|---|---|---|---|
| 0 days | -7 days | -14 days | <-14 days |
| 2.5 times | 1.75 times | 1.25 times | <1.25 times |
| >1% | >0% | <-1% | >-1% |
| =>0% | <-1% | <-2% | >-2% |
| <0% | <25% | <50% | >=50% |

### 9.2 2018/19 Financial Plan

#### 9.2.1 Introduction

The 2018/19 plan is based on the following key drivers;

- Acceptance of the NHS Improvement proposed control total of a £18.5m surplus. This includes receipt of £15.5m Provider Sustainability Funding (PSF) and obviates the need to pay core performance fines.
- The Trust's savings target is set at 5.1% of recurrent budgets generating £25.5m (5.1%)
- The stretch to the proposed control of £18.5m beyond the 2017/18 plan is £3.4m which is included in the savings target.
- The plan still carries a risk around the unresolved issue of Wales HRG4+ tariffs (valued at £1.5m) which is assumed to be received as income in year.
- A gross inflation uplift of 2.1% (plus the CNST tariff uplift) includes a 1% pay award and incremental drift together valued at £5.2m, the balance to full year impact of the new Junior Doctors contract at £0.8m, pensions auto-enrolment at £0.8m, an increase in the cost of Clinical Negligence Scheme for Trusts (CNST) premiums at £2.9m and non-pay inflation at 3% or £2.2m. The 2.1% uplift is considered just about adequate but makes no allowance for other cost pressures;
- Net activity growth of £10.0m, additional high cost drugs of £12.6m, Research & Development growth of £3.5m, CEA Awards of £0.4m and a loss of £1.5m relating to HRG4+ Wales income;
- Service Level Agreement (SLA) proposals have been agreed with Commissioners. This included Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCGs) and associates and NHS England (Specialised and Non-Specialised);
- The Divisional 2017/18 over-spending of £7.2m has been covered by non-recurrent measures in 2017/18. Of these measures c.£6m are non-repeatable in 2018/19 hence the underlying shortfall requires recurrent CIPs to be delivered to prevent this going to the bottom line. The derivation of the £7.2m is from accumulated cost pressures (mainly Nursing and Medical Pay) and unachieved prior year savings targets.

The Trust believes the plan continues to describe an excellent level of financial performance. A surplus plan has been delivered for the 15 years up to 2017/18 and 2018/19 will be the 16th year. The Trust is proud of this track record which it has used to underpin its achievements in terms of capital infrastructure and quality improvement.

#### 9.2.2 Financial Plan

The 2018/19 financial plan of a £20.6m surplus is summarised below

**Table 6. Summary of the 2018/19 financial plan**

| **Surplus / (Deficit)** | **£m** | |
|---|---|---|
| Underlying position brought forward | (0.4) | Position excludes £13.3m PSF |
| National Tariff efficiency requirement | (10.1) | 2.0% deflator included in the 2018/19 National Tariff |
| Divisional underlying deficit from 2017/18 | (6.1) | |
| Savings programme | 25.5 | |
| Cost pressures | | |
| Divisional clinical cost pressures | (0.7) | Increase offset in part by Tariff. |
| Capital Charges volume growth | (1.2) | Volume growth. |
| Medical and Dental SIFT | (0.7) | Estimated HEE impacts |
| Corporate risk prioritised cost pressures | (0.5) | Unavoidable recurrent costs only. |
| Pharmacy out-sourcing costs | (0.3) | Unavoidable recurrent costs only. |
| CEA awards | (0.4) | Not fully funded |
| Other cost pressures | (0.2) | |
| Tariff Loss | (0.1) | Tariff Adjustment |
| **2018/19 Underlying position** | **4.8** | |
| Non-recurrent | | |
| Provider Sustainability Funding | 15.5 | |
| Change costs / spend to save | (0.3) | To fund schemes generating recurring savings. |
| Corporate risk prioritised cost pressures | (0.5) | Unavoidable non-recurrent costs only. |
| Transition costs for strategic schemes | (0.3) | In support of strategic capital schemes. |
| Clinical IT programme | (0.7) | Funds the IT Programme support costs. |
| **Net I&E Surplus / (Deficit) exc. PSF & technical items** | **18.5** | Definition used for Control Total purposes. |
| Donated asset depreciation | (1.5) | |
| Donated asset income | 3.0 | |
| Net impairments | 0.6 | |
| **Net I&E Surplus / (Deficit) inc. technical items** | **20.6** | |

### 9.2.3 Income

The Trust's total income is £690.2m and is summarised below.

**Table 7: 2018/19 Income build up**

| | | £m | £m |
|---|---|---|---|
| Rollover Income | Recurrent income from 2017/18 | | 653.5 |
| Tariff | Gross inflation including CNST | 13.2 | |
| | Efficiency | (10.1) | |
| | | | 3.1 |
| Impact of Guidance | Tariff impact | (0.1) | |
| | | | (0.1) |
| Activity / SLA Changes | Service transfers | 0.9 | |
| | Recurrent activity (including undelivered QIPP) | 6.3 | |
| | Non-recurrent activity (including undelivered QIPP) | 2.0 | |
| | Remove prior year non-recurring activity | (4.3) | |
| | Non RTT activity changes | 5.0 | |
| | Revenue Developments (ERPs) | 0.2 | 10.0 |
| Provider Sustainability Funding | | | 2.2 |
| Other | High cost drug / devices assessment (including NICE) | 12.6 | |
| | Research & Development growth | 3.5 | |
| | CQUINs | 0.5 | |
| | Other | 4.9 | |
| | | | 21.5 |
| | **Total 2018/19 Income (Including Donation Income of £3m)** | | **690.2** |

### 9.2.4 Costs

The 2018/19 level of cost pressures for the Trust is very challenging and should be considered in the context of operational pressures on spending, the full delivery of savings plans and transformation initiatives. Firm control will continue to be required to avoid the Trust's medium term plans being undermined beyond 2018/19. The main assumptions included in the Trust's cost projections are:

- Inflation costs of £13.2m;
- Agency costs of £5.8m;
- Savings requirement of £25.5m;
- Recurrent unavoidable cost pressures of £4.1m;
- Non Recurrent unavoidable cost pressures of £1.8m;
- Payment of loan interest at £2.7m;
- Depreciation of £25.9m; and
- Capital charges volume growth of £1.2m.
- Stretch to deliver control total surplus of £3.4m (0.7%)

### 9.2.5 Cost Improvement Plans

The Trust sets CIP targets for 2018/19 to include the following requirements:

- Commissioner efficiency requirement of £10.1m (2.0%);
- Divisional underlying deficits of £6.1m (1.2%);
- Unavoidable recurrent cost pressures of £4.1m (0.9%); and
- Unavoidable non-recurrent cost pressures of £1.8m (0.3%).
- Stretch to deliver control total surplus of £3.4m (0.7%)

This represents a CIP requirement of £25.5m or 5.1% of operational budgets.

The Trust has an established process for generating CIPs operated under the established Transforming Care programme. There is an increased focus in 2018/19 on delivering savings from productivity hence the Trust has established a series of targeted programmes led by executive directors directed at delivering productivity from:

- Out patients;
- Length of stay;
- Theatres;
- Consultant productivity; and
- Diagnostics.

These programmes are using all available benchmarking in order to identify areas for improvement and develop actions plans to ensure delivery. The Trust also has a series of programmes focussing on increased and robust controls including in the areas of non-pay, drugs and pay areas particularly medical staffing and nursing. Further work streams dedicated to delivering transactional CIPs have also been established, for example:

- Improving purchasing and efficient usage of non-pay including drugs and blood;

- Ensuring best value in the use of the Trust's Estates and Facilities. This includes a review of the delivery of specific services, and further improvements in energy efficiencies;
- Ensuring best use of technology to improve efficiency, linking productivity improvement with the introduction of new tools in clinical records management and patient administration;
- Addressing and reducing expenditure on premium payments including agency spend; and
- Focussing on reducing any requirement to outsource activity to non-NHS bodies.

The Trust's risk assessed CIP plan is summarised below. The total of unidentified savings is currently £2.4m.

| **Workstreams** | **£m** |
|---|---|
| Allied Healthcare Professionals Productivity | 0.9 |
| Medical Staff Efficiencies Productivity | 0.6 |
| Nursing & Midwifery Productivity | 1.1 |
| Diagnostic testing | 0.2 |
| Reducing and Controlling Non Pay | 4.9 |
| Medicines savings (Drugs) | 0.8 |
| Trust Services efficiencies | 0.6 |
| HR Pay and productivity | 0.1 |
| Estates and Facilities productivity | 0.7 |
| Productivity | 3.1 |
| Other | 6.7 |
| **Subtotal – savings identified** | **19.7** |
| Unidentified savings | 5.8 |
| Total – savings requirement | **25.5** |

### 9.2.7 Capital expenditure

The Trust has a significant capital expenditure programme investing £613m from April 2007 until March 2023 in the development of its estate. In 2018/19, the Trust's planned capital expenditure totals £47.0m, after estimated £22.5m slippage into 2019/20 which will be reviewed later in the year when the position is firmed up. The net 2018/19 capital expenditure plan is summarised below:

**Table 8: Source and applications of capital**

| Source of funds | 2018/19 Plan £m | Application of funds | 2018/19 Plan £m |
|---|---|---|---|
| Cash balances | 7.6 | Carry forward schemes – Phase 5 | 15.8 |
| Depreciation | 24.3 | Carry forward schemes – Other | 16.1 |
| Loan – Car Park Scheme * | 3.2 | IM&T | 4.1 |
| Donations | 3.0 | Medical equipment | 8.9 |
| Public Dividend Capital | 1.6 | Operational capital | 6.2 |
| 2017/18 Incentive STF Funds | 7.3 | Estates replacement | 2.5 |
| | | MSCP | 3.2 |
| | | Phase 5 | 5.4 |
| | | Additional Capital Investment (unallocated) | 7.3 |
| | | Net slippage estimated | (22.5) |
| **Total** | **47.0** | **Total** | **47.0** |

The Trust completed a loan application in support of University Hospital's Bristol Marlborough Hill Car Park Scheme for £19.1m. This was submitted to the Independent Trust Financing Facility (ITFF) in March 2017 and the ITFF recommended the application.

### 9.2.8 Use of Resources Rating

The planned net surplus of £22.0 and acceptance of the proposed 2018/19 control total of £22.0m is the driver behind the Trust's overall Use of Resources Rating (UORR) of 1. The position is summarised below:

**Table 9: 2018/19 Use of Resources Rating**

| | Metric | Rating |
|---|---|---|
| Liquidity | 22.9 days | 1 |
| Capital service cover | 3.0 times | 1 |
| Net I&E margin | 2.7% | 1 |
| I&E margin variance | 0% | 1 |
| Agency expenditure variance against ceiling | 56.1% | 1 |
| **Overall UORR rounded** | **1** | **1** |

| Rating 1 | Rating 2 | Rating 3 | Rating 4 |
|---|---|---|---|
| 0 days | -7 days | -14 days | <-14 days |
| 2.5 times | 1.75 times | 1.25 times | <1.25 times |
| >1% | >0% | <-1% | >-1% |
| =>0% | <-1% | <-2% | >-2% |
| <0% | <25% | <50% | >=50% |

**9.2.9 Summary Statement of Comprehensive Income**

The 2018/19 Statement of Comprehensive Income (SoCI) and closing cash balance is summarised below:

**Table 10: SoCI and closing cash balance**

| | 2018/19 Plan £m |
|---|---|
| Income (Excluding Donations) | 687.2 |
| Operating expenditure | (631.7) |
| EBITDA (excluding donation income) | 55.5 |
| Non-operating expenditure | (37.0) |
| **Net surplus / (deficit) excluding technical items** | **18.5** |
| Net impairments | 0.6 |
| Donation income | 3.0 |
| Donated asset depreciation | (1.5) |
| **Net surplus / (deficit) including technical items** | **20.6** |
| **Year-end cash** | **80.0** |

**9.3 Financial Risks**

The main risks to the delivery of the 2018/19 plan include:

- CQUIN schemes are not earnable and may cost more to deliver;
- Cost pressures exceed that budgeted for – particular concern exists over the cost of the new Junior Doctors contract and the proposed Agenda for Change contract
- Delivery of the Trust's new savings programme is considered high risk;
- Planned activity is not delivered hence compromising the Trust's Operational Plan including the potential need to use premium cost delivery methods; and
- Growth in emergency activity cannot be managed within planned capacity or there is a failure to invest in Community and Primary Care schemes to support this demand – leading to loss of elective activity and premium rate solutions.

**9.4 Changes from the 2018/19 Operating Plan included as year two in the 2017/18 – 2018/19 Operating Plan Submission**

The original two year control total of £24.642m was rejected so sustainability funding was not included. For the final plan this forms a major reason for the increase to the £690.2m income plan. The full reconciliation is shown below:

The planned level of income is higher – as follows:

| | **£m** |
|---|---|
| • Original 2018/19 plan | 649.5 |
| • Tariff inflation | 0.7 |
| • Net activity changes | 7.0 |
| • High cost drugs | 9.6 |
| • Loss of CQUINs | (1.6) |
| • R&D increases | 3.5 |
| • HEE Reductions | (0.7) |
| • Donations | 3.0 |
| • Service Transfer | 0.9 |
| • Other net changes | 2.8 |
| • Provider Sustainability Funding | 15.5 |
| • **Total** | **690.2** (Including Donation Income of £3.0m) |

**9. <u>Membership and elections</u>**

**10.1 Governor elections in the previous years and plans for the coming 12 months**

In 2017, 14 governor roles were available for election, across seven constituencies, including public, patient and staff members. We received 29 nominations in total. One candidate was elected unopposed and the other six constituencies went forward to election. Turnout was largely in line with previous elections.

The staff governor representing the medical and dental constituency stepped down on 31 October 2017 and a by-election for this seat will be held in spring 2018. The next elections are due to be held in 2019.

**10.2 Governor recruitment, training and development and member engagement activities**

Governors are provided with a comprehensive programme of training and development that begins upon appointment with an induction seminar. The induction seminar is one of four governor development seminars each year; the content of the seminars now focuses on either core skills, updates and/or training. The governor development sessions are useful mechanisms to ensure that the Council of Governors builds understanding of the workings of the Trust alongside the governor role and statutory duties. In addition to the development sessions the governors hold regular focus group meetings on Trust strategy, quality and performance, and constitution, which are attended by Executive Directors/senior managers and a Non-executive Director.

In terms of member engagement, at the start of 2017, the membership team agreed with governors a set of priorities around membership engagement for each quarter of the year, focusing first on the election campaign, then on governor induction. In the last three months of 2017, there was a review of membership engagement methods and practices, with a full programme of activities in place for 2018. The membership team has continued with regular membership engagement activities with governor support, including a monthly e-newsletter, Health Matters events (health talks for members/members of the public) and a members' page in the Trust's 'Voices' magazine which is sent to every member twice a year.

**10.3 Membership strategy – plans for next 12 months**

A renewed focus on engagement for 2017-18 has seen the membership team put in place a full events programme: increasing Health Matters events from quarterly events to near monthly; introducing monthly hospital 'Meet and Greet' stalls to enable governors to meet their constituents; undertaking an online membership survey (to assess the benefits and impact of membership) and a postal mailshot inviting feedback. Over the coming months, the membership office will be assessing the activities undertaken and formulating a new strategy to ensure membership remains fit for purpose to 2020 and beyond, with support from governors through the governor-led Constitution Focus Group.

**10. Conclusion**

This Operational Plan reflects significant work across the Trust and has been built up from detailed and integrated Divisional plans. While this provides assurance on achievability, we will continue to develop the plan to enhance our confidence in its delivery and to reflect continuing work within our system as part of *Healthier Together.*

**Cover report to the Public Trust Board. Meeting to be held on 24 May 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 13 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Thursday, 24 May 2018 |
| **Report Title** | **Finance Report** | | |
| **Author** | Kate Parraman, Deputy Director of Finance | | |
| **Executive Lead** | Paul Mapson, Director of Finance and Information | | |
| **Freedom of Information Status** | | Open | |

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

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

## Executive Summary

Purpose

To inform the Finance Committee of the financial position of the Trust for April

Key issues to note

- The Operational Plan for the year is a surplus of £18.480m excluding technical items. This includes £15.480m of Provider Sustainability Funding (PSF). The Operational Plan for April is a deficit of £0.116m excluding technical items.
- The Trust is reporting a deficit of £0.778m, £0.662m adverse to plan. This is due to :
    - PSF funding not being earnt due to ED performance (£0.232m)
    - Divisional and Corporate overspends of £0.430m
- April requires significant funding allocations to Divisions to establish the new financial year budgets, including activity contracts, cost pressures and other operating plan adjustments.

| |
|---|
| Month one results should be treated with caution. |
| **Recommendations** |
| Members are asked to:<br>• 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)** |
| | | | | |

# Report of the Finance Director

## Section 1 – Executive Summary

| | 2018/19 Annual Plan £m | Income / (Expenditure) Plan to date £m | Income / (Expenditure) Actual to date £m | Variance Favourable /(Adverse) £m |
|---|---|---|---|---|
| Corporate Income | 615.573 | 50.103 | 50.072 | (0.031) |
| Divisions & Corporate Services | (562.240) | (47.987) | (48.429) | (0.442) |
| Financing | (34.532) | (3.006) | (2.963) | 0.043 |
| Reserves | (12.801) | - | - | - |
| **Surplus/(deficit) excl STF funding** | **3.000** | **(0.890)** | **(1.320)** | **(0.430)** |
| STF Core Funding | 10.836 | 0.542 | 0.542 | - |
| STF Performance Funding | 4.644 | 0.232 | - | (0.232) |
| **Surplus/(deficit) incl STF funding** | **18.480** | **(0.116)** | **(0.778)** | **(0.662)** |

April requires significant funding allocations to Divisions to establish the new financial year budgets, including activity contracts, cost pressures and other operating plan adjustments. The allocation of this funding to individual budget lines necessarily spans the first two months of the year therefore the subjective reporting in month one represents work in progress.

Month one results should be treated with caution.

- The Operational Plan for the year is a surplus of £18.480m excluding technical items. This includes £15.480m of Provider Sustainability Funding (PSF).
- The Operational Plan for April is a deficit of £0.116m excluding technical items.
- The Trust is reporting a deficit of £0.778m, £0.662m adverse to plan. This is due to :
  - PSF funding not being earnt due to ED performance (£0.232m)
  - Divisional and Corporate overspends of £0.430m
- The Clinical Divisional deficit in April is £0.455m, compared to an Operating Plan trajectory of £0.323m. This is primarily due to medical pay (£0.358m) and nursing pay (£0.248m).
- PSF core funding is shown as achieved for month one. Whilst the core control total has not been achieved it is expected to recover by quarter one and therefore PSF funding will be earnt.
- PSF performance funding has not been achieved for month one. ED performance was 83.96% against a target of 90.00% and is not expected to improve to the level required to meet the quarter one cumulative target.

**Year to Date Position**

**Section 2 – Division and Corporate Services Performance**

Performance by Division and Corporate Service Area:

| | Variance to Budget favourable/(adverse) | | | Operating Plan trajectory favourable/(adverse) | |
|---|---|---|---|---|---|
| | To 30 April £m | | | To 30 April £m | Var £m |
| Diagnostic & Therapies | 0.012 | | | 0.013 | (0.001) |
| Medicine | (0.071) | | | (0.072) | 0.001 |
| Specialised Services | (0.176) | | | (0.067) | (0.109) |
| Surgery | (0.075) | | | (0.065) | (0.010) |
| Women's & Children's | (0.145) | | | (0.132) | (0.013) |
| Estates & Facilities | 0.003 | | | 0.007 | (0.004) |
| Trust Services | (0.008) | | | - | (0.008) |
| Other Corporate Services | 0.018 | | | - | 0.018 |
| **Total** | **(0.442)** | | | **(0.316)** | **(0.126)** |

- Division and Corporate Services adverse variance was £0.442m in April. This compares with the Operating Plan trajectory of an adverse variance of £0.316m.
- Diagnostic and Therapies – a favourable variance of £0.012m in line with the Operating Plan trajectory.
- Medicine – an adverse variance of £0.071m in line with the Operating Plan trajectory. Pay was £0.108m adverse in month, of which £0.040m related to medical and £0.067m nursing. Income from activities was £0.077m favourable.
- Specialised Services – an adverse variance of £0.176m, £0.109m adverse to Operating Plan trajectory. Income from activities was £0.222m adverse. Cardiac surgery underperformed by £0.082m. April had a significantly higher than average volume of patients awaiting discharge and therefore the income is expected to improve in May. Cardiology was £0.209m adverse primarily due to lost sessions whilst essential systems were installed.
- Surgery – an adverse variance of £0.075m in the month due, broadly in line with Operating Plan trajectory. Pay was £0.162m adverse of which medical pay accounted for £0.139m driven by additional hours payments. Income from activities was £0.176m favourable of which £0.193m related to Ophthalmology.
- Women's & Children's – an adverse variance of £0.145m in the month, broadly in line with Operating Plan trajectory. Pay was £0.377m adverse of which £0.153m related to medical pay and £0.156m nursing. Non pay was £0.155m favourable reflecting funding yet to be allocated.

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**Section 2 – Division and Corporate Services Performance continued**

Performance by subjective heading:

| | January £m | February £m | March £m | 2017/18 Outturn £m | April £m |
|---|---|---|---|---|---|
| Nursing & midwifery pay | (0.283) | (0.196) | (0.447) | (3.941) | (0.248) |
| Medical & dental pay | (0.263) | (0.623) | (0.209) | (4.233) | (0.358) |
| Other pay | 0.079 | 0.075 | (0.053) | 0.912 | 0.120 |
| Non-pay | (0.343) | (0.173) | (0.222) | (4.655) | 0.002 |
| Income from operations | (0.071) | (0.019) | 0.343 | (0.030) | (0.069) |
| Income from activities | 0.848 | 1.265 | 0.448 | 4.753 | 0.111 |
| **Total** | **(0.033)** | **0.329** | **(0.140)** | **(7.195)** | **(0.442)** |

For 2018/19 the subjective reporting is no longer adjusted to allocate the under/over recovery of savings targets across the headings. This reflects the way that Divisional budgets are reported and managed within the Trust. Savings delivery and performance is reported and managed within the workstreams described in section 5.

