Agenda for the Meeting of the Trust Board of Directors held in Public to be held at 11am on Thursday 29th September 2016, in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

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1. Chairman's Introduction and Apologies David Armstrong, Jill Youds	Chairman	
2. Patient Story	Chief Nurse	3
3. Declarations of Interest To declare any conflicts of interest arising from items on the agenda	Chairman	
4. Minutes from previous meeting To approve the Minutes of the Board of Directors Meeting held in public on 28th July 2016	Chairman	5
5. Matters Arising (Action log) To review the status of actions agreed	Chairman	21
6. Chief Executive's Report To receive the report to note	Chief Executive	23
Delivering Best Care and Improving Patient Flow		
7. Independent Review of Children's Cardiac Services in Bristol To receive the report for assurance	Chief Nurse	27
8. Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Board Review – Quality, Workforce, Access	Chief Operating Officer	38
9. Quality and Outcomes Committee Chair's report To receive the report for assurance	Quality & Outcomes Committee Chair	96
10. Six Monthly Staff Nursing Report To receive the report for assurance	Chief Nurse	To follow
11. Quarterly Complaints Report To receive the report for assurance	Chief Nurse	101
12. Quarterly Patient Experience report To receive the report for assurance	Chief Nurse	138
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13. Finance Report To receive the report for assurance	Director of Finance & Information	165
14. Finance Committee Chair's Report	Finance	To be

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To receive the report for assurance	Committee Chair	tabled
Compliance, Regulation and Governance		
15. NHS Improvements Q1 Risk Assessment Framework Feedback To receive the report for assurance	Chief Executive	204
16. Freedom to Speak Up To receive the report for approval	Acting Director of Workforce	206
Information		
17. Governors' Log of Communications To receive the Governors' log to note	Chairman	218
18. Any Other Business To consider any other relevant matters not on the Agenda	Chairman	
Date of Next Meeting of the Board of Directors held in public: Thursday 31st October 2016, Conference Room,Trust HQ, Marlborough St, BS1 3NX		

Cover report to the Board of Directors meeting held in public
To be held on Thursday 29th September 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
2. Patient Story									
Sponsor and Author(s)									
Sponsor: Carolyn Mills, Chief Nurse **Author:** Tony Watkin Public and Patient Involvement Lead									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

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.

Patient Story Summary

University Hospitals Bristol has been recruiting its own volunteers for around 25 years. Currently, the Trust has around 250 volunteers helping in various roles including reception desks, playroom, chaplaincy, befriending and helping at mealtimes across the Trust's hospital sites.

There is an increasing amount of research which demonstrates the positive impact volunteering can have on delivering high quality patient care. The Board will be exploring the contribution of volunteering at a board seminar in November, prior to reviewing the Trust's Volunteering Strategy in January.

This story charts the experience of a Trust Volunteer who has worked in the Trust in various volunteer roles over a period of nine years. The volunteer is soon to be a patient in our care.

After a period of unemployment, the volunteer began to work with UH Bristol in 2007 supporting the stroke rehabilitation team in the then Bristol General Hospital. After a brief association with the South Bristol Hospital, he now offers reception and wayfinding services to patients and visitors at the Bristol Heart Institute in addition to a training and supporting role for new volunteer intakes.

The story explores the importance of volunteering in providing great care to our patients and how the support and development of Trust volunteers is central to that. It considers the motivations behind joining the Trust as a volunteer, how the role of the volunteer has developed over the years, the way in which volunteers are portrayed in the organisation and touches on some of the day to day pressures volunteers face as they support patients and carers.

The story ends with a personal reflection on planning for elective surgery and how the volunteer's

observations of our Trust have influenced his expectations of the care he will receive.
Recommendations
To receive the patient story, and note the context from which it was generated.
Impact Upon Board Assurance Framework
Impact Upon Corporate Risk
None
Implications (Regulatory/Legal)
Learning from feedback supports compliance with CQC's fundamental standards, in particular: regulation 9, person centred care; regulation 10, dignity and respect; regulation 17, good governance.
Equality & Patient Impact
None
Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	✓

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

Minutes of the Meeting of the Trust Board of Directors held in Public on Thursday 28 July 2016 at 11:00, Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Board members present:
John Savage, Chairman
Robert Woolley, Chief Executive
Paul Mapson, Director of Finance and Information
Sean O'Kelly, Medical Director
Alex Nestor, Acting Director of Workforce and Organisational Development
Alison Ryan, Non-Executive Director
John Moore, Non-Executive Director
Julian Dennis, Non-Executive Director
Lisa Gardner, Non-Executive Director
David Armstrong, Non-executive Director,

In attendance:
Helen Morgan, Deputy Chief Nurse (attending in place of Carolyn Mills)
Alison Grooms, Deputy Chief Operating Officer (attending in place of Owen Ainsley)
Pam Wenger, Trust Secretary
Sarah Murch, Membership & Governance Administrator (minutes)
Rev Brenda Dowie, Chaplaincy Team Leader
Sue Taylor, Nurse Consultant, Research Delivery
Kay Collings, Head of Education
Fiona Reid, Head of Communications
Sarah Wright, Head of Risk Management
Cat McElvaney, Cardiac Review Project Manager, Women's and Children's Division
Kathryn Bateman, Consultant
Jeanette Jones, Royal College of Nursing Lead and Appointed Governor
Angelo Micciche, Patient Governor (joint Lead Governor)
Mo Schiller, Public Governor (joint Lead Governor)
Tom Frewin, Public Governor
Carole Dacombe, Public Governor
Clive Hamilton, Public Governor
Graham Briscoe, Public Governor
Malcolm Watson, Public Governor
Rashid Joomun, Patient Governor
Ray Phipps, Patient Governor
Garry Williams, Patient (Carer) Governor
Lorna Watson, Patient (Carer) Governor
Sharmily Yogananth, Staff Governor
Florene Jordan, Staff Governor
Andy Coles-Driver, Staff Governor
Bridget James, Head of Quality, Bristol Clinical Commissioning Group
Sarah Talbot-Williams, Chief Executive, Above and Beyond
Alan Condon, member of the public
Caroline Wilson, member of the public

62/07/16 Chairman's Introduction and Apologies (Item 1)
John Savage, Chairman, welcomed everyone to the meeting. Apologies for absence were received from Guy Orpen, Non-Executive Director, Jill Youds, Non-executive Director, Emma Woollett, Vice-Chair, Sue Donaldson, Director of Workforce and Organisational Development, Carolyn Mills, Chief Nurse, Paula Clarke, Director of Strategy and Transformation and Owen Ainsley, Interim Chief Operating Officer.

63/07/16 Patient Story and Chaplaincy Annual Report (Item 2)
The meeting began with a Patient Story, to set a patient-focussed context for the meeting and to enable Board members to understand the impact of patient experience.

This month's Patient Story was related by Brenda Dowie, Chaplaincy Team Leader. Brenda told the Board the story of a 13-year-old boy who had been admitted to the Paediatric Intensive Care Unit at Bristol Royal Hospital for Children following an accident on a family outing. The boy had an emergency operation; however, the trauma was so great that doctors were unable to save his life.

The family had requested support from the Trust's chaplaincy. Brenda gave a moving description of the case which raised a variety of issues, including:

- The impact on families, staff and the supporting chaplain in complex situations which have a traumatic outcome
- The relationship between spiritual, religious and existential care.
- The enabling and processing of guilt especially in accidental circumstances
- The ability and skills needed to form a relationship quickly with families at their most vulnerable.
- The process of ongoing support for staff
- The debrief and process required for the chaplains to process their own feelings, reflections and theological/philosophical understanding.

Brenda then introduced the Chaplaincy Annual Report for 2015/2016, which summarised the activities and contribution of the Trust chaplaincy in the past year. There had been 289 emergency call-outs in the year, and 4,188 'significant visits' with patients, which had included around 900 requests for religious rites. She highlighted the chaplaincy's links with other healthcare organisations in the region, with round-the-clock on-call arrangements with North Bristol Trust and Avon and Wiltshire Mental Health Trust. She drew the Board's attention to the current relocation of the chaplaincy offices and sanctuary from the Old Building to the King Edward Building, with the redevelopment of the new sanctuary due to be complete in late September.

Alison Ryan requested assurance that the chaplains themselves received sufficient support, and Brenda confirmed the existence of peer support structures and access to a clinical psychologist if necessary.

Garry Williams, Patient (Carer) Governor, enquired whether the chaplains noticed any pressures experienced by families in relation to external interest from the media in their stories. Brenda explained that while in the Trust's care, families were afforded as much privacy as possible, though she acknowledged that such issues could arise subsequently.

David Armstrong noted Brenda's remarkable skill in communicating with compassion and empathy and asked whether her work extended to training others in the Trust. Brenda responded that this did not yet happen but could become an area for future focus.

Concluding the discussion, the Chairman warmly expressed gratitude on behalf of the Board for the work of Brenda and her team.

MEMBERS RESOLVED TO:
- **Receive** the patient story; and
- **Receive** the Chaplaincy Annual Report for 2015/16.

Brenda Dowie left the meeting.

64/07/16 Declarations of Interest (Item 3)
In accordance with Trust Standing Orders, all Board members present were required to declare any conflicts of interest with items on the meeting agenda. There were no new declarations made.

65/07/16 Minutes from previous meeting (Item 4)
The Board considered the minutes of the meeting held in public on 28 June 2016.

A minor amendment was agreed to the response to John Moore's question about patient letters containing inaccurate information (minute ref 52/06/16, Item 11- Complaints and Patient Experience Reports, page 7) to read:

*'Alison Grooms explained that previously, Trust staff **did** have control over the ability to edit letters'* (amended from '*did not have much control*').

MEMBERS RESOLVED TO:
- **Approve** the minutes of the meeting held on 28 June 2016 as a true and accurate record of proceedings subject to this amendment.

66/07/16 Matters Arising (Item 5)
Outstanding and completed actions were noted by the Board.

67/07/16 Chief Executive's Report (Item 6)
The Board received a report summarising the key business issues considered by the Senior Leadership Team in July 2016.

Robert Woolley, Chief Executive, highlighted several further matters.

The service of thanksgiving for Bristol Royal Infirmary Old Building and the decommissioning of the chapel therein had taken place yesterday, marking an important moment in history of the Trust's estate.

Last week UH Bristol had teamed up with the University of Bristol to support an application for a biomedical research centre. This would include the two biomedical research units currently hosted by the Trust as well as other elements. The application had been presented to an international expert panel and the result would be known by the end of September.

Robert reported to the Board his involvement in a discussion convened by the new Mayor of Bristol Marvin Rees about the feasibility of the establishment of a 'City Office': bringing every part of the public sector in Bristol together to work together with a central co-ordinating office. He welcomed this development and undertook to keep the Board updated.

He also informed the Board that Bristol, South Gloucestershire, and Bath and North East Somerset had voted for devolution for the West of England, which was now under consultation. If approved, this would result in the election of a 'Metro Mayor' by May next year which would be a very significant development for the region.

Robert informed the Board of a visit to the Trust yesterday by Jeremy Hunt, Secretary of State for Health, at which Mr Hunt had announced that he was taking personal charge of the national agenda for developing mental health. UH Bristol had presented to him the work of the Improving Care in Self-Harm (STiTCH) health integration team in relation to services in the Emergency Department for people at risk of suicide or self-harm. Mr Hunt had been particularly interested in the health integration team model of collaboration between academic researchers, GPs and others.

Further to the national agenda, the consequences for the NHS of the UK's vote to leave the European Union continued to be analysed in detail. There was as yet a lack of clarity about the implications, but some could be severe, for example, a fall in sterling could create a very substantial new procurement cost. The Board would continue to monitor the situation while continuing to send the message to all European nationals working at UH Bristol that the Trust valued enormously the contribution they made to clinical care, and would do its utmost to keep them informed about their ongoing position.

A further significant national announcement last week for the NHS was the 'Financial Reset' launched by NHS England and NHS Improvement. Entitled 'Strengthening financial performance and accountability in 2016/17', this initiative brought together a number of financial measures, greater capital controls, and the move to a 2-year planning cycle as well as signalling a single oversight framework for Foundation Trusts and NHS Trusts together so that they would be regulated in the same way. UH Bristol had accepted a financial control total of £15.9m surplus, and if this was achieved, it would then be in receipt of £13m of national money though this had significant conditions attached in relation to financial and waiting time performance.

Robert further advised the Board that three NHS organisations locally had been placed into financial special measures: North Bristol Trust, North Somerset Clinical Commissioning Group, and South Gloucestershire Clinical Commissioning Group. UH Bristol was currently seeking to understand the implications for its partnership and contracts with these organisations as well as for the region's health system as a whole.

MEMBERS RESOLVED TO:
- **Note** the report from the Chief Executive.

68/07/16 Independent Review of Children's Cardiac Services in Bristol (Item 7)
Robert Woolley, Chief Executive, introduced this item. The Independent Review of Children's Cardiac Services in Bristol, led by Eleanor Grey QC with Sir Ian Kennedy as advisor, had published its findings on 30 June. At the same time a related expert case review undertaken by the Care Quality Commission (CQC) had been published. The full

reports had been published on Trust's website, and the Trust had published a statement fully accepting the findings of both reports and indicating its willingness to learn from its mistakes.

Robert welcomed the acknowledgement in the reports that UH Bristol was already taking steps to improve, that the Trust's care was comparable with other similar centres in the UK in terms of quality, and that the CQC had not identified any concerns about the cases it had reviewed.

However, he acknowledged that the Trust had not got everything right for some families and in particular had not dealt with their concerns effectively, or provided answers when they had needed them, to the extent that the Trust had been reported to the CQC in 2012. This had resulted in the issue of a CQC warning notice on the cardiac ward, and while the Trust had responded to this very quickly, it had left the families involved suffering much uncertainty about the care of their children.

The Independent Review had concluded that the issues that they had seen in children's cardiac services from 2010-2014 were nothing like the failures of care and treatment that had been revealed by the public inquiry from 1998-2001. It had however found that nursing staff on the wards were under significant pressure which had led on some occasions to less than good care and poor communication. The Trust had apologised openly for these failings and had taken significant learning from its mistakes.

The Trust had issued an open letter inviting any family who contributed to the Review to contact the Trust to discuss their issues or to register interest in working more closely with the Trust going forward. The Trust would also write to families who had received the Expert Case reports to respond to the findings where this was possible, apologise where appropriate, and invite them for further discussion where welcomed.

Robert drew the Board's attention to the recommendations outlined in the report, which included timescales and the allocation of responsibilities. Carolyn Mills, Chief Nurse, had agreed to be the Board lead for oversight of the action plan, and Cat McElvaney had been appointed as programme manager to ensure sufficient co-ordination of reporting. The establishment of a parent reference group had been included in line with the wish explicitly stated by Eleanor Grey that the Trust endeavour to put parents at the heart of communication to create a partnership with parents in both the delivery of care and the management of services.

Robert asked that Board agree the recommendations, including reiterating the apology to the families, reaffirming the Board's acceptance of the recommendations in both reports, and acknowledging the role played by parents in bringing about changes already.

The Board wholeheartedly voiced support for these measures and approved the allocation of responsibilities. Alison Ryan enquired whether the parents' reference group was intended for the Division as a whole, or just for cardiac service. Robert responded that for the purpose of the delivery of the recommendations of the Review, the group was aimed at cardiac patients, but he accepted that the partnership could be used as a template across the Trust.

David Armstrong welcomed the Trust's approach. He requested that the action plan make explicit the assurance process for the closure of each action. Robert undertook to provide the Board with evidence of assurance in the monthly updates that they would receive.

David further referred to Actions 12, 14 and 27, which related to reviewing and updating documentation and identifying training opportunities. He suggested that the timescales for these actions appeared overly conservative, and requested that these be re-evaluated with a greater sense of urgency. Robert undertook to request that the timescales for these actions be reviewed.

Julian Dennis referred to the recommendation in the report to record discussions with families, expressing uncertainty about how this would achieve the stated aim of avoiding inconsistency. Robert explained that recording of conversations was not currently a consistent practice and he accepted that issue was a wider one of communication generally.

John Moore referred to recommendations on training and asked for assurance that the Trust was embedding lessons in communication and behaviour from the outset, and was included sharing learning with other organisations. He also asked whether a training programme would be rolled out for existing staff to improve communication. Robert responded that Sean O'Kelly had already issued guidance to staff to help them prepare for meetings with families. He confirmed that discussions were ongoing with other organisations where there were recommendations in the review that were outside UH Bristol's control.

David Armstrong requested that in addition to employing formal communication training methods, the Trust use its own resources to train medical staff in informal communication, and he identified the Chaplaincy as a potential resource in this regard.

Garry Williams, Patient (Carer) Governor, asked whether the families' panel would also include older children, and Robert confirmed that the Children's Hospital took into account the needs of older children, particularly in their transition towards adult services, and that one of focus groups would include consideration of issues of consent.

MEMBERS RESOLVED TO:

- **Note** the Independent Review of Children's Cardiac Services in Bristol for assurance;
- **Approve** the action plan and review the timescales to ensure that actions were undertaken in a timely manner; and
- **Consider** using the Trust's own resources (for example the chaplaincy) to aid communication training to give medical staff the tools to communicate effectively with families.

69/07/16 Congenital Heart Disease Commissioning Standards (Item 8)

Robert Woolley, Chief Executive, introduced this report. He explained that NHS England had undertaken a national review of congenital heart disease (CHD) services in both adult and children's services. As part of this process, UH Bristol's ability to meet a set of key requirements was assessed by a national panel. The panel had concluded that UH Bristol was still recognised as a Level 1 centre (a specialist surgical centre), and had been rated Amber which meant that the Trust was expected to fully meet the requirements with further development of its plans.

No organisation had met all the standards, and two surgical units were expected to close as a result of the review. In response to a question from Garry Williams about the effect of

the potential closure of Royal Brompton, Robert commented that he would expect other centres in London to meet the displaced demand. He added that UH Bristol might benefit from a displacement of staff in other areas, but in response to a question from Malcolm Watson, Public Governor, about whether the Trust would approach these staff, he did not believe it was appropriate to do so at this stage.

Clive Hamilton, Public Governor, referred to the staffing requirements outlined in the report, and asked whether the Trust had sufficient surgeons to meet the requirements. Robert responded that the Trust would create a fourth consultant post as required, but he cautioned that they would need to evaluate the changes in activity levels and demand to ensure that each surgeon was doing at least the minimum required number of operations.

MEMBERS RESOLVED TO:

- **Note** the Congenital Heart Disease Commissioning Standards for assurance.

70/07/16 Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital (Item 9)

Robert Woolley, Chief Executive, introduced the report informing the Board about the delivery of the recommendations arising from an independent investigation commissioned from Verita (an independent consultancy) into events following the death of a baby at the Bristol Royal Hospital for Children in April 2015. A parent of the child concerned was in attendance at the meeting.

Robert asked the Board to note the Trust's apology to the family for the failings that Verita had identified. The Trust accepted Verita's findings that the Trust had missed significant opportunities to engage proactively with the family after the child's death, to be more open and candid, to understand the serious nature of the allegations made about the Trust's behaviour and response, and to give clear answers to a range of questions. Robert expressed deep regret that the Trust had failed to get a grip of the complaint, and offered his unreserved apologies to the parents concerned.

The family had been given the opportunity to respond to the report, and their response had been distributed to all Board members individually.