The allocation of new year funding to individual budget lines continues into month two and therefore the subjective reporting in month one represents work in progress.

- Nursing pay expenditure overspend improved in April to £0.248m adverse compared to £0.283m adverse in March. The Divisions of Medicine and Specialised showed a significant improvement whereas both Surgery and Women's and Children's nursing variance deteriorated.
- Medical and dental pay variances have worsened compared to March with an adverse variance of £0.358m compared a £0.209m. The position reflects a worsening adverse variance in Women's and Children's Division more comparable with earlier months in 2017/18. This reflects funding changes to be reviewed rather than an increase in overall expenditure.
- Non pay budgets are still being reviewed following the start of the financial year in order to accurately allocated CIP and reserve monies as such the movement in variance is not an accurate reflection of performance at month 1.
- Income from Operations had a significant favourable variance in March due to adjusting billing at year end, however it returns to an adverse run rate in April.
- Income from Activities showed a favourable variance of £0.11m. Specialised Services was £0.222m adverse, primarily due to Cardiology. Surgery was £0.176m favourable primarily due to Ophthalmology.

## Section 3 – Subjective Analysis Detail

### a) Nursing (including ODP) and Midwifery Pay

| Favourable/ (Adverse) | January £m | February £m | March £m | 2017/18 Outturn | April £m |
|---|---|---|---|---|---|
| Substantive | 0.854 | 0.903 | 0.940 | 10.046 | 0.775 |
| Bank | (0.716) | (0.690) | (0.876) | (7.997) | (0.595) |
| Agency | (0.421) | (0.409) | (0.510) | (5.988) | (0.428) |
| **Total** | **(0.283)** | **(0.196)** | **(0.446)** | **(3.939)** | **(0.248)** |

- Nursing pay variance improved in month by 0.198m.
- Lost time percentages improved slightly to 124% compared to 127% in March.
- Medicine and Specialised Divisions reduced their overspend compared to March reflecting significant reductions in agency costs both due to shift numbers reducing and reduced use of high cost agencies. There was also a reduction in bank costs. Women's and Children's had a deterioration in position reflecting both maternity and sickness cover and also an additional bed opening in Renal services.
- Enhanced observation costs increased slightly in April to £0.146m, and remain above target, particularly in Medicine Division.

### b) Medical and Dental Pay

| Favourable/ (Adverse) | January £m | February £m | March £m | 2017/18 Outturn £m | April £m |
|---|---|---|---|---|---|
| Consultant | | | | | |
| substantive | 0.065 | (0.134) | 0.317 | 0.768 | 0.062 |
| additional hours | (0.182) | (0.178) | (0.187) | (2.143) | (0.163) |
| locum | (0.114) | (0.140) | (0.158) | (0.736) | (0.112) |
| agency | 0.005 | (0.006) | (0.041) | (0.190) | 0.004 |
| Other Medical | | | | | |
| substantive | 0.138 | 0.096 | 0.306 | 0.932 | 0.100 |
| additional hours | (0.123) | (0.181) | (0.146) | (1.575) | (0.133) |
| Jr Dr excep | 0.000 | 0.000 | 0.000 | (0.007) | (0.001) |
| locum | (0.075) | (0.077) | (0.097) | (1.059) | (0.096) |
| agency | 0.023 | (0.003) | (0.203) | (0.224) | (0.017) |
| **Total** | **(0.263)** | **(0.623)** | **(0.221)** | **(4.927)** | **(0.358)** |

- The adverse variance in April of £0.358m is a slight worsening than the March position (£0.221m adverse) and reflects continuing overspends in all Clinical Divisions. Women's and Children's position worsened compared to March with cost pressures for maternity leave and sickness cover remaining a significant issue across the Trust.

**Section 3 – Subjective Analysis Detail continued**

c) Non pay

| Favourable/ (Adverse) | January £m | February £m | March £m | 2017/18 Outturn £m | April £m |
|---|---|---|---|---|---|
| Blood | (0.086) | 0.031 | (0.058) | (0.248) | (0.055) |
| Clinical supplies & services | (0.185) | 0.032 | (0.083) | (0.950) | (0.007) |
| Drugs | (0.115) | (0.179) | (0.212) | (0.961) | 0.037 |
| Establishment | (0.079) | 0.037 | (0.010) | (0.166) | (0.010) |
| General supplies & services | (0.024) | 0.019 | (0.005) | 0.007 | 0.044 |
| Outsourcing | (0.039) | (0.054) | (0.026) | (1.117) | (0.072) |
| Premises | (0.064) | 0.054 | (0.124) | (0.067) | 0.034 |
| Services from other bodies | (0.120) | (0.136) | (0.068) | (1.031) | (0.042) |
| Research | (0.100) | 0.040 | (0.016) | 0.034 | 0.008 |
| Other non-pay expenditure | (0.007) | (0.472) | (0.076) | (1.526) | 0.065 |
| Tranche 1 Winter Funding | 0.457 | 0.457 | 0.456 | 1.370 | 0 |
| **Total inc CIP** | **(0.343)** | **(0.171)** | **(0.222)** | **(4.655)** | **0.002** |

- There is minimal variance on non pay in April. This reflects continued lower levels of outsourcing than in the early months of 2017/18, although there was a small increase when compared to the run rate of the final quarter of the last financial year. It also reflects some budget rebasing to reflect new year operating plans and funded cost pressures.

## Section 4 – Clinical and Contract Income

Contract income by work type: (further detail at agenda item 2.2)

| | March 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 | 0.091 | 1.532 | 1.623 | 0.091 |
| Bone Marrow Transplants | 0.109 | 0.637 | 0.746 | 0.109 |
| Critical Care Beddays | 0.045 | 3.687 | 3.731 | 0.045 |
| Day Cases | 0.041 | 3.167 | 3.208 | 0.041 |
| Elective Inpatients | (0.311) | 4.558 | 4.247 | (0.311) |
| Emergency Inpatients | 0.158 | 7.790 | 7.949 | 0.158 |
| Excess Beddays | 0.004 | 0.451 | 0.455 | 0.004 |
| Non-Elective Inpatients | (0.308) | 2.644 | 2.336 | (0.308) |
| Other | 0.005 | 7.662 | 7.667 | 0.005 |
| Outpatients | 0.266 | 6.480 | 6.746 | 0.266 |
| **Total Activity Based** | **0.099** | **38.609** | **38.708** | **0.099** |
| Contract Penalties | 0.043 | (0.083) | (0.040) | 0.043 |
| Contract Rewards | 0.000 | 0.817 | 0.817 | 0.000 |
| Pass through payments | (0.345) | 7.721 | 7.376 | (0.345) |
| S&T Funding | (0.232) | 0.774 | 0.542 | (0.232) |
| **2018/19 Total** | **(0.435)** | **47.838** | **47.403** | **(0.435)** |

Following the Trust's receipt of £1.33m from NHS Improvement in respect of losses on HRG4+ related to Wales in 2017/18, £1.53m has been planned for and assumed in 2018/19.

- Activity based income was £0.099m favourable in April,
- Emergency activity was above plan by £0.250m.
- Inpatient under performance in month of £0.619m was predominantly within Surgery (£0.228m) and Specialised Services (£0.151m).
- Bone Marrow Transplant was £0.109m above plan, of this £0.086m was within Women's and Children's and £0.022m within Specialised Services.
- Given the Trust has accepted the control total, national core penalties and local penalties do not apply. Other national penalties do apply and the Trust has received penalties of £0.040m in April, £0.043m less than planned.
- CQUIN reporting will commence at the end of quarter one.
- Income relating to pass through payments was £0.345m below plan in April. This was primarily due to excluded devices which was £0.242m below plan of which the largest underspend was within Cardiology.

## Section 5 – Savings Programme

Analysis by work streams: (further detail at agenda item 2.4)

| | 2018/19 Annual Plan £m | Year to date Plan £m | Actual £m | Variance fav/(adv) £m |
|---|---|---|---|---|
| AHP productivity | 0.779 | 0.065 | 0.069 | 0.004 |
| Diagnostic Testing | 0.156 | - | - | - |
| Estates & Facilities | 0.746 | 0.077 | 0.076 | (0.001) |
| Healthcare Scientists Productivity | 0.120 | 0.012 | 0.012 | - |
| Income, Fines, External | 2.290 | 0.188 | 0.174 | (0.014) |
| Medical Pay | 0.625 | 0.027 | 0.027 | - |
| Medicines | 0.751 | 0.061 | 0.034 | (0.027) |
| Nursing Pay | 1.061 | 0.083 | 0.051 | (0.032) |
| Other / Corporate | 7.874 | 0.656 | 0.656 | - |
| Productivity | 3.268 | 0.195 | 0.136 | (0.059) |
| Non-Pay | 5.019 | 0.383 | 0.447 | 0.063 |
| HR Pay and Productivity | 0.097 | 0.007 | 0.007 | - |
| Trust Services | 0.653 | 0.055 | 0.055 | - |
| Blood | 0.046 | - | - | - |
| Unidentified | 1.991 | 0.166 | - | (0.166) |
| **Total** | 25.474 | 1.976 | 1.743 | (0.233) |

Analysis by Division:

| | 2018/19 Annual Plan £m | Year to date Plan £m | Actual £m | Variance fav/(adv) £m |
|---|---|---|---|---|
| Diagnostics & Therapies | 1.934 | 0.138 | 0.153 | 0.015 |
| Medicine | 2.858 | 0.257 | 0.148 | (0.109) |
| Specialised Services | 2.727 | 0.201 | 0.182 | (0.020) |
| Surgery | 3.521 | 0.252 | 0.226 | (0.026) |
| Women's and Children's | 4.869 | 0.315 | 0.224 | (0.091) |
| Facilities and Estates | 0.976 | 0.088 | 0.092 | 0.004 |
| Finance | 0.186 | 0.017 | 0.016 | (0.001) |
| Human Resources | 0.126 | 0.011 | 0.011 | - |
| IM&T | 0.201 | 0.020 | 0.017 | (0.003) |
| Trust HQ | 0.203 | 0.021 | 0.019 | (0.002) |
| Corporate | 7.874 | 0.656 | 0.656 | - |
| **Total** | 25.474 | 1.976 | 1.743 | (0.233) |

- The savings requirement for 2018/19 is £25.474m. The Trust has achieved savings of £1.976m against a plan of £1.976m.
- Medicine is £0.109m behind plan, primarily due to unidentified savings.
- Women's and Children's is £0.091m behind plan of which £0.024m is within nursing pay and £0.041m unidentified.
- The Trust is forecast to make savings of £23.445m by year end, an underachievement against plan of £2.030m (92%); unidentified savings at the start of the financial year is £1.991m.

## Section 6 – Use of Resources Rating

The Trust's Use of Resources Rating is summarised below:

| | | Year to date | |
|---|---|---|---|
| | Weighting | Plan | Actual |
| **Liquidity** | | | |
| Metric Result – days | | 25.2 | 25.5 |
| Metric Rating | 20% | 1 | 1 |
| **Capital servicing capacity** | | | |
| Metric Result – times | | 2.8 | 2.1 |
| Metric Rating | 20% | 1 | 2 |
| **Income & expenditure margin** | | | |
| Metric Result | | -0.2% | -1.4% |
| Metric Rating | 20% | 3 | 4 |
| **Performance against control total** | | | |
| Metric Result | | 0.0% | -0.8% |
| Metric Rating | 20% | 1 | 2 |
| **Variance from agency ceiling** | | | |
| Metric Result | | 56.1% | 47.7% |
| Metric Rating | 20% | 1 | 1 |
| **Overall URR** | | **1.4** | **2.0** |
| **Overall URR (rounded)** | | **1** | **2** |
| **Overall URR (subject to override)** | | **1** | **3** |

- The Trust's Use of Resources Rating for the period to 30th April 2018 is 3 against a plan of 1. An override applies in this case as a result of scoring a 4 against the income & expenditure margin variance.

- The variance in income and expenditure margin scores a metric rating of 4 compared with a plan of 3. This is due to the net deficit to date including Provider Sustainability Funding (PSF) of £0.778m being £0.662m adverse to plan. The main reason for this variance is the loss of month 01 A&E Performance PSF of £0.232m and the current divisional position in particular overspending on medical pay. The position is being reviewed.

## Section 7 – Capital Programme

The Trust's sources and application of capital funding is summarised below:

| 2018/19 Annual Plan £m | Subjective Heading | Year to Date | | |
|---|---|---|---|---|
| | | Internal Plan £m | Actual £m | Variance £m |
| | **Sources of Funding** | | | |
| 1.600 | PDC | - | - | - |
| 3.189 | | | | |
| 3.000 | Donations - cash | - | - | - |
| | Donations – direct | - | - | - |
| | Cash: | | | |
| 24.338 | Depreciation | 1.975 | 2.060 | 0.085 |
| 14.962 | Cash balances | 0.124 | (1.335) | (1.335) |
| **47.089** | **Total Funding** | **2.099** | **0.725** | **(1.374)** |
| | **Application/Expenditure** | | | |
| (11.618) | Strategic Schemes | (0.075) | (0.056) | 0.019 |
| (17.619) | Medical Equipment | (0.745) | (0.495) | 0.250 |
| (16.173) | Operational Capital | (0.760) | (0.194) | 0.566 |
| (7.711) | Information Technology | (0.446) | 0.088 | 0.534 |
| (2.367) | Estates Replacement | (0.073) | (0.068) | 0.005 |
| **(55.488)** | **Gross Expenditure** | **(2.099)** | **(0.725)** | **1.374** |
| 8.399 | In-year Slippage | - | - | - |
| **(47.089)** | **Net Expenditure** | **(2.099)** | **(0.725)** | **27.333** |

The capital programme for the year submitted in the NHS Improvement Operational Plan is £47.089m. It includes £31.862m slippage from the previous year, £7.334m of additional Sustainability and Transformation Funding from 2017/18 as a result of achieving the control total, £16.290m of new schemes and forecast slippage of £8.399m

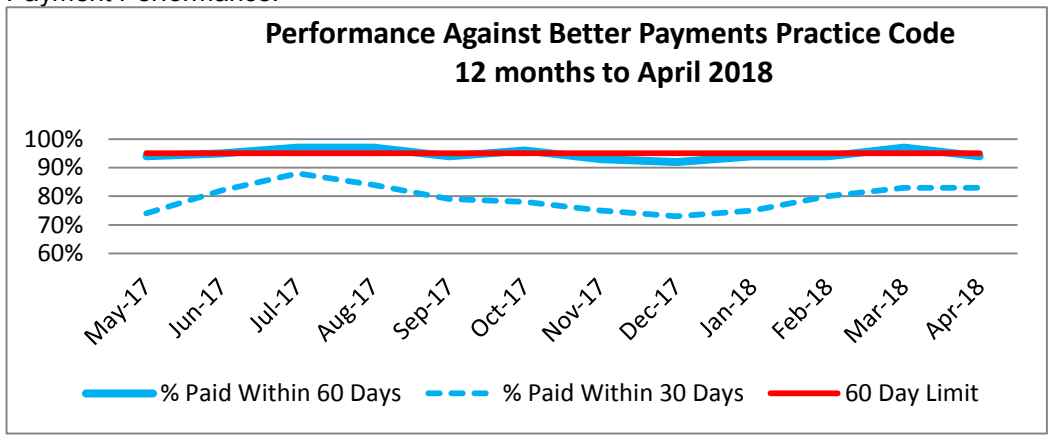
- Capital expenditure to 30th April was £0.725m against an internal plan of £2.099m.
- The planned capital spend in the Operational Plan for April is £2.099m which has been used this month in lieu of a profiled internal plan which is being finalised.
- Public Dividend Capital (PDC) is expected in respect of the Global Digital Exemplar (GDE) programme.
- Expenditure in April has been incurred against those schemes which have been carried forward from 2017/18. Spend profiles for these schemes are due to be advised by the end of May and will be reflected in subsequent reports. Spend against the 2018/19 allocations will occur in later months recognising the input and planning required from Procurement, Information Technology and the Estates Department.

## Section 8 – Statement of Financial Position and Cashflow

Statement of Financial Position: (further information is at agenda item 4.1)

| | Plan at 30 April £m | Actual as at 30 April £m | Variance £m |
|---|---|---|---|
| Inventories | 13.190 | 12.930 | (0.260) |
| Receivables | 40.506 | 33.437 | (7.069) |
| Accrued Income | 19.425 | 18.557 | (0.868) |
| Debt Provision | (10.112) | (9.517) | 0.595 |
| Cash | 73.990 | 77.562 | 3.572 |
| Other assets | 3.193 | 4.364 | 1.171 |
| Total Current Assets | 140.192 | 137.333 | (2.859) |
| Payables | (41.537) | (35.904) | 5.633 |
| Accruals | (25.502) | (28.536) | (3.034) |
| Borrowings | (6.170) | (6.168) | 0.002 |
| Deferred Income | (6.481) | (5.643) | 0.838 |
| Other Liabilities | (4.514) | (4.484) | 0.030 |
| Total Current Liabilities | (84.204) | (80.735) | 3.469 |
| **Net Current Assets/(Liabilities)** | **55.988** | **56.598** | **0.610** |

Payment Performance:




- Net current assets as at 30 April 2018 were £56.598m, £0.610m higher than the Operational Plan. Current assets are £2.859m lower than plan and current liabilities were £3.469m lower than plan.
- Inventories were £12.930m, £0.260m lower than plan.
- Receivables are £7.069m lower than plan, primarily due to higher than planned payments received from local providers and commissioners.
- The bad debt provision relates to the receivables position.
- The Trust's cash and cash equivalents balance at 30 April 2018 was £77.562m, which is £3.572m higher than the Operating Plan.
- The total value of debtors was £37.905m, (£28.680m SLA and £9.225m non-SLA). This represents a decrease in the month of £2.619m (SLA increase of £0.407m and non-SLA decrease of £3.026m). Debts over 60 days old have increased by £0.748m to £14.377m, (SLA increase of £0.797m and non-SLA decrease of £0.049m)
- In April, 94% of invoices were paid within the 60 day target set by the Prompt Payments Code and 83% were paid within the 30 day target set by the Better Payment Practice Code.

**Section 9 – Risk**

The financial risks are being reviewed for the new financial year.

Appendix 1

# UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

## Finance Report April 2018- Summary Income & Expenditure Statement

| Approved Budget / Plan 2018/19 | Heading | Position as at 30th April Plan | Actual | Variance Fav / (Adv) |
|---|---|---|---|---|
| £'000 | | £'000 | £'000 | £'000 |
| | **Income** | | | |
| 579,675 | From Activities | 46,820 | 47,159 | 339 |
| 91,734 | Other Operating Income (Excluding Sustainability and Transformation funding) | 7,880 | 7,555 | (325) |
| **671,409** | **Sub totals income** | **54,700** | **54,714** | **14** |
| | **Expenditure** | | | |
| (376,135) | Staffing | (31,713) | (32,198) | (485) |
| (244,941) | Supplies and Services | (20,871) | (20,873) | (2) |
| **(621,076)** | **Sub totals expenditure** | **(52,584)** | **(53,071)** | **(487)** |
| (12,801) | Reserves | - | - | - |
| - | NHS Improvement Plan Profile | | - | - |
| **37,532** | Earnings before Interest,Tax,Depreciation and Amortisation | **2,116** | **1,643** | **(473)** |
| **5.59** | **EBITDA Margin - %** | | **3.00** | |
| | **Financing** | | | |
| (22,643) | Depreciation & Amortisation - Owned | (2,015) | (1,976) | 39 |
| 244 | Interest Receivable | 20 | 28 | 8 |
| (242) | Interest Payable on Leases | (21) | (20) | 1 |
| (2,507) | Interest Payable on Loans | (208) | (213) | (5) |
| (9,384) | PDC Dividend | (782) | (782) | - |
| **(34,532)** | **Sub totals financing** | **(3,006)** | **(2,963)** | **43** |
| **3,000** | NET SURPLUS / (DEFICIT) before Technical Items excluding Provider Sustainability Funding | **(890)** | **(1,320)** | **(430)** |
| 4,644 | Sustainability & Transformation funding - Performance | 232 | - | (232) |
| 10,836 | Sustainability & Transformation funding - Core | 542 | 542 | - |
| **18,480** | SURPLUS / (DEFICIT) before Technical Items including Provider Sustainability Funding | **(116)** | **(778)** | **(662)** |
| | **Technical Items** | | | |
| 3,000 | Donations & Grants (PPE/Intangible Assets) | 50 | 7 | (43) |
| 629 | Impairments | - | - | - |
| - | Reversal of Impairments | - | - | - |
| (1,519) | Depreciation & Amortisation - Donated | (127) | (135) | (8) |
| **20,590** | SURPLUS / (DEFICIT) after Technical Items including Provider Sustainability Funding | **(193)** | **(906)** | **(713)** |