Robert drew the Board's attention to the recommendations within the report. Stated in the annex was the Trust's assessment of the progress of specific recommendations, and timelines for delivery. He highlighted that where some recommendations had been indicated as complete, this had been challenged by the family, as while they may be complete from Trust's perspective against the narrow recommendation from Verita, there may be other related questions and concerns which were not complete from the family's perspective. He emphasised the importance of Recommendation 9 in this regard: that a senior clinician, independent of children's services, had been appointed to work with the family to understand the family's remaining questions and develop a plan with them to address these. Alan Bryan, Clinical Chair for the Specialised Services Division had been appointed to this role and meeting date would be set imminently.

Robert further drew the Board's attention to Recommendation 3 which was not yet completed: that the trust should share with Ben's family further findings from the investigation undertaken by the deputy medical director into a particular allegation against

a member of staff. It was Robert's view that the Trust's duty of care to its employees meant that it could not release the report as a whole, though they had released its findings. He proposed that this be included in Recommendation 9, and that Mr Bryan in consultation with the family to should work through the outstanding questions, including why a suggestion was made to conceal certain information that had been recorded, as in Verita's view this had not yet been satisfactorily answered.

Robert confirmed that, while recommendations were being actioned by several Executive Directors, he would maintain an active interest in the complaint personally. He clarified that the Board had decided against commissioning a further independent investigation into the allegations around conspiracy to conceal as Verita had found there was not conclusive proof of a conspiracy and further investigation would be futile.

John Moore referred to the need to establish why the suggestion had been made to conceal certain information, and asked who would be conducting this investigation. Robert noted that Recommendation 9 would enable both the family and the Trust to co-design the plan by which the Trust would answer this and other outstanding issues, so that any steps taken towards further investigation would be informed by the family's perspective.

Julian Dennis asked for assurance that the Trust consistently monitored reporting from laboratory systems to ensure that there was an effective way of delivering urgent results. Robert responded that, expectations had now been clarified in relation to reporting procedures. Compliance with these operating procedures would be audited.

Alison Ryan informed the Board that the Quality and Outcomes Committee had discussed the Child Death Review (CDR) process and improvements that could be made to avoid lack of clarity and confusion in the process. This was being monitored by the Committee. The Committee had also strongly emphasised the need to give more weight to the input from parents, families and carers in the process. She felt that the Trust's response to Recommendation 2 (that the Trust must review its CDR process to ensure appropriate support for families) was too narrow in this regard. Robert reassured the Board that the Trust's response to this recommendation was part of a larger piece of work.

David Armstrong asked that the Board establish timescales to deliver on the actions as quickly and effectively as possible. This was agreed.

MEMBERS RESOLVED TO:

- **Note** for assurance the Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital; and
- **Ensure** that any further actions would be established and delivered on with urgency.

71/07/16 Quality and Performance Report (Item 10)

Alison Grooms, Deputy Chief Operating Officer, presented this report, the purpose of which was to review the Trust's performance on Quality, Workforce and Access standards.

She highlighted the key issues. Progress in improving performance against the access standards had slowed this month. Whilst the 92% national standard for the percentage of patients waiting under 18 weeks Referral to Treatment (RTT) was achieved at month-end, the total number of long waiters increased. There had been a small deterioration in

performance against the A&E 4-hour standard, although the trajectory continued to be met. Performance against both the 6-week diagnostic waiting times standard and the 62-day GP cancer standard had deteriorated in the period.

In relation to Quality standards, Helen Morgan, Deputy Chief Nurse, drew the Board's attention to two metrics. Firstly, she was pleased to report that hospital-acquired pressure ulcers had been the lowest since robust reporting began in 2010 with only one grade 2 pressure ulcer in the Trust for June 2016. Secondly, there had been an increase in the number of early warning scores not acted upon in June. The performance figure for was 79% compared with a 100% score in May. She advised that the breach was caused by seven cases and reassured the Board that they were aware of the detail behind it.

Sean O'Kelly, Medical Director, reported that there had been a decrease in WHO surgical checklist compliance this month to 98.9% (representing 40 breaches out of 3605 procedures). The decline had been seen across all divisions and reasons for this were being reviewed. In some cases the new checklist had been completed but the data had been incorrectly entered onto the Medway patient records system.

He referred to the Trust's disappointing performance in relation to the management of Fractured Neck of Femur patients, and informed the Board that a report had now been received from the British Orthopaedic Association and the Divisions had been asked to draw up a plan of action to respond to the recommendations therein.

He reported that the Trust had recorded one occurrence of a Never Event last week which had resulted in the need for a further operation shortly after a first operation. He confirmed that this had been reported through the proper channels and that a Root Cause Analysis would be carried out in due course.

In relation to patient flow, Alison Grooms reported that the number of patients arriving and being admitted via the Trust's Emergency Departments had increased from 3% last month to 6% this month. The level of growth in emergency activity was highest at the Bristol Royal Hospital for Children, which despite this had still achieved the 95% national standard for the percentage of patients admitted, discharged or transferred within 4 hours of arrival in the Emergency Department. However, on the adult side there was some deterioration in patient flow and the 4-hour standard. Performance on cancelled operations had remained broadly similar. The Trust had achieved the 92% national standard for the percentage of patients waiting under 18 weeks from Referral to Treatment (RTT) but as the number of patients waiting longer for their surgery had increased (particularly in dental) the Trust would be at high risk of failing the 92% standard for July.

The 6-week diagnostic waiting times standard had been failed again this month, as planned improvements had not delivered, mainly due to increased demand. She reassured the Board that the Division was now working on a plan to recover the position by September, including a recruitment plan in endoscopy. Disappointing performance against the 62 day GP cancer waiting times had been reported, largely to do with issues outside the Trust's control such as late referrals, patient choice, and delayed reporting of histopathology results following the transfer of the service to North Bristol Trust.

In relation to Workforce performance, Alex Nestor, Acting Director of Workforce and Organisational Development, highlighted that agency usage was currently still too high; however, nursing agency usage had reduced in the period. Staff sickness levels were

reducing, and turnover was at the lowest level since August 2014, with in month reductions across every staff group except Estates and Ancillary.

72/07/16 Quality and Outcomes Committee Chair's Report (Item 11)
Alison Ryan introduced a report on the business of the Quality and Outcomes Committee (QOC) meeting held on 28 June 2016.

Highlights had included a presentation on Stroke Services showing comparative performance figures for the stroke indicator set. The committee was continuing to monitor the changes to the Trust's Serious Incident Reporting Policy and documentation, including responses complaints, and had received Root Cause Analyses from the serious incidents that had occurred. They had considered the governance arrangements for the new ORLA virtual ward and had received considerable assurance that standards around governance and quality would remain the same as in the rest of the Division. The committee had also discussed the Quality and Performance report and the National In-Patient Survey results for 2015.

Lisa Gardner enquired as to when the Board would be informed of the results of the action plans for Fractured Neck of Femur, and Sean confirmed that the Quality and Outcomes Committee would receive a report in September or October.

Lisa Gardner further asked about the Trust's pilot scheme for tackling short-term staff sickness, and Alex Nestor responded that it did not appear that this had made much impact, and the Trust was now adopting a wider approach.

In response to a question from David Armstrong regarding the recruitment action plan to address outstanding vacancies, Alex Nestor confirmed that a greater range of measures were being taken in addition to the marketing and management activities mentioned in the report. She agreed to share the marketing plan with the Board for assurance.

MEMBERS RESOLVED TO:
- **Note** the Quality and Performance Report for assurance;
- **Note** that the report from the Quality and Outcomes Committee Chair's Report for assurance;
- **Receive** a report on the Fractured Neck of Femur action plans at the Sept/Oct Quality and Outcomes Committee; and
- **Receive** a report detailing the marketing plan for vacancies.

73/07/16 Quarterly report on achievement of Quality Objectives (Item 12)
Sean O'Kelly, Medical Director, introduced this report, the purpose of which was to track the progress towards achieving the 2016/17 quality objectives set out in the Trust's Quality Report for 2015/16. Sean reported that at the end of Quarter 1, progress was broadly on track in most areas. Alison Ryan confirmed that the report had also been presented in some detail to the Quality and Outcomes Committee.

MEMBERS RESOLVED TO:
- **Note the** Quarterly report on achievement of Quality Objectives for assurance.

74/07/16 Quarterly Report on Research and Innovation (Item 13)
Sean O'Kelly, Medical Director, introduced this item, the purpose of which was to provide an update to the Trust Board on performance and governance of the Trust's Research and Innovation activities.

Among the key issues highlighted by Sean was that the Trust was showing approximately the same level of activity as in 2015/16 for total recruitment; however, several high-recruiting studies had closed in the past year which would affect delivery funding, as would an adjustment to study weightings. Planning for this was underway.

David Armstrong pointed out that the Trust's stated ambition in its strategic aim was to be a leading research organisation. The report would therefore benefit from the inclusion of comparisons with other Trusts. He also enquired whether this report had previously been submitted to a committee, and Alison Ryan responded that Research and Innovation was currently not covered by the Board sub-committee structure.

MEMBERS RESOLVED TO:
- **Note** the quarterly report on research and innovation; and
- **Review** research and Innovation reporting structures.

75/07/16 Annual Education, Learning and Development Report (Item 14)
Alex Nestor, Acting Director of Workforce and Organisational Development, introduced this report, the purpose of which was to describe how UH Bristol delivered against its education and teaching priorities during 2015/16.

David Armstrong referred to the outcomes of the Education, Development and Learning Strategy detailed on page 239 and suggested that the outcomes be more rigorous and include success criteria. For example, Outcome 3: 'Best place to teach, best place to learn' could be more specific.

MEMBERS RESOLVED TO:
- **Note** the Annual Education, Learning and Development Report for assurance.

76/07/16 Equality and Diversity Annual Report 2015/16 (Item 15)
Alex Nestor, Acting Director of Workforce and Organisational Development, introduced this report, which highlighted successes during the past year, performance in regulatory areas, and the Trust's commitment to promoting a culture of inclusion for patients and staff through plans for the future, including the strategic objectives for 2016 - 2019. She asked the Board to support the Senior Leadership Team's recommendation to further strengthen the Workforce Race Equality Scheme (WRES) objectives for 2016/17 in line with national guidance received subsequent to the submission of this report.

MEMBERS RESOLVED TO:
- **Note** the Equality and Diversity Annual Report 2015/16 for assurance; and
- **Support** the Senior Leadership Team's recommendation to further strengthen the WRES objectives in line with national guidance.

77/07/16 Complaints Annual Report 2015/16 (Item 16)

Helen Morgan, Deputy Chief Nurse, introduced this report, which fulfilled a statutory requirement for the Trust to publish a summary of complaints received during the year. The Board had previously reviewed the data through detailed quarterly reports, and in summary form via the Trust's annual Quality Report (Account). Alison Ryan confirmed that the Quality and Outcomes Committee had also received this report.

MEMBERS RESOLVED TO:

- **Note** the Complaints Annual Report 2015/16 for assurance.

78/07/16 National In-Patient Survey Results 2015 (Item 17)

Helen Morgan, Deputy Chief Nurse, introduced this report, which provided an overview of the Trust's performance in the 2015 national inpatient survey and a response to the key issues identified. Two reports were provided: a local analysis of the Trust's performance in this survey; and the Care Quality Commission benchmark report comparing UH Bristol's results against the national average.

Helen confirmed that the reports had been discussed in detail by the Quality and Outcomes Committee. She drew the Board's attention to the survey's findings that the Trust had now started to perform above the national average but not enough to move into the top 20%, which is what it was aiming for. She also highlighted the Trust's approach to implementing improvements, which would link very closely with the Quality Strategy (to be received by the Trust Board in September), and which would include a key focus on moving to a more customer-focussed culture in the organisation.

John Moore asked that the Trust benchmark against the best 20% of Trusts instead of the average in the summary of the report as well as in the body of the report.

MEMBERS RESOLVED TO:

- **Note** the National In-Patient Survey Results 2015 for assurance.

79/07/16 Transforming Care Report (Item 18)

Robert Woolley, Chief Executive, introduced this report, the purpose of which was to update the Trust Board on the progress of Trust-wide programmes of work under the Transforming Care programme.

He highlighted that the key programmes of work to improve patient flow (Unscheduled Care & Ward Processes and Planned Care) had been brought together into a single Operating Model programme. The team were also building on work done on ward processes, real time information, planned care, and had recently run an initiative called 'Plans for the Weekend', which focussed on preparations for and discharges across the weekend and had made a significant difference to the efficiency of discharge in the weekend it was used. There was a continuing focus on outpatients, theatres, Bristol Royal Hospital for Children, staff engagement and leadership development.

Clive Hamilton, Public Governor, enquired about the aim stated in the report to use email to send appointment letters to patients, and Alison Grooms confirmed that work was underway on this, though there were some technological issues to overcome. She offered

to provide an update to a governor meeting to explain the issues in more detail. This was welcomed.

MEMBERS RESOLVED TO:

- **Note** the Transforming Care Report for assurance; and
- **Note** that governors would be provided with an update on patient appointment letters and emails**.**

80/07/16 Clinical Research Network Annual Report 2015/16 and Annual Plan 2016/17 Report (Item 19)

Sean O'Kelly, Medical Director, introduced this report, explaining that the Trust Board provided oversight and governance to the Clinical Research Network as part of its hosting arrangements. The reports had been approved already by the partnership group which represented the member organisations and the Clinical Research Co-ordinating centre in Leeds.

He introduced Sue Taylor, Nurse Consultant in Research Delivery. Sue drew the Board's attention to the report summary, adding that the CRN had performed consistently well in 2016. The main challenge was that in 2015/16 they had achieved 82% of their recruitment target, partly due to the increased complexity of research studies available on the portfolio, and that this would limit the time available for clinical researchers to deliver on additional research studies.

MEMBERS RESOLVED TO:

- **Note and Approve** the Clinical Research Network Annual Report 2015/16 and Annual Plan 2016/17.

81/07/16 Finance Report (Item 20)

Paul Mapson, Director of Finance, provided an update to the Board on the Trust's financial position. The summary income and expenditure statement showed a surplus of £3.871m (before technical items) for the first three months of the year. The 2016/17 financial plan, which included receipt of £13.0m sustainability funding, had been revised to deliver a surplus of £15.9m before technical items. At month three the Trust was £0.013m favourable against the revised plan.

Paul explained that the plan was still very tight. The Trust was still struggling with agency costs, and activity was particularly low last month in Medicine, which had caused some difficulties. He expressed a concern that a continuation of the current run rate could compromise delivery of the Control Total, though fortunately there were offsets which enabled the overall Trust position to be reported as being on plan. However, he cautioned that the Trust's control total was the seventh biggest in the country, and even if the Trust achieved it this year, it was unlikely to be able to continue to do so in future years. This position would be made clear to regulators.

He also stated to the Board that the Trust was using the last non-recurrent measures available to the Trust which was likely to lead to a deficit position in 2017/18.

MEMBERS RESOLVED TO:

- **Note** the Finance Report.

82/07/16 Finance Committee Chair's Report (Item 21)
Lisa Gardner, Chair of the Finance Committee, introduced the report of the business discussed at the meeting of the Finance Committee on 25 July.

Highlights had included a presentation by the Women's and Children's Division about their operating plan and the risk to this posed by a historical savings deficit. There was positive progress reported from the Division in terms of recruitment, and plans to improve staff retention through listening events.

MEMBERS RESOLVED TO:
- **Receive** the Finance Committee Chair's report for assurance

83/07/16 Quarterly Capital Projects Status Report (Item 22)
Alison Grooms introduced this report, the purpose of which was to update the Board on the progress of the Trust's remaining major capital developments and associated programme infrastructure. She added that there was now a revised proposal to progress the work needed to the pavement in front of the Bristol Royal Infirmary.

She drew the Board's attention to the risk highlighted in the report around the work required to release the Bristol Royal Infirmary Old Building and the mitigations outlined.

MEMBERS RESOLVED TO:
Note the Quarterly Capital Projects Status Report for assurance.

Julian Dennis left the meeting.

84/07/16 Annual Review of Risk Management Strategy (Item 23)
Robert Woolley introduced this report, highlighting that the Risk Management Strategy had been revised in accordance with the required review schedule. The revised Strategy presented a high-level strategic statement on the management of risk, including the Risk Appetite statement to be considered by the Trust Board of Directors.

It was requested that any amendments should be submitted in writing to Pam Wenger.

MEMBERS RESOLVED TO:
- **Note** the report;
- **Approve** the risk appetite statement for the period 2016/17; and
- **Approve** the risk management strategy and policy.

85/07/16 Board Assurance Framework Report: Quarter 1 Update (Item 24)
Robert Woolley introduced this report, the purpose of which to provide assurance that the organisation was on track to achieve its strategic and annual objectives for the current year. He thanked the Executive Team for pulling this together and Pam Wenger for leading the development of the new format.

The Board welcomed the new format which was simple to follow and focussed on the strategic priorities.

Alison Ryan noted that Assurance Committees needed to be added in relation to several areas including some areas of workforce and Research & Innovation.

Carole Dacombe, Public Governor, referred to the Trust's plans to deploy new digital capability as described under Strategic Priority 2, and suggested that the Trust proactively sought comment on and reported on any incidents relating to failure of digital systems. Robert Woolley agreed to consider this via the information management committee.

MEMBERS RESOLVED TO:

- **Note** the Board Assurance Framework Report: Quarter 1 Update; and
- **Consider** via the information management committee how near misses and minor incidents relating to the failure of new digital systems could be captured and reported.

86/07/16 Q1 Risk Assessment Framework Declaration Report (Item 25)

Robert Woolley introduced this report, explaining that Risk Assessment Framework constituted Monitor's approach to assess compliance with two specific aspects of the Trust's work: the Continuity of Services and Governance conditions in their provider licences.

He asked the Board to approve submission declaring standards failed in quarter 1 to be the A&E 4-hour standard, the 31-day first definitive, the 31-day subsequent surgery, the 62-day GP and 62-day Screening cancer standards. He reassured the Board that the Trust would plan this failure according to the recovery trajectories agreed with commissioners. He added that the Board anticipated that the Trust would continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months, though asked the Board to note risks highlighted in the report.

MEMBERS RESOLVED TO:

- **Approve** the Q1 Risk Assessment Framework Declaration Report for submission to NHS Improvement.

87/07/16 Governors' Log of Communications (Item 26)

The report provided the Trust Board with an update on governors' questions and responses from Executive Directors.

MEMBERS RESOLVED TO:

- **Note** the Governors Log of Communications.

82/07/16 Any Other Business (Item 27)

There was no other business.