| Approved Budget / Plan 2018/19 | Division | Total Budget to Date | Total Net Expenditure / Income to Date | Variance [Favourable / (Adverse)] | | | | Total Variance to date | Operating Plan Trajectory Year to Date | Variance from Operating Plan Year to Date | CIP Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Pay | Non Pay | Operating Income | Income from Activities | | | | |
| £'000 | | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| | **Corporate Income (excluding Sustainability & Transformation funding)** | | | | | | | | | | |
| 579,087 | Contract Income | 47,064 | 47,296 | - | - | - | - | - | | | |
| - | Sustainability and Transformation Funding | - | - | - | - | - | - | - | | | |
| - | Penalties | - | - | - | - | - | - | - | | | |
| - | Contract Rewards | - | - | - | - | - | - | - | | | |
| - | Overheads | - | (48) | - | (4) | 232 | (44) | 184 | | | |
| 36,486 | NHSE Income | 3,039 | 2,824 | - | - | (215) | - | (215) | | | |
| **615,573** | **Sub Total Corporate Income** | **50,103** | **50,072** | **-** | **(4)** | **17** | **(44)** | **(31)** | | | |
| | **Clinical Divisions** | | | | | | | | | | |
| (54,691) | Diagnostic & Therapies | (4,604) | (4,592) | 67 | (1) | (25) | (29) | 12 | 13 | (1) | (9) |
| (85,208) | Medicine | (7,143) | (7,214) | (108) | (39) | (1) | 77 | (71) | (72) | 1 | (90) |
| (113,388) | Specialised Services | (9,310) | (9,486) | 46 | (11) | 11 | (222) | (176) | (67) | (109) | (46) |
| (109,556) | Surgery | (9,259) | (9,334) | (162) | (82) | (7) | 176 | (75) | (65) | (10) | (67) |
| (126,423) | Women's & Children's | (10,395) | (10,540) | (377) | 155 | 4 | 73 | (145) | (132) | (13) | (182) |
| **(489,266)** | **Sub Total - Clinical Divisions** | **(40,711)** | **(41,166)** | **(534)** | **22** | **(18)** | **75** | **(455)** | **(323)** | **(132)** | **(394)** |
| | **Corporate Services** | | | | | | | | | | |
| (36,525) | Estates and Facilities | (3,003) | (3,000) | 28 | (26) | 2 | (1) | 3 | 7 | (4) | 11 |
| (26,601) | Trust Services | (2,147) | (2,155) | 28 | (28) | (8) | - | (8) | - | (8) | 3 |
| (12,848) | Other | (2,126) | (2,108) | (8) | 34 | (45) | 37 | 18 | - | 18 | 0 |
| **(75,974)** | **Sub Totals - Corporate Services** | **(7,276)** | **(7,263)** | **48** | **(20)** | **(51)** | **36** | **13** | **7** | **6** | **14** |
| **(565,240)** | **Sub Total (Clinical Divisions & Corporate Services)** | **(47,987)** | **(48,429)** | **(486)** | **2** | **(69)** | **111** | **(442)** | **(316)** | **(126)** | **(380)** |
| (12,801) | Reserves | - | - | - | - | - | - | - | | | |
| - | NHS Improvement Plan Profile | - | - | - | - | - | - | - | | | |
| **(12,801)** | **Sub Total Reserves** | - | - | - | - | - | - | - | | | |
| **37,532** | **Earnings before Interest,Tax,Depreciation and Amortisation** | **2,116** | **1,643** | **(486)** | **(2)** | **(52)** | **67** | **(473)** | | | **(380)** |
| | **Financing** | | | | | | | | | | |
| (22,643) | Depreciation & Amortisation - Owned | (2,015) | (1,976) | - | 39 | - | - | 39 | | | |
| 244 | Interest Receivable | 20 | 28 | - | 8 | - | - | 8 | | | |
| (242) | Interest Payable on Leases | (21) | (20) | - | 1 | - | - | 1 | | | |
| (2,507) | Interest Payable on Loans | (208) | (213) | - | (5) | - | - | (5) | | | |
| (9,384) | PDC Dividend | (782) | (782) | - | - | - | - | - | | | |
| **(34,532)** | **Sub Total Financing** | **(3,006)** | **(2,963)** | - | **43** | **-** | **-** | **43** | | | |
| **3,000** | **NET SURPLUS / (DEFICIT) before Technical Items excluding Provider Sustainability Funding** | **(890)** | **(1,320)** | **(486)** | **41** | **(52)** | **67** | **(430)** | | | **(380)** |
| 4,644 | Sustainability & Transformation funding - Performance | 232 | - | - | - | (232) | - | (232) | | | |
| 10,836 | Sustainability & Transformation funding - Core | 542 | 542 | - | - | - | - | - | | | |
| **15,480** | **Sub Total Sustainability & Transformation funding** | **774** | **542** | - | - | - | - | **(232)** | | | |
| **18,480** | **SURPLUS / (DEFICIT) before Technical Items including Provider Sustainability Funding** | **(116)** | **(778)** | **(486)** | **41** | **(284)** | **67** | **(662)** | | | **(380)** |
| | **Technical Items** | | | | | | | | | | |
| 3,000 | Donations & Grants (PPE/Intangible Assets) | 50 | 7 | - | - | (43) | - | (43) | | | |
| 629 | Impairments | - | - | - | - | - | - | - | | | |
| - | Reversal of Impairments | - | - | - | - | - | - | - | | | |
| (1,519) | Depreciation & Amortisation - Donated | (127) | (135) | - | (8) | - | - | (8) | | | |
| **2,110** | **Sub Total Technical Items** | **(77)** | **(128)** | - | **(8)** | **(43)** | - | **(51)** | | | |
| **20,590** | **SURPLUS / (DEFICIT) after Technical Items including Provider Sustainability Funding** | **(193)** | **(906)** | **(486)** | **33** | **(327)** | **67** | **(713)** | | | **(380)** |

**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* | *3.1%* | *3.1%* | *3.1%* | *4.3%* | *4.3%* | *4.3%* | *3.9%* | *3.9%* | *3.9%* | *3.8%* | *3.8%* | *3.8%* |
| Medicine | Actual | 3.2% | | | | | | | | | | | |
| *Specialised Services* | *Target* | *3.6%* | *3.6%* | *3.6%* | *3.5%* | *3.5%* | *3.5%* | *3.8%* | *3.8%* | *3.8%* | *3.9%* | *3.9%* | *3.9%* |
| Specialised Services | Actual | 2.2% | | | | | | | | | | | |
| *Surgery, Head & Neck* | *Target* | *3.8%* | *3.8%* | *3.8%* | *3.8%* | *3.8%* | *3.8%* | *3.8%* | *3.8%* | *3.8%* | *3.8%* | *3.8%* | *3.8%* |
| Surgery, Head & Neck | Actual | 3.3% | | | | | | | | | | | |
| *Women's & Children's* | *Target* | *4.0%* | *4.0%* | *4.0%* | *4.1%* | *4.1%* | *4.1%* | *4.6%* | *4.6%* | *4.6%* | *4.4%* | *4.4%* | *4.4%* |
| Women's & Children's | Actual | 4.5% | | | | | | | | | | | |

*Source: HR info available after a weekend- Mth 8 data not available*

**Graph 2** **Vacancies**

| Division | Target/Actual | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Medicine* | *Target* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* |
| Medicine | Actual | 7.9% | | | | | | | | | | | |
| *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 | 9.0% | | | | | | | | | | | |
| *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 | 7.9% | | | | | | | | | | | |
| *Women's & Children's* | *Target* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* | *5.0%* |
| Women's & Children's | Actual | 2.2% | | | | | | | | | | | |

*Source: HR*

**Graph 3** **Turnover**

| Division | Target/Actual | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Medicine* | *Target* | *14.0%* | *14.0%* | *14.0%* | *14.0%* | *14.0%* | *14.0%* | *14.0%* | *14.0%* | *14.0%* | *14.0%* | *14.0%* | *14.0%* |
| Medicine | Actual | 14.8% | | | | | | | | | | | |
| *Specialised Services* | *Target* | *13.5%* | *13.5%* | *13.5%* | *13.5%* | *13.5%* | *13.5%* | *13.5%* | *13.5%* | *13.5%* | *13.5%* | *13.5%* | *13.5%* |
| Specialised Services | Actual | 17.8% | | | | | | | | | | | |
| *Surgery, Head & Neck* | *Target* | *11.8%* | *11.8%* | *11.8%* | *11.8%* | *11.8%* | *11.8%* | *11.8%* | *11.8%* | *11.8%* | *11.8%* | *11.8%* | *11.8%* |
| Surgery, Head & Neck | Actual | 16.2% | | | | | | | | | | | |
| *Women's & Children's* | *Target* | *10.1%* | *10.1%* | *10.1%* | *10.1%* | *10.1%* | *10.1%* | *10.1%* | *10.1%* | *10.1%* | *10.1%* | *10.1%* | *10.1%* |
| Women's & Children's | Actual | 12.9% | | | | | | | | | | | |

*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* | *135.2* | *113.8* | *113.8* | *95.2* | *95.2* | *95.2* | *95.2* | *113.8* | *135.2* | *135.2* | *128.0* | *113.8* |
| Medicine | Actual | 118.0 | | | | | | | | | | | |
| *Specialised Services* | *Target* | *50.8* | *50.8* | *50.8* | *50.8* | *50.8* | *50.8* | *36.3* | *36.3* | *36.3* | *36.3* | *36.3* | *36.3* |
| Specialised Services | Actual | 43.0 | | | | | | | | | | | |
| *Surgery, Head & Neck* | *Target* | *49.7* | *54.6* | *49.7* | *54.6* | *49.7* | *39.7* | *39.7* | *39.7* | *29.8* | *39.7* | *39.7* | *39.7* |
| Surgery, Head & Neck | Actual | 90.2 | | | | | | | | | | | |
| *Women's & Children's* | *Target* | *90.7* | *90.7* | *90.7* | *82.5* | *82.5* | *82.5* | *66.0* | *66.0* | *33.0* | *74.2* | *41.2* | *49.5* |
| Women's & Children's | Actual | 186.4 | | | | | | | | | | | |
| *Trust Total* | *Target* | 326.4 | 309.9 | 305.0 | 283.2 | 278.2 | 268.3 | 237.2 | 255.8 | 234.3 | 285.5 | 245.3 | 239.3 |
| Trust Total | Actual | 437.6 | - | - | - | - | - | - | - | - | - | - | - |

*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* | *24.6* | *21.8* | *21.8* | *19.0* | *19.0* | *19.0* | *19.0* | *21.8* | *24.6* | *24.6* | *24.6* | *21.8* |
| Medicine | Actual | 20.1 | | | | | | | | | | | |
| *Specialised Services* | *Target* | *5.0* | *5.0* | *5.0* | *5.0* | *5.0* | *5.0* | *3.5* | *3.5* | *3.5* | *3.5* | *2.0* | *2.0* |
| Specialised Services | Actual | 6.5 | | | | | | | | | | | |
| *Surgery, Head & Neck* | *Target* | *10.0* | *11.0* | *10.0* | *11.0* | *10.0* | *8.0* | *8.0* | *8.0* | *6.0* | *8.0* | *8.0* | *8.0* |
| Surgery, Head & Neck | Actual | 10.1 | | | | | | | | | | | |
| *Women's & Children's* | *Target* | *11.0* | *11.0* | *11.0* | *10.0* | *10.0* | *10.0* | *8.0* | *8.0* | *3.0* | *9.0* | *5.0* | *6.0* |
| Women's & Children's | Actual | 22.9 | | | | | | | | | | | |
| *Trust Total* | *Target* | 50.6 | 48.8 | 47.8 | 45.0 | 44.0 | 42.0 | 38.5 | 41.3 | 37.1 | 45.1 | 39.6 | 37.8 |
| Trust Total | Actual | 59.6 | - | - | - | - | - | - | - | - | - | - | - |

*Source: Finance GL (excludes NA 1:1)*

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

| Division | Target/Actual | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Medicine* | *Target* | *7.4%* | *6.3%* | *6.3%* | *5.3%* | *5.3%* | *5.3%* | *5.3%* | *6.2%* | *7.3%* | *7.3%* | *7.0%* | *6.2%* |
| Medicine | Actual | 6.3% | | | | | | | | | | | |
| *Specialised Services* | *Target* | *3.6%* | *3.6%* | *3.6%* | *3.6%* | *3.6%* | *3.6%* | *2.5%* | *2.5%* | *2.5%* | *2.5%* | *2.5%* | *2.5%* |
| Specialised Services | Actual | 3.1% | | | | | | | | | | | |
| *Surgery, Head & Neck* | *Target* | *2.4%* | *2.7%* | *2.4%* | *2.7%* | *2.4%* | *2.0%* | *1.9%* | *1.9%* | *1.5%* | *1.9%* | *1.9%* | *1.9%* |
| Surgery, Head & Neck | Actual | 5.0% | | | | | | | | | | | |
| *Women's & Children's* | *Target* | *2.5%* | *2.5%* | *2.5%* | *2.3%* | *2.3%* | *2.3%* | *1.8%* | *1.8%* | *0.9%* | *2.0%* | *1.1%* | *1.4%* |
| Women's & Children's | Actual | 5.2% | | | | | | | | | | | |
| Trust Total | Actual | 5.0% | | | | | | | | | | | |

*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 | 9,172 | | | | | | | | | | | |
| Specialised Services | Actual | 4,580 | | | | | | | | | | | |
| Surgery, Head & Neck | Actual | 4,493 | | | | | | | | | | | |
| Women's & Children's | Actual | 6,647 | | | | | | | | | | | |
| Trust Total | Actual | 24,892 | - | - | - | - | - | - | - | - | - | - | |

*Source: Info web: KPI Bed occupancy*

**Graph 8** **ECO £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 | 66 | | | | | | | | | | | |
| *Specialised Services* | *Target* | *20* | *20* | *20* | *20* | *20* | *20* | *20* | *20* | *20* | *20* | *20* | *20* |
| Specialised Services | Actual | 29 | | | | | | | | | | | |
| *Surgery, Head & Neck* | *Target* | *43* | *43* | *43* | *43* | *43* | *43* | *43* | *43* | *43* | *43* | *43* | *43* |
| Surgery, Head & Neck | Actual | 40 | | | | | | | | | | | |
| *Women's & Children's* | *Target* | *12* | *12* | *12* | *12* | *12* | *12* | *12* | *12* | *12* | *12* | *12* | *12* |
| Women's & Children's | Actual | 11 | | | | | | | | | | | |
| *Trust Total* | *Target* | 119.6 | 119.6 | 119.6 | 119.6 | 119.6 | 119.6 | 119.6 | 119.6 | 119.6 | 119.6 | 119.6 | 119.6 |
| Trust Total | Actual | 145.6 | - | - | - | - | - | - | - | - | - | - | - |

*Source: Finance temp staffing graphs (history changes)*

**Cover report to the Public Trust Board. Meeting to be held on 24 May 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 15 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Thursday, 24 May 2018 |
| **Report Title** | **Treasury Management Policy** | | |
| **Author** | Kate Parraman, Deputy Director of Finance | | |
| **Executive Lead** | Paul Mapson, Director of Finance and Information | | |
| **Freedom of Information Status** | | Open | |

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

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

## Executive Summary

Purpose

The Board is required to annually approve the Trust's Treasury Management Policy.

Key issues to note

The Treasury Management Policy, last reviewed in April 2017, requires a number of minor changes primarily to update terminology. The Finance Committee reviewed the updated policy on the 26 March 2018 and approved the minor changes for Board approval.

The Finance Department keeps the policy under review and will bring any future required amendments to Finance Committee and Board.

| Recommendations |
|---|
| The Board is asked to note that the Treasury Management Policy remains largely unchanged and to **approve** the minor changes |

| ntended 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 to note |

| 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)** |
| | **26 March 2018** | | | |

# Treasury Management Policy

## 1. Introduction

The Trust's Treasury Management Policy provides the framework for the Trust's treasury management activities and defines its objectives, attitude to risk, responsibilities, and policies. The policy is required to be regularly reviewed and formally approved by the Trust Board.

The policy was last reviewed and amended in April 2017. A review of the policy a year later requires minor changes as follows:

- Dates and cross referencing updates
- A number of job titles have been changed to reflect current titles
- Page 6 – insert Government Banking Services in the Investments section of Attitude to Risk in Key Treasure Activities
- Page 16 – reference to NHS Supplier payments in the Short Term Shortages section of Treasury Organisation and Responsibilities.
- Appendix 2 Schedule of Matters Reserved for the Board has been updated to reflect the Standing Financial Instructions approved in December 2017.

It is proposed that the Treasury Management Policy is kept under review over the next twelve months and any further amendments required will be identified and reported to the Finance Committee for approval at Trust Board.

A copy of the Treasury Management Policy showing the changes detailed above has been circulated electronically but has not been printed. It is available on FinWeb and will be printed and sent to Board members on request.

## 2. Recommendation

The Board is asked to note that the Treasury Management Policy remains largely unchanged and to **approve** the minor changes.

# Treasury Management Policy

| Document Data | | | |
|---|---|---|---|
| **Subject:** | Treasury Management | | |
| **Document Type:** | Policy | | |
| **Document Reference** | 19031 | | |
| **Document Status:** | Draft | | |
| **Document Owner:** | Deputy Director of Finance | | |
| **Executive Lead:** | Director of Finance | | |
| **Approval Authority:** | Trust Board of Directors | | |
| **Review Cycle:** | 12 months | | |
| **Date Version Effective From:** | 01/06/2018 | **Date Version Effective To:** | 31/05/2019 |

| Introduction |
|---|
| The emphasis the Trust places on good corporate governance requires it to have a formally approved Treasury Management policy which sets out its current treasury management activities and establishes a treasury risk management environment in which objectives, polices and operating parameters are clearly defined. |

| Document Change Control | | | | |
|---|---|---|---|---|
| **Date of Version** | **Version Number** | **Lead for** | **Type of Revisio** | **Description of Revision** |
| 23/02/15 | 0.01 | Deputy Director of Finance | None | No changes since last reviewed by Trust Board on 27 February 2014. (Original policy 2008) |
| 18/02/16 | 0.03 | Deputy Director of Finance | Minor | Minor changes to titles of posts, organisations and groups etc. Removal of consumer credit license |
| 28/04/2017 | 0.04 | Deputy Director of Finance | | Changes to external references and internal cross references. |
| 31/5/2018 | 0.05 | Deputy Director of Finance | | Changes to job titles, changes to external references and internal cross references, and minor amendments to wording. |

## Contents

## 1. Introduction

NHS Foundation Trusts have a wide discretion in the way that they manage and invest cash. This policy sets out how these areas will be assessed, reported, and monitored. It closely follows best practice issued by NHS Improvement 'Managing Operating Cash in NHS Trusts' and 'safe harbour' for investment of surplus operating cash. The guidance advises that Foundation Trusts should establish written policies covering their treasury management activities which should be formally approved by the Trust Board and regularly reviewed. The Trust's treasury management activities are assessed by NHS Improvement as part of their financial risk assessment. This policy has been set up as a practical way of reviewing and monitoring treasury management activities.

On a quarterly basis a Treasury Management Report will be presented to the Trust's Finance Committee to provide an update on any new issues, movements and Key Performance Indicators, as set out in the detailed sections in the policy.

## 2. Framework

Whilst the Trust has significant freedom to invest cash it has a number of responsibilities that it must discharge including;

i. Under section 17 of the Health & Social Care Act (Community Health and Standards) Act 2003 ("the Act"), the Trust has discretion to invest money for the purposes of or in connection with its functions, but must ensure this is managed carefully to avoid financial and/or reputational risks.
ii. Under Section 29 of the Act the Trust is required to exercise its function effectively, efficiently and economically.
iii. Under the Terms of the NHS Provider Licence, the Trust shall at all times remain a going concern.
iv. Under NHS Improvement's Single Oversight Framework the Trust is assessed monthly as part of the use of resources rating on five metrics[1], including liquidity and any adverse fluctuations may result in reductions in the risk rating of the Trust.

It is essential that the Trust protects itself by ensuring that no imprudent or inappropriate treasury management or investment behavior occurs. This policy will assist by providing a clearly defined risk management framework to be used by those responsible for treasury operations. The framework lays down responsibilities, protocols and procedures for the various aspects of treasury activities and sets out what should be reviewed and when.

## 3. Treasury Management

Treasury Management is the process of managing cash, availability of short term and long term funds, foreign currency and interest rate risk, and relationships with banks and other financial institutions.

In order to facilitate effective corporate governance, it is necessary to formally set out the expected treasury activities and establish a treasury risk management environment in which all objectives and operating parameters are clearly defined.

In the main, the treasury management activities of the Trust will be conducted in accordance with the guidance given by Monitor/NHS Improvement for dealing with cash and working capital.

[1] 1. Liquidity 2. Capital Service Cover 3. Income & Expenditure Margin, 4. Income and Expenditure Variance 5. Agency spend v Agency Ceiling

### *3.1 Treasury Aims and Objectives*

The treasury management function aims to support the Trust's activities by;

- Ensuring that cash is managed effectively.
- Ensuring the most competitive return on surplus cash balances, within an agreed risk profile.
- Ensuring that there is competitively priced funding available to meet borrowing requirements should it be needed.
- Ensuring that the Trust is aware of its cash position by regular, thorough reporting.
- Ensuring that all transactions and reviews are carried out within the appropriate timeframe and by the appropriate persons.
- Identifying and managing financial risks, including interest rate and foreign currency risks, arising from operating activities.
- Ensuring compliance with all banking covenants.

In order to meet these aims the treasury management function has the following key objectives:

i. Surplus Cash: To obtain the most competitive deposit rates using National Loans Fund and a group of relationship banks, in line with the deposit guidelines approved by the Trust's Finance Committee.
ii. Funding: Ensure the availability of flexible and competitively priced funding to meet the Trust's current and future requirements.
iii. Interest Rate Management: Maintain an interest rate structure which smoothes out the impact of rises or falls in interest rates on the Trust's Income and Expenditure position.
iv. Foreign Currency Management: Reduce the Trust's exchange rate movement risk by covering known foreign exchange exposures and mitigating material risks.
v. Bank Relationships: Develop and maintain strong, long-term relationships with a core group of quality banks ("relationships banks") that can meet current and future funding requirements.

These objectives are targeted to ensure that the Trust is able to continue its operational activities without facing financial constraints and that financial support is available to fund future approved developments.

**Treasury activities for purely speculative purposes are strictly prohibited.**

## *3.2 Attitude to Risk in Key Treasury Activities*

**a) Funding**

The Trust will maintain a prudent approach to funding, recognising the on-going requirement to have funds available to cover existing business cash flows and reasonable headroom for seasonal debt fluctuations and capital programme expenditure. Additional finance required for longer term developments and investments will be built into cash flow workings as and when agreed and advised by the Finance Committee.