Meeting close and Date and Time of Next Meeting

There being no other business, the Chair declared the meeting closed at 1.25pm. The next meeting of the Trust Board of Directors will take place on Thursday 29 September

2016, 11:00 – 13:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Board of Directors meeting held in Public 28 July 2016
Action tracker

Outstanding actions following meeting held 28 July 2016					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1	**68/07/16**	**Independent Review of Children's Cardiac Services in Bristol** • Review timescales of action plan to ensure that actions were undertaken in a timely manner. • Consider using the Trust's own resources (for example the chaplaincy) to aid communication training to give all staff the tools to communicate effectively with families.	Chief Nurse	August 2016	**Work in Progress** Chaplaincy Team invited to the preceptorship programme for newly qualified nurses, midwives and Operating Department Practitioners.
2	**70/07/16**	**Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital** • Ensure that any further actions would be established and delivered on with urgency	Chief Executive	August 2016	**Work in Progress** Update on progress reported at the meeting.
3	**71/07/16**	**Quality and Performance Report** • Receive a report on the Fractured Neck of Femur action plans at the Sept/Oct Quality and Outcomes Committee. • Receive a report detailing the marketing plan for vacancies.	Interim Chief Operating Officer	October 2016	**Work in Progress** Scheduled for October 2016.
4	**74/07/16**	**Quarterly Report on Research and Innovation** • Review Research and Innovation reporting structures, potentially to include comparisons with other Trusts.	Medical Director	October 2016	**Work in Progress**

5	**79/07/16**	**<u>Transforming Care Report</u>** • Governors to be provided with an update on patient appointment letters and emails**.**	Director of Strategy & Transformation	October 2016	**Work in progress.** Scheduled for an update to be provided at the Quality Focus Group.
6	**85/07/16**	**Board Assurance Framework Report** • Consider via the information technology group how near misses and minor incidents relating to the failure of new digital systems could be captured and reported.	Director of Finance and Information	October 2016	**Work in progress** Scheduled discussion at next Information Management & Technology Group.
7	**181/02/16**	The Board to receive an update on the major strategic schemes for consideration and prioritisation.	Director of Strategy & Transformation	October 2016	**Work in progress** Update provided at the Board in June 2016. A timeline for the strategy refresh and strategic capital programme to be presented to the October Board.
Completed actions following meeting held 28 July 2016					
8					
9					

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 29th September 2016 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
6 Chief Executive Report									
Sponsor and Author(s)									
Sponsor & Author: Robert Woolley, Chief Executive									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

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

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

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.

Impact Upon Board Assurance Framework

The Senior Leadership Team is the executive management group responsible for delivery of the Board's strategic objectives and approves reports of progress against the Board Assurance Framework on a regular basis.

Impact Upon Corporate Risk

The Senior Leadership Team oversees the Corporate Risk Register and approves changes to the Register prior to submission to the Trust Board.

Implications (Regulatory/Legal)

There are no regulatory or legal implications which are not described in other formal reports to the Board.

Equality & Patient Impact

There are no equality or patient impacts which are not addressed in other formal reports to the Board.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	✓

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – SEPTEMBER 2016

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in September 2016.

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

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

The group **noted** an updated in relation to the Care Quality Commission Inspection, and the comprehensive risk-based assessment of compliance undertaken by the Trust.

3. STRATEGY AND BUSINESS PLANNING

The group **noted** the update for the Business Planning process for 2017/2018.

The group noted and **agreed** the proposal to pre-commit funding from the 2017/18 Capital for the image viewing solution machine for paediatric cardiology, noting the impact this will have on the already limited capital available for 2017/18.

The group **received** a risk assessment in relation to the impact of the introduction of the additional hours payments in Surgery, Head and Neck.

The group received the Supporting Attendance Plan and **supported** the transformative recommendations put forward.

The group **noted** the update in relation to the Clinisys WinPath laboratory information system (LIMS) go /no go update and noted the go live date of 2nd October.

4. RISK, FINANCE AND GOVERNANCE

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

The group received and **noted** the Quarter 1 Complaints and Patient Experience Reports for ongoing submission to the Quality and Outcomes Committee and Trust Board.

The group received and **noted** the National Cancer Patient Experience Survey.

Reports from subsidiary management groups were **noted,** including updates on the Transforming Care Programme.

The group **received** an update on the Internal Audit Report in relation to Resuscitation, and **supported** the development of a business case for a Radio Frequency Identification system for all resuscitation trolleys.

The group **received** and **endorsed** the revised process for the engagement of staff 'off payroll'.

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

5. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
September 2016

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Thursday 29th September 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
7 Independent Review of Children's Cardiac Services progress report
Sponsor and Author(s)
Sponsor: Carolyn Mills, Chief Nurse **Author:** Carolyn Mills, Chief Nurse

Intended Audience									
Board members	√	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

This paper provides a brief progress report on the actions taken in the last month to:

- Develop and implement a programme plan, which addresses the recommendations set out in the Independent Review of Children's Services at the BRCH.
- Develop the governance/reporting arrangements to ensure that this plan describes the detailed actions, timescales and responsibilities that will ensure recommendations are fully responded to.
- Ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the action plans.

Key issues to note

- Letters have been issued by the Trust to all 27 families who had a case review report, apologising where appropriate and inviting them to further discussion on any queries they may have, to review what improvements have already been made and to be involved in the shaping of the actions or co-design work to deliver the recommendations, where appropriate
- Governance arrangements have been set up to ensure delivery of the recommendations
- A plan is in place for involving families with improvement work and also in the Parents and Young Persons reference group
- The Independent Review of Children's Cardiac Services Steering Group, chaired by Carolyn Mills, Chief Nurse and Senior Responsible Officer has been set up. The first meeting took place on the 6th September 2016.
- There have been three Key Delivery Groups set up with responsibility for the delivery of specific recommendations - Terms of reference have been agreed for these groups, along with a Senior Responsible Officer, and initial meetings are scheduled September to Early October.
- A draft communications plan to ensure openness and transparency has been reviewed and approved by the Steering Group

Recommendations
The Board is asked to: - Note the actions taken since the publication of the Independent Review of Children's Cardiac Services and the CQC report. - Approve the terms of reference for the Steering group - Approve the revised governance structure - Receive the progress report
Impact Upon Board Assurance Framework
Impact Upon Corporate Risk
Risk ID
Implications (Regulatory/Legal)
Equality & Patient Impact

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	√	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

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

1.0 Introduction

This paper provides a brief progress report on the actions taken in the last month to:

- Develop and implement a programme plan, which addresses the recommendations set out in the Independent Review of Children's Services at the BRCH.
- Develop the governance/reporting arrangements to ensure that this plan describes the detailed actions, timescales and responsibilities that will ensure recommendations are fully responded to.
- Ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the action plan.

2.0 Background

The reports of the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and a CQC expert review of clinical outcomes of the children cardiac service were published on 30 June 2016 setting out 32 recommendations for the Trust, South West and Wales Congenital Heart Network, Department of Health and NHS England to implement.

The Board received a paper in July detailing actions already taken to improve care and support to children and their families and an initial assessment of the expected time to complete initial actions towards delivery of each recommendation.

3.0 Governance arrangements

The agreed governance arrangements supporting implementation of the recommendations for UHBristol and the South West and Wales Congenital Heart Network are illustrated in figure 1 below. The South West and Wales Congenital Heart Network has been set up, is governed and financed by the Trust therefore the governance of the delivery of the actions for the network will be via the Trust' steering group.

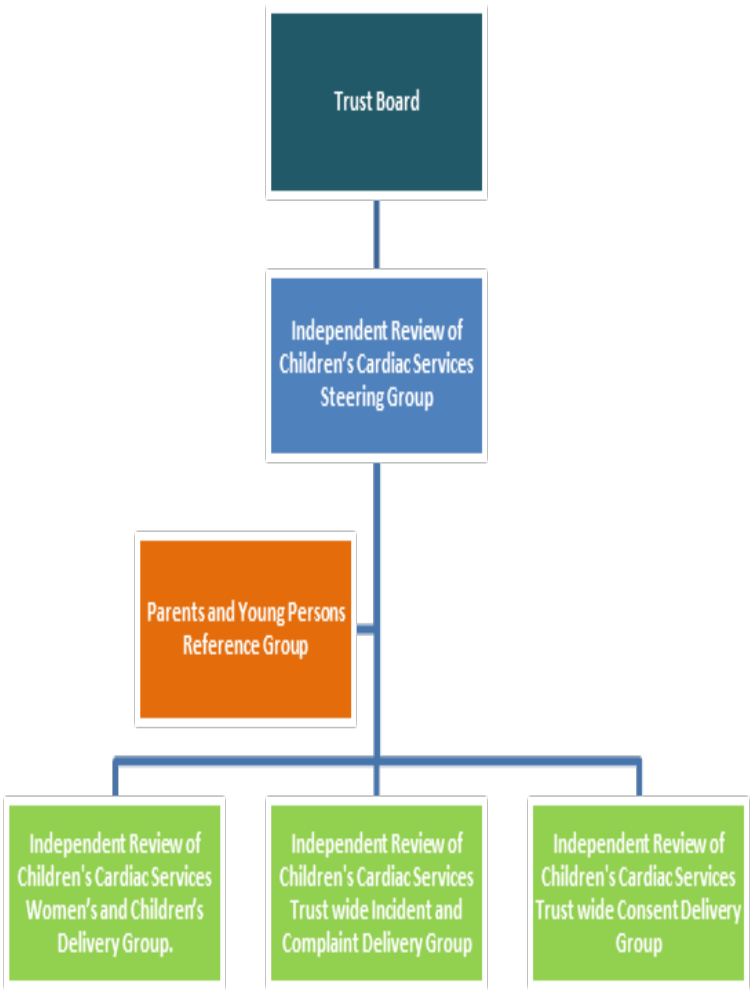


Figure 1: Governance arrangements

Since the last Board meeting where these arrangements were approved there has been one subsequent change made to the governance arrangements in discussion with the Chairman and the Chair of the Trusts Quality and Outcomes Committee. It has been agreed that the Independent Review of Children's cardiac services steering group will report directly to Board and not via the Quality and Outcomes Committee (a Non-Executive subcommittee of the Board). This change is consistent with the priority given to the programme by the Trust Board and its commitment to transparency in reporting progress with delivery of the recommendations.

The first meeting of the Steering Group was held on the 6th of September 2016, chaired by Carolyn Mills, Chief Nurse and Senior Responsible Officer for delivery of the recommendations from the independent review. The terms of terms of reference of the Steering Group were finalised by the group and are attached as appendix one of this paper for approval by the Trust Board. The Trust Board will receive monthly progress reports from the Steering group.

Terms of reference and the membership of each delivery sub group to the steering group were approved by the steering group. Each of the three delivery groups of the steering group have a Senior Responsible Officer (SRO) agreed. These are Mr Ian Barrington Divisional Director Women's and Children's Division who is the SRO for the Women's and Children's independent review delivery group, Dr Jane Luker is the SRO for the trust wide consent independent review delivery group, and Helen Morgan Deputy Chief Nurse is the SRO for the trust wide incident and complaints independent review delivery group. These groups are responsible for delivery of recommendations that have trust wide implications for service improvement.

4.0 Programme management

Work has commenced to develop and implement a programme plan which addresses all the recommendations set out in the Independent Review of Children's Cardiac Services at the Bristol Royal Hospital for Children. The plan will be completed by the end of September and it is the role of the steering group to provide assurance to the board that.

- this plan describes the detailed actions, timescales and responsibilities that will ensure recommendations are fully responded to.
- the actions fully address the body and spirit of the report
- all actions are completed in a timely and well-coordinated way
- there are comprehensive and auditable processes established to enable scrutiny of performance and the delivery of actions by the Trust Board
- that the reporting demonstrates the ways in which stakeholders are informed and engaged as appropriate in the governance and delivery of actions.
- there is a defined process to establish and build a comprehensive portfolio of evidence in support of actions taken and the improvements in place.

5.0 Engagement: parent and young person's reference group

The parent and young person's reference group is part of a much wider parent and young person's involvement plan which has been developed by the BRHC, which is currently engaged in service improvement work related to the independent cardiac review recommendations. The principle of this programme is to build on the existing framework for family involvement currently within the children's hospital and to use the recommendations from the review to further strengthen this partnership. This work will align with the patient and public involvement work planned within the Congenital Heart Disease Network. The objectives of the group will be to:

- To establish the expectations of parents and young persons as to how they would like to be involved in the implementation of the recommendations and the shaping of future cardiac services

- To engage and involve parents and young persons in an open, transparent and inclusive manner.
- To establish a structure that enables parents and young persons to meet regularly to and to be involved in the improvement work.
- To ensure that meetings occur at a minimum of quarterly and at a time, place and manner that is convenient for parents, young persons and supporting staff for the duration of the project.
- To ensure there are opportunities for parents and young persons to be involved virtually if they are unable to attend events/meetings in person.
- To assure the Independent Review of Children's Cardiac Service Steering Group that the views of Parents and Young Persons have been heard and that the development of the actions to implement the recommendations reflects what is important to patients and families.

Families are being invited to be involved in a number of different ways including:

- Membership of the Cardiac Parents and Young Persons Reference Group
- Co-designing and involvement with specific work they are interested in- for example consent pathway
- Showcase of existing improvements; families will be invited to come and see what has been done to date via open days or 1:1 meetings.

There will be an initial parents and young person's reference group engagement event in October to understand how parents and young people would like to be involved, recognising that a "meeting" may not be the most appropriate way, that we need to provide a structure in terms of setting direction but have enough flexibility to allow for innovation. A lead/voice representing the parents and young person's reference group will be identified in October. The terms of the reference for the group will be finalised in November.

Recommendations

The Trust Board is recommended to:

- Approve the terms of reference for the Steering group
- Approved the revised governance structure
- Receive the progress report

University Hospitals Bristol NHS
NHS Foundation Trust

Terms of Reference – Independent Review of Children's Cardiac Services Steering Group

Document Data		
Corporate Entity	Independent Review of Children's Cardiac Services Steering Group	
Document Type	Terms of Reference	
Document Status	Draft version 0.5	
Executive Lead	Carolyn Mills (Chief Nurse and Senior Responsible Officer)	
Document Owner	Programme Manager	
Approval Authority	Trust Board	
Next Review Date:	**Date of First Issue:**	**Date Version Effective From:**
	DRAFT v0.5	3T
Estimated Reading Time	5 mins	

Document Abstract
This document provides the Terms of reference for the Cardiac Review Programme Steering Group (Children's Cardiac Services), giving guidance on the purpose and makeup of the group and identifying duties carried out by the group.

Document Change Control

Date of Version	Version Number	Lead for Revisions	Type of Revision	Description of Revision
15/8/2016	0.1	CMcE created		Created
17/8/2016	0.2	IB	Content	Membership of group, governance
18/8/2016	0.3	CM	Content	Title and Content of TOR
01/09/2016	0.4 & 0.5	CM	Content	Membership

1. Introduction

In February 2014, the Medical Director of NHS England commissioned an independent review of the children's cardiac service at the Bristol Royal Hospital for Children, in response to the continuing concerns by families. NHS England worked with the families to develop and publish terms of reference for the review and asked Eleanor Grey QC to lead it, with Sir Ian Kennedy acting as an advisor. In September 2014 the CQC carried out a comprehensive inspection of University Hospitals Bristol NHS Foundation Trust, which included the services provided by the Bristol Royal Hospital for Children. The reports of the Independent Review and the CQC expert review were published on 30 June 2016. The Trust fully accepted the findings of both these reports and welcomed their publication as a way to learn from mistakes.

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

A schedule of all the recommendations, along with proposed organisational and individual ownership, proposed governance and details of initial actions and timescales was approved by the Trust Board on 28 July 2016.

2. Purpose & Role

The overall purpose of the Independent Review of Children's Cardiac Services Steering Group is to oversee the timely and appropriate implementation of the recommendations as set out in the Cardiac Review and the CQC report and to provide assurance to the Trust Board on both the implementation and completion of the recommendations. It will be responsible for;

2.1 Monitoring progress and overseeing the coordination of activities/action plan, within agreed timescales, to deliver the recommendations, assigned to the Trust, as set out in the Cardiac Review and CQC report.

2.2 To ensure that the patients and families are at the centre of planning, designing and reviewing the efficacy and impact of implementation of the recommendations.

2.3 Reporting progress against plan and providing assurance to the Trust Board on a monthly basis that the action plan is being delivered to achieve the recommendations.

2.4 Ensuring that actions are only closed when there is robust evidence of completion.

2.5 To ensure that the programme reporting is open and transparent.

2.6 To manage any risks and issues with the delivery of the programme, which cannot be managed by the delivery groups, ensuring effective mitigation/resolution, and escalating as appropriate where there these cannot be resolved.

2.7 To ensure that effective communication and liaison is maintained with the Trust Board, Cardiac Review Steering Group, Parents and Young Persons Reference Group, Cardiac Delivery Group and Working Groups and external parties as required.

2.8 Ensure that the principles of good governance are maintained throughout the programme, including matters of confidentiality, information governance and data security.

3. Authority

3.1 The Independent Review of Children's Cardiac Services Steering Group, is authorised to discharge the duties set out in these Terms of Reference.

3.2 The functions and actions of the Independent Review of Children's Cardiac Services Steering Group, do not replace the individual responsibilities of its members as set out in job descriptions and other forms of delegations.

3.3 Individuals remain responsible for their duties and accountable for their actions.

4. Governance and Reporting

4.1 The Independent Review of Children's Cardiac Services Steering Group, is accountable to the Trust Board and is required to report regularly in the following forum:

(a) Trust Board (Monthly)

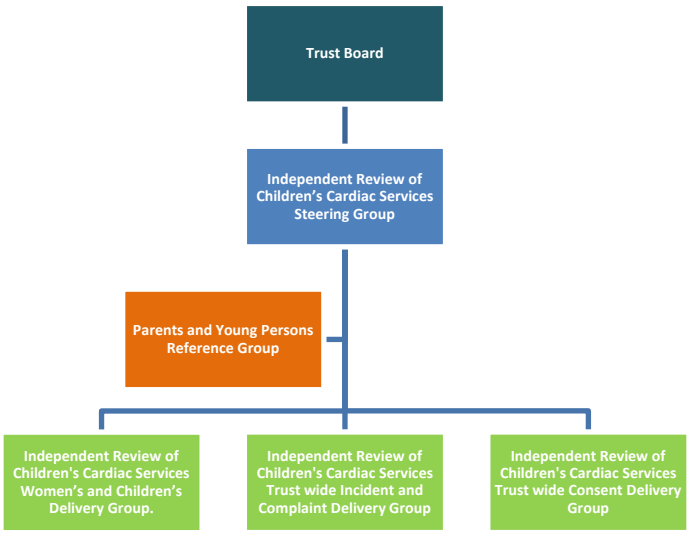


Figure 1: Governance Model.

5. Membership

5.1 The Cardiac Review Programme Steering Group (Children's Cardiac Services), consists of the following members:

Name	Job Title
Carolyn Mills	Senior Responsible Officer & Chair, Chief Nurse
Mark Calloway	Deputy Chair, Deputy Medical Director
Tbc	Representative from the Parent and Young Persons reference group
Dr. Bryony Strachan	Clinical Director, Women's and Children's Division
Ian Barrington	Divisional Director, Women's and Children's Division
Mark Goninon	Head of Nursing, Women's and Children's Division
Chris Swonnell	Head of Quality (Patient Experience and Clinical Effectiveness)
Cat Mc Elvaney	Cardiac Review Programme Manager
Dr. Andy Tometzki	Congenital Heart Disease Network Clinical Director

5.2 Attendance

5.3 There will be a standing invitation to Dr. Vaughan Lewis, Clinical Director, Specialist Commissioning, NHS South and Carole Bell, Director of Nursing and Quality, Welsh Specialised Services Committee and also to Jane Luker and Helen Morgan, the Senior Responsible Officers of the Delivery Groups.

5.4 The Chair of the Independent Review Steering Group (Children's Cardiac Services), may require others to attend meetings either in full, or for specific agenda items.

6. Quorum

6.1 The quorum necessary for the transaction of business shall be 50% of the total membership (i.e. 5/10) members plus the Chair or deputy Chair.

6.2 A representative from Bristol Royal Children's Hospital to attend all meetings.

7. Secretariat Services

7.1 Secretariat services for the administration of the group will be provided by the PA to the Chief Nurse.

7.2 The secretariat will maintain and monitor a Schedule of Matters Arising of agreed actions.

7.3 Notice and Conduct of Meetings

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 Cardiac Review Programme Steering Group (Children's

Cardiac Services), and any other person required to attend, no later than three working days before the date of the meeting.

7.4 Minutes of Meetings

Draft minutes of meetings shall be provided to the Chair not later than 1 week after the meeting and distributed to members and attendees (as appropriate) not later than 2 weeks thereafter.

8. Frequency of Meetings

8.1 The Independent Review Steering Group (Children's Cardiac Services), shall meet monthly, on the 1st Tuesday of the month, and at such other times as the Chair shall require.

9. Standing Agenda Items

- Minutes and matters arising
- Update on actions from the last meeting
- Progress report on the delivery of action plan and recommendations, agreeing any recovering actions as required.
- Review and address key risks and issues to delivery

10. Review of Terms of Reference

10.1 The Independent Review Steering Group (Children's Cardiac Services) shall, at least every 6 months, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Chair.

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 29th September 2016 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
08 Quality and Performance Report

Sponsor and Author(s)
Report sponsors: • Overview and Access – Owen Ainsley, Interim Chief Operating Officer • Quality – Carolyn Mills, Chief Nurse and Sean O'Kelly, Medical Director • Workforce – Sue Donaldson, Director of Workforce & Organisational Development **Report authors:** • Xanthe Whittaker, Associate Director of Performance • Anne Reader, Head of Quality (Patient Safety) • Heather Toyne, Head of Workforce Strategy & Planning

Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary
<u>Purpose</u> To review the Trust's performance on Quality, Workforce and Access standards.

Recommendations
The Committee is recommended to receive the report for **assurance.**

Impact Upon Board Assurance Framework
Links to achievement of the standards in Monitor's Risk Assessment Framework.

Impact Upon Corporate Risk
As detailed in the individual exception reports.

Implications (Regulatory/Legal)
Links to achievement of the standards in Monitor's Risk Assessment Framework.

Equality & Patient Impact
As detailed in the individual exception reports.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees				
Finance Committee	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

September 2016

Executive Summary

Levels of demand have remained high, and in contrast to last month, performance against the headline measures of patient access has in some cases deteriorated. Disappointingly, the percentage of patients waiting under 18 weeks Referral to Treatment (RTT) has dipped below the 92% national standard for the first time since December 2015, following further increases in the number of patients on the waiting list. This is despite an increase in outpatient activity in the month. Performance against both the A&E 4-hour and 6-week diagnostic waiting times standard have, however, been maintained above the recovery trajectory. Encouragingly, performance against the 62-day GP cancer standard is also expected to be above trajectory for August, when final reporting is completed. The Overview page of this report provides further details of the priorities, risks and threats for the coming months, along with noteworthy successes in the period.

In August there was an 11% increase in the levels of emergency admissions through the Bristol Royal Infirmary (BRI) Emergency Department, relative to the same period last year. This was in contrast to the Bristol Children's Hospital, which had significantly fewer emergency admissions than in recent months, and performed comfortably above the 95% national standard. Delayed discharges have increased, as have the number of patients staying over 14 days in hospital. But despite this, bed occupancy within the BRI stayed at the lower levels seen in July, which helped maintain 4-hour performance above trajectory. The improvement in bed occupancy, and hence bed availability levels, also enabled the 0.8% national standard for the percentage of operations cancelled at last minute for non-clinical reasons to be achieved for the first time since December 2015.

A greater number of patients were seen for their new outpatient appointments in August than in July, with activity levels being above the seasonal norm. However, this higher level of activity was insufficient to offset the number of new patients added to the list, with a resulting growth in the waiting list for the sixth month running. As a consequence of six months of higher additions than removals from the waiting list, the number of patients waiting over 18 weeks from Referral to Treatment has increased, resulting in failure to meet the 92% national standard. A recovery plan has been developed, which includes actions to make a step change in activity levels, but also improvements to the administrative processes in recognition of the need to make sure the new Patient Access Policy is being appropriately applied and as many clock stops are captured in real-time as possible. The underperformance in July against the 62-day GP cancer waiting times standard continued to be materially driven by factors outside of the Trust's control, including increases in late referrals from other providers and delayed reporting of histopathology results following the transfer of the service to North Bristol Trust (NBT). However, histopathology reporting times have started to improve, and as forecast, August's performance is expected to represent a significant improvement on recent months.

There were more changes in performance against the range of quality indicators that sit within the Trust's Summary scorecard, than we have seen in recent months. These included an increase in dissatisfied complainants, but an improvement in our responsiveness to deteriorating patients as measured by the National Early Warning Scores (NEWS). Underlying performance against the full range of Quality indicators continues to be good, with many core indicators such as the Safety Thermometer measure of Harm Free Care, pressure ulcers and falls rates, and omitted doses of critical medication, continuing to perform well within the targets set. Performance against the range of measures of the management of Fracture Neck of Femur patients, continue to be disappointing but remain the focus of significant attention.

System pressures continue to provide context to the current workforce challenges, especially bank and agency spend and considerable focus is being placed on the reasons and necessity for each band and agency shift. There remains a strong internal focus on recruitment and retention of staff, in order to stay responsive to rising demand. We continue to work in partnership with other organisations within the community to mitigate these system risks, and improve the responsiveness of the Trust's services.

Performance Overview

External views of the Trust

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

Care Quality Commission

Ratings for the main University Hospitals Bristol NHS Foundation Trust sites

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

NHS Choices

Website

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

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

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

NHS Improvement Risk Assessment Framework

For the quarter to date the Trust is not achieving five of the standards in the NHS Improvement 2016/17 Risk Assessment Framework, as shown in the table below. Of these five standards, the 31-day subsequent surgery drug therapy cancer waiting times standard is, however, forecast to be met for the quarter as a whole.

Overall the Trust has a Service Performance Score of 3.0 against Monitor's Risk Assessment Framework, including the two 62-day cancer waiting times standards which are scored as a single standard. Although the A&E 4-hour standard and 62-day standards continue to not be met, Monitor restored the Trust to a GREEN risk rating in quarter 1 2015/16, following its review of actions being taken to recover performance against the RTT, Cancer 62-day GP and A&E 4-hour standards and an acceptance of the factors continuing to affect Trust performance, which are outside of its control.

NHS Improvement Risk Assessment Framework - dashboard

Number	Target	Weighting	Target threshold	Reported Year To Date	Risk Assessment Framework					Q2 Forecast	Notes	Q2 Forecast Risk Assessment Risk rating
					Q2 15/16	Q3 15/16	Q4 15/16*	Q1 16/17*	Q2 16/17*			
1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	3	✓	✓	✓	✓	1**	✓	Limit to the end of Q4 = 45 cases	Achieved
2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	98.1%	✓	✓	✓	✓	97.5%	✓	31-day drug therapy forecast to be met for the quarter as a whole.	Achieved
2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	91.6%	✓	✓	✓	✖	95.1%	✓		
2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	97.4%	✓	✓	✓	✓	96.1%	✓		
3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	72.8%	✖	✖	✖	✖	78.9%	✖	62-day GP standard lower than expected in July due to late referrals and histopathology delays.	Not achieved
3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	51.1%	✖	✖	✖	✖	57.9%	✖		
4	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	91.9%	Not achieved	Not achieved	Achieved	Achieved	91.2%	✖		Not achieved
5	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	95.9%	✓	✓	✓	✖	97.4%	✓		Achieved
6a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	94.5%	✓	✓	✓	✓	94.6%	✓		Achieved
6b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		
7	A&E Total time in A&E 4 hours	1.0	95%	89.5%	✖	✖	✖	✖	89.7%	✖	95% standard not achieved but trajectory met.	Not achieved
8	Self certification against healthcare for patients with learning disabilities (year-end compliance)	1.0	Agreed standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met		Achieved
	CQC standards or over-rides applied	Varies	Agreed standards met	None in effect	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		Achieved
				Risk Rating	GREEN	GREEN	GREEN	GREEN	To be confirmed	Triggers further investigation		

Please note: If the same indicator is failed in three consecutive quarters, a trust will be put into escalation and Monitor will investigate the issue to identify whether there are any governance concerns. For A&E 4-hours, escalation will occur if the target is failed in two quarters in a twelve-month period and is then failed in the subsequent nine-month period or for the year as a whole.

***Q2 Cancer figures based upon confirmed figures for July, and draft figures for August.**
**** August C. diff cases still subject to commissioner review, but within limit**

3.0
To be confirmed (see narrative)

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:

GREEN to RED:
- Length of stay
- Referral to Treatment Times

AMBER to RED
- Complaints response

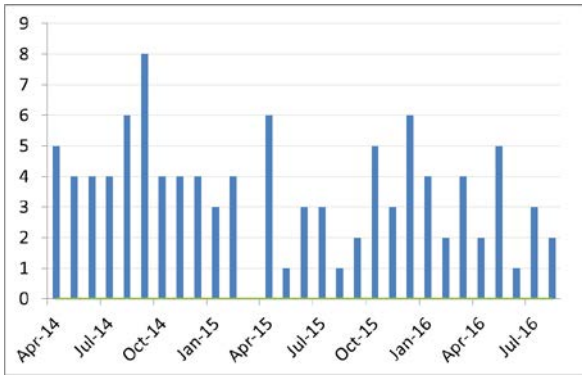
RED to GREEN:
- Cancelled operations

RED to AMBER:
- Deteriorating patient

Overview

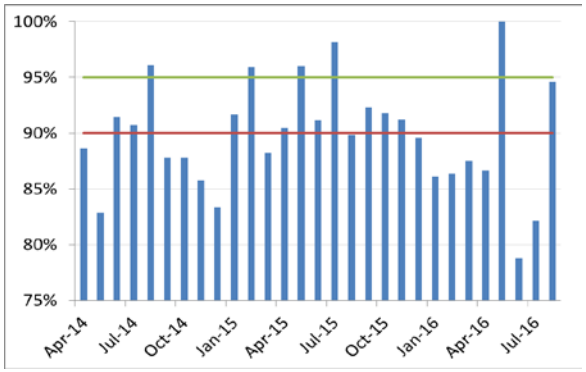
The following summarises the key successes in August 2016, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 2 2016/17.

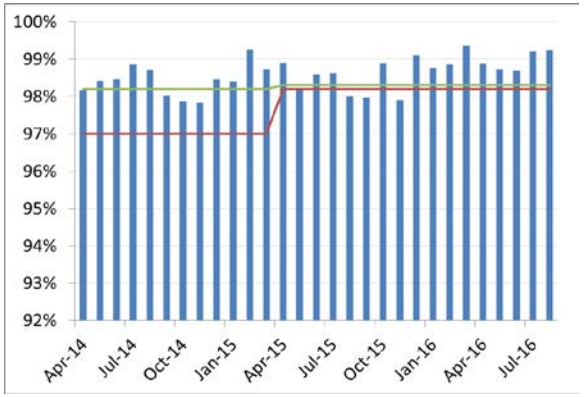
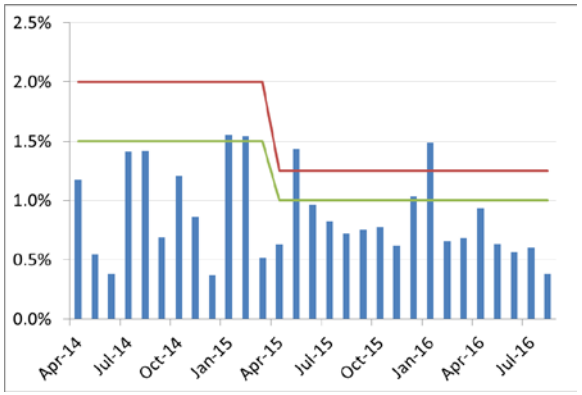
Successes	Priorities
• Non-purposeful omitted doses of critical medicines reduced to 0.38% (4 out of 1054 patients reviewed); • Turnover rates in Specialised Services have been steadily reducing; a year ago it was the Division with the highest turnover at 16.7%, and it is now the lowest at 11.4%; • Percentage of last minute cancelled operations reduced to 0.46%, significantly below the 0.8% national standard.	• Improvement in care of patients with fractured neck of femur, including timeliness to theatre; • Reduction in the percentage of complaints responses with which the complainant was dissatisfied from 16.67% (7 out of 42 of responses); • Continued focus on the reduction of staff turnover and vacancies with the development of action plans to support the achievement of the 2016/17 KPIs; • Reduction in the number of patients waiting over 18 weeks Referral to Treatment (RTT), by delivering additional activity in September and October; • Continued improvement in performance against the 62-day GP cancer waiting times standard; • Implementation of a recovery plan for restoring performance against the 6-week wait diagnostic standard by the end of October if possible.
Opportunities	**Risks & Threats**
• In addition to a range of actions already in place, we are commissioning a focus group to better understand the issues and human factors that prevent escalation and response in accordance with protocol for a small number of deteriorating patients. Performance in August was 94.6% (2 breaches out of 37 deteriorating patients out of 575 adult patients reviewed) ; • A physiotherapist, an Associate Counsellor and Clerical support have been recruited to support achievement of the well-being CQUIN and sickness KPI.	• Mortality alerts regarding coronary atherosclerosis are under continuing investigation; • Changes in the requirements to achieve compliance in Information Governance and Fire Safety means levels have reduced. A recovery trajectory has been developed; • The continued rise in waiting lists due to an increase in outpatient referrals will make recovery of the 92% RTT national waiting times standard more challenging; • Delays in histopathology reporting, following centralisation of the service at North Bristol Trust, continues to impact on performance against the cancer waiting times standards.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Infection control
The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16).</td>
<td>There were three case of Clostridium difficile (C. diff) attributed to the Trust in August. These were attributed to the Division of Surgery, Head & Neck and the Division of Specialised Services.
<table>
<tr><th></th><th>C. difficile</th></tr>
<tr><td>Medicine</td><td>0</td></tr>
<tr><td>Surgery, Head and Neck</td><td>2</td></tr>
<tr><td>Specialised Services</td><td>1</td></tr>
<tr><td>Women’s & Children’s</td><td>0</td></tr>
</table>
</td>
<td>Total number of C. diff cases
 

A total of 13 cases (unavoidable + avoidable) have been reported in the year to date against a limit of 45 for April 2016 to March 2017.</td>
<td>The annual limit for the Trust for 2016/17 is 45 avoidable cases. The monthly assessment of cases continues with the Clinical Commissioning Group. The total number of cases to date attributed to the Trust is thirteen. Seven cases have been assessed as unavoidable, and three cases assessed as avoidable. Three cases are still to be assessed.
There have been no MRSA bacteraemia cases attributed to the Trust to date since August 2015.</td>
</tr>
<tr>
<td>Deteriorating patient
National early warning scores (NEWS) acted upon in accordance with the escalation protocol (excluding paediatrics). This is an area of focus for our Sign up to Safety Patient Safety Improvement Programme. Our three year goal is sustained improvement above 95%.</td>
<td>Performance in August was 94.6% (two breaches) against a three year improvement goal of 95%. This is an improvement on the score for July (82%).
Reasons for the breaches are:

One patient should have had their observations re-checked within 4 hours, but this did not occur;
One patient was escalated by the nurses, but without response from the relevant medical team; the observations should have been repeated within one hour, but this was not done until two hours later.

</td>
<td>Deteriorating patient: percentage of early warning scores acted upon
 
</td>
<td>One breach occurred in the Division of Medicine and one in the Division of Surgery, Head & Neck. Neither patient came to any harm. Work continues in the deteriorating patient work stream of our patient Safety Improvement Programme and is reported in detail to the Programme Board.
Details of the actions being taken are described in the actions section (Actions 1A to 1E).</td>
</tr>
</table>

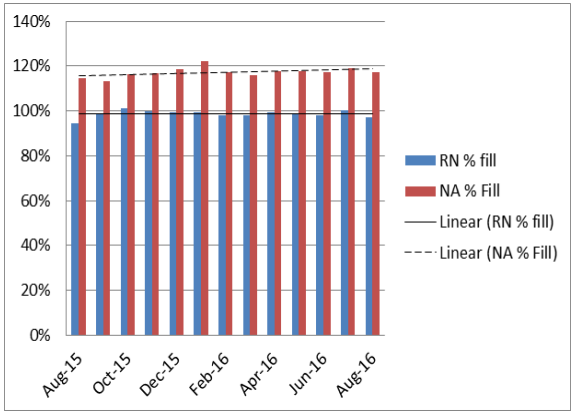
Description	Current Performance	Trend	Comments
Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.	In August 2016, the percentage of patients with no new harms was 99.2%, against an upper quartile target of 98.26% (GREEN threshold) of the NHS Improvement patient safety peer group of trusts	**The percentage of patients surveyed showing No New Harm each month** 	The August 2016 Safety Thermometer point prevalence audit showed two new catheter associated urinary tract infections, three falls with harm, no new pressure ulcers and one incidence of a new venous thrombo-emboli.
Non-purposeful omitted doses of listed critical medicines Monthly audits by pharmacy incorporate a review of administration of critical medicines: insulin, anti-coagulants, Parkinson's medicines, injected anti—infectives, anti-convulsants, short acting bronchodilators and 'stat' doses.	In August 2016, 0.38% of critical medications were omitted. This is similar to the previous month's figure of 0.6%, and below the target 1% on average for the year to date (0.65%). The 0.38% for August relates relate to 4 patients who had a non-purposeful missed / omitted dose of the listed critical medication in the 3 days prior to prescription review in the month, from a review of 1054 patients. All omitted doses were on different wards.	**Percentage of omitted doses of listed critical medicines** 	Reasons for omissions were as follows: for two patients the drug was not on ward at the time, for one patient the dose was unintentionally omitted and for one patient the reason is unknown. Actions being taken are described in the actions section (Actions 2A and 2B)

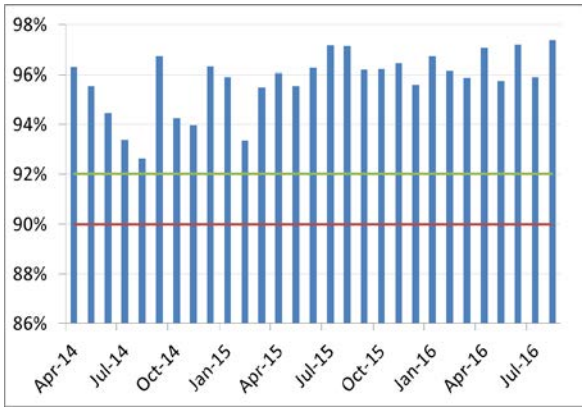
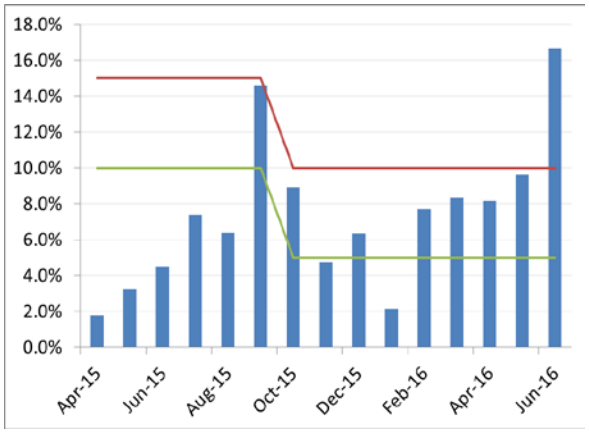
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Achievement of the Green threshold for this indicator depends on all five categories of Essential Training achieving 90%. Overall compliance is 84.7% (excluding Child Protection Level 3). Compliance with each of the new reporting categories is provided below.