**b) Investments**

All cash balances should remain in a comparatively liquid form in order to reduce the Trust's exposure to risk. If there is surplus cash it should ideally be placed in investments that meet the "safe harbour" criteria. If "safe harbour" investments are not available or do not provide a competitive return then investments that meet all of the criteria except the credit rating for long term investments (greater than 12 months) will be considered. Note that the Trust does not make long term investments. Appendix 1 details the criteria for "safe harbour" investments.

Where investments are made with institutions that meet the above conditions, but which subsequently drop in their short term credit ratings, the Finance Committee will be notified, but unless the Director of Finance considers there to be excessive risk, the investment will continue to maturity.

**The use of investments that do not satisfy the above conditions are prohibited unless explicitly approved by the Trust Board and should only be made to manage operational risk.** This includes general equities, derivative products and speculative investments such as leveraged investments, hedge funds, derivatives, futures, options and swaps. If there is any doubt as to whether an investment meets the necessary conditions it should be referred to the Finance Committee.

**Investments for a period of three to six months will require the prior written approval of the Director of Finance or the Deputy Director of Finance. Proposed investments resulting for longer than six months must have the prior approval of the Finance Committee. No investment may be placed beyond 31 March.**

Cash deposits should only be placed with the National Loans Fund and relationship banks in line with the deposit limits approved by the Trust's Finance Committee. Cash should only be placed with organisations that hold appropriate credit ratings, based on the "safe harbour" criteria, with a recognized credit rating agency (Moody's, Fitch, or Standard and Poor's). The approved limits, at any one time, are as follows:

i. Investments made with the National Loans Fund are unlimited.
ii. Individual Clearing Banks each have a limit of £15 million if backed by UK Government, £12m otherwise, (subject to the rate of return offered being at least 10 basis points higher than that offered by the higher of the National Loans Fund or Government Banking Service). Details of further limits applied to particular Clearing Banks can be found below.

**c) Permitted Institutions**

The Trust will place investments with institutions that:

- Have been granted permission, or any European institution that has been granted a passport, by the Financial Conduct Authority to do business with UK institutions providing it has a short term investment grade credit rating of P1/F1/A1 issued by a recognised rating agency; or

- Are an executive agency that is legally and constitutionally part of any department of the UK Government.

The list of institutions being used for treasury deposits will be reviewed at least annually or earlier where market conditions or intelligence suggest the need to ensure:

- That each one meets the criteria set out in this policy; and
- That it is appropriate to add (or delete) any new institutions from the list of active deposit takers.

If an institution is downgraded or put on credit watch by a recognised rating agency then the decision to invest with them should be reviewed.

The table below provides the investment limits for permitted financial institutions based on the credit ratings provided by recognised agencies.

Table: Investment limits

| **Institutions** | **Recognised Credit Rating Long-term/(Short-term)** | **Deposit Limit** |
|---|---|---|
| Clearing Banks: | | |
| *Backed by UK Government* | (P-1) | Lower of 50% cash available and £15m |
| *Not Backed by UK Government* | (P-1) | Lower of 25% cash available and £12m |
| Other permitted institutions: | Aaa/(P-1) | Lower of 10% and £7.5m |
| | Aa1, Aa2, Aa3/(P-1) | Lower of 10% and £5.0m |
| | A1, A2, A3/(P-1) | Lower of 10% and £2.5m |
| | Below the above | Nil |

*NB Appendix 1 provides definitions of risk ratings*

**Note that cash available is defined as the lowest projected cash balance over the period of the proposed investment.**

**d) Interest Rate Management**

If the Trust enters into long-term borrowings it should negotiate terms that incorporate a fixed interest rate, swaps, or a cap, in order to mitigate risk.

If the Trust decides to borrow over a number of projects, this policy will be amended to include guidance on hedging interest rates exposure by use of interest rate swaps.

**e) Foreign Exchange Management**

The Trust holds no foreign currency cash balances.

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date~~s~~ of the transaction. Resulting exchange gains and losses are taken to the Income and Expenditure Account. The vast majority of foreign currency transactions are made in relatively stable currencies (the Euro or U.S. Dollar). In light of the above the Trust has a minimal risk exposure to foreign exchange rate fluctuation.

If foreign currency transactions with a value of over £50,000 (based on the current spot rate) are planned then the Trust will consider mitigating risk by the use of a forward contract. Whether or not this is deemed appropriate will be depend on the currency the transaction is denominated in and current market conditions.

**f) Bank Relationships**

The Trust's approach is to develop long term relationships with a core group of high quality banks. This will be subject to a periodic tendering process by the Trust for banking services.

The Trust currently transacts with the Government Banking Service (GBS) and NatWest Bank. The Deputy Director of Finance is able to meet with other high quality banks to discuss the products and services they offer for information gathering purposes. If a new banking relationship proposal is suggested, this must be pre-approved by the Director of Finance before a proposal is made to the Trust's Finance Committee. The proposal will detail the need and potential benefit of the new banking relationship, and the Finance Committee will sanction or reject the proposal.

The quarterly Treasury Management Report update will include details of any significant meetings with banks, the outcome of any new banking proposals and any forthcoming new banking relationship proposals.

**g) Banking Covenants**

The Deputy Director of Finance will keep a master list of all of the covenants attached to bank, investment and funding arrangements and will report quarterly to the Trust's Finance Committee on performance against these covenants.

## *3.3 Treasury Organisation and Responsibilities*

The specific responsibilities of the Trust Board, Finance Committee, Director of Finance and individual Finance Department teams relating to treasury activities are noted below.

Operational management of treasury related issues sits with the Deputy Director of Finance and the ~~Head of Treasury Management~~Head of Exchequer Services.

**a) The Trust Board**

The Trust Board will be responsible for those treasury management issues specified by the Trust's Schedule of Matters Reserved for the Trust Board (Appendix 2), namely:

i. Approval of external funding arrangements.
ii. Approval of overall Treasury Management policy.

The Trust Board delegates responsibility for approval of Treasury Management procedures, controls and detailed policies to the Finance Committee.

**b) The Finance Committee**

The Finance Committee shall make such arrangements as it considers necessary on matters relating to the control and management of the finances of the Trust. On matters relating to treasury management this will

include:

i. Approval of the overall Treasury Management policy for approval by the Trust Board.
ii. Approval of Treasury Management procedures, controls and detailed policies.
iii. Liquidity and cash planning and forecasting.
iv. Approval of the Trust's investment and borrowing strategy, ensuring compliance where appropriate with Monitor/NHS Improvement best practice guidance.
v. Approval of the Trust's interest rate risk management strategy.
vi. Approval of relevant benchmarks for measuring investment and general treasury management operational performance.
vii. Reviewing and monitoring investment and borrowing policies and performance against relevant benchmarks in respect of all the Trust's funds.
viii. Ensuring proper safeguards are in place for security of the Trust's funds by:

    a. Approving the Trust's Commercial Bankers, selected by competitive tender.
    b. Approving a list of permitted relationship banks and investment institutions.
    c. Setting investment limits for each permitted investment institution.
    d. Approving permitted types of investments/instruments.
    e. Approving the establishment of new/changes to existing bank accounts.
    f. Ensuring approved bank mandates are in place for all accounts and that these are updated regularly for any changes in signatories and authorised limits.

ix. Monitoring compliance with treasury management policies and procedures on investments, borrowing and interest rate management in respect of limits, approved institutions and types of investment/instruments.
x. Approval of external funding arrangements, within delegated limits.
xi. Approval of long term borrowing for capital and investment programmes.
xii. Approval of dispute compromises with suppliers in excess of £25,000.

The Finance Committee delegates the following treasury management responsibilities to the Capital Programme Steering Group, which is directly accountable to the Trust's Senior Leadership Team. The Finance Committee receives the minutes of the Capital Programme Steering Group.

i. Formulating the Trust's balanced medium term capital programme budget that will contribute to the implementation of the Clinical Services Strategy for the Trust.
ii. Reviewing and setting the prioritisation criteria for capital projects
iii. Ensuring capital projects support Divisional Operating Plans, the Local Health Economy Strategy and the delivery of the Trust's annual Operational Plan and the National NHS Plan.
iv. Reporting actions, decisions and progress on the Trust's capital programme to the Finance Committee.
v. Ensuring all capital projects have a robust business case, and for operational and major medical capital been appropriately scored using the designated prioritisation matrix and offer value for money.
vi. Considering and recommending changes to the Trust's capital programme to the Finance Committee.
vii. Ensuring that the Trust's capital programme complies with the overall Financial Strategy of the Trust.

The Finance Committee delegates responsibility for treasury management operations to the Director of Finance.

**c) The Director of Finance**

The Director of Finance shall:

i. Take responsibility for treasury management operations.
ii. Approve and maintain operational treasury management policies and procedures.
iii. Approve cash management systems.
iv. Open all bank accounts in the name of the Trust or any of its constituent parts.
v. Open and operate Patient Money Deposit accounts as may be considered necessary and authorise minor imprest bank accounts to be opened at such branches as may be decided and operated according to instructions by any officers specified by the Director of Finance.
vi. Approve the use of the Trust's credit card and ensure adequate controls are in place to prevent misuse.
vii. Approve dispute compromises with suppliers in excess of £1,000, up to £25,000. Proposed compromises in excess of £25,000 shall be considered by the Finance Committee for approval.
viii. Hold meetings with the Deputy Director of Finance and members of the Treasury Management team to discuss and consider any issues that should be brought to the attention of the Finance Committee.

**d) Debtors**

Responsibility for the prompt collection of Non-NHS debts sits with the ~~Head of Treasury Management~~Head of Exchequer Services.

Invoices for charges based on actual activity must be raised as soon as the activity data becomes available and no later than 4 weeks after the end of the month to which the charge relates. Invoices for fixed price service contracts must be raised monthly in advance and are due for payment in the month in which the service is provided.

**Non-NHS Debtors**

Non NHS debtors can be split into the following categories;

- Private patients – before a private procedure is carried out the Divisional Private Patient Officers and/or the patient's Consultant will have agreed a price (as per the annual published private patient tariff) with the patient and the patient will have completed and signed a Private Patient Undertaking to Pay form.
- Overseas patients – Changes in legislation from 01 April 2017 will require all overseas visitors to be charged upfront and in full for any care not deemed by a clinician to be 'immediately necessary' or 'urgent' and / or cease to provide such non urgent care where payment is note received in advance of treatment. The Non NHS Patient Income Manager must provide detailed written instructions on how to identify potential overseas patients, the treatment classification and the charging mechanisms.
- Other non-NHS debtors – various customers may be charged for services provided such as catering, rent and accommodation charges and occupational health services.

The following payment options are available to customers – cheque sent to the Finance Department, direct payment into the Trust's bank account, credit card / debit card payment and via the Trust's website. All debts are due for payment within 30 days of the date of the invoice.

The process for recovering Non NHS Debts is primarily an automated dunning process comprising copy invoices, reminder letters and monthly statements of account. This process includes the issuing of court

proceedings and the use of a debt recovery agency as appropriate.

The quarterly Treasury Management report to the Finance Committee will note the number, value and details of any debts passed to the Trust's debt administration and collection company, arbitration cases and court proceedings issued.

**NHS Debtors**

- **NHS Healthcare Service Agreement Charges**

Responsibility for the prompt invoicing and collection of Healthcare Service Agreement charges sits with the Head of Contract Income and Costing.

Invoices will be raised for the following services:

i. Agreed Contracts/Service Level Agreements (SLAs) with Clinical Commissioning Groups and other commissioners.
ii. Contract variations as agreed with Clinical Commissioning Groups and other commissioners.

- **Block Invoices**

Block invoices for 1/12 of the expected annual value of service agreement contracts will be raised on a monthly basis and are due in the month the service is provided. Settlement is due on the 15th of each month. Where a block invoice is not paid on time then processes approved by the Deputy Director of Finance and the Head of Contract Income and Costing will commence.

- '**Over / Under Performance' Invoices:**

A reconciliation of the services provided will be sent to the commissioner after the end of the quarter. If the commissioner raises a valid query the Service Agreement team will respond and resolve it in line with the timescales agreed in contract documents.

Activity information is sent to the Secondary User Service (SUS) on a monthly basis, in addition to local data feeds in support of contract reporting and on a quarterly basis activity information is agreed between commissioners and the Trust, in line with the SUS reconciliation dates.

- **Non-contract activity**

For non-contract activity, where services are provided outside of contracts, invoices will be sent within 30 days after the end of the month, with supporting activity information.

The under/over performance recovery process will be applied to debts of more than 30 days old.

- **NHS Non Healthcare Provider to Provider Charges**

Responsibility for the prompt collection of Non Healthcare Provider to Provider debts sits with the ~~Head of Treasury Management~~Head of Exchequer Services.

Invoices will be raised for the following services:

i. Ad hoc service contracts agreed by Divisions and customer organisations.
ii. Other services such as medical staff recharges, catering, facilities provision etc.

Invoices for charges based upon actual activity must be raised as soon as the activity data becomes available and no later than 4 weeks after the end of the month to which the charge relates. Charges for fixed priced service contracts must be raised monthly in advance and are due for payment in the month in which the service is provided.

The process for the recovery of outstanding NHS Provider to Provider debts comprises an automated dunning process consisting of reminder letters and monthly statements of account, complimented by personal contact with debtor organisations, with escalation to Director of Finance level as appropriate. The quarterly Treasury Management report to the Finance Committee will note the number, value and details of any Director of Finance to Director of Finance meetings.

- **Credit Notes**

Where a credit note is required, the information sent to the Non NHS and NHS Debtors Teams must quote the invoice number to be credited against and must be coded to the same code as the invoice. All credit notes must be reviewed by the Contract Income Team or the Treasury Management Team. Where a credit note is for items invoiced in previous financial years, the Division that earned the income must absorb the costs against the current year unless the Deputy Director of Finance has approved the use of the year end bad debt provision.

Where a credit note relates to a Block Service Agreement invoice it must be signed off by the Finance Manager (Contract Income) with a supporting reconciliation to show why the credit note is required.

The Finance Manager (Contract Income) and ~~Head of Treasury Management~~Head of Exchequer Services will review the credit notes raised in the month after each month end and report on any credit notes greater than £50k to the Head of Contract Management and Costing and Deputy Director of Finance respectively.

The quarterly Treasury Management Report to the Finance Committee will note the number and value of credit notes issued in the quarter.

- **Aged Debtor Review**

Aged debt reports will be reviewed on a monthly basis by the ~~Head of Treasury Management~~Head of Exchequer Services and Head of Service Agreements for old unpaid items, to check that they have had the appropriate chasing letters issued. The Deputy Director of Finance and Head of Contract Income and Costing will review the aged debt reports at least quarterly and ensure that a recovery plan is in place for any significant outstanding debt.

- **Bad Debt Write Off**

The debtors ledger will be reviewed at least quarterly for any debt that potentially needs to be written off. The ~~Head of Treasury Management~~Head of Exchequer Services and Head of Service Agreements will provide lists of invoices proposed for write off to the Deputy Director of Finance and Head of Contract Income & Costing respectively. The Deputy Director of Finance and Head of Contract Income & Costing will review these lists;

- Against the payables ledger to check that there are no ongoing disputes on payments
- Against any other write offs that have happened in the past on this customer
- Against the GBS Unallocated Receipt suspense.
- Against the bad debt provision already held and
- To check that all the necessary steps to recover this money have been taken.

Debts that pass this checking process and require write off, must be authorised for write off in line with the delegated responsibilities contained within the Trust's Standing Financial Instructions. Write offs will be reported to the Trust's Audit Committee and will be summarised in the quarterly Treasury Management Report to the Finance Committee.

- **Unapplied Cash**

When a customer sends money to the Trust without an explanation of what the funds are for the funds will be initially credited to an unallocated receipt suspense account and further investigations undertaken.

For cash receipts and funds received direct to the Trust's NatWest Main Account the receipt will initially be credited to the Commercial Unidentified Receipt Suspense account. The Treasury Management Team will contact the customer for a remittance advice note. Assistance will also be sought from Divisional Financial Management teams to help identify the reason for the receipt and to reinforce to Service Managers that invoices must be raised for all income due to the Trust.

For funds received into the Trust's Government Banking Service (GBS) account from commissioners (primarily block service agreement invoice payments) where no remittance is provided the receipt will be initially credited to the GBS Unidentified Receipt Suspense account. The Assistant ~~Head of Treasury Management~~Head of Exchequer Services will, in the absence of any alternative instructions from the Service Agreements Team, use such receipts to clear the oldest Service Level Agreement invoices relating to the payment period, i.e. a payment received in April will only be used to clear invoices raised for the period of April with any excess funds remaining in the GBS Unidentified Receipt Suspense account.

A reconciliation of the Commercial and GBS Unidentified Receipt suspense will be maintained identifying the balance remaining in each account, by period received and customer.

On a quarterly basis any cash still unallocated or under customer investigation on this report that is older than 6 months will be taken to the Trust's central reserves and it will be at the Director of Finance's discretion as to what the reserve is used for.

The value of unallocated cash taken to central reserves will be included in the quarterly Treasury Management Report to the Finance Committee.

**e) Creditors**

**Cash Management**

Cash is forecast on a daily basis to check that there are sufficient funds available to pay forthcoming liabilities.

Responsibility for the payment of NHS and NHS Non-NHS Creditors sits with the ~~Head of Treasury Management~~Head of Exchequer Services ~~Head of Accounts Payable. Responsibility for the payment of NHS Creditors sits with the Head of Treasury Management~~.

**Processing of Payments**

- **Non NHS Payables**

The ~~Head of Accounts Payable~~Head of Exchequer Services will process any invoices that are due for payment on the twice weekly BACS run. A weekly cheque payment run is also produced to facilitate the payment of creditors who have not provided bank details. The list of invoices ready for payment will be reviewed to ensure that only due invoices are paid, or if invoices are being paid early it is because there is an advance payment discount available.

- **NHS Payables**

The ~~Head of Treasury Management~~Head of Exchequer Services will process any invoices that are due for payment on the weekly Government Banking Service inter account transfer (IAT). The list of invoices ready for payment will be reviewed to ensure that only due invoices are paid.

The Trust's credit card will only be used for payment to suppliers where this is the only accepted this method of payment or where to do so will allow the Trust to achieve savings. The use of the credit card is governed by a written procedure which is subject to review.

Standard terms of payment for both Non-NHS and NHS are 30 days from date of receipt of the invoice or the receipt of good/services (whichever is the later) unless they fall into a list of special categories (e.g. utilities, mobile phones, capital payment certificates, Department of Health PbR repayment). No invoices will be paid on any other terms unless expressly agreed by the Deputy Director of Finance or if a vital clinical supply that will delay patient care will be delayed if payment is not made.

**Review of Old Invoices**

- **Non NHS Payables**

The ~~Head of Accounts Payable~~Head of Exchequer Services will review the aged creditor report monthly to ensure that resolution of issues preventing the payment of outstanding invoices is being adequately progressed. Information regarding invoices awaiting authorisation will be used to escalate delays in processing to operational managers, Divisional Finance Managers and the Deputy Director of Finance as appropriate.

- **NHS Payables**

The ~~Head of Treasury Management~~Head of Exchequer Services will review the aged creditor report monthly to ensure that resolution of issues preventing the payment of outstanding invoices is being adequately progressed. Information regarding invoices awaiting authorisation will be used to escalate delays in processing to operational managers, Divisional Finance Managers and the Deputy Director of Finance as appropriate.

The Deputy Director of Finance will review the Non-NHS and NHS aged creditor positions quarterly with the ~~Head of Accounts Payable~~Head of Exchequer Services ~~and Head of Treasury Management~~ to ensure that action plans are in place to resolve problems with old outstanding invoices. Any significant difficulties will be reported to the Deputy Director of Finance to ensure that appropriate action is taken.

**Negotiations with Suppliers over Disputes**

The ~~Head of Accounts Payable~~Head of Exchequer Services will liaise with suppliers where there are ongoing disputes. Where this involves compromise, the ~~Head of Accounts Payable~~Head of Exchequer Services must demonstrate to the Deputy Director of Finance that a compromise is necessary with the supplier. The Deputy Director of Finance can agree compromise arrangements up to £1,000. Any values over this amount will need to be approved by the Director of Finance or Finance Committee in accordance with delegated limits. Any compromise deal agreement will be reported in the quarterly Treasury Management Report to the Finance Committee.

**f) Bank Reconciliations**

Reconciliations of the Trust's bank accounts are undertaken monthly by the Financial Accounting Team. Accounts are also scrutinised daily, by the Cashier and Assistant ~~Head of Treasury Management~~Head of Exchequer Services for any 'rogue' transactions.

**g) Short-Term Investments (Cash Deposits)**

Short-term investments or deposits are defined as those of less than 12 months duration. Effective cash monitoring and forecasting on a daily, weekly, monthly and longer term basis by the ~~Head of Treasury Management~~Head of Exchequer Services will identify cash surpluses and an appropriate time to be able to invest them for. The ~~Head of Treasury Management~~Head of Exchequer Services will review and produce forecasts and calculations for investment. The ~~Head of Treasury Management~~Head of Exchequer Services will contact the National Loans Fund and all 'relationship' banks and financial institutions and identify the product that generates the best return for the potential investment, ensuring all limits contained in this policy are met. The Director of Finance or Deputy Director of Finance will review the investment proposals

and approve if appropriate to do so. If any of these post holders refuse to authorise the deposit on principal, authorisation from the other post holders should not be sought unless the original authoriser has suggested onward discussion.

**Investments of more than 3 months but less than 6 months require the prior written approval of the Director of Finance. Cash must not be placed on deposit for more than 6 months without the prior approval of the Finance Committee.**

If longer term investment is required, this must be referred to Finance Committee detailing the reasons why there are such surplus funds, the duration of the proposed investment, and the product proposed. The Finance Committee can refuse this investment because it may decide that it is more appropriate that the cash be spent on other alternatives (capital, quality bids, and longer term investment).