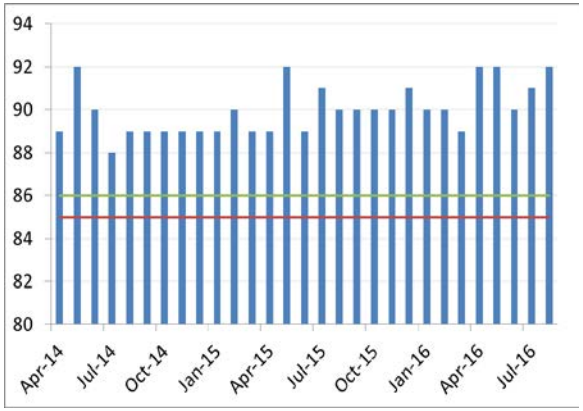
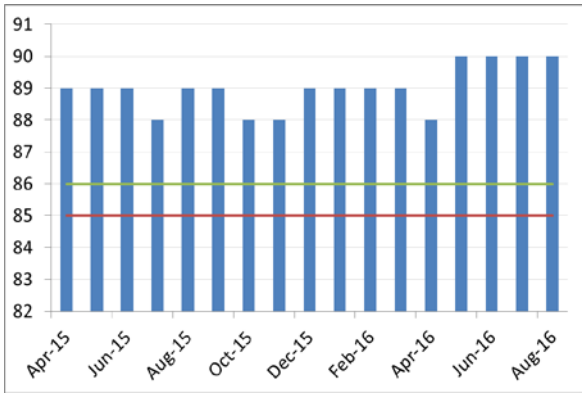
<table>
<tr><th>August 2016</th><th>UH Bristol</th></tr>
<tr><td>Total</td><td>85%</td></tr>
<tr><td>Three Yearly (14 topics)</td><td>85%</td></tr>
<tr><td>Annual (Fire & IG)</td><td>67%</td></tr>
<tr><td>Induction</td><td>94%</td></tr>
<tr><td>Resuscitation</td><td>77%</td></tr>
<tr><td>Safeguarding</td><td>86%</td></tr>
</table>
</td>
<td>There are four graphs included in Appendix 2 which show the performance for Fire and Information Governance (IG), which are the most challenged topics, against the new trajectories that have been set. It should be noted that the reporting for Fire has now been refined due to the changes in the training requirements, and is no longer comparable with previous months.</td>
<td>The reduction in overall compliance to 85% is associated with the way training is recorded for new starters. The new junior doctor intake is reflected in the target audience, but not in the training completed in their first month. If junior doctors were excluded from the target audience, compliance would be 86.7%, compared with 86.6% last month.

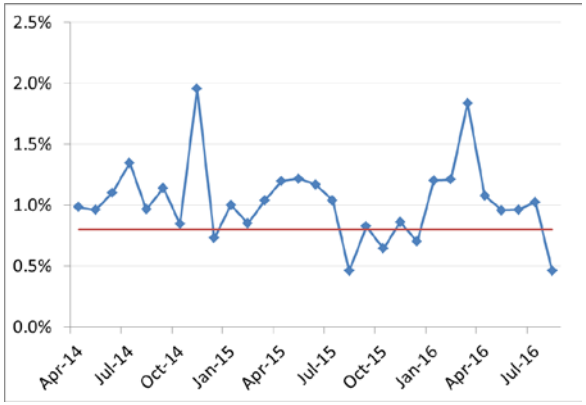
Action plan 3 provides details of the ongoing work to achieve compliance across all topics.</td>
</tr>
<tr>
<td>Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.</td>
<td>The report shows that in August the Trust had rostered 224,446 expected nursing hours, with the number of actual hours worked of 230,579.

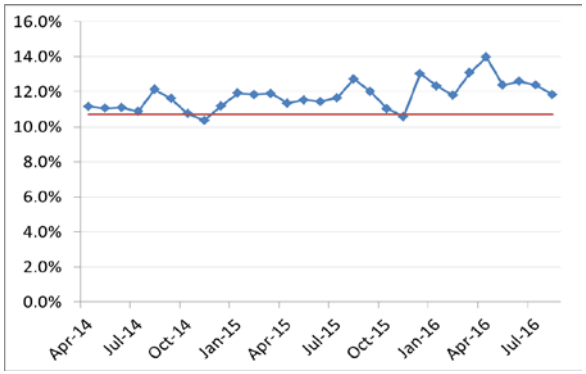
This gave a fill rate of 102.7%

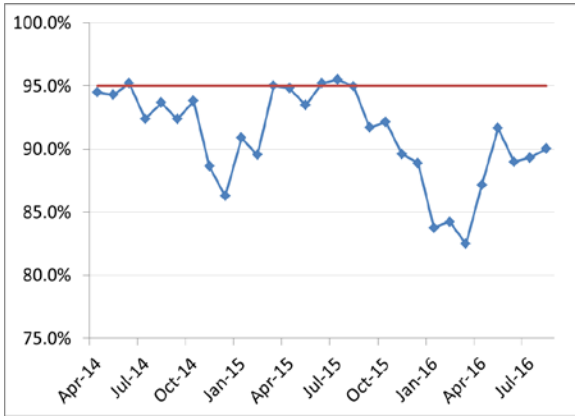
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>67,056</td><td>61,584</td><td>+5,472</td></tr>
<tr><td>Specialised Services</td><td>41,443</td><td>40,187</td><td>+1256</td></tr>
<tr><td>Surgery Head & Neck</td><td>45,237</td><td>42,660</td><td>+2,587</td></tr>
<tr><td>Women’s & Children’s</td><td>76,843</td><td>80,016</td><td>-3173</td></tr>
<tr><td>Trust - overall</td><td>230,759</td><td>224,446</td><td>+6,133</td></tr>
</table>
</td>
<td>The percentage overall staffing fill rate by month
 
</td>
<td>Overall for the month of August 2016, the Trust had 97% cover for registered nurses on days and 98% registered nurse cover for nights. The unregistered nursing level of 115% for days and 121% for nights reflects the activity seen in August. This was due primarily to nursing assistant specialist assignments to safely care for confused or mentally unwell patients in adults. See also Action 4.</td>
</tr>
</table>

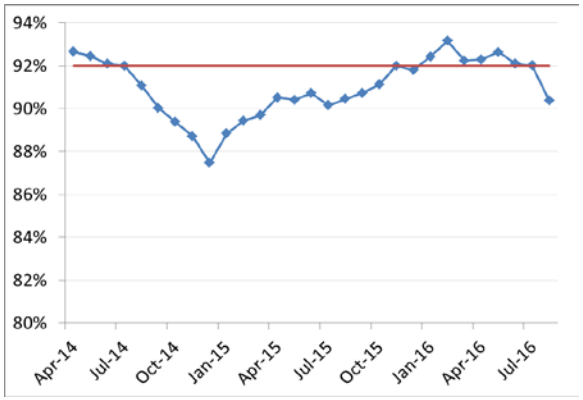
Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for August 2016 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. Division and hospital-level data is provided to the Trust Board on a quarterly basis and will be provided at the end of quarter 2.	**Inpatient Friends & Family scores each month** 	The scores for UH Bristol are in line with national norms. A very high proportion of the Trust's patients would recommend the care that they receive to their friends and family. These results are shared with ward staff and are displayed publically on the wards. Division and hospital-level data is provided to the Trust Board and is explored within the Quarterly Patient Experience report.
Dissatisfied Complainants. By October 2015 we are aiming for less than 5% of complainants to report that they are dissatisfied with our response to their complaint by the end of the month following the month in which their complaint response was sent.	Following an agreed change, dissatisfied cases are now measured as a proportion of complaints responses and reported two months in arrears. This means that the latest data in the board dashboard is for the month of June 2016. Performance for June was 16.67% against a green target of 5%. As of 14th September, seven of the forty-two complaints responses sent out in June had resulted in dissatisfied replies. Four cases were for the Division of Women & Children, two were for the Division of Surgery, Head & Neck and one was the Division of Specialised Services.	**Percentage of compliantaints dissatisfied with the complaint response each month** 	Our performance for 2015/6 was 6.15% compared with 11.19% in 2014/15. Informal benchmarking with other NHS Trusts suggests that rates of dissatisfied complainants are typically in the range of 8% to 10%. Actions continue as previously reported to the Board (Actions 5A to 5C).

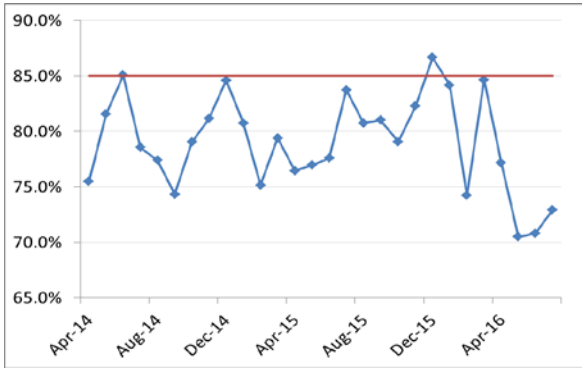
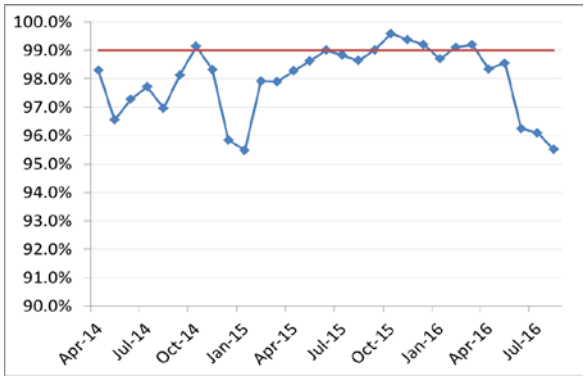
Description	Current Performance	Trend	Comments
Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as "key drivers" of patient satisfaction via analysis and focus groups.	For the month of August, the score was 92 out of a possible score of 100. Divisional scores are broken down for Q1 below. Trust: Q4 2015/2016 = 90; Q1 2016/2017 = 90 Medicine: 86; 87 Surgery, Head & Neck: 92; 92 Specialised Services: 91; 92 Women's & Children's (Bristol Royal Hospital for Children): 91; 92 Women's & Children's Division (Postnatal wards): 90; 90	**Inpatient patient experience scores (maximum score 100) each month** 	UH Bristol performs in line with national norms in terms of patient-reported experience. This metric would turn red if patient experience at the Trust began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the score remains green. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report.
Outpatient experience tracker comprises four scores from the Trust's monthly survey of outpatients (or parents of 0-11 year olds): 1) Cleanliness 2) Being seen within 15 minutes of appointment time 3) Being treated with respect and dignity 4) Receiving understandable answers to questions.	The score for the Trust as whole was 90 in August 2016 (out of score of 100). Divisional scores are broken down at the end of each quarter as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful. Trust: Q4 2015/2016 = 89; Q1 2016/2017 = 90 Medicine: 87; 93 Specialised Services: 88; 85 Surgery, Head & Neck: 88; 87 Women's & Children's (Bristol Royal Hospital for Children): 86; 80 Diagnostics & Therapies: 94; 94	**Outpatient Experience Scores (maximum score 100) each month** 	UH Bristol performs in line with national norms in terms of patient-reported experience. This metric would turn red if outpatient experience at UH Bristol began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the Trust score remains green. Divisional scores are examined in detail in the Trust's Quarterly Patient Experience Report.

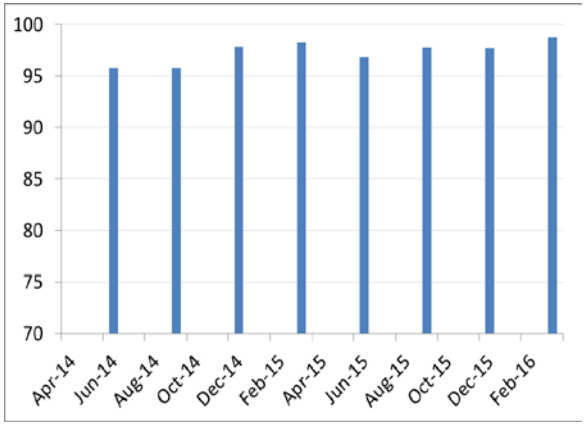
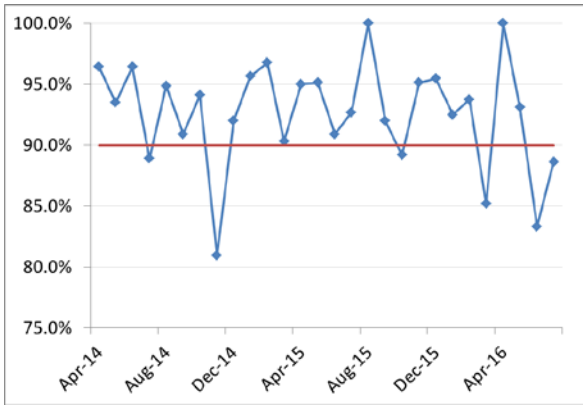
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In August the Trust cancelled 30 (0.46% of) operations at last-minute for non-clinical reasons. The reasons for the cancellations are shown below:
<table>
<tr><th>Cancellation reason</th><th></th></tr>
<tr><td>Emergency patient prioritised</td><td>8 (27%)</td></tr>
<tr><td>No HDU/ITU bed available</td><td>7 (23%)</td></tr>
<tr><td>Lack of time</td><td>5 (17%)</td></tr>
<tr><td>No Cardiac Intensive Care staff</td><td>4 (13%)</td></tr>
<tr><td>No ward bed available</td><td>3 (10%)</td></tr>
<tr><td>Other causes (2 different breach reasons - no themes)</td><td>3 (10%)</td></tr>
</table>
Three patients cancelled in July were readmitted outside of 28 days due to emergency pressures and other patients taking priority. This equates to 95.2% of cancellations being readmitted within 28 days, which is above the former national standard of 95%.</td>
<td>Percentage of operations cancelled at last-minute
 

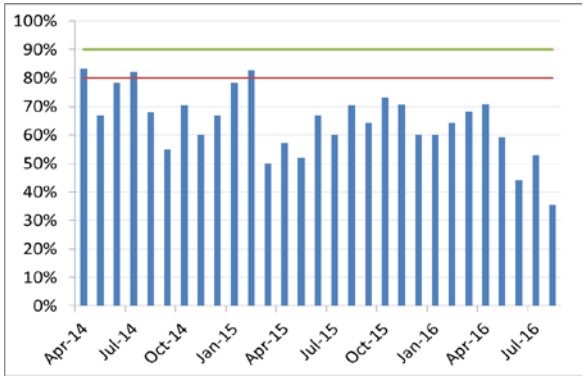
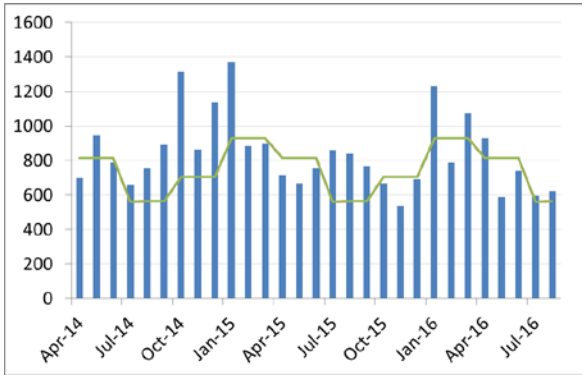
National 0.8% standard is currently forecast to be achieved again in September.</td>
<td>Emergency pressures continues to be the predominant cause of cancellations this month, with emergency patients needing to be prioritised and a lack of High Dependency / Intensive Therapy Unit beds (due to these being occupied by emergency patients), making-up 50% of all cancellations. An action plan to reduce elective cancellations continues to be implemented (Actions 6A and 6B). However, please also see actions detailed under A&E 4 hours (8A to C) and outlier bed-days (13A to B).</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 August 11.8% of outpatient appointments were cancelled by the hospital, which is similar to the level of performance reported for the last three months.
The Patient Administration System has a large number of different reasons for cancellation which can be selected by users. This creates confusion and impacts on the consistency of reporting of causes of cancellation. For this reason the list of cancellations reasons has been simplified and is in the process of being piloted in the test environment, prior to being implemented in Medway before the end of September.</td>
<td>Percentage of outpatient appointments cancelled by the hospital
 
</td>
<td>Ensuring outpatient capacity is effectively managed on a day-to-day basis is a core part of the improvement work overseen by the Outpatients Steering Group. The improvement plan for this key performance indicator was recently refreshed, prioritising those actions that are likely to reduce the current underlying rate of cancellation by the hospital (Actions 7A to D).</td>
</tr>
</table>

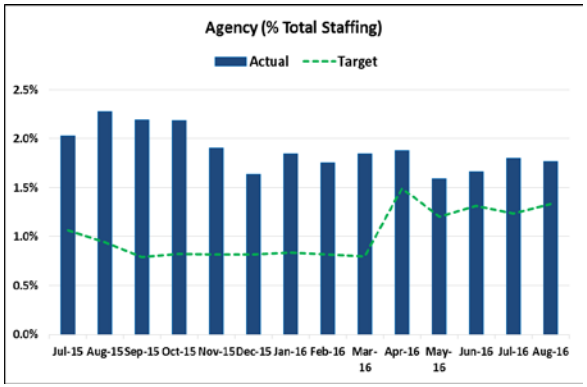
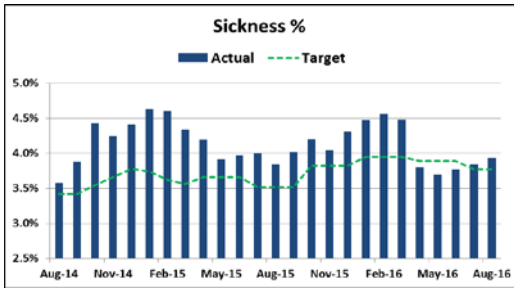
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% national standard was not achieved in August. However, performance at 90.0% was better than trajectory (88.4%). Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Aug 2015</th><th>Jul 2016</th><th>Aug 2016</th></tr>
<tr><td>Attendances</td><td>5529</td><td>5785</td><td>5723</td></tr>
<tr><td>Emergency Admissions</td><td>1702</td><td>1891</td><td>1889</td></tr>
<tr><td>Patients managed < 4 hours</td><td>5166
93.4%</td><td>4844
83.7%</td><td>4791
83.7%</td></tr>
<tr><th>BCH</th><th>Aug 2015</th><th>Jul 2016</th><th>Aug 2016</th></tr>
<tr><td>Attendances</td><td>2547</td><td>3395</td><td>2655</td></tr>
<tr><td>Emergency Admissions</td><td>718</td><td>874</td><td>661</td></tr>
<tr><td>Patients managed < 4 hours</td><td>2419
95.0%</td><td>3177
93.6%</td><td>2583
97.3%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments
 