**Approval of New Commercial Deposit Options**

Where there is already an approved relationship with a Clearing Bank or other financial institution (section 3.2.6), the Deputy Director of Finance can identify new interest generating deposit account products that may benefit the Trust but will not increase, together or separately, the risk to the Trust's asset base.

Where a new product is required the Director of Finance or Deputy Director of Finance will pre-approve the product. Because the product is changing the risk profile of the Trust, the decision must be reported to the Finance Committee. If any of these post holders refuse to authorise the deposit on principal, authorisation from the other post holders should not be sought unless the original authoriser has suggested onward discussion.

Where a new product is available but not with an already approved relationship Clearing Bank or financial institution this must be referred to the Finance Committee for approval.

**Reporting**

The quarterly Treasury Management Report to Finance Committee will report on investments placed, returns earned and new investments set up.

**h) Long Term investments**

Long term investments are defined as those over 12 months. The Trust does not undertake such investments.

**i) Borrowing**

Weekly and monthly treasury and cash reporting (section 3.4) will identify whether there are any cash flow shortages.

**Short Term Shortages**

Where short term cash flow shortages are identified due to working capital movements the following steps will be taken;

a. The ~~Head of Treasury Management~~Head of Exchequer Services will notify the Deputy Director of Finance and suggest a course of action.
b. The Deputy Director of Finance will refer to the Director of Finance depending on the seriousness of the issue.
c. Any cash held in investments with no or minimal penalty (other than lost interest) will be called back, short term first, followed by long term.

~~c.~~d. NHS Supplier payments will be delayed until funds become available.
~~d.~~e. Non-NHS Supplier payments will be delayed until funds become available.
~~e.~~f. Additional pressure will be placed on debtors to make sure all debts are being paid on time or promptly chased.
~~f.~~g. Any cash held in investments where penalties will be incurred will be called back.
~~g.~~h. Non vital non-urgent stock orders will be delayed.
~~h.~~i. All non-vital capital will be delayed where possible.
~~i.~~j. Monitor/NHS Improvement may be approached.

The quarterly Treasury Management Report to Finance Committee will report on any overdraft usage.

**Long Term Borrowings**

Long term borrowings will only be used to fund longer term capital or investment programmes.

All strategic capital projects will be approved using the normal Trust Board and committee structure, and at Capital Programme Steering Group, Finance Committee or Trust Board whichever is relevant to the particular project. All projects will have produced a detailed business case have been approved in line with the Trust's Capital Investment Policy.

The Capital Programme Steering Group is responsible for identifying which projects will be funded using long term borrowing as part of the planning process. This will be formally approved by the Finance Committee.

Once the need for borrowing has been established, the Deputy Director of Finance will search financial institutions for the best available source of finance to match the particular project. The Independent Trust Financing Facility (ITFF) will be the first option considered, as this has been set up specifically to assist NHS Trusts. A proposal to use the selected borrowing product will be sent to the Director of Finance for pre-approval before being presented to the Finance Committee for approval.

Once borrowings have been set up they will be reported in the Director of Finance's report on a monthly basis.

Progress on existing borrowings and any pending or approaching borrowings will be reported in the quarterly Treasury Management Report.

## *3.4 Treasury and Cash Reporting*

**a) Daily Reporting**

On a daily basis the Cashier:

i. Downloads statements and transaction reports for the previous day's activities on the Trust's Government Banking Service account (via RBS Bankline) and NatWest commercial bank accounts (via NatWest Bankline).
ii. Updates the daily cashflow plan for the month in light of actual receipts and payments made (e.g. Payroll, Supplier Payments).
iii. Reviews and updates, as appropriate, future planned receipts and payments in the daily cashflow plan in light of actual results for the next 21 days.
iv. Ensures the daily cashflow plan agrees with the actual results/plan figures recorded in the monthly cashflow plan.

The ~~Head of Treasury Management~~Head of Exchequer Services reviews the daily cashflow plan to assess the potential for cash surpluses and shortfalls.

**b) Weekly Cash Reporting**

On a weekly basis the ~~Head of Treasury Management~~Head of Exchequer Services undertakes a comprehensive review of the daily cashflow plan with the Deputy Director of Finance, focusing on expected receipts and payments, by major 'category' for:

i. The next 14 days
i. 6 weeks after that
ii. The rest of that month
iii. The next month

This process gives sound assurance than any medium term cash flow surpluses/shortfalls are identified and allows sufficient time to develop action plans.

Any issues causing serious concern are immediately discussed with the Director of Finance.

**c) Monthly Reporting**

On a monthly basis the monthly cashflow plan for the current financial year and rolling plan for the next 12 months will be produced and reviewed by the Director of Finance.

**d) Quarterly Reporting to the Finance Committee**

Appendix 3 details the items relating to treasury management that will be reported in a Treasury Management Report to the Finance Committee on a quarterly basis

## *3.5 Performance Management*

Internal Audit conducts an annual review of the Finance Department that incorporates aspects of treasury management. This review will be used to assess how well this policy has been applied. In addition, on an annual basis the Director of Finance sets an internal target for interest receivable. Achievement against this target will assess how effective the interest maximisation aspect of this policy has been.

## Appendix 1 – Safe Harbour Investments

Safe harbour investments are those that ensure adequate safety and liquidity for the Trust, and ***must*** meet ***all*** of the following criteria;

a. They meet the permitted short-term rating requirement issued by a recognised rating agency;
b. They are held at a permitted institution;
c. They have a defined maximum maturity date;
d. They are denominated in sterling;
e. They pay interest at a fixed, floating or discount rate; and
f. They are within the preferred concentration limit.

The use of safe harbour investments negates the need for the Trust Board to undertake an individual investment review for these investments. In addition Monitor will not require a report of these investments as part of its risk assessment process as they are deemed to have sufficiently low risk and high liquidity.

Safe harbour investments include (but are not limited to) money market deposits, money market funds, government and local authority bonds and debt obligations, certificates of deposit and sterling commercial paper provided that they meet the above criteria. The Treasury Management function is not permitted to undertake any of these investment options other than placing money on deposit at the National Loans Fund or pre-approved Clearing Bank without the prior approval of the Finance Committee.

Explanation of Terms

Each of the terms above and their limits for the trust are explained below. The appropriateness of the limits needs to be reviewed on an annual basis to confirm that they are still appropriate for the Trust.

- Recognised rating agency - are agencies that grade companies and investments on their long term standing and future viability based on information available in the market. Only Standard and Poor's, Moody's Investors Services and Fitch Ratings Ltd are recognised rating agencies.
- Permitted rating requirement – the short term rating should be A-1 (S&P), P-1 (Moody's') or F-1 (Fitch), which are the highest level of risk ratings and suggest a good quality investment.
- Permitted institutions - include institutions that have been granted permission by the Financial Services Authority to do business with UK institutions, and the UK Government.
- Maximum maturity date – for general investments, the maturity date must be before the date when the invested funds are needed and in any event should not exceed 6 months unless approved by the Finance Committee.
- Preferred concentration limit - is to ensure that all the risk is not held in the one institution. The preferred concentration rate for the Trust is, with the exception of the National Loans Fund (where the concentration limit is unlimited) set out in the Treasury Management Policy.

## Appendix 2 – Schedule of Matters Reserved to the Board issues requiring Trust Board approval

- ~~Strategic Direction including Research and Development Plans, Teaching and links with the Universities~~
- ~~Annual Report~~
- ~~Annual Business Plan~~
- ~~Budget~~
- ~~Business Cases for capital investments £5m or more~~
- ~~Employment Strategies~~
- ~~Major Organisation Change~~
- ~~Losses and Compensation Reports~~
- ~~Major Service Changes~~
- ~~Banking Arrangements~~
- ~~Approval of overall Treasury Management Policy~~
- ~~Standing Financial Instructions and Standing Orders~~
- ~~Acceptance of Accounts~~

~~Creations and Terms of Reference of Trust Board Committees and Working Parties.~~

- Defining the overall strategic aims and objectives of the Foundation Trust.
- Approving the Membership Council's proposals for amendments to the Constitution (unless routed through the Joint meeting)
- Approving the scheme of delegation to officers and committees
- Appointing, dismissing and receiving reports of Board Committees
- Approving the draft Annual Report and accounts for submission
- Approving the Annual Plan
- Approving corporate organisational structures
- Approving proposals for the acquisition, disposal or change of use of land and/or buildings
- Approving HR policies incorporating the appointment, dismissal and remuneration of staff
- Approving the health and safety policy
- Approving revenue and capital budgets
- Approving those matters reserved to it under the scheme of delegation:
- approval of variations to capital schemes of over £500,000
- all high risk investments and all major investments (OBC and FBC) and greater than 1% (£5m) of the Trust's turnover.
- individual write-offs and ex-gratia payments over £50,000
- approving supplies or services contracts with a value over £1m
- Approving and monitoring the Foundation Trust's policies and procedures for the management of risk and provision of assurance
- Approving proposals for the acquisition, disposal or change of use of land and/or buildings affecting the Trust's services
- All monitoring returns required by the regulators shall be reported, at least in summary, to the Trust Board

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- Approving major regulatory submissions affecting the Trust as a whole
- Approving the Standing Orders and Standing Financial Instructions of the Foundation Trust

## Appendix 3 – Contents of Quarterly Treasury Management Report to the Finance Committee

The following information will be reported quarterly to the Finance Committee in a Treasury Management Report:

New banking relationships entered into in the current quarter, proposals presented to Finance Committee and outcome, any pending proposals, any good products seen at any meetings with institutions (3.2.f~~6~~)

An update on compliance with covenant (3.2.g~~7~~)

The number, value and details of any debts passed to the Trust's debt administration and collection company, Director of Finance to Director of Finance meetings, arbitration cases issued and court proceedings issued (3.3.d4)

The number and value of NHS credit notes raised in the quarter (3.3.d~~4~~)

Number and value of bad debt write offs in the quarter (3.3.d~~4~~)

The value of unallocated credits over six month~~'~~s old taken to central reserves.

Compromise deal agreements following negotiations with suppliers over disputes (3.3.e~~5~~)

Investments placed, returns earned and new investments set up (3.3.g~~7~~)

Overdraft usage (3.3.i~~9~~ )

Potential requirements for working capital support identified in the next 12 months (3.3.i~~9~~)

Borrowings taken out in the quarter, borrowings proposed, pending or approaching in the quarter (3.3.i~~9~~)

Progress on any existing borrowing, including whether repayments are up to date (3.3.i~~9~~)

Performance against Key Performance Indicators for any investments and proposed Key Performance Indicators for any new investments.

| | Item | Information Provided by | Information Required | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | Initial Set Up | Daily | Weekly | Monthly | Quarterly | Annually | Other Periodically |
| **1.** | **Finance Committee Reporting** | | | | | | | | |
| **1.1** | **Monthly Finance Directors Report (3.4.d4)** | | | | | | | | |
| | a. Cash Flow Plan – Monthly for current year | Deputy Director of Finance | | | | ✓ | | | |
| | b. Amounts placed on deposit and interest earned. | Deputy Director of Finance | | | | ✓ | | | |
| | c. Invoiced Aged Debt Report | Deputy Director of Finance | | | | ✓ | | | |
| | d. Performance against Better Payments Practice Code (BPPC) – NHS & Non NHS Suppliers | Deputy Director of Finance | | | | ✓ | | | |
| | e. Capital Report | Deputy Director of Finance | | | | ✓ | | | |
| | f. Statutory Statement of Financial Position | Deputy Director of Finance | | | | ✓ | | | |
| | g. Capital Programme Steering Group (CPSG): (3.2.2) | Chair of the CPSG | | | | | | | |
| | • Seek approval for annual Capital Programme and sources of financing | | | | | | | ✓ | |
| | • Recommend changes to Capital Programme | | | | | ✓ | | | |
| | • Report on actions, decisions and progress against the Capital Programme | | | | | ✓ | | | |
| | • Report on quarterly post capital spending reviews and assessments of returns on capital spend | | | | | | ✓ | | |
| | • Seek approval for strategic capital projects and source of financing | | | | | ✓ | | | ` |
| **1.2** | **Quarterly Treasury Management Report (Appendix 3)** | | | | | | | | |
| | a. New banking relationships entered in the current quarter, proposals presented to the Finance Committee and outcome, any pending proposals, any good products seen at meetings with Financial Institutions. | Deputy Director of Finance | | | | | ✓ | | |
| | b. Compliance with ~~covenents~~covenants | Deputy Director of Finance | | | | | | | |
| | c. The number, value and details of: | Deputy Director of Finance Services/Head of Contract Income & Costing | | | | | ✓ | | |
| | • Any debts passed to the Trust's debt administration and collection company. | | | | | | | | |
| | • Finance Director to Finance Director Meetings | | | | | | | | |
| | • Arbitration cases issued | | | | | | | | |
| | • Court Proceedings issued | | | | | | | | |

| | | Information Provided by | Information Required | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Item** | | **Initial Set Up** | **Daily** | **Weekly** | **Monthly** | **Quarterly** | **Annually** | **Other Periodically** |
| | d. The number and value of NHS and Non-NHS credit notes raised in the quarter | Deputy Director of Finance /Head of Contract Income & Costing | | | | | ✓ | | |
| | e. The number and value of bad debts written off in the quarter | Deputy Director of Finance /Head of Contract Income & Costing | | | | | ✓ | | |
| | f. The value of unallocated credits over six month's old taken to central reserves. | Deputy Director of Finance | | | | | ✓ | | |
| | g. Investments placed, maturity period, returns earned and new investments set up. | Deputy Director of Finance | | | | | ✓ | | |
| | h. Overdraft usage | Deputy Director of Finance | | | | | | | |
| | i. Potential requirements for working capital support identified in the next 12 months. | Deputy Director of Finance | | | | | ✓ | | |
| | j. Borrowing taken out in the quarter, borrowings proposed, pending or approaching in the quarter | Deputy Director of Finance | | | | | ✓ | | |
| | k. Progress on any existing borrowing including whether repayments are up to date | Deputy Director of Finance | | | | | ✓ | | |
| | l. Performance against Key Performance Indicators for any investments and proposed Key Performance Indicators for any new investments. | Deputy Director of Finance | | | | | ✓ | | |
| **1.3** | **Other Reporting Requirements** | | | | | | | | |
| | a. Approve Commercial Banking Services Provider (3.3.b~~2~~) | Deputy Director of Finance | | | | | | | ✓ |
| | b. Approve list of permitted Relationship Banks (3.3.b~~2~~) | Deputy Director of Finance | ✓ | | | | | | |
| | c. Approve new/changes to Relationship Banks (3.3.b~~2~~) | Deputy Director of Finance | | | | ✓ | | | |
| | d. Approve Bank Mandates for all Accounts (3.3.b~~2~~) | Deputy Director of Finance | ✓ | | | | | | ✓ |
| | e. Approve new/changes to Bank Mandates (3.3.b~~2~~) | Deputy Director of Finance | | | | ✓ | | | |
| | f. Approve list of permitted Investment Banks and Institutions satisfying Treasury Management Policy (3.2.c~~3~~) | Deputy Director of Finance | ✓ | | | | | ✓ | |
| | g. Approve list of permitted Investment Products satisfying Monitor Safe Harbour criteria (3.2.c~~3~~) | Deputy Director of Finance | ✓ | | | | | ✓ | |
| | h. Approve concentration limits for each permitted Investment Institution and product (3.2.c~~3~~) | Deputy Director of Finance | ✓ | | | | | ☐ | |

| | Item | Information Provided by | Information Required | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | Initial Set Up | Daily | Weekly | Monthly | Quarterly | Annually | Other Periodically |
| | i. Approve investments with a maturity period in excess of 36 months (3.2.h~~8~~) | Deputy Director of Finance | | | | ✓ | | | |
| | j. Approve use of Investment Banks/Institutions and products which do not satisfy the Treasury Management Policy (3.3.g~~7~~) | Deputy Director of Finance | | | | ✓ | | | |
| | k. Approve Key Performance Indicators for all existing and new investments (3.3.b~~2~~ and Appendix 4) | Deputy Director of Finance | ✓ | | | ✓ | | | |
| | l. Approve external funding arrangements within delegated limits (3.3.b~~2~~) | Deputy Director of Finance /Chair of Capital Prioritisation Group | | | | ✓ | | ✓ | |
| | m. Approve external funding arrangements within delegated limits (3.3.b~~2~~) | Deputy Director of Finance /Chair of Capital Prioritisation Group | | | | ✓ | | ✓ | |
| | n. Approve long term borrowing for Capital and Investment Programmes (3.3.b~~2~~) | Deputy Director of Finance /Chair of Capital Prioritisation Steering Group | | | | ✓ | | ✓ | |
| | o. Approve Supplier dispute compromises over £25,000 (3.3.b~~2~~) | ~~Head of Accounts Payable~~Head of Exchequer Services | | | | ✓ | | | |
| **2.** | **Internal Finance Reporting** | | | | | | | | |
| **2.1** | **Finance Director** | | | | | | | | |
| | i. Approve Supplier dispute compromises over £1,000 and up to £25,000 (3.3.c~~3~~) | ~~Head of Accounts Payable~~Head of Exchequer Services | | ✓ | | | | | |
| | ii. Monthly meeting with Head of Accounting Services to consider items for Finance Committee (3.3.c~~3~~) | | | | | ✓ | | | |
| | iii. Write off of Bad Debt Schedules – within limits contained in Scheme of Delegation | ~~Head of Treasury Management~~Head of Exchequer Services | | | | ✓ | | | |
| | iv. Review monthly/annual cashflow plan (3.4.c~~3~~) | Deputy Director of Finance | | | | ✓ | | | |
| | v. Review of Interest Received v Budget (3.5) | Deputy Director of Finance | | | | | | ✓ | |
| **2.2** | **~~Head of Finance~~Deputy Director of Finance** | | | | | | | | |
| | i. Approve Supplier dispute compromises up to | ~~Head of Accounts Payable~~Head of Exchequer | | ✓ | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | £1,000 (3.3.e~~5~~) | Services | | | | | | | |
| | ii. Approve payment of Supplier invoices on terms other than NHS terms and conditions (3.3.e~~5~~) | ~~Head of Accounts Payable~~Head of Exchequer Services | | ✓ | | | | | |
| | | **Information Provided by** | **Information Required** | | | | | | |
| | **Item** | | **Initial Set Up** | **Daily** | **Weekly** | **Monthly** | **Quarterly** | **Annually** | **Other Periodically** |
| | iv. Approve us of Bad Debt Provision for Bad Debt write-offs (3.3.d4) | ~~Head of Treasury Management~~Head of Exchequer Services | | ✓ | | | | | |
| **2.3** | **Head of ~~Accounting~~ Financial Services** | | | | | | | | |
| | i. Review of Age Debtor Reports (3.3.d4) | ~~Head of Treasury Management~~Head of Exchequer Services | | | | | ✓ | | |
| | ii. Review Proposed Bad Debt Write-offs (3.3.d4) | ~~Head of Treasury Management~~Head of Exchequer Services | | | | ✓ | | | |
| | iii. Review and approval of Court Proceedings (3.3.d4) | ~~Head of Treasury Management~~Head of Exchequer Services | | | | ✓ | | | |
| | iv. Advise Finance Director of balance of unapplied cash older than 6 months – take to Central Reserves (3.3.d4) | ~~Head of Treasury Management~~Head of Exchequer Services | | | | | ✓ | | |
| | v. Review daily cashflow plans with ~~Head of Treasury Management~~Head of Exchequer Services (3.4.b~~2~~) | ~~Head of Treasury Management~~Head of Exchequer Services | | | ✓ | | | | |
| | vi. Approve short term investments (3.3.g~~7~~) | ~~Head of Treasury Management~~Head of Exchequer Services | | | ✓ | ✓ | | | |
| | vii. Report forecast cash shortages to Head of Finance/ Finance Director (3.3.i~~9~~) | ~~Head of Treasury Management~~Head of Exchequer Services | | ✓ | | | | | |
| | viii. Review NHS & Non-NHS Age Creditor Reports (3.3.e~~5~~) | ~~Head of Accounts Payable~~Head of Exchequer Services | | | | | ✓ | | |
| **2.4** | **~~Head of Treasury Management~~Head of Exchequer Services** | | | | | | | | |
| | i. Review proposed Court proceedings (3.3.d4) | Assistant ~~Head of Treasury Management~~Head of Exchequer Services | | | | ✓ | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | ii. Review credit notes raised – report items over £50,000 to Head of Accounting Services (3.3.d4) | Assistant ~~Head of Treasury Management~~Head of Exchequer Services | | | | ✓ | | | |
| | iii. Review NHS and Non-NHS Aged Debtor Reports (3.3.d4) | Assistant ~~Head of Treasury Management~~Head of Exchequer Services | | | | ✓ | | | |
| | iv. Review NHS Aged Creditor Report. Report significant difficulties to Head of Finance (3.3.e5) | Assistant ~~Head of Treasury Management~~Head of Exchequer Services | | | | ✓ | | | |
| | v. Report forecast cash shortages to Head of Accounting Services (3.3.i9) | Cashier | | ✓ | | | | | |
| | vi. Review daily cashflow plan with Cashier (3.4.a1) | Cashier | | ✓ | | | | | |
| | vii. Review daily cashflow plan with Head of Accounting Services (3.4.b2) | Cashier | | | ✓ | | | | |

| | | **Information Provided by** | **Information Required** | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Item** | | **Initial Set Up** | **Daily** | **Weekly** | **Monthly** | **Quarterly** | **Annually** | **Other Periodically** |
| | viii. Approve short term investments/cash deposits (3.3.g7) | Cashier | | ✓ | | | | | |
| **2.5** | **Head of Contract Income & Costing** | | | | | | | | |
| | i. Review Age Debtor Report (3.3.4d) | Head of Service Agreements | | | | | ✓ | | |
| | ii. Review Proposed Bad Debt Write-offs (3.3.d4) | Head of Service Agreements | | | | ✓ | | | |
| ~~2.6~~ | ~~**Head of Service Agreements**~~ | | | | | | | | |
| | iii. Review credit notes raised – report items over £50,000 to Head of Accounting Services (3.3.d4) | Head of Service Agreements | | | | ✓ | | | |
| | iv. Review Aged Debtor Report (3.3.d4) | Head of Service Agreements | | | | ✓ | | | |
| **2.7** | ~~**Head of Accounts Payable**~~**Head of Exchequer Services** | | | | | | | | |
| | i. Review Non-NHS Age Creditor Report. Report significant difficulties to Head of Finance (3.3.e5) | - | | | | ✓ | | | |