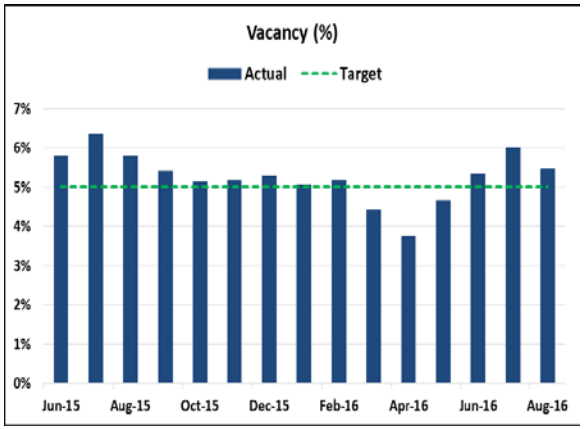
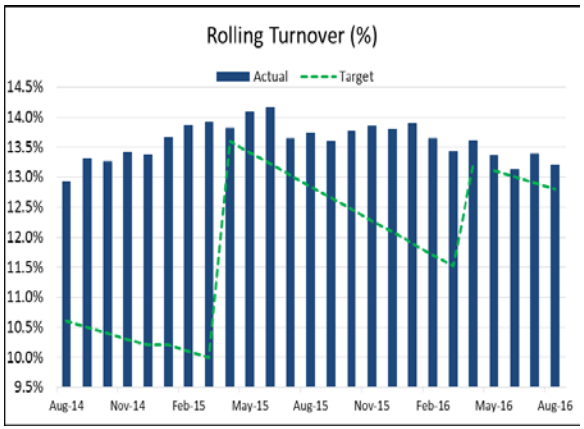
Trajectory of 92.2% not forecast to be met in September, due to a rise in delayed discharges and patients aged 75 years + being admitted.</td>
<td>Levels of emergency admissions into the BRI were 11.0% higher in August than in the same period in 2015. The number of patients on the Green to Go (delayed discharge) list increased from 52 at the end of July to 69 at the end of August. However, BRI bed occupancy remained at the lower level similar to that seen in July, which allowed 4-hour performance to be maintained above trajectory. Actions continue to be taken to manage demand and to reduce delayed discharges (Actions 8A to 8C).</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 achieved at the end of August, with the Trust reporting 90.5% of patients waiting less than 18 weeks at month-end. There was a significant increase in the number of patients waiting over 18 weeks on a non-admitted pathway (see Appendix 3).
The number of patients waiting over 40 weeks RTT at month-end increased in August, against the trajectory of zero.
<table>
<tr><th></th><th>Jun</th><th>Jul</th><th>Aug</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>14</td><td>27</td><td>33</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>0</td><td>0</td><td>0</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 
</td>
<td>The level of outpatient demand seen in recent months could not be met, which resulted in a failure to meet the 92% standard at the end of August. A recovery plan has been developed. Delivery of the RTT trajectories is monitored weekly, with significant variances from plan escalated to Divisional Directors. The weekly RTT Operational Group oversees the management of longest waiting patients (Action 9).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.	The Trust reported performance of 72.9% against the 85% 62-day GP standard in July. This is below the agreed performance trajectory for the month of 84.7%. Performance against the 90% 62-day screening standard was 66.7%. The main reasons for failure to achieve the 85% national 62-day GP standard are shown below. **Breach reason** / **Jul 16** Late referral by/delays at other provider: 9.5 Medical deferral/clinical complexity: 5.0 Histopathology delay: 3.0 Outpatient appointment delay: 3.0 Administrative/pathway tracking issue: 1.5 Delayed admitted diagnostic procedures: 1.0 **TOTAL**: **23.0**	**Percentage of patients treated within 62 days of GP referral**  There were 1.5 breaches of the 62-day screening pathway out of 4.5 patients treated. The breach reasons were: patient choice (1.0) and delayed admitted diagnostic (0.5).	Performance continues to be impacted by very high levels of late referrals, medical deferrals, and histopathology reporting delays, following the transfer of the service to NBT. Performance is, however, expected to improve for August, to circa 82%. Timescales for tertiary referral are included in a local CQUIN for 2016/17, with automatic breach reallocation for late referral. An improvement plan continues to be implemented to minimise avoidable delays (Action 10A to 10B).
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.	The 99% national standard was not achieved at the end of August, with reported performance 95.5% against the recovery trajectory of 95.2%. The number and percentage of over 6-week waiters at month-end, is shown below: **Diagnostic test** / **Jun** / **Jul** / **Aug** MRI: 49 / 17 / 7 Ultrasound: 25 / 9 / 23 Sleep: 47 / 47 / 86 Endoscopies: 130 / 223 / 208 Audiology: 30 / 9 / 12 Echo: 43 / 17 / 16 Other: 1 / 9 / 4 **TOTAL**: **325** / **331** / **356** Percentage: **96.3%** / **96.1%** / **95.5%** Recovery trajectory: 95.2%	**Percentage of patients waiting under 6 weeks at month-end**  Achievement of the 99% standard is at risk for the end of September, with potential, although not certain, recovery for the end of October.	Although the number of patients waiting over 6 weeks for a diagnostic test increased between July and August, performance was better than the recovery trajectory. The 99% standard was achieved for all except four types of tests (endoscopy, sleep studies, echo and audiology tests). The number of patients waiting over 6 weeks is expected to reduce by circa 60 by the end of September. A recovery plan continues to be enacted. (Action 11A to 11C).

Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator is the ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors. This is nationally published quarterly, six months in arrears.	Summary Hospital Mortality Indicator (SHMI) for March 2016 was 98.7. As reported last month, further discussions have taken place regarding mortality reporting and the impact of periodic rebasing. It has been agreed that we will report national SHMI which is available quarterly, but six months in arrears, and is rebased every publication providing a more accurate indication of our comparative mortality rates. Threshold have been set on the following basis: Red = SHMI above 100 and Lower Confidence Interval above 100 Amber = SHMI above 100 but Lower Confidence Interval below 100 Green = SHMI below 100	**Summary Hospital Mortality Indicator (SHMI) for in hospital deaths each month** 	Our overall performance continues to indicate that fewer patients died in our hospitals than would have been expected given their specific risk factors. The Quality Intelligence Group continues to conduct assurance reviews of any specialties that have an adverse SHMI score in a given quarter. Coronary atherosclerosis alerts remain under investigation. 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 July (latest data), 39 out of 44 patients (88.6%) were treated within 90 minutes of arrival in the hospital. Performance for the year as a whole, however, remains above the 90% standard at 91.4%.	**Percentage of patients with a Door to Balloon Time < 90 minutes by month** 	Routine monthly analysis of the causes of delays in patients being treated within 90 minutes continues. No common themes were identified in July.

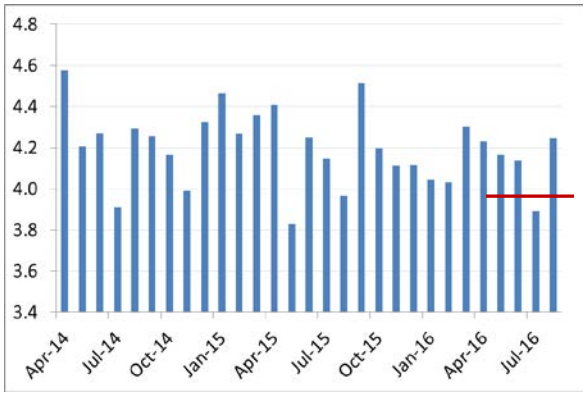
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In August 2016 we achieved 35.5% (11/31 patients) overall performance in Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 61.3% (19/31 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number</th></tr>
<tr><td>Lack of theatre capacity</td><td>Eight patients. Only two went to theatre within 48 hrs.</td></tr>
<tr><td>Fracture not revealed on first X-Ray</td><td>One patient. Initial x-ray did not report a fracture. Patient had CT scan which showed an un-displaced fracture</td></tr>
<tr><td>Need for specialist surgeon</td><td>One patient needed a specialist hip surgeon who was not covering the trauma list that day</td></tr>
<tr><td>Not medically fit</td><td>Two patients needed cardiology medical optimisation</td></tr>
</table>
</td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.
 
</td>
<td>Nine patients did not receive an ortho-geriatrician review due to annual leave. One patient was not reviewed because they had not been clerked when the ortho-geriatrician came to review them, and one patient was in X-ray when the ortho-geriatrician came to review them. The ortho-geriatrician was not available again with 72 hours. Actions are being taken to establish a future service model across Trauma &Orthopaedics, and ensure that consistent, sustainable cover is provided (Actions 12A to 12D).</td>
</tr>
<tr>
<td>Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.</td>
<td>In August 2016 there were 622 outlier bed-days against a target of 563 outlier bed days. Performance deteriorated slightly by 26 bed-days from July, after a big improvement in June. A further slight improvement has been seen in Medicine, but a deterioration in Specialised Services with more cardiac patients outlying in Medicine due to pressures in this service.
<table>
<tr><th>Outlier bed-days</th><th>August 2016</th></tr>
<tr><td>Medicine</td><td>232</td></tr>
<tr><td>Surgery, Head & Neck</td><td>206</td></tr>
<tr><td>Specialised Services</td><td>172</td></tr>
<tr><td>Women's & Children's Division</td><td>12</td></tr>
<tr><td>Total</td><td>622</td></tr>
</table>
</td>
<td>Number of days patients spent outlying from their specialty wards
 
</td>
<td>In quarter 2 we have agreed a significantly reduced target which means that we have still narrowly missed achieving it, and although there has been some evidence of improved flow, occupancy has continued to run higher than planned, with continued demand on services across the summer.
Ongoing actions are shown in the action plan section of this report. (Actions 13A and 13B).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Agency usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2015/16. The red threshold is 10% over the monthly target.	Agency usage reduced by 1.3 FTE, but remained at 1.8% of total staffing. There was a slight increase in nursing usage (5.6 FTE), but this was offset by slight reductions in medical and administrative and clerical usage. **August 2016** / **FTE** / **Actual %** / **KPI** **UH Bristol** / **148.5** / **1.8%** / **1.2%** Diagnostics & Therapies / 6.4 / 0.7% / 0.7% Medicine / 38.7 / 3.0% / 2.3% Specialised Services / 23.0 / 2.4% / 1.6% Surgery, Head & Neck / 31.4 / 1.8% / 0.8% Women's & Children's / 19.8 / 1.0% / 0.6% Trust Services / 16.8 / 2.3% / 2.3% Facilities & Estates / 12.5 / 1.5% / 1.3%	**Agency usage as a percentage of total staffing by month** 	The agency action plans continue to be implemented and the headlines are in the improvement plan (Action 14). A summary of compliance with agency caps is attached in Appendix 2.
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2015/16. The red threshold is 0.5% over the monthly target.	Sickness absence remained at 3.8% (target: 3.8%). Rates reduced in all Divisions except Diagnostics & Therapies, Facilities & Estates and Medicine. **August 2016** / **Actual** / **KPI** **UH Bristol** / **3.8%** / **3.8%** Diagnostics & Therapies / 2.8% / 2.7% Medicine / 5.2% / 4.6% Specialised Services / 3.7% / 3.7% Surgery, Head & Neck / 3.1% / 3.7% Women's & Children's / 3.8% / 3.5% Trust Services / 3.1% / 3.2% Facilities & Estates / 5.3% / 5.2%	**Sickness absence as a percentage of full time equivalents by month**  *Please note: Sickness data is refreshed retrospectively to capture late data entry, and to ensure the data are consistent with what we finally submit for national publication*	Action 15 describes the ongoing programme of work to address sickness absence.

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%.	Vacancies reduced from 6.0%, to 5.5% (452.7 FTE), largely due to reductions in medical and dental vacancies partly associated with the new intake of trainee doctors. There was little change in nursing vacancies, which remained the same as last month at 6.1%.	**Vacancies rate by month** 	The recruitment action plan is summarised in Action 16. Appendix 2 details progress in reducing specialist nursing vacancies where additional recruitment support has been provided. Ward D703, and Coronary Intensive Care Unit are close to trajectory. Heygroves Theatres have 9 Band 5 staff starting between August and October 2016, including cardiac scrub practitioners, which are particularly difficult to recruit.
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 11.5% by the end of 2015/16. The red threshold is 10% above monthly trajectory**.**	Turnover reduced from 13.4% to 13.2% in August. Turnover reduced in all Divisions except Trust Services and Women's & Children's. Rates in Specialised Services have steadily been reducing; a year ago it was the Division with the highest turnover at 16.7%, and is now the lowest at 11.4%.	**Staff turnover rate by month** 	Programmes to support staff recruitment remain a key priority for the Divisions and the Trust (Action 17).

August 2016	Rate
UH Bristol	**5.5%**
Diagnostics & Therapies	7.2%
Medicine	7.8%
Specialised Services	4.3%
Surgery, Head & Neck	6.9%
Women's & Children's	3.3%
Trust Services	3.3%
Facilities & Estates	5.0%

August 2016	Actual	Target
UH Bristol	**13.2%**	**12.8%**
Diagnostics & Therap.	11.7%	12.7%
Medicine	14.7%	13.9%
Specialised Services	11.4%	13.4%
Surgery, Head & Neck	14.3%	13.2%
Women's & Children's	12.1%	10.8%
Trust Services	15.2%	13.9%
Facilities & Estates	13.7%	13.8%

Description	Current Performance	Trend	Comments
Length of Stay (LOS) measures the number of days inpatients on average spent in hospital. This measure excludes day-cases. LOS is measured at the point at which patients are discharged from hospital.	In August the average length of stay for inpatients was 4.24 days, which is above the RED threshold. This is a 0.35 day increase on the previous month. At the end of August the number of Green to Go delayed discharges was higher than the same period last year, (60 in Aug 15, versus 69 in Aug 16), and also higher than the number at the end of July (52). The jointly agreed planning assumption of 30 patients continues to not be met. Last month the number of long stay patients discharged in the period was at the lowest level it had been for a year. It was therefore anticipated that Length of Stay would rise in August, as more of these patients were discharged.	**Average length of stay (days)**  Length of stay is forecast to remain above the RED threshold in September, due to an increase in delayed discharges, and also patients admitted who were 75 years and over.	Work to reduce delayed discharges and over 14 days stays continues as part of the emergency access community-wide resilience plan and additional exceptional actions being taken (Actions 8A to 8C and 13A to 13B).

Improvement Plan

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Safe					
Deteriorating patient Early warning scores for acted upon.	1A	Further targeted teaching for areas where NEWS incidents have occurred.	Commenced February 2016 and on-going	Monthly progress reviewed in the deteriorating patient work stream and quarterly by the Patient Safety Improvement Programme Board, Clinical Quality Group and Quality and Outcomes Committee	Sustained improvement to 95% by 2018.
	1B	Accessing doctor education opportunities to assist with resetting triggers safely	Commenced April 2016 and on-going	As above	Sustained improvement to 95% by 2018.
	1C	Convening of a focus group to further understand the reasons why nurses and doctors are unable to escalate or respond to escalation and address these accordingly. Also please see 1E below.	November 2016	As above	Sustained improvement to 95% by 2018.
	1D	Testing approach to point of care simulation training in adult general ward areas to address human factors elements of escalating deteriorating patients and use of structured communication.	September 2016 and on-going	As above	Sustained improvement to 95% by 2018.
	1E	Additional time allocated for patient safety in doctors'	From September 2016 and ongoing	As above	Sustained improvement to 95% by 2018.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		induction to train new appointees on resetting triggers safely and human factors awareness of escalation conversations.			
Non-purposeful omitted doses of critical medication	2A	Feedback detailed results to Heads of Nursing to follow up the four omitted doses	September 2016	Ensuring detailed focus is maintained to avoid omitted doses	Maintain current improvement and sustain performance below 1%
	2B	Trust-wide bulletin on medicines for Parkinson's disease. Information to be sent to Matrons for dissemination to ward staff.	October 2016	Highlight this issue and the drug availability.	Maintain current improvement and sustain performance below 1%
Essential Training	3	Continue to drive compliance including increasing e-learning.	Ongoing	Oversight by Workforce and OD Group via the Essential Training Steering Group	Divisional Trajectories show compliance by the end of March 2017.
		Detailed plans focus on improving the compliance of Safeguarding Resuscitation, Information Governance (IG) and Fire Safety.	Ongoing	Oversight of safeguarding training compliance by Safeguarding Board /Workforce and Organisational Development Group.	
		Newly developed trajectories for Fire and IG will be monitored at a divisional level at monthly and quarterly Performance and Operations meetings	September 2016 to March 2017.	Monthly and quarterly Divisional Performance Reviews.	
Monthly Staffing levels	4	Continue to validate temporary staffing assignments against agreed criteria.	Ongoing	Monitored through agency controls and action plan.	Action plan available on request.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Caring					
Dissatisfied complainants	5A	Response writing training continues to be rolled-out to Divisions	Ongoing	Completion of training signed-off by Patient Support & Complaints Team and Divisions.	Achieve and maintain a green RAG rating for this indicator.
	5B	Upon receipt of written response letters from the Divisions, there is a thorough checking process, whereby all letters are firstly checked by the case-worker handling the complaint, then by the Patient Support & Complaints Manager. The Head of Quality for Patient Experience & Clinical Effectiveness also checks a selection of response letters each week. All responses are then sent to the Executives for final approval and sign-off.	Ongoing	Senior Managers responsible for drafting and signing off response letters before they leave the Division are named on a Response Letter Checklist that is sent to the Executives with the letter. Any concerns over the quality of these letters can then be discussed individually with the manager concerned and further training provided if necessary.	
	5C	Dissatisfied responses are now routinely checked by the Head of Quality (Patient Experience & Clinical Effectiveness) to identify learning where appropriate. All cases where a complaint is dissatisfied for a second time are escalated to and reviewed by the Chief Nurse.	Implemented September 2015 and ongoing		
Last minute cancelled operations	6A	Continued focus on recruitment and retention of staff to enable all	Ongoing	Monthly Divisional Review Meetings;	Improvement to be evidenced by a reduction in cancellations

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		adult BRI ITU beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited and in post. Development and implementation of a strategy for managing ITU/HDU beds across general adult and cardiac units, to improve ability to manage peaks in demand.	To be confirmed – expected to be by quarter 4, when virtual ward up to full impact, relieving ward bed pressures	Relevant Steering Group to be confirmed, but likely to be Cancer Steering Group, due to the recent impact on cancer	in Q2. Achievement of quality objective on a quarterly basis.
	6B	Specialty specific actions to reduce the likelihood of cancellations.	Ongoing	Monthly review of plan with Divisions by Associate Director of Operations.	As above.
Outpatient appointments cancelled by hospital	7A	Review and revise cancellation reasons available on Medway to improve consistency of reporting and improve the Trust's understanding of the root cause of cancellations.	Review completed but testing of changes required – new deadline End of September	Changes approved through Change Board and Medway revised.	See action 7C
	7B	Produce summary analysis of first month's use of the new cancellation codes, and test the reasonableness of the target thresholds currently set. This analysis will include a break-down of the reasons for cancellation, and the percentage of cancellations that relate to patients being able to book on the national Electronic	End October	Report provided for Outpatient Steering Group;	Outpatient Steering Group to identify any new actions arising from this analysis, which may alter performance trajectory.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Referral Service, beyond the period of notification for annual leave.			
	7C	Select six highest hospital cancellation specialities and investigate reasons for cancellations with frontline staff and Performance & Operations Managers. Share learning with all over specialities via the Outpatient Steering Group.	End of September	Report provided for Outpatient Steering Group	Amber threshold expected to be achieved by the end of October.
	7D	Using the new cancellations codes set-up on Medway, confirm that no leave is being agreed within six weeks (or timescale locally agreed).	End of November	Report provided for Outpatient Steering Group	See action 6C