## 1. Appendix A – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this Policy.

| Objective | Evidence | Method | Frequency | Responsible | Committee |
|---|---|---|---|---|---|
| The management and investment of cash will be assessed, reported, and monitored.<br>Referenced in detail at Appendix 3 | Reports to relevant committees | Audit | Monthly through the Finance Directors Report with a Quarterly Treasury Management Policy report. | Director of Finance<br>Deputy Director of Finance<br>~~Head of Treasury Management~~Head of Exchequer Services | Finance Committee |

## 2. Appendix B – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

| Plan Elements | Plan Details |
|---|---|
| **The Dissemination Lead is:** | ~~Head of Treasury Management~~Head of Exchequer Services |
| **This document replaces existing documentation:** | Yes |
| **Existing documentation will be replace by:** | Deputy Director of Finance and ~~Head of Treasury Management~~Head of Exchequer Services |
| **This document is to be disseminated to:** | ~~All finance staff and budgetholders~~All finance staff and budget holders |
| **Method of dissemination:** | It will be available to download from FinWeb or upon request from the ~~Head of Treasury Management~~Head of Exchequer Services |
| **Training is required:** | No |
| **The Training Lead is:** | N/A |

| Additional Comments |
|---|
| None |

## 3. Appendix C – Document Checklist

The checklist set out in the following table confirms the status of 'diligence actions' required of the 'Document Owner' to meet the standards required of University Hospitals Bristol NHS Foundation Trust Procedural Documents. The 'Approval Authority' will refer to this checklist, and the Equality Impact Assessment, when considering the draft Procedural Document for approval. All criteria must be met.

| Checklist Subject | Checklist Requirement | Document Owner's Confirmation |
|---|---|---|
| **Title** | The title is clear and unambiguous: | Yes |
| | The document type is correct (i.e. Policy, Policy, Protocol, Procedure, etc.): | Yes |
| **Content** | The document uses the approved template: | Yes |
| | The document contains data protected by any legislation (e.g. 'Personal Data' as defined in the Data Protection Act 2000): | N/A |
| | All terms used are explained in the 'Definitions' section: | N/A |
| | Acronyms are kept to the minimum possible: | Yes |
| | The 'target group' is clear and unambiguous: | Yes |
| | The 'purpose and scope' of the document is clear: | Yes |
| **Document Owner** | The 'Document Owner' is identified: | Yes |
| **Consultation** | Consultation with stakeholders (including Staff-side) can be evidenced where appropriate: | N/A |
| | The following were consulted: | N/A |
| | Suitable 'expert advice' has been sought where necessary: | Yes |
| **Evidence Base** | References are cited: | Yes |
| **Trust Objectives** | The document relates to the following Strategic or Corporate Objectives: | Strategic Priority 6: Ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal |
| **Equality** | The appropriate 'Equality Impact Assessment' or 'Equality Impact Screen' has been conducted for this document: | Yes |
| **Monitoring** | Monitoring provisions are defined: | Yes |
| | There is an audit plan to assess compliance with the provisions set out in this procedural document: | Yes |
| | The frequency of reviews, and the next review date are appropriate for this procedural document: | Yes |
| **Approval** | The correct 'Approval Authority' has been selected for this procedural document: | Yes |

| Checklist Subject | Checklist Requirement | Document Owner's Confirmation |
|---|---|---|
| **Additional Comments** | | |
| None | | |

## 4. Appendix D - Equality Impact Assessment

| Query | Response | |
|---|---|---|
| What is the aim of the document? | To provide guidance for the management of procedural documents within the organisation. | |
| Who is the target audience of the document (which staff groups)? | Authors of procedural documents and members of approval authorities.<br>Add ☑ or ☒ | |
| Who is it likely to impact on and how? | **Staff** | ☑ |
| | **Patients** | ☒ |
| | **Visitors** | ☒ |
| | **Carers** | ☒ |
| | **Other** | ☒ |
| Does the document affect one group more or less favourably than another based on the 'protected characteristics' in the Equality Act 2010: | **Age** (younger and older people) | ☒ |
| | **Disability** (includes physical and sensory impairments, learning disabilities, mental health) | ☒ |
| | **Gender** (men or women) | ☒ |
| | **Pregnancy and maternity** | ☒ |
| | **Race** (includes ethnicity as well as gypsy travelers) | ☒ |
| | **Religion and belief** (includes non-belief) | ☒ |
| | **Sexual Orientation** (lesbian, gay and bisexual people) | ☒ |
| | **Transgender** people | ☒ |
| | **Groups at risk of stigma** or social exclusion (e.g. offenders, homeless people) | ☒ |
| | **Human Rights** (particularly rights to privacy, dignity, liberty and non degrading treatment) | ☒ |

**Cover report to the Public Trust Board. Meeting to be held on 24 May 2018 at 11:00-13:00 in the Conference Room, Trust Headquarters**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 16 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Thursday, 24 May 2018 |
| **Report Title** | **Emergency Preparedness Annual Report** | | |
| **Author** | Simon Steele, Resilience Manager | | |
| **Executive Lead** | Mark Smith, Chief Operating Officer/Deputy Chief Executive | | |
| **Freedom of Information Status** | | Open | |

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

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

**Executive Summary**

Purpose

To highlight the trust position in relation to emergency preparedness, resilience and response over the past 12 months.

Key issues to note

Between April 2017 and March 2018 the Trust has achieve substantial compliance with the NHS England Core Standards for Emergency Preparedness Resilience and Response from a previous position of partial compliance. This report provides an overview of this position and the focus of work for the forthcoming year.

**Recommendations**

Members are asked to:

- **Approve** 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)** |
| | | | | |

# Emergency Preparedness, Resilience and Response

## Annual Report 2017 – 2018

Prepared by: **Simon Steele,** Resilience Manager

Presented by: **Mark Smith,** Deputy Chief Executive and Chief Operating Officer

### Executive Summary

The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect the safe and effective operation of the Trust's services. These could be anything from severe weather to an infectious disease outbreak or a major transport accident.

Under the Civil Contingencies Act (2004), NHS organisations must show that they can effectively respond to emergencies and business continuity incidents while maintaining critical services to patients. This work is referred to in the health service as Emergency Preparedness, Resilience and Response (EPRR).

The Civil Contingencies Act 2004 (CCA) places a number of statutory duties on NHS organisations which are classed as either Category 1 or Category 2 responders.

Category 1 responders are those organisations at the core of an emergency response. As a Category 1 responder, University Hospitals Bristol NHS Foundation Trust (the Trust) is required to prepare for emergencies in line with its responsibilities under;

- The Civil Contingencies Act 2004,
- The Health and Social Care Act, 2012, and
- NHS England Core Standards for Emergency Preparedness Resilience and Response 2016.

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The Trust is positioned centrally in what is known as a 'Core' city. This position places an even greater emphasis on there being robust up to date emergency plans in place. This report outlines the position of the Trust in relation to Emergency Preparedness, Resilience and Response and how the trust will meet the duties set out in legislation and associated guidance, as well as any other issues identified by way of risk assessments and identified capabilities. The report also includes information relating to the Trust's position in the NHS England annual EPRR assurance audit led by NHS England.

## Acronym's and Definitions

| Acronym | Definition |
|---|---|
| AEO | Accountable Emergency Officer – at UH Bristol this is the Chief Operating Officer & Deputy Chief Executive |
| BCWG | Business Continuity Working Group *(Internal Group)* |
| CBRN | Chemical, Biological, Radiological and Nuclear |
| CCSG | Civil Contingencies Steering Group *(Internal Group)* |
| EPRR | Emergency Preparedness, Resilience and Response |
| IRPG | Incident Response Planning Group *(Internal Group)* |
| ISO 22301 | International Standardisation Organisation *(the International Standard for Business Continuity Management)* |
| LHRP | Local Health Resilience Partnership |
| LRF | Local Resilience Forum |
| OCMF | On Call Managers Forum *(Internal Group)* |
| SWASFT | South Western Ambulance Service NHS Foundation Trust |

## Contents

# 1. Introduction

## 1.1 Purpose

This report outlines the Trust's EPRR activities during the period April 2017 to March 2018 that relate to the requirements of the Civil Contingencies Act 2004, its associated regulations, statutory and non-statutory guidance.

The report is presented to the University Hospitals Bristol NHS Foundation Trust Board in line with the requirements of the NHS Core Standards for Emergency Preparedness, Resilience and Response 2017.

## 1.2 Background

The Civil Contingencies Act 2004 (CCA) sets out a single framework for civil protection in the United Kingdom. The Civil Contingencies Act provides a statutory framework for civil protection at a local level and divides local responders into two categories depending on the extent of their involvement in civil protection work, and places a set of duties on each.

Category 1 responders are those organisations at the core of emergency response. Acute Trusts are identified as Category 1 responders and are subject to the full set of civil protection duties.

The Trust is therefore required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning,
- Put in place emergency plans,
- Put in place business continuity plans,
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency,
- Share information with other local responders to enhance co-ordination,
- Co-operate with other local responders to enhance co-ordination and efficiency.

## 1.3 Context

Nationally across EPRR in 2017/18 there has been a continued and increased focus on ensuring incident response plans are fit for purpose, particularly for major incidents categorised as mass casualty events. With recent incidents in Manchester and London and the increasing of the threat level to critical twice, this focus gives an added importance to ensuring the Trust meets its statutory obligations and is able to provide high levels of patient care when responding to incidents.

EPRR within the Trust is overseen by the Deputy Chief Executive and Chief Operating Officer who acts as the Emergency Accountable Officer (ERO), supported by the Deputy Chief Operating Officer. The ERO chair's the Civil Contingencies Steering Group which drives the EPRR agenda. Under this group are two substantive working groups chaired by the Resilience Manager; the Incident Response Planning Group and the Business Continuity Working Group. An Infection Control group can also be enacted as required.

In the 2017 NHS England EPRR Core Standards review the Trust was deemed to be substantially compliant with the standards having been non-compliant in 2015 and partially compliant in 2016. This audit process required the Trust to complete a self-assessment against each of the core standards for EPRR. This self-assessment was subsequently reviewed by NHS England and Bristol Clinical Commissioning Group in discussion with the Trust and a final rating assigned.

# 2 Risk Assessment

This section details how the Trust is complying with the duty to undertake risk assessments for the purpose of informing contingency planning activities.

## 2.1 Community Risk Register (CRR)

University Hospitals Bristol NHS Foundation Trust contributes to the development and maintenance of the Avon and Somerset Community Risk Register (CRR) by the Resilience Manager attending the NHS England Avon & Somerset Local Health Resilience Partnership (Tactical Group), where amongst other areas, health related risks to the community are reviewed and updated.

## 2.2 Trust Risk Register

The Civil Contingencies Steering Group maintains an EPRR Risk Register for risks identified relating to EPRR. Risks assessed as scoring 12 or above are reviewed by the Trust Risk Management Group and Trust Board.

| Risk No. | Category | Description | Inherent Risk | Current Risk | Target Risk |
|---|---|---|---|---|---|
| 199 | Mass Gatherings | There are a number of large public events which attract a large crowd. An incident at one of these events could result in a major incident declaration impacting on the trusts ability to operate normally. | 4 | **4** | 4 |
| 210 | Snow and Ice | This is a seasonal risk which could result in an increased number of potential slips and falls or impact on ability of staff and patients to travel to site. | 6 | **6** | 6 |
| 212 | River Avon tidal surge | Adverse weather conditions could cause a tidal surge up the River Avon. If this resulted in flooding, parts of Bristol could be affected leading to increased pressure on health services. | 4 | **4** | 4 |
| 800 | Pandemic Influenza Outbreak | This is one of the highest risks the UK currently faces. Pandemic Influenza could put the health system under severe pressure due to a number of reasons. Impacts on the trust workforce and its ability to effectively manage an influx of patients with influenza type illness, the ability of the trust to manage an increase in pandemic influenza related deaths. | 4 | **4** | 4 |
| 802 | Heatwave | Demand on Trust services could increase significantly due to heat related illness especially in the elderly. Internal hospital building temperatures could impact on patient wellbeing and staff working environment. | 9 | **6** | 6 |

| | | | | | |
|---|---|---|---|---|---|
| 1909 | Incident response whilst in extreme escalation | If during periods of extreme escalation a major incident or business continuity incident were to occur there is the risk of the response being hampered due to pressures faced by the Trust. | 12 | **6** | 6 |
| 2031 | Risk of self-presenting contaminated patients to ED | There is a risk of contamination to patients, staff and the physical environment if the contaminated patient is not identified promptly, isolated and decontaminated by trained staff. | 5 | **3** | 3 |
| 2453 (New Risk) | Lack of a coordinated clinical networks response to a major incident | Whilst the Trust, and other neighbouring trusts, have major incident plans the equivalent plans for the trauma, critical care and burns network are not up to date. If a large scale incident were to happen there is the risk of a lack of coordination across these networks if capacity was stretched beyond individual trusts ability to respond. | 9 | **6** | 4 |

# 3 Emergency Planning

This section details the activities undertaken to develop and maintain arrangements for responding to a major incident. The Trust has a number of EPRR related internal planning groups identified in the governance section. Since last year the only change in these has been the Resilience Manager taking over the chair of the Incident Response Planning Group from the ED Clinical Lead. Both Trust ED departments are still active members however it was agreed the Resilience Manager was best placed to drive the work programme of the group.

## 3.1 Incident Response Plan

The Incident Response Plan (formerly major incident plan) has had a wholesale review incorporating a number of lessons identified from internal and regional major incident exercises as well as comprehensive debrief reports from the London and Manchester major incidents. A large part of this review has focused on areas of the trust previously not engaged in planning with roles now included in the plan for the bereavement team, clinical psychologists, psychiatry liaison, the resuscitation team and therapy services among others.

There is now ongoing training and exercising within the Trust to support preparedness to implement the plan if required.

## 3.2 Chemical, Biological, Radiological and Nuclear (CBRN) Response Plan

The CBRN plan has been updated by the Adult ED CBRN leads supported by the Resilience Manager. Quarterly training days continue ensuring nursing staff in both EDs are trained in the elements of the plan including wearing the PPE suits and procedures for decontaminating patients. The Powered Respiratory Protective Suits (PRPS) which are the required PPE for any caustic substance are being replaced in 2018. New suits will be funded centrally and last for a period of 10 years. The storage unit has also been replaced in the ambulance bay for CBRN equipment following a successful bid for capital funds.

The ambulance service has recently completed an annual audit of the Trust's CBRN response, commissioned by NHS England. This found the Trust is compliant with all 51 requirements and one recommendation to complete a live exercise in 2018 which is being planned.

### 3.3 Evacuation Planning

The Trust updated its Evacuation Plans which were identified as a gap in last year's annual report. The plan is a scalable response if the evacuation of patients and staff is required from a single ward through to a whole hospital site. Since the plan has been signed off training has been delivered to both the Adult and Children's site teams who play a critical role in coordinating an evacuation. This area has now been rated as compliant by NHS England.

In 2018 the Trust will hold two exercises to further embed evacuation plans. The Bristol Royal Hospital for Children will hold a table top exercise to run through the simulated evacuation of the Children's hospital. Hey Groves Theatres will also run a live exercise to test the response to a fire whilst a patient is in theatre. Once complete these will further inform evacuation plans.

### 3.4 Mass Countermeasure Planning

Due to changes in regional guidance the Trust is required to develop plans for establishing a mass countermeasure distribution centre. This centre, which is planned to be based out of the Education Centre, would be utilised to distribute countermeasures to the public who have been exposed to certain substances which require prophylaxis (e.g. radiation) or antidotes (e.g. cyanide or anthrax). Planning is in progress with key stakeholders in the Trust and a plan is currently being drafted prior to consultation and publication.

### 3.5 Severe Weather and Heatwave Plans

Both the Severe Weather and Heatwave Plans were enacted in 2017-18 (see section 11 for specific details of events). Both plans are reviewed annually and learning from incidents is being used to further develop plans. In particular the snow fall and associated Met Office red warning was a significant event for the trust in ensuring critical services were maintained. There is since been a large focus on identifying lessons which will be used for a wholesale review of Severe Weather Plans over the summer of 2018.

### 3.6 Lockdown Planning

Lockdown planning, led by the Trust's Local Security Management Specialist, has progressed significantly during the course of 2017-18. The trust's lockdown plan was updated with a focus on learning lessons from two lockdowns of adult ED due to disruptive patients and relatives. This year the plan will be exercised to test timeframes and assumptions. There is also a significant capital bid in process to upgrade key doors within the trust ensuring a more automated, timely and reliable system.

### 3.7 Trauma Risk Management (TRiM)

Over the course of 2017-18 the Trust has begun to implement support and risk assessment of staff who have experienced potential traumatic incidents whilst at work. This process, called Trauma Risk Management (TRiM), is currently focused on the Bristol Royal Hospital for Children and is coordinated by the Resilience Manager. In 2018 there are now plans in place to extend TRiM to cover key areas in Adult services with an initial focus on ED, ITU and A522.

## 4 Business and Service Continuity Planning

This section details the Trust's activities to develop, maintain and embed arrangements to ensure the continuity of service provision during an emergency or other disruption.

In previous years the NHS recognised that the British Standard BS25999 was the definitive standard for business continuity management and the Trust aligned all Business Continuity Plans to this standard. This standard has since been updated and has been adopted worldwide. The standard is now known as ISO22301. There are a number of changes with this standard and therefore the NHS England 2016 EPRR assurance identified that Trust Business Continuity Plans did not fully reflect this standard.

Over the course of 2017-18 there has been a large focus on ensuring plans are updated to adhere to this updated standard as well as being fit for operational use in the Trust. In the most recent 2017 assurance NHS England rated the Trusts Business Continuity Plans as being substantially compliant.

With the support of divisional leads and the Business Continuity Working Group the ongoing review and updating of the plans is monitored by the Resilience Manager. Incidents and ongoing actions from debriefs are regularly reviewed by the group alongside other business continuity related agenda items.

# 5 Cooperation

This section details how the Trust engages with regional EPRR groups.

## 5.1 Local Health Resilience Partnerships (LHRP)

The Local Health Resilience Partnership, chaired by NHS England, brings together all NHS organisations to ensure coordinated and joined up planning across Avon and Somerset.

There is a strategic group which meets quarterly and is attended by the Accountable Emergency Officers (AEO) from all organisations in the Avon and Somerset area. The Chief Operating Officer & Deputy Chief Executive is the UH Bristol Accountable Emergency Officer (AEO) supported by the Deputy Chief Operating Officer. This group defines the strategic direction, the priorities and actively monitors the progress of the Tactical Planning Group.

The Tactical Planning Group also meets quarterly and is attended by the Resilience Manager. It is this group that develops the Avon and Somerset local health community overarching emergency plans and delivers against the Strategic Group work programme.

## 5.2 Local Health Resilience Partnership Sub-groups

There are a number of LHRP subgroups and task and finish groups; membership of these groups is dependent on the area of focus of the group. For example there is an Acute Provider Sub-group, which focusses on planning and issues which solely affect acute hospitals and the Ambulance Trust. The Resilience Manager attends a number of these groups as required.

## 5.3 Local Resilience Forum (LRF)

The LRF is a statutory planning group attended by Category 1, 2 and uncategorised responders in Avon and Somerset, as defined by the Civil Contingencies Act 2004. Health is represented by NHS England, who acts in the interests of all providers. This group also informs some of the planning activity undertaken by the LHRP.

# 6 Warning and Informing

As a Category One responder under the Civil Contingencies Act 2004 the Trust has a “duty, in partnership with others to warn and inform the public”.

The Trust Communications Team continue to work in partnership with NHS England and the CCG to inform and warn the public when circumstances warrant it. The Communications Team issue messages either directly or in collaboration with the CCG and Public Health England and are part of a local network of NHS Communications teams. In the event of a major incident NHS England would ensure communications are coordinated and link into the Trust communications department.