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Responsive					
A&E 4-hours	8A	Commissioner-led task and finish group established in January, and recently refresh, to understand drivers of increase in paediatric emergency demand and to identify possible demand management solutions.	Ongoing	Urgent Care Board	Achievement of recovery trajectory each month.
	8B	Delivery of internal elements of the community-wide resilience plan.	Ongoing	Emergency Access Steering Group	Achievement of recovery trajectory each month.
	8C	Working with partners to continue to mitigate shortfalls in social services provision and other causes of higher levels of delayed discharges. See also actions 12A to 12D relating to delayed discharges and flow.	Ongoing	Urgent Care Board	Achievement of recovery trajectory each month.
Referral to Treatment Time (RTT)	9A	Recovery plan to be developed, including actions to increase capacity, manage demand and improve adherence to correct administrative processes	End September	Oversight by RTT Steering Group	Reduction in over 18 week RTT pathways through to the end of December.
	9B	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory. Continued weekly review of management of longest waiting	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review meetings.	Reduction in over 18 week RTT pathways through to the end of December.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		patients through RTT Operations Group.			
Cancer waiting times	10A	Implementation of Cancer Performance Improvement Plan, including ideal timescale pathways, and reduced waits for 2-week wait appointments.	Ongoing	Oversight of implementation by Cancer Performance Improvement Group, with escalation to Cancer Steering Group.	Achieve monthly recovery trajectory submitted for quarter 3 2016/17
	10B	Escalate issues and seek assurance on North Bristol Trust's (NBT) plan to reduce delays in histopathology reporting post service transfer	Ongoing	Exec to Exec escalation complete; action plan provided.	NBT meeting the agreed Service Level Agreement standards (currently on track).
Diagnostic waits	11A	Increase adult endoscopy capacity by recruiting to the Nurse Endoscopist post, completing the in-house training of a nurse endoscopist, booking additional waiting list initiatives and sessions through Glanso, and outsourcing as much routine work as possible to a private provider through the contract which has recently been agreed.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Recovery of 99% standard by end of October.
	11B	GP with Specialist Interest undertaking additional Sleep Studies outpatient sessions (late June to September), to help address the bulge in demand; additional waiting list sessions also being undertaken.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	As above

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	11C	Establish additional sessions for Echo, Ultrasound and MRI.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Recovery of 99% standard for total Radiology (including Ultrasound and MRI) by end July (now achieved) and Echo by the end of September.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Effective					
Fracture neck of femur Best Practice Tariff (BPT)	12A	Live flow tracker in situ across Division from June to increase visibility and support escalation standards.	Ready to trial in February with full implementation in June 2016 (deadline revised again from April 2016 to October 2016)	Inclusion of three new fields to include all trauma patients waiting without a plan, all fractured Neck of Femur (NOF) patients waiting, and all fractured NOF patients over 24 hours. IM&T needs to build a new system in order to be able to retrieve this information into the live tracker. Deadline slipped. Ongoing project in IM&T.	Improve in overall fractured neck of femur pathway
	12B	Review and prioritise/action the recommendations of the British Orthopaedic Association (BOA) Fractured Neck of Femur mortality review (review took place 10/11 May 2016 – awaiting report due within 3 weeks). Assess potential causes and mitigating actions for increased Fractured Neck of Femur mortality	End of September 2016	Identifiable actions to take to improve the fracture NOF service for patients which is likely to lead to improved Best Practice Tariff performance	Final report received and an action plan to address the recommendations is under development.
	12C	Build and submit case for middle grade medical ortho-geriatric support (1.0 WTE 1-year fixed term with focus on quality/pathway work relating to Fractured Neck of Femur). This will enable consistent and regular ortho-geriatric cover across orthopaedic wards, and	September 2016	Successful funding bid and subsequent recruitment to post.	Being worked up – but expected to be influenced by the recommendations in the final BOA report. Agreement to fund has been provided by the Division of Surgery.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		avoid breaches due to annual leave etc.			
	12D	Build and submit case for specialist acute fracture nurse support (Band 6 permanent).	April 2017	Successful funding bid and subsequent recruitment to post.	Being worked up – but expected to be influenced by the recommendations in the final BOA report. Expected to form part of investment proposal for the 2017/18 operating plan.
Outlier bed-days	13A	Reduce demand on beds to support optimal occupancy. Range of initiatives in place to reduce demand for acute services. Limited impact to and further significant initiative now being pursued – community virtual ward.	Ongoing Working to Q4	Oversight in fortnightly Urgent Care Working Group Urgent Care Working Group and System Resilience Group	Maintain modelled occupancy of 90% Increased use of virtual ward for appropriate patients
	13B	Ward processes to increase early utilisation of discharge lounge to facilitate patients from Acute Medical Unit getting into the correct speciality at point of first transfer.	Ongoing	Oversight in Ward Processes Project Group	Linked to increased and timely use of discharge lounge

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Efficient					
Agency Usage	14	Corporate actions to directly target agency expenditure (in addition to sickness absence, recruitment and turnover actions – see section 14,15 and 16) are detailed below:		Nursing agency: oversight by Savings Board through its sub group (Nursing Controls Cost Improvement Group). Medical agency: oversight through the Medical Efficiencies Group.	An annual workforce KPI of 1.1% for agency as a percentage of total staffing was agreed through the operating planning process. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance reviews.
		Effective rostering: To reduce "lost time" - currently above funded establishment - ensuring annual leave, study leave, and sickness are planned and monitored appropriately. Actions include:			
		• Planning rosters six weeks in advance	Ongoing		
		• Procurement of new rostering system with integrated acuity and dependency system to enable staff to be moved to areas of greatest need	Pilot new system November 2016, go live April 2017		
		• Pending the new rostering system, a staffing dashboard provides a cross trust overview of inpatient staffing	June 2016 to April 2017		
		Controls: • Robust Escalation policy with clear sign off process and flow chart of questions to be asked	Ongoing		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		before resorting to agency			
		• Operating plan agency trajectories monitored and tracked through divisional reviews	Monthly and quarterly reviews		
		Enhancing bank provision: • Internal and external local marketing to develop an increased pool of bank nurses	Ongoing		
Sickness Absence	15	**A dedicated lead**: To develop a sickness absence management plan: • Reviewing current strategies and develop impact assessment measures; • Making further recommendations, supported by an action plan. Current actions include:	Lead in post and paper to go to Senior Leadership Team in September 2016.	Oversight by Workforce and Organisational Development (OD) Group via the Staff Health and Well Being Sub Group	A KPI for 2016/17 of 3.9% has been set through the operating planning process.
		Pilot of self-certification for absences of 1-3 days: Targets the 11% of sickness which is for 3 days or less, and ensuring timely return to work interviews are undertaken.	To be spot audited in Q2 16/17		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Supporting Attendance Policy: • Audit Action plan to be implemented; • Full review of policy including simplifying content/ structure, sign-posting and tools to assess attendance.	September 2016 to March 2017 January 2017		
		Training for managers: Training review complete to ensure training meets the needs of managers and achieves improved competence/confidence	To commence January 2017		
		Resource allocation: Ensuring that the Employee Services resource is focussed appropriately and targeted at areas of greatest need.	Ongoing		
		Supporting Attendance Surgeries: Process to be reviewed as part of policy review in Q2. To support managers to expedite cases where possible	Ongoing		
		Musculo-skeletal: As a significant cause of absence, targeted actions include continued interventions by Occupational Health Musculo-skeletal services, Physio direct, and Manual Handling Team	Ongoing		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Staff Health and Well Being: Annual action plan, including the following: • Free on site health checks - target of reaching 2000 staff; • Combined back care week and staff health and wellbeing week.	January 2016 to January 2018 October 2016		
		Flu Vaccination: A communications plan has been developed and Costa/ Deli Marche in BRI and SBCH are funding a free drinks voucher for all staff who have been vaccinated by the 100+ vaccinators in UH Bristol.	Campaign October 2016 to February 2017		
		Staff Health and Well Being CQUIN: Implementation plan has been developed, focussed on improving health and wellbeing. Three posts to assist in delivery of CQUIN agreed – already successfully recruited a physiotherapist and Associate Counsellor with recruitment to Admin and Clerical support pending.	October 2017 (Peer review Bristol Clinical Commissioning Group) Funded until March 2017	CQUIN short term working group	
Vacancies	16	Recruitment action plan includes the following activities.		Workforce and OD Group /Recruitment Sub Group.	Detailed trajectories are in place for key recruitment

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Marketing and advertising: • Divisional Performance and Operations Meetings monitor performance against operating plan requirements and ongoing vacancies.	Review quarterly		hotspots, including theatres; critical care, haematology and ancillary staff
		• Marketing activity plans focused on hard to fill posts including nursing and midwifery is in development. An activity schedule, completed in August, will continue to be adjusted to respond to demand. • An overview of the impact of the Marketing Plan on vacancies will be provided to Trust Board	Ongoing October 2016	Divisional Performance and Operational Reviews	
		Service level agreements and KPIs for recruitment have been developed to measure performance and support improvement. The agreed KPI of 45 days for time to recruit will be tracked through divisional reviews against an improvement trajectory.	Reviewed quarterly		

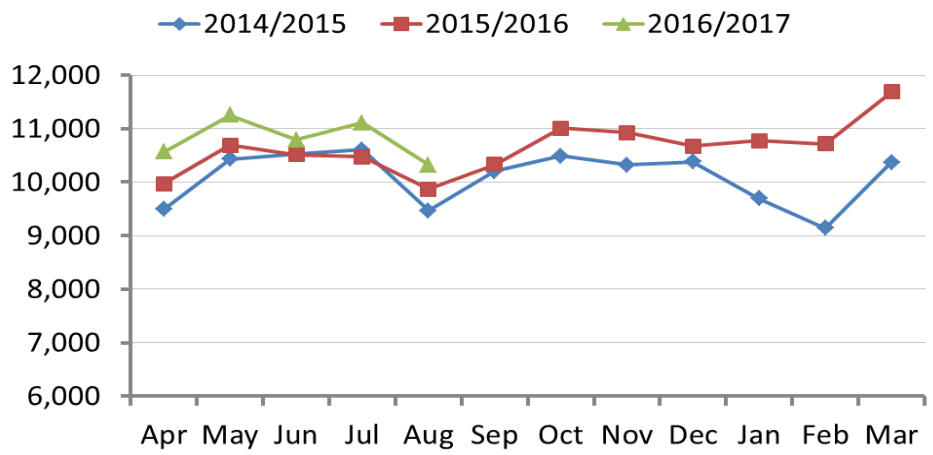
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Business cases have been agreed for recruitment and retention initiatives in specialist areas - Heygroves Theatres, Ward D703 and CICU as an alternative to targeted overseas campaigns. Trajectories are shown in appendix 3.	Reviewed monthly		
Turnover	17	Key corporate and divisional actions include the following:			The KPI for 2016/17 has been set at 12.1%.
		Complete review of appraisal: To improve their quality and application, in response to feedback from the staff survey 2014, including: • Revised policy, in conjunction with staff side; • E-Appraisal, working with our Learning and Development portal supplier; • Engaging staff through feedback sessions.	January 2017	Workforce and OD Group	
		Targeted leadership and management development programme: Includes Healthcare Leadership Model training and Learning and Leading Together - target of 800 managers trained annually was met for 2015.	Second cohort of Leadership for supervisors will commence in October following a review of the first cohort	Transformation Board	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Team building and local decision making: Work with Aston Organisational Development to develop team coaches, taking teams through a programme of work-based activities. Findings from the pilot will be evaluated to inform future roll-out.	October 2016 (Diagnostic and Therapies pilot Divisional Board) Evaluation in October 2016		
		Staff experience workshops: Divisions have incorporated actions with detailed milestones into their operating plans.	November 2015 - March 2017	Divisional Boards/ Senior Leadership Team/Workforce and OD Group.	
		Transformational Engagement and retention: A short life working group established to develop high impact projects to improve staff experience and improve retention in response to 2015 Staff Survey. The Group drafted plans for workshops during the autumn across the Trust to identify and develop expected behaviours of our leaders.	Workshops Autumn 2016	Senior Leadership Team/Board	
		Family and Friends Test: This survey asks “Would you recommend UHB as a place to receive treatment” and “Would you recommend UH Bristol as a place to work” distributed to all staff.	Results received, included in the Quarterly Workforce Report.	Workforce and OD Group	

Operational context

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

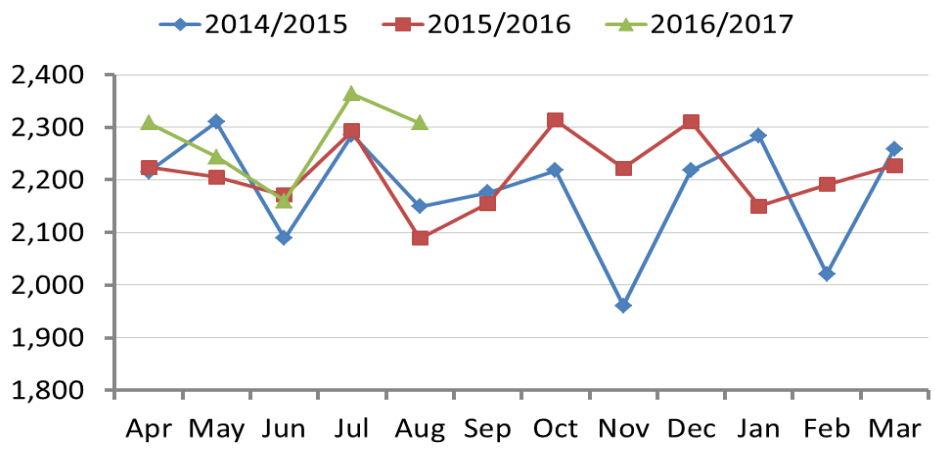
Emergency Department (ED) attendances



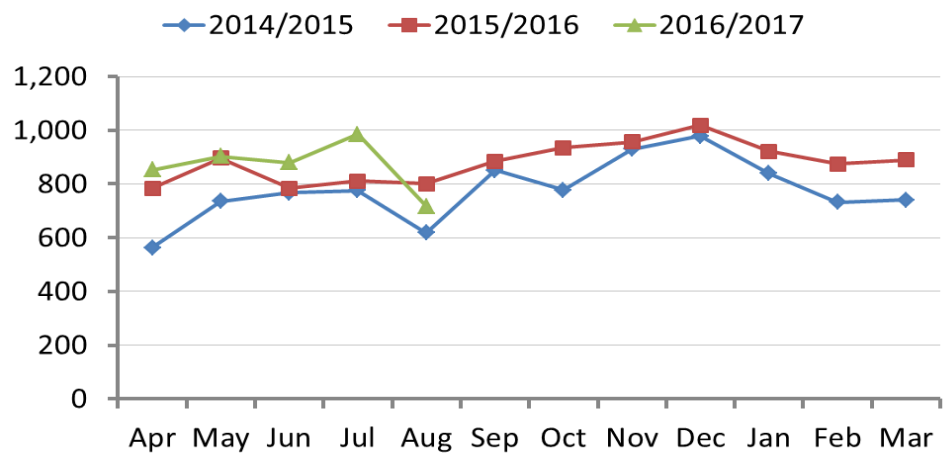
Summary points:

- Emergency attendances remains above the same period last year; emergency admissions into the BRI are significantly above the same period last year (see the A&E 4-hour report);
- The number of elective admissions increased in August, to above the seasonal norm; as will be seen from the Assurance section, the number of patients on the elective waiting list has decreased, due to higher activity levels and fewer outpatients being seen for their new outpatient appointment, than during the first quarter of the year (see below);
- The number of new outpatient appointments also increased in the period to above the normal seasonal norm; despite the increase in activity, the outpatient waiting list size has increased due to demand remaining higher than activity.

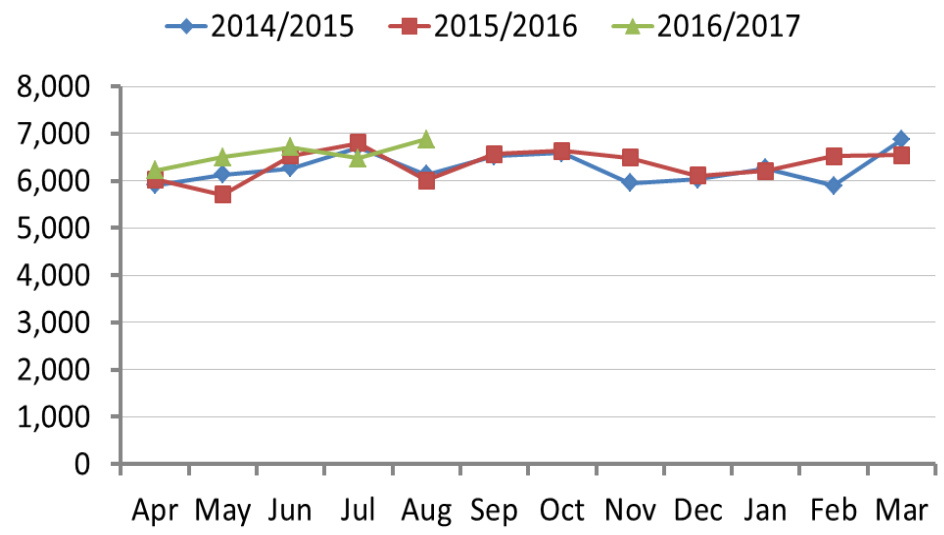
Emergency admissions (BRI)



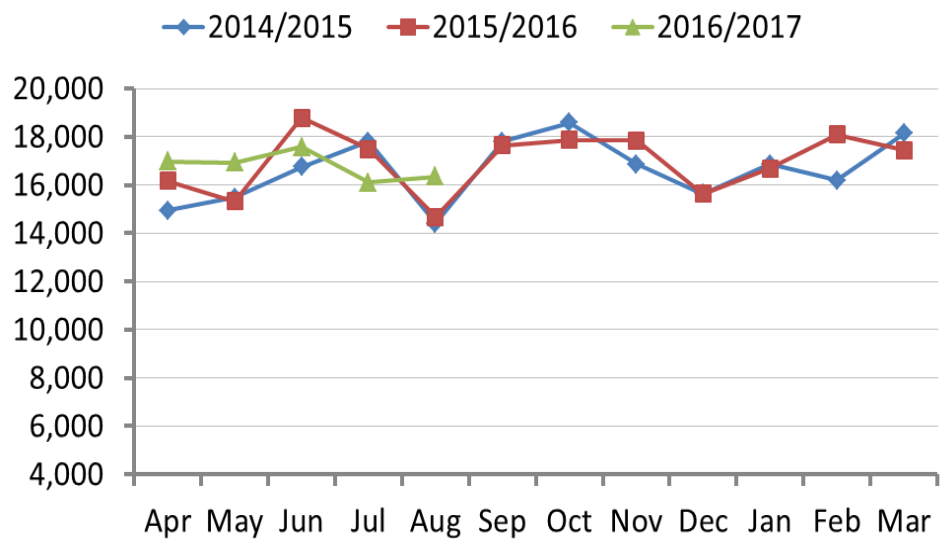
Emergency admissions (BCH)