# 7 Training and Exercising

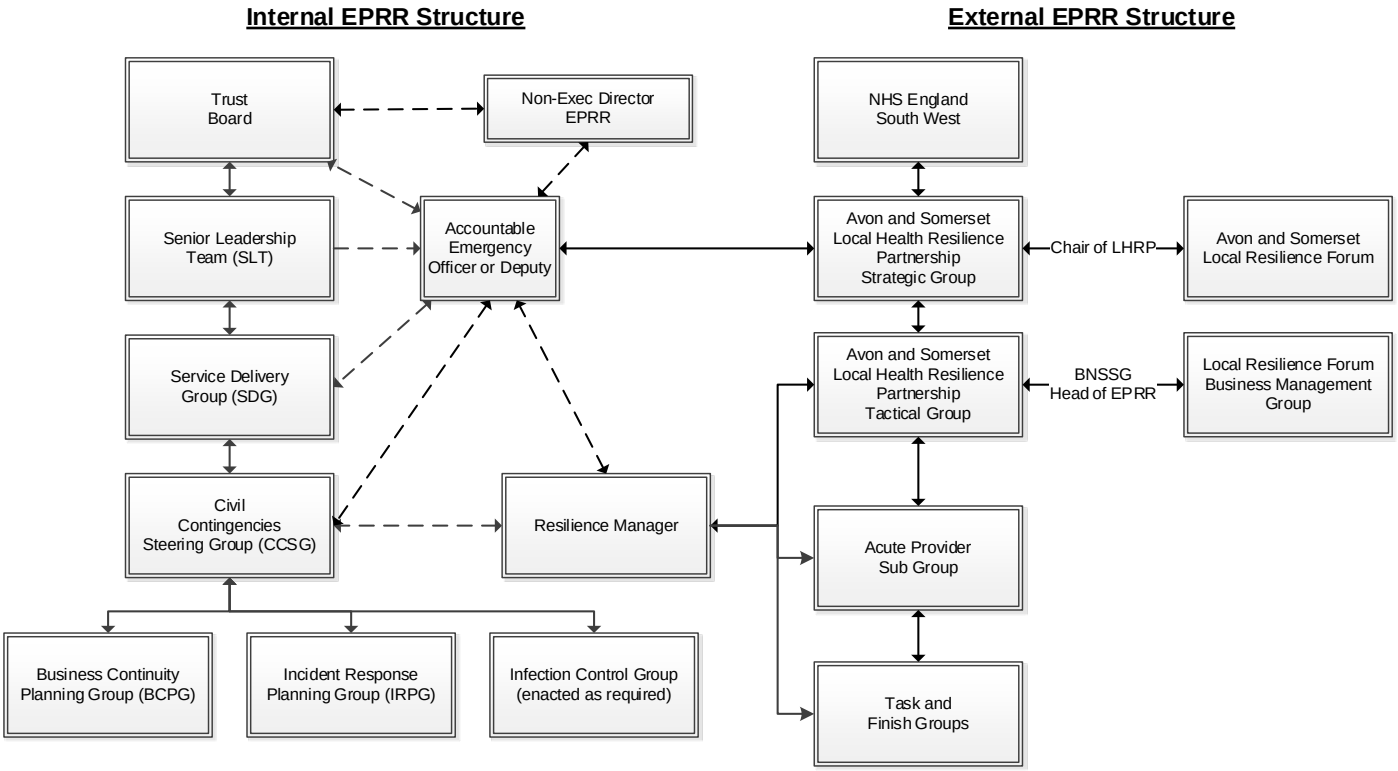
Below is a summary of EPRR training and exercising which has taken place over the past year:

- The Adult and Children’s Major Incident leads supported by the Resilience Manager facilitate regular training for Adult and Children’s ED personnel in both Major Incidents and decontamination of members of the public. This training also includes training about safely donning and doffing the Powered Respirator Protective Suit (PRPS) which is a one piece, gas tight, chemical protective suit for use by emergency response personnel after a CBRN incident.
- Additional major incident training has been delivered to other key areas in the Trust. This includes adult and children’s site teams, BRHC theatres and outpatients departments, on call managers, BRI anaesthetic department and BRHC therapy teams.

- In April and September 2017 two exercises were run to simulate the Trusts response to mass casualty incidents. Both exercises were run using the EMERGO training system which is an effective way of mapping hospital flow and resources in a major incident. Learning from both exercises was then used to support the review of the Trust's Incident Response Plan.
- A number of clinical staff and the Resilience Manager attended regional workshops and conferences focused on the response to mass casualty incidents and learning lessons from Manchester and London incidents.
- On Call Managers have a monthly forum to review on call matters with alternative forums now being utilised for training in key areas identified internally as well as legislated externally by NHS England.
- All Adult ED reception staff and other ED admin staff have attended major incident training. This looks at their role in a major incident as well as if they suspect self-presenting patients of being contaminated. Major Incident training and an exercise have also been delivered to the ED Registrars.
- Several members of clinical staff attending the Trauma Risk Management course led by March on Stress. Practitioners are trained to perform peer to peer risk assessments for staff involved in traumatic incidents. A further course is scheduled in June 2018 to support the implementation of post incident support to staff across key areas in the Trust.

# 8 Governance

The diagram below represents the internal and external Emergency Planning, Resilience and Response (EPRR) governance structure.



## 9 Audit and Assurance

The Resilience Manager provides regular updates, assurance and work progress briefings to the Civil Contingencies Steering Group.

As mentioned above, NHS England and Bristol CCG conduct an annual EPRR audit and assurance process. This was conducted in October 2017. Their findings have been shown in appendix 1 alongside other organisations across Avon and Somerset.

As a trauma centre, the Bristol Royal Hospital for Children also took part in a detailed NHS England review of preparedness for mass casualty incidents. Work is now ongoing with the clinical networks on highlighted areas and is incorporated into the work of the Incident Response Planning Group.

## 10 Recent Significant Events

The Trust has experienced the following untoward events during the April 2017 to March 2018 period. Relevant debriefs have been undertaken with the exception of the learning from the planned heating shutdown which was postponed due to the March snow.

| Title | Date | Debrief / RCA Held? |
|---|---|---|
| Separate uninterrupted power supply failure in SMH and BRHC theatres | 14/4/17<br>8/6/17 | Y |
| Cyber Attack impacting on NHS | 18/5/17 | Y |
| UK Threat Level increase to 'Critical' in response to incidents in Manchester and London | 23/5/17<br>&15/9/17 | Op Haven enacted |
| Heatwave response and PHE level 3 alert | June 2017 | Y |
| Water mains burst impacting on South Bristol Community Hospital supply | 19/7/17 | Y |
| Fire in staff area and evacuation of Ward 38 in BRHC | 03/9/17 | Y |
| Lockdown of Adult ED due to disruptive patients and family | 10/10/17 &<br>30/12/17 | Y |
| Overnight heating shutdown to facilitate urgent repair works | 15/12/17 | To be scheduled |
| Water leak in BRHC impacting on Renal Dialysis Service | 25/1/18 | Y |
| Heavy Snowfall and Met Office Red Warning | March 2018 | Y |

## 11 Conclusions

2017/18 has been a year where the focus has been on finalising plans and training key areas as well as ensuring the Trust achieves a substantial compliance in the NHS England EPRR Assurance Programme. This was successfully achieved along with a wholesale update of the Trust's Incident Response and Evacuation planning.

Priorities for the upcoming year are:

- Maintain substantial compliance in the 2018 EPRR assurance process
- Development of Mass Countermeasure plans as well as a review of Severe Weather planning following recent snow incident.
- Continuing to deliver training and exercises to identified staff and services to support Trust plans
- A focus on embedding and exercising of Evacuation and Lockdown plans following the publication of plans last year.

## Appendix 1 NHS England EPRR Annual Assurance Outcomes 2017

Please see attachment.

| Avon and Somerset LHRP Core Standard Summary October 2017 Version 2 | Core Standard | BNSSG CCG | Somerset CCG | BANES CCG | UHB | WAHT | TST | YDH | NBT | RUH | BCH | NSCP | SomPar | Sirona | Virgin Health | AWP | Care UK | Vocare | SWAST | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Governance** | | | | | | | | | | | | | | | | | | | | |
| 1 | Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management) | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | a | g | g | |
| 2 | Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response. | g | g | g | g | g | g | g | g | a | g | g | g | g | g | g | r | a | g | |
| 3 | Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response. | a | g | g | g | g | g | g | g | g | g | g | g | g | a | g | r | g | g | |
| 4 | The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards. | g | g | g | g | g | g | a | g | g | g | g | g | g | a | a | r | r | g | |
| **Duty to assess risk** | | | | | | | | | | | | | | | | | | | | |
| 5 | Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions. | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | r | a | g | |
| 6 | There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers. | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | r | a | g | |
| 7 | There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners. | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | r | a | g | |
| **Duty to maintain plans – emergency plans and business continuity plans** | | | | | | | | | | | | | | | | | | | | |
| 8 | Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan)) | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | r | g | g | |
| 9 | corporate and service level Business Continuity (aligned to current nationally recognised BC standards) | a | g | g | g | a | g | a | g | a | g | g | g | g | g | g | a | g | g | |
| 10 | HAZMAT/ CBRN - see separate checklist on tab overleaf | n/a | n/a | n/a | g | g | g | g | g | g | g | g | g | g | g | a | n/a | n/a | g | |
| 11 | Severe Weather (heatwave, flooding, snow and cold weather) | g | g | g | g | a | g | g | g | g | g | g | g | g | g | g | a | a | g | |
| 12 | Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions) | a | g | g | g | g | g | g | g | g | g | g | g | g | g | g | n/a | n/a | g | |
| 13 | Mass Countermeasures (eg mass prophylaxis, or mass vaccination) | n/a | n/a | n/a | a | a | a | a | g | g | a | a | a | g | g | n/a | n/a | n/a | g | |
| 14 | Mass Casualties | n/a | n/a | n/a | g | g | g | g | g | g | a | a | a | a | a | n/a | n/a | n/a | g | |
| 15 | Fuel Disruption | g | g | g | g | a | g | g | g | a | g | g | g | g | a | g | a | r | g | |
| 16 | Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care) | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | a | g | |
| 17 | Infectious Disease Outbreak | a | g | g | g | g | g | g | g | g | g | g | g | g | a | g | n/a | n/a | g | |
| 18 | Evacuation | g | g | g | g | a | g | g | g | g | g | a | g | g | g | a | n/a | n/a | g | |
| 19 | Lockdown | n/a | n/a | n/a | a | g | g | g | g | a | a | a | g | g | a | a | n/a | n/a | g | |
| 20 | Utilities, IT and Telecommunications Failure | g | g | g | g | g | g | g | g | g | g | g | g | g | a | g | a | a | g | |
| 21 | Excess Deaths/ Mass Fatalities | n/a | n/a | n/a | g | g | g | g | g | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | |
| 22 | having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | |
| 23 | firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | |
| 24 | Ensure that plans are prepared in line with current guidance and good practice which includes: | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | r | g | g | |
| 25 | Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources. | g | g | g | g | | g | g | g | g | g | g | g | g | g | g | r | g | g | |
| 26 | Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical. | a | g | g | g | g | g | a | g | a | g | g | g | g | g | a | r | r | g | |
| 27 | Arrangements explain how VIP and/or high profile patients will be managed. | n/a | n/a | n/a | g | g | g | a | g | g | g | g | g | g | g | g | n/a | n/a | g | |
| 28 | Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | |
| 29 | Arrangements include a debrief process so as to identify learning and inform future arrangements | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Command and Control (C2)** | | | | | | | | | | | | | | | | | | | |
| 30 | Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary. | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g |
| 31 | Those on-call must meet identified competencies and key knowledge and skills for staff. | a | g | r | a | g | a | g | a | g | g | a | g | g | a | g | r | a | g |
| 32 | Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist . | g | g | a | g | g | g | g | g | g | g | g | g | g | g | g | r | g | g |
| 33 | Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident. | g | g | g | g | g | g | g | g | g | g | g | a | g | a | g | r | r | g |
| 34 | Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response. | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | a | g |
| 35 | Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events. | n/a | n/a | n/a | g | g | g | g | g | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g |
| 36 | Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements; | n/a | n/a | n/a | g | g | g | g | g | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g |
| **Duty to communicate with the public** | | | | | | | | | | | | | | | | | | | |
| 37 | Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents. | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | n/a | n/a | g |
| 38 | Arrangements ensure the ability to communicate internally and externally during communication equipment failures | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | G | a | g |
| **Information Sharing – mandatory requirements** | | | | | | | | | | | | | | | | | | | |
| 39 | Arrangements contain information sharing protocols to ensure appropriate communication with partners. | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | R | g | g |
| **Co-operation** | | | | | | | | | | | | | | | | | | | |
| 40 | Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate) | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | n/a | n/a | g |
| 41 | Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | a | g |
| 42 | Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained. | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | n/a | n/a | g |
| 43 | Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas. | n/a | n/a | n/a | n/a | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | n/a | n/a | n/a | g |
| 44 | Arrangements outline the procedure for responding to incidents which affect two or more regions. | n/a | n/a | n/a | n/a | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | n/a | n/a | n/a | g |
| 45 | Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | n/a | n/a | g |
| 46 | Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared | n/a | n/a | g | n/a | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | n/a | n/a | n/a | g |
| 47 | Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months | n/a | n/a | g | n/a | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | n/a | n/a | n/a | g |
| 48 | Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level | g | g | g | g | g | g | g | a | g | g | g | a | g | g | a | n/a | n/a | g |
| **Training And Exercising** | | | | | | | | | | | | | | | | | | | |
| 49 | Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents | a | g | g | g | g | g | g | g | g | g | g | g | g | a | g | r | a | g |
| 50 | Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work. | a | g | g | g | g | g | g | g | g | g | g | g | g | g | g | r | a | g |
| 51 | Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises | g | g | g | g | g | g | g | g | g | g | g | g | g | g | g | n/a | n/a | g |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 52 | | Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation. | g | a | g | g | g | a | a | g | g | g | g | a | g | g | g | r | a | g | |
| **HAZMAT / CBRN** | | | | | | | | | | | | | | | | | | | | | |
| **Preparedness** | | | | | | | | | | | | | | | | | | | | | |
| 53 | | There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex) | n/a | n/a | n/a | g | g | g | g | g | g | g | g | g | g | n/a | a | n/a | n/a | g | |
| 54 | | Staff are able to access the organisation HAZMAT/ CBRN management plans. | n/a | n/a | n/a | g | g | g | g | g | g | g | g | g | g | n/a | a | n/a | n/a | g | |
| 55 | | HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation. | n/a | n/a | n/a | g | g | g | g | g | g | g | g | g | g | n/a | g | n/a | n/a | g | |
| 56 | | Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7. | n/a | n/a | n/a | g | g | g | g | g | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | |
| 57 | | Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7. | n/a | n/a | n/a | g | g | g | g | g | g | g | n/a | g | n/a | n/a | g | n/a | n/a | g | |
| **Decontamination Equipment** | | | | | | | | | | | | | | | | | | | | | |
| 58 | | There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. | n/a | n/a | n/a | g | g | g | g | g | g | g | g | g | g | g | a | n/a | n/a | g | |
| 59 | | The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable) | n/a | n/a | n/a | g | g | g | g | g | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | |
| 60 | | There are routine checks carried out on the decontamination equipment including:<br>A) Suits<br>B) Tents<br>C) Pump<br>D) RAM GENE (radiation monitor)<br>E) Other decontamination equipment | n/a | n/a | n/a | g | g | g | g | g | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | |
| 61 | | There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for:<br>A) Suits | n/a | n/a | n/a | g | g | g | g | g | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | |
| 62 | | There are effective disposal arrangements in place for PPE no longer required. | n/a | n/a | n/a | g | g | g | g | g | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | |
| **Training** | | | | | | | | | | | | | | | | | | | | | |
| 63 | | The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training | n/a | n/a | n/a | g | g | g | g | g | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | |
| 64 | | Internal training is based upon current good practice and uses material that has been supplied as appropriate. | n/a | n/a | n/a | g | g | g | g | g | g | g | g | g | g | g | a | n/a | n/a | g | |
| 65 | | The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme. | n/a | n/a | n/a | g | g | g | g | g | g | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | g | |
| 66 | | Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant. | n/a | n/a | n/a | g | g | g | g | g | g | g | g | **g** | g | g | a | n/a | n/a | g | |
| | | **Number of partial and non-compliant CSs and compliance levels** | **8** | **1** | **2** | **3** | **5** | **3** | **5** | **2** | **4** | **3** | **5** | **5** | **1** | **10** | **10** | **22** | **18** | **0** | |

| **Compliance Levels** |
|---|
| Full- Arrangements are in place that appropriately addresses all the core standards |
| Substantial- Arrangements are in place however they do not appropriately address one to five of the core standards. |
| Partial- Arrangements are in place, however they do not appropriately address six to ten of the core standards. |
| Non-compliant- Arrangements in place do not appropriately address 11 or more core standards |

**Cover report to the Public Trust Board. Meeting to be held on 24 May 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 17 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Thursday, 24 May 2018 |
| **Report Title** | **General Data Protection Regulation Compliance Update** | | |
| **Author** | Eric Sanders, Trust Secretary | | |
| **Executive Lead** | Mark Smith, Chief Operating Officer/Deputy 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. | ☐ | 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 General Data Protection Regulation (GDPR) comes into force on 25 May 2018 and the Trust has been working hard to ensure compliance in advance of this date.

The Trust Secretary, via the GDPR Implementation Group, has led the programme of work to ensure that the policy and procedural framework to underpin compliance is up to date and available to staff, that staff understand their responsibilities, and that staff are trained on new requiremnts as a result of GDPR.

There is confidence that the actions taken are sufficient but three areas have been identified where further work is needed. These include ensuring the Trust has sufficient resources to effectively manage the Subject Access Request process in line with the new tiemscales, that all information assets and their owners are identified, and that data processing agreements are updated to reflect GDPR. This work will now move into business as usual and will be monitored by the Information Risk Management Group, which is chaired by the Senior Information Risk Officer (SIRO) who is the Medical Director.

| Recommendations |
|---|
| The Board is asked to note the progress made and the assessment of compliance in advance of GDPR coming into force on 25 May 2018.<br><br>Members are asked to:<br><br>• **Note the Report** |

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

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

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

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

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

| Date papers were previously submitted to other committees | | | | |
|---|---|---|---|---|
| **Audit Committee** | **Finance Committee** | **Quality and Outcomes Committee** | **Remuneration & Nomination Committee** | **Other (specify)** |
| | | | | SLT - 16/05/18 |

## 1. Purpose

1.1. To present an update on compliance against the General Data Protection Regulation (GDPR).

## 2. Background

2.1. The GDPR comes into force from 25 May 2018 along with a new Data Protection Act 2018, which will repeal the existing legislation. The key requirements of the new combined legislation may be summarised:

- The Trust must appoint a Data Protection Officer – a protected post with specific responsibilities to advise and monitor compliance.
- There is an enhanced focus on lawful and transparent processing. The Trust needs to identify a legal basis for all processing of personal data. With limited exceptions data subjects including patients, staff and others must be clearly told, in prescribed detail, what we do with their data. The guiding principle is “no surprises”.
- Data Protection Impact Assessments (DPIA) must be carried out and documented for any new or changed high risk processing commencing after 25 May 2018.
- There are enhanced subject rights – in particular under the right of subject access to their information additional information must be provided and there will be no fee.
- Generally the Trust must be able to *demonstrate compliance* with all of the requirements of GDPR.
- The potential level of fines is much greater than under the current regime. In addition fines can now be clearly levied for serious administrative non-compliance in addition to data security breaches.

## 3. Key Actions Taken

3.1. To ensure compliance with GDPR the Trust Secretary has overseen the implementation of the following actions:

- The Trust has an Interim Data Protection Officer in place and a permanent appointment has been made. The permanent appointment is to a new Head of Information Governance role to pick up the whole Information Governance portfolio and the specific DPO role. At the time of writing this report, the recruitment process was still being progressed and a start date has not yet been agreed, however the Trust will ensure that a suitable qualified individual is in the DPO role in the interim before the permanent appointment starts.
- A GDPR Implementation Group has been meeting weekly to co-ordinate actions. This has focussed on priority actions, achievable by 25 May 2018, to meet the key requirements listed above.
- The Trust’s Information Governance Policy has been updated and a new Data Protection Policy has been created. These reflect the requirements of the new legislation and commit the Trust to best practice in these areas.
- A new privacy notice has been developed and agreed which describes how individual’s data will be processed. This includes information relating to patients and staff and is now live on the Trust’s website.

- The Trust's Information Asset Register, a database of all systems which hold and are used to process personal data, has been reviewed and updated, with work to ensure Information Asset Owners are identified for all systems.
- A Managers Guide to GDPR has been issued and is available on Connect which now has a dedicated area relating to GDPR under the banner "Healthy Data".
- A communications strategy is in place using existing channels and is supplemented by an awareness poster, which has been distributed to key notice boards. A simple guide for all staff has also been created and has been shared with all staff through the usual communications routes.
- Steps have been taken to upgrade key data processing contracts.
- Steps have been taken to identify and upgrade data processing contracts to "GDPR strength".
- A revised training needs analysis has been developed to ensure the Trust understands the training requirements for all groups of staff. This has resulted in new enhanced training being delivered to key health records staff on the new Subject Access Rights, with similar training planned for staff in Human Resources.
- Updated e-learning training is now in place for all staff to ensure they understand the new requirements. Training for Board members will be scheduled once the appropriate training package has been released by NHS Digital.
- A process and guidance for Data Protection Impact Assessments has been developed and piloted in a number of areas. These impact assessments are required for any new process, which involves the processing of personal data.
- The process and guidance for managing data sharing agreements has been revised and a new register of sharing agreements created.
- Revised process and guidance for Subject Access Requests has been developed, which includes a more robust mechanism for logging, tracking and reporting on requests.

## 4. Assessment of Compliance

4.1. The actions and outputs outlined above represent significant progress. There is now a robust policy framework in place, supported by targeted and more general training based on a new needs analysis. The Trust has processes in place to review new processes involving personal data to identify any risks and support their mitigation. A communicating programme is in place to ensure staff are aware of the changes and the impact on their role.

4.2. There are three areas where further work is required:

**Subject Access Requests**

The Trust needs to ensure there is sufficiently skilled resource to support the responding to Subject Access Requests in line with the new timescales. There is a risk that the removal of fees will substantially increase the volume of requests above the 120 currently received each week.

**Information Asset Register**

Whilst the Trust has a register in place further work is required to ensure that the Information Asset Register is complete which will include identifying the legal basis for processing data and identifying Information Asset Owners.

**Data Processing Agreements**

Work is required to ensure that the Trust has a register of all data processing agreements and that these are updated to reflect the changes resulting from GDPR. All new agreements, from the start of the project have been reviewed by Legal Services and the DPO, and focus will now turn to historic agreements.

4.3. Based on the actions taken to date, identified areas for further work, and an understanding of the risks, the Trust has put in place a strong framework to support compliance with GDPR. Focus will now move to embedding processes, ensuring staff understand their roles and responsibilities fully and that the areas identified for further work are completed. This will form part of the business as usual process for the Information Governance team within the Trust Secretariat.

**Eric Sanders**
**Trust Secretary**

**Philip Bradshaw**
**Interim Data Protection Officer**

**Cover report to the Public Trust Board Meeting to be held on 24 May 2018 at 11:00-13:00 in the Conference Room, Trust Headquarters**

| | | | 19 |
|---|---|---|---|
| **Meeting Title** | Public Trust Board | **Meeting Date** | Thursday, 24 May 2018 |
| **Report Title** | **Provider Licence – Self-Certifications** | | |
| **Author** | Eric Sanders, Trust Secretary | | |
| **Executive Lead** | Eric Sanders, 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**

<u>Purpose</u>

NHS foundation trusts are required to self-certify, on an annual basis, whether or not they have:

(1) complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution);
(2) the required resources available if providing commissioner requested services (CRS);
(3) complied with governance requirements; and
(4) have provided Governors with the necessary training

This paper has been written by the Trust Secretary to provide the Board with assurance that the Trust fully meets the NHS provider licence conditions

Key issues to note

The Trust Secretary has reviewed the statements and evidence sets and is proposing that the Board of Directors responds with confirmed for all elements. The evidence to support the response is outlined in **Appendix 1** of the paper.

**Recommendations**

The Board is asked to **consider** the evidence aligned to each element of the provider licence conditions, which the Board is required to self-certify against, and confirm the response, noting the risks and mitigations.

**The Board is asked to:**

- **Recommend that the Board approve the Trust's provider licence self certifications.**

| **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)** |
| 20 April 2018 | | | | Exec Directors – 11 April 2018 |

## Provider Licence - Self-Certifications

### 1. Purpose

1.1. To provide evidence of compliance against the Provider Licence to support a decision by the Board.

### 2. Background

2.1. NHS foundation trusts are required to self-certify whether or not they have:

(1) complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution);

(2) the required resources available if providing commissioner requested services (CRS); and

(3) complied with governance requirements.

### 3. Self-Certification Requirements

3.1. Providers need to self-certify the following after the financial year-end:

| **NHS provider licence conditions** |
|---|
| The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) |
| The provider has complied with required governance arrangements (Condition FT4(8)) |
| If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3)) |
| Governors have received the necessary training to ensure they are equipped with the skills and knowledge they need to undertake their role. |

3.2. It is up to providers how they undertake the self- certification; however a number of templates have been provided which the Trust has used as the basis of the document in Appendix 1.

3.3. Trusts are required to state either “confirmed” or “not- confirmed” against each element of the licence condition, and if the Trust chooses “not-confirmed” must provide an explanation why.

3.4. Boards must sign off on self-certification no later than

- G6/CoS7: 31 May 2018
- FT4: 30 June 2018

3.5. The outcome of the assessment must be reported to NHS Improvement via their online portal. The Trust Secretary will complete this task once the Board has considered its position, having taking into account the views of governors.

### 4. Proposed Outcome

4.1. The Trust Secretary has reviewed the statements and evidence sets and is proposing that the Board of Directors responds with “confirmed” for all elements.

The evidence to support the response is outlined in Appendix 1.

4.2. For FT4, the Board is also required to consider any risks and mitigating actions for each element of the provider licence condition. These are described in Appendix 1.

4.3. The responses will be translated into the NHS Improvement template once agreed.

## 5. Recommendations

5.1. The Board of Directors is asked to consider the evidence aligned to each element of the provider licence conditions, which the Board is required to self-certify against, and confirm its response, noting the risks and mitigations.

**Eric Sanders**
**Trust Secretary**
**13 April 2018**

**Appendix 1 – Provider Licence Self-Certification**

| | | Proposed Response | Evidence | Risks | Mitigating Actions |
|---|---|---|---|---|---|
| **FT4 - Corporate Governance Statement** | | | | | |
| 1 | The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | **Confirmed** | • Annual Governance Statement<br>• Well-led Framework - External Review<br>• Head of Internal Audit Opinion<br>• Board Assurance Framework<br>• Board annual effectiveness evaluation<br>• Compliance with the Code of Governance<br>• External audit of the annual report and accounts | • The size and complexity of the organisation means there is a risk that good governance is not fully embedded in all divisions | • The Trust utilises its management and committee structures to ensure that good governance is embedded. This is complemented by the risk, performance and planning frameworks.<br>• Guidance and advice is provided by the Trust Secretary |
| 2 | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time | **Confirmed** | • As above plus:<br>• Alignment of performance reports to the Single Oversight Framework in the Quality and Performance Report | • Guidance is not identified or implemented in a timely manner | • The Trust ensures that regular communications from NHSI, CQC and other key bodies are reviewed and acted upon.<br>• Internal and external audit consider application of good governance during their audit programmes. |
| 3 | The Board is satisfied that the Licensee has established and implements:<br>(a) Effective board and committee structures;<br>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) Clear reporting lines and accountabilities throughout its organisation. | **Confirmed** | • Governance structure<br>• Board and Committee annual effectiveness reviews<br>• Scheme of Reservation and Delegation and Standing Financial Instructions<br>• Committee Terms of Reference<br>• Reports from the Chairs of the Committees to the Board and Council of Governors, and its focus groups | Committee Terms of Reference are not fit for purpose/aligned with up to dates guidance on effective governance. | Annual reviews of Committee Terms of Reference, with reference to relevant up to date guidance. |
| 4 | The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:<br>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;<br>(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; | **Confirmed** | • Quality and Performance Report and Finance Report to Board each month<br>• Annual Operating Plan and Budget (Trust and Divisional)<br>• Standing Financial Instructions<br>• Head of Internal Audit Opinion<br>• Annual Governance Statement<br>• Clinical Audit Programme and Reports<br>• Financial Strategy<br>• Committee Structure and | • The Trust's internal control systems are not sufficiently robust to ensure compliance | • The systems and processes are regularly tested through the internal and external audit programmes, and the robust approach to risk management |

| | | Proposed Response | Evidence | Risks | Mitigating Actions |
|---|---|---|---|---|---|
| | (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);<br>(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;<br>(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;<br>(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and<br>(h) To ensure compliance with all applicable legal requirements. | | Terms of Reference<br>• External Audit of the Trust Annual Report and Accounts<br>• Risk Management Strategy<br>• Corporate and Divisional Risk Register<br>• Board Assurance Framework<br>• Annual Operating Plan | | |
| 5 | The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:<br>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;<br>(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;<br>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;<br>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;<br>(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and<br>(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. | **Confirmed** | • Well-led Framework – External Review<br>• Board Skills and Knowledge Review<br>• Board Development Programme<br>• Board member annual appraisals<br>• Non-Executive Director and Executive Challenge of proposals<br>• Monthly Quality and Performance Report<br>• Active engagement with Commissioners, local Health Scrutiny, Health & Well-being Boards and Healthwatch<br>• Quality Governance Framework (safety, experience, outcomes and access) | • As above | • As above |
| 6 | The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence. | **Confirmed** | • Board Skills and Knowledge Review<br>• Remuneration, Nominations and Appointments Committee Terms of Reference and work programme<br>• Management and Organisational Development Programmes<br>• Divisional Performance Reviews<br>• Senior Leadership Team | • There is a risk of unforeseen changes at Board level which may impact on the requirements | • There are deputies in post for all Executive Directors and succession planning arrangements are being developed<br>• The Board has appointed to all Non-Executive Directors roles and has one Board observer and one NED joining the Trust in a developmental role from May 2018 |

| | | Proposed Response | Evidence | Risks | Mitigating Actions |
|---|---|---|---|---|---|
| | | | oversight<br>• Monthly and Six Monthly Nurse Staffing Reviews<br>• Revalidation and appraisal processes (Medical and non-Medical)<br>• Other workforce metrics included in the Quality and Performance Report | | |
| **General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)** | | | | | |
| 1 | Following a review for the purpose of paragraph 2(b) of licence condition G6[1], the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. | **Confirmed** | • Internal Audit and clinical audit work programmes<br>• Annual Operating Plan reviews<br>• Governance structure<br>• Risk Management Strategy<br>• Corporate Risk Register<br>• Board Assurance Framework<br>• Monthly Quality and Performance Report and Finance Report | N/A | N/A |
| **Continuity of services condition 7 – Availability of Resources** | | | | | |
| 1 | After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. | **Confirmed** | • Annual Operating Plan and Budget<br>• Financial Strategy<br>• Annual accounts and going concern statement | N/A | N/A |
| **Training of Governors** | | | | | |
| | The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. | **Confirmed** | • Seminar Programme (4 per year)<br>• Induction programme<br>• Access to external training via NHS Providers<br>• Specific and targeted training and updates – quality, strategy, auditor appointment<br>• Governor skills audit | N/A | N/A |

[1] "2. (b) regular review of whether those processes and systems have been implemented and of their effectiveness."

**Cover report to the Public Trust Board meeting to be held on Thursday 24 May 2018 at 11.00 – 13.00, Board Room, Trust HQ**

| | | | |
|---|---|---|---|
| | | Agenda Item | 20 |
| Meeting Title | Public Trust Board | Meeting Date | Thursday, 24 May 2018 |
| Report Title | **Quality and Outcomes Committee Terms of Reference** | | |
| Author | Sophie Melton Bradley, Deputy Trust Secretary | | |
| Executive Lead | Eric Sanders, Trust Secretary | | |
| Freedom of Information Status | | Open | |

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

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

**Executive Summary**

Purpose

The Quality and Outcomes Committee is required to review its own terms and conditions on an annual basis, and recommend any proposed changes to the Board for approval.

The Committee has reviewed the Terms of Reference and this paper outlines the proposed changes for the Board's approval.

The Annual Business Cycle for 2018/19 is attached for information.

Key Issues:

The following revisions to the Committee Terms of Reference are proposed for 2018/19::

- Revise the quorum of the Committee from three to two Non-Executive Directors. This reflects agreement by the Chair of the Board that the quora for all Committees of the

Board should be appropriately aligned.

- Update staff attendees' titles where appropriate.
- Make minor changes for clarity and accuracy.

**Recommendations**

Members are asked to:

- **Approve** of the terms of reference to the Board of Directors; and
- **Note** the Annual Business Cycle for the Quality and Outcomes Committee for information.

| **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** |
|---|
| None identified. |

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

| **Date papers were previously submitted to other committees** | | | | |
|---|---|---|---|---|
| **Audit Committee** | **Finance Committee** | **Quality and Outcomes Committee** | **Remuneration & Nomination Committee** | **Other (specify)** |
| | | 23/05/2018 | | |

University Hospitals Bristol NHS
NHS Foundation Trust

# Terms of Reference – Quality and Outcomes Committee

| Document Data | |
|---|---|
| **Corporate Entity** | Quality and Outcomes Committee |
| **Document Type** | Terms of Reference |
| **Document Status** | Approved |
| **Executive Lead** | Carolyn Mills, Chief Nurse & Sean O'Kelly, Medical Director |
| **Document Owner** | Trust Secretary |
| **Approval Authority** | Board of Directors |
| **Review Cycle** | 12 months |
| **Next Review Date** | 01/06/2019 |

| Document Change Control | | | | |
|---|---|---|---|---|
| **Date of Version** | **Version Number** | **Lead for Revisions** | **Type of Revision (Major/Minor)** | **Description of Revisions** |
| 16/03/2011 | 1 | Trust Secretary | Major | Initial draft for comment |
| 26/04/2011 | 2 | Trust Secretary | Major | Incorporated committee Chair's comments |
| 27/04/2011 | 3 | Trust Secretary | Minor | Revisions following initial meeting of committee members |
| 25/05/2011 | 4 | Trust Secretary | Minor | Final consideration by the Quality and Outcomes Committee |
| 26/05/2011 | 5 | Trust Secretary | Minor | For approval by the Trust Board of Directors |
| 27/03/2012 | 6 | Trust Secretary | Minor | Revisions recommended by Quality and Outcomes Committee for approval by the Trust Board of Directors |
| 27/09/2012 | 7 | Trust Secretary | Minor | Revision to meeting regularity from bi-monthly to monthly (in months where there is a meeting of the Board of Directors) in accordance with the purpose of scrutinising the Quality and Performance report prior to each meeting of the Board of Directors |
| 21/04/2015 | 8 | Trust Secretary | Major | Complete review |
| 18/05/2015 | 9 | Trust Secretary | Minor | Incorporation of comments from Quality and Outcomes Committee held 30/04/15 |
| 17/05/2016 | 10 | Trust Secretary | Minor | Change from 'Monitor' to 'NHS Improvement'; Section 2.1.1. |
| 11/05/18 | 11 | Deputy Trust Secretary | ~~Minor~~Minor besides change of quorum | Change of quorum from three members to two. This reflects agreement by the Chair of the Board that the quora for all Committees of the Board should be appropriately aligned.<br>Update to attendee titles to reflect updated roles in the Trust.<br>Minor changes for clarity and consistency of wording. |

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## 1. Constitution of the Committee

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

## 2. Purpose and function

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

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

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

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

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

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

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

2.2 To achieve this, the Committee shall:

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

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

2.2.3 Support and encourage quality improvement where opportunities are identified.

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

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

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

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

## 3. Authority

3.1 The Quality and Outcomes Committee will:

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

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

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

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

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

## 4. Membership and attendance

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

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

4.2.1 Chief Nurse

4.2.2 Medical Director

4.2.3 Chief Operating Officer

4.2.4 Director of ~~Workforce and OD~~People

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

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

4.4.1 ~~Associate~~ Deputy Chief Operating Officer ~~Director of Performance~~

4.4.2 Head of Quality (Patient Experience and Clinical Effectiveness)

4.4.3 Head of Quality (Patient Safety)

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

## 5. Quorum

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

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

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

## 6. Duties

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

### 6.1 Quality Strategy

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

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

### 6.2 Annual Plan and Quality Report

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

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

### 6.3 Clinical and Service Quality, Compliance and Performance

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

6.3.1.1 Clinical and service quality;

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

6.3.1.3 Organisational performance measured against specified standards and targets.

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

6.3.3 Review the Board Quality and Performance Report; and

6.3.4 Review the Quarterly Workforce and Organisational Development report.

**6.4 Action Plan Monitoring**

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

**6.5 Benchmarking, Learning and Quality Improvement**

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

6.5.2 Review the Annual Clinical Audit report;

6.5.3 Receive quarterly reports on complaints and patient experience;

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

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

6.5.6 Receive and review quarterly reports on Infection Control;

6.5.7 Receive and review the annual report on Safeguarding;

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

6.5.9 Receive and review the Equality and Diversity Annual Report;

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

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

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

**6.6 Risk**

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

**6.7 Quality Governance**

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

**6.8 Procedural Documents and Corporate Record Keeping**

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

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

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

## 7. Reporting and Accountability

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

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

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

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

## 8. Administration

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

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

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

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

8.5 ~~The secretary~~ A member of the Trust Secretariat shall minute the proceedings and resolutions

of all Committee meetings, including the names of those present and those in attendance.

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

## 9. Frequency of Meetings

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

## 10. Review of Terms of Reference

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

**Cover report to the Public Trust Board. Meeting to be held on 24 May 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**

| | | | |
|---|---|---|---|
| | | **Agenda Item** | 21 |
| **Meeting Title** | Public Trust Board | **Meeting Date** | Thursday, 24 May 2018 |
| **Report Title** | **Governor's Log of Communication** | | |
| **Author** | Kate Hanlon, Membership Engagement Manager | | |
| **Executive Lead** | Jeff Farrar, Chair | | |
| **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: 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>• **Note the Report.** |

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

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

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

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

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

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

| ID | Governor Name | | |
|---|---|---|---|
| 202 | Malcolm Watson | ***Theme:*** Histopathology | ***Source:*** From Constituency/ Members |

**Query** **08/05/2018**

There was recent publicity about a former nurse who is terminally ill with cancer after her histopathology samples were negative when examined by Severn Pathology. This is a centralised service which UH Bristol also uses. Is there assurance that everything is being done now to reduce this risk by having sufficiently trained staff and double reporting (peer review) as recommended by the 2010 Mishcon enquiry?

***Division:*** Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:*** 15/05/2018

**Response** **16/05/2018**

The commencement of Severn Pathology saw the establishment of specialist teams of Consultant Pathologists who work in a limited number of specialisms rather than the more generalist approach that was practiced previously. This system allows individuals to build up expertise within those fields and was always a key aim of the merging of the services. The concentration of expertise into teams also facilitates a better approach to double-reporting which has been implemented fully and according to the policy developed for Severn Pathology.

Due to a national shortage of suitable applicants, there remain some gaps in total numbers of Consultant staff which mean that some teams have fewer members than would be optimal. However, with the exception of Paediatric / Perinatal Pathology (PPP), all teams have sufficient numbers to be able to maintain a sufficiently high level of expertise and the numbers to support double-reporting. For PPP, there is support from system-specific teams reporting adult pathology and from PP pathologists in other centres to maintain a safe service. A second pathologist in this field will come in to post in August 2018.

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

| ID | Governor Name | | |
|---|---|---|---|
| 201 | Pauline Beddoes | ***Theme:*** Clinic letters | ***Source:*** Governor Direct |

**Query** **08/05/2018**

Patients who have hospital clinic appointments are often advised to have further tests, e.g. blood tests, or are prescribed new medication or changed dosages of existing drugs. The letters are then typed by the secretaries, but unfortunately these take days or even weeks to be sent to the patient's GP.

I understand that other Trusts are providing official forms outlining medication changes at the time of the appointment which patients can then bring into the surgery and the GP can action the changes. The official letter can then be sent later, as it usually is. Are there any plans to implement a similar process at UH Bristol?

***Division:*** Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 22/05/2018

**Response** **09/05/2018**

There are national standards for letter turnaround currently being implemented that will reduce the turnaround time to 7 days. There are no plans to make any changes at present. If it is an urgent prescription change the consultant should give the patient an outpatient prescription before they leave the appointment.

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

| ID | Governor Name | | |
|---|---|---|---|
| 200 | John Rose | ***Theme:*** Management consultants | ***Source:*** From Constituency/ Members |

**Query** **03/05/2018**

Bristol University, in collaboration with others, has been evaluating the benefit of employing consultants in NHS organisations. The study, 'The impact of management consultants on public service efficiency', came to the conclusion that, overall, the employment of external consultants resulted in inefficiency rather than the expected improvements in efficiency. Is the Trust acting on the suggested policy actions and what conclusions has it come to in relation to its future use of external consultants?

***Division:*** Trust-wide ***Executive Lead:*** *Director of Strategy and Transformation* ***Response requested:*** 14/05/2018

**Response** **09/05/2018**

The Trust approach is first and foremost to seek to resource all activities internally. Consultancy is defined as the provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives. In general we would only consider use of external consultancy where we do not have the appropriate capability or expertise; where we specifically need independent advice; or where the capacity required to complete a necessary piece of work within a defined timescale, is not feasible to achieve internally.

The study referred to was completed by Warwick University based on analysis of 'consulting services' expenditure from the Annual Reports of acute care hospital trusts in England for four years (2009/10 to 2012/13). Using pooled time series regression analysis, the study looked at the relationship between this spending and the efficiency of each hospital trust over time. The assessment was not of the efficiency or impact of the individual projects for which the consultancy had been secured. Nonetheless, we continue to scrutinize any proposal for expenditure with external consultants very closely and have maintained low levels of such spend. In 2016/17 our spend on external consultancy was £615, 000 (0.09% of total income) and in 2017/18 this was £373,000 (0.06% of total income).

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

| ID | Governor Name | | |
|---|---|---|---|
| 199 | Garry Williams | ***Theme:*** Food sales | ***Source:*** Governor Direct |

**Query** **24/04/2018**

The Journal of the Royal Society for Public Health ('Perspectives in Public Health') January 2018 vol. 138 no. 1 p. 5 carries a brief article commenting on the decision of Public Health England to forbid the sale of 'super-size' chocolate bars and regulate the sale of snacks, pre-packaged meals and sandwiches and some drinks, sold in hospital shops, canteens and vending machines.

May governors please be told whether the cafes and shops in UH Bristol's hospitals/premises need to comply with NHS England's directives in relation to calories, saturated fat, added sugar and other. If outlets on UH Bristol premises are not subject to this oversight and regulation, should the fact be made clear to patients using on-site facilities; and does the Trust have a policy aimed at making it more likely that these outlets will accept the NHS England standards for hospital shops, canteens and vending machines?

***Division:*** Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 03/05/2018

**Response**

***Status:*** *Assigned to Executive Lead*

| ID | Governor Name | | |
|---|---|---|---|
| 198 | John Rose | ***Theme:*** Patient safety | ***Source:*** Governor Direct |

**Query** **14/03/2018**

Recent media coverage seems to suggest that surgeons (and doctors) can carry out procedures with only themselves aware of their histories of success or otherwise. What processes are in place to monitor the effectiveness and safety of medical and surgical activities at UH Bristol?

***Division:*** Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:*** 28/03/2018

**Response** **11/04/2018**

We have a system for proactively monitoring our quality intelligence data for any potential outlier alerts which need further investigation. Where a potential alert is identified this is reviewed to see if it is statistically significant, that coding and mode of admission data is accurate and, if both, then a clinical review of the care of the patients which comprise the alert is undertaken. Where possible we triangulate the information with other data sources if they are available to us, such as national clinical audits, serious incident investigations, mortality review process. Occasionally we receive outlier alerts from third parties such as the CQC who may use slightly different datasets and statistical methodology. Increasingly when this occurs we are finding that we are already aware of a similar outlier alert which has already been investigated and, if relevant, improvement actions are in place or is being investigated.

Update 03/05/18: The quality intelligence data in the original reply refers to Hospital Episode Statistics data derived from clinical coding of every single patient's inpatient treatment as recorded in the clinical notes. This is reviewed in a number of ways to identify any outlier alerts and themes which can be drilled down into further detail, including to individual consultants. This includes such things and complications, misadventures, surgical site infections, readmissions, mortality. Alerts are reviewed and investigated further via an agreed standard operating procedure, including a review of individual patients if indicated, and reported into the Trust's Quality Intelligence Group chaired by the Medical Director.

With regard to the data in the quality dashboard, this comes from a wide range of internal and external sources e.g. NHS Digital (Summary Hospital Mortality Indicator) and local monitoring systems e.g. observational handwashing audits.

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