Elective admissions



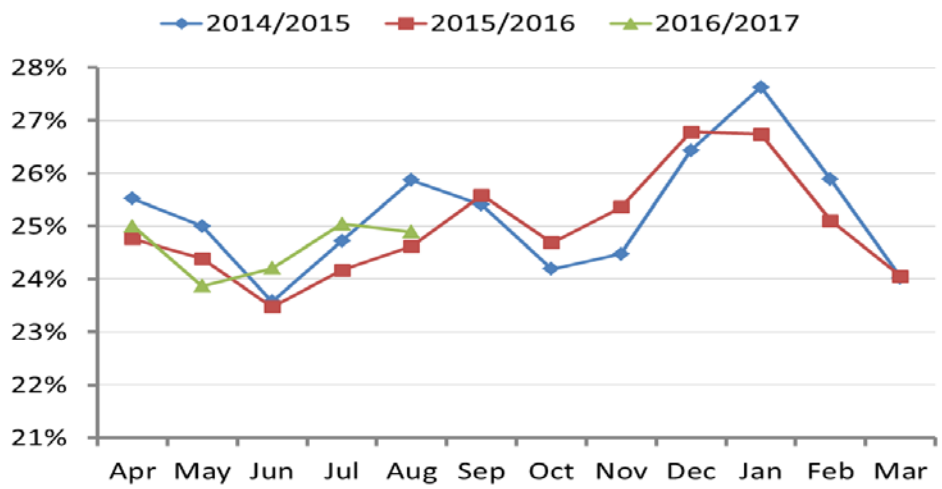
New outpatient attendances



Assurance and Leading Indicators

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

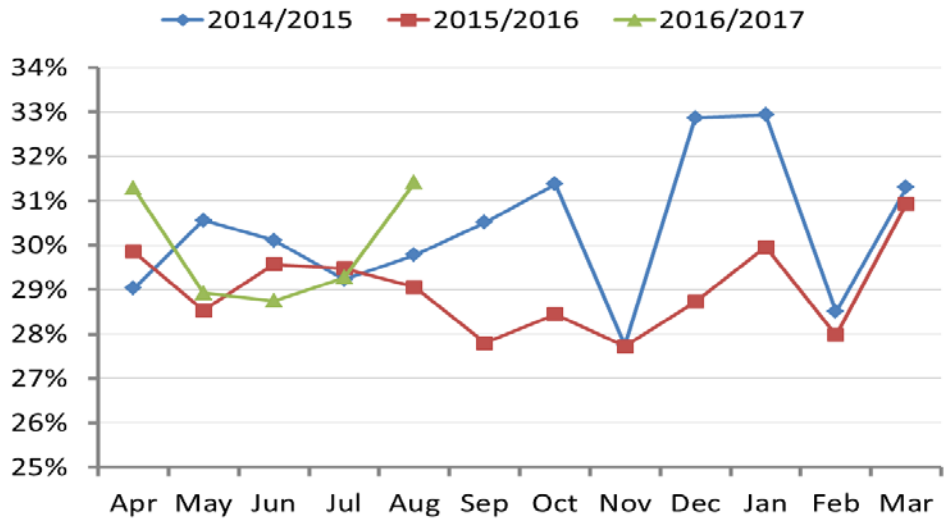
Percentage ED attendances resulting in admission



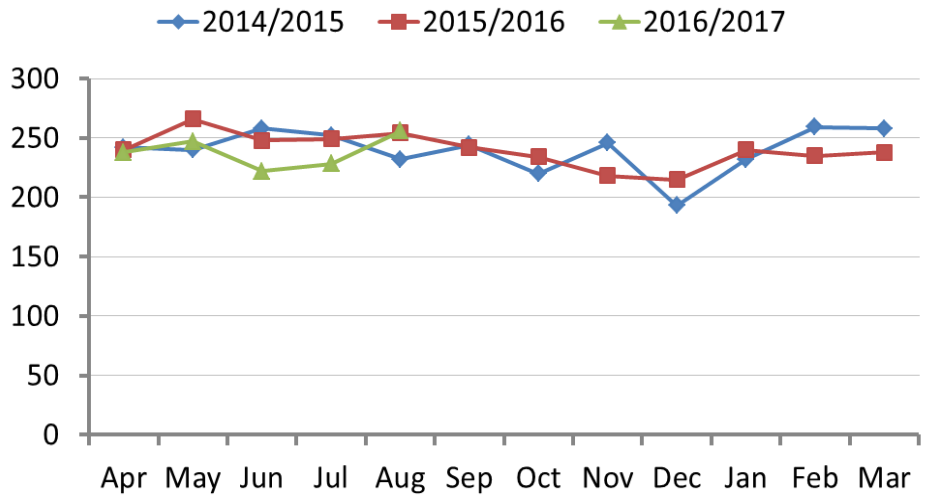
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission has stayed broadly similar to the same period last year, but the percentage of patients admitted aged 75 years and over is now significantly above the seasonal norm;
- The number of delayed discharges has increased to slightly above last year's level, but BRI bed occupancy has stayed at the lower level achieved in July;
- The number of patients on the outpatient waiting list has increased again, which in combination with a lower than expected level of RTT clock stops, has resulted in an increase in the number of patients on non-admitted pathways waiting over 18 weeks RTT (see Appendix 3).
- The number of 62-day GP cancer treatments is expected to rise, following the higher levels of 2-week wait referrals in quarter 1.

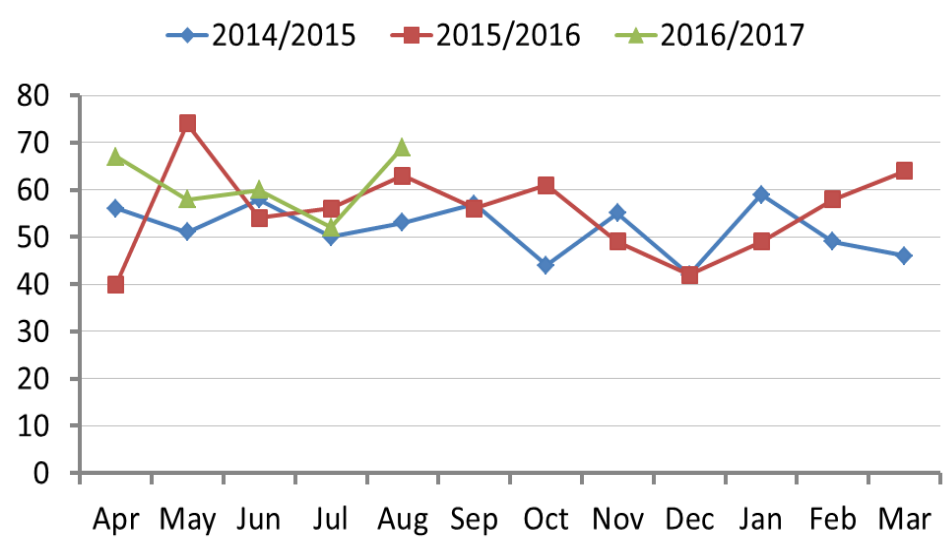
Percentage of Emergency BRI spells patients aged 75 years and over



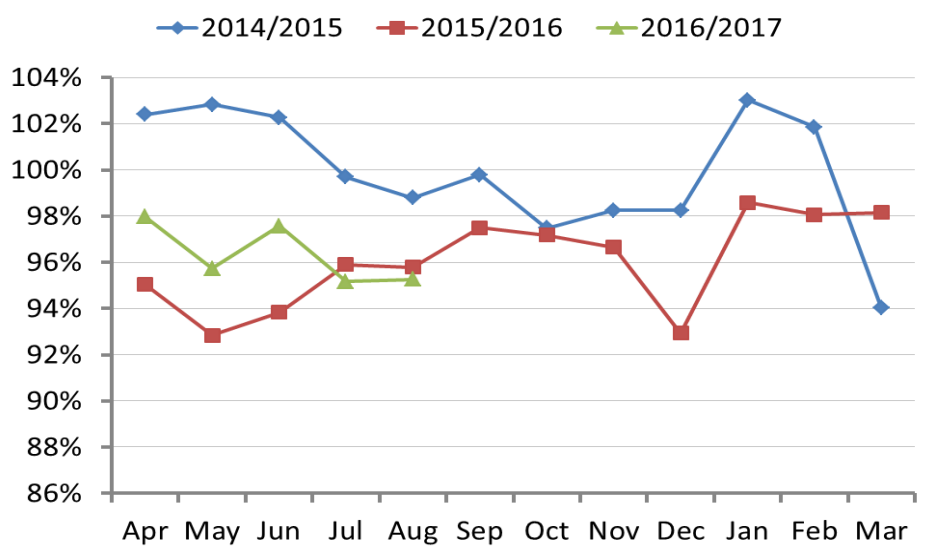
Over 14 day stays



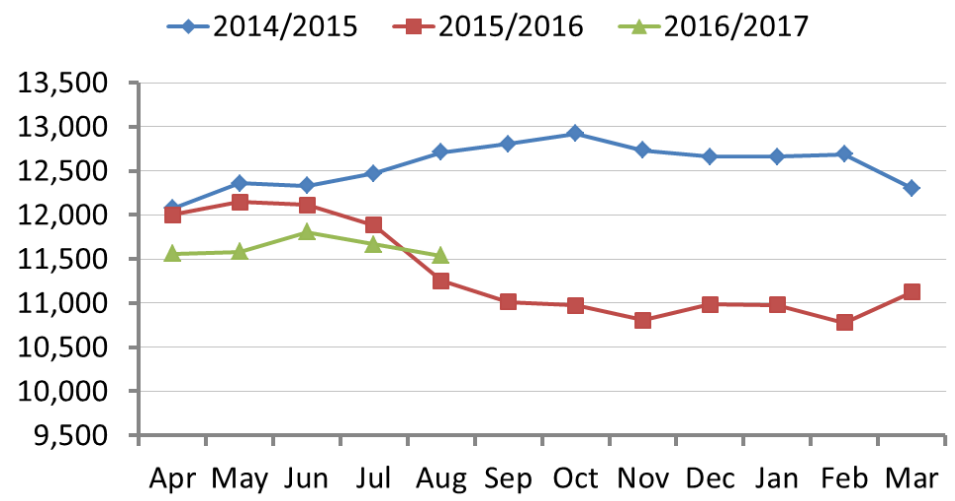
Delayed discharges (Green to Go)



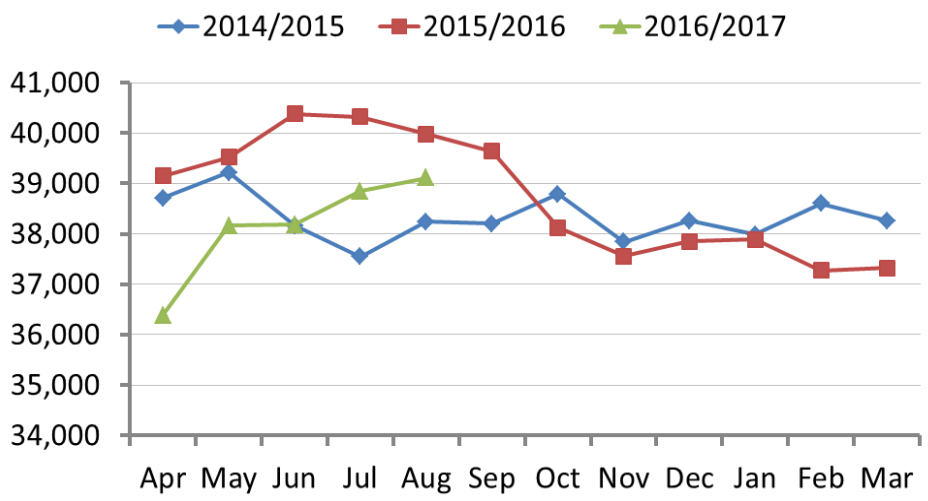
BRI Bed Occupancy



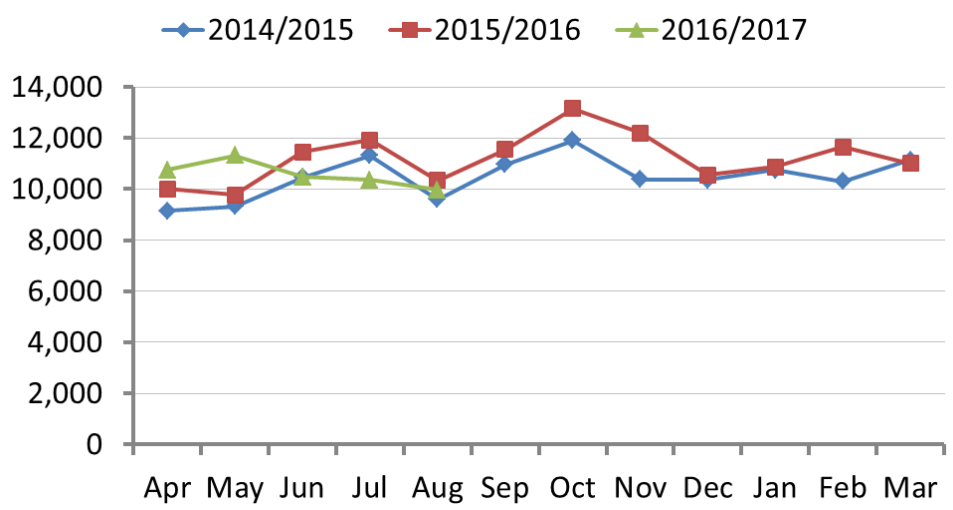
Elective waiting list size



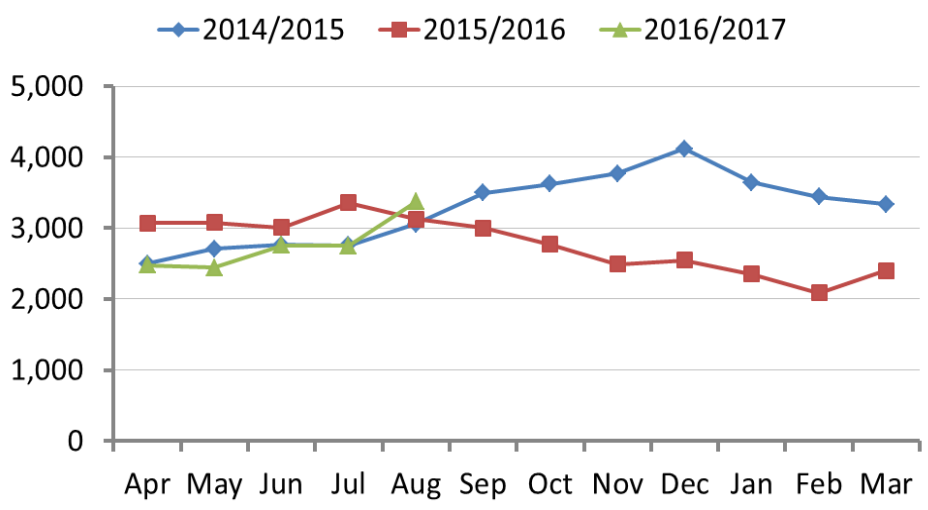
Outpatient waiting list size



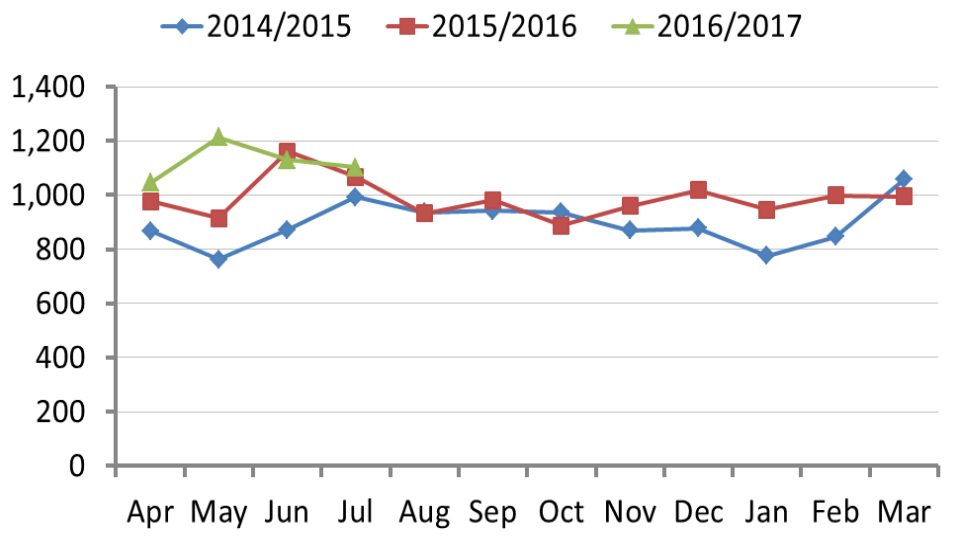
Number of RTT pathways stopped (i.e. treatments)



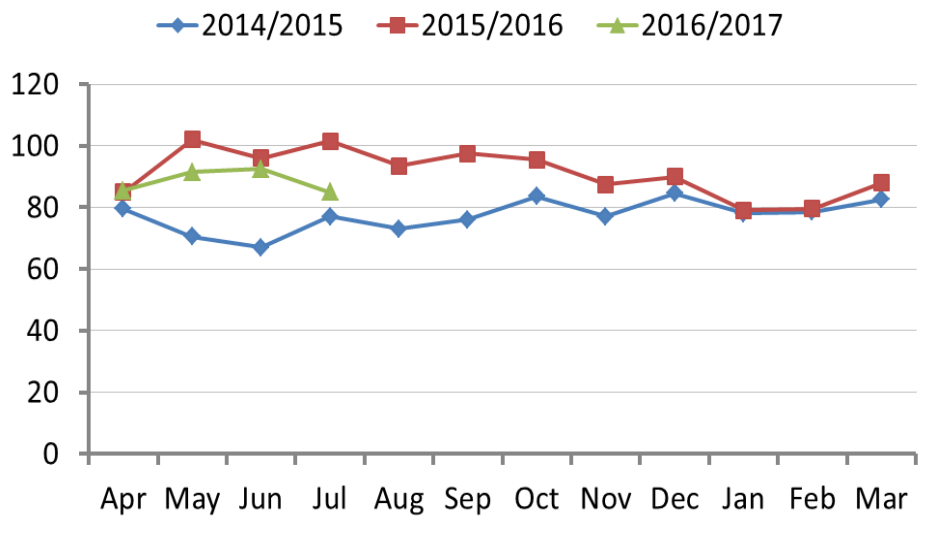
Number of RTT pathways over 18 weeks



Cancer 2-week wait – urgent GP – referrals seen



Cancer 62-day GP referred treatments



Trust Scorecards

SAFE, CARING & EFFECTIVE

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	15/16	16/17 YTD	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2
									Patient Safety											
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	3	3	3	3	3	3	3	0	0	0	0	0	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	DA03	C.Diff Cases - Monthly Totals	40	13	2	5	3	6	4	2	4	2	5	1	3	2	14	10	8	5
	DA02	MSSA Cases - Monthly Totals	26	19	2	3	2	2	2	1	0	2	3	3	7	4	7	3	8	11
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	5	7	7	9	12	14	17	0	1	2	3	-	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.3%	97.4%	97.9%	95.8%	98.1%	98.1%	96.4%	97.7%	96.8%	96.6%	97.3%	98%	96.9%	98.4%	97.3%	97%	97.3%	97.7%
	DB02	Antibiotic Compliance	87.6%	86.1%	82.3%	85.7%	86%	90.6%	86.5%	88.2%	86.1%	84.4%	85.3%	83.9%	88.2%	86.5%	87.2%	86.9%	84.5%	87.6%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	93%	93%	94%	94%	94%	95%	94%	95%	95%	95%	96%	97%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	97%	96%	97%	97%	97%	98%	98%	98%	98%	98%	98%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	94%	95%	95%	95%	95%	96%	95%	96%	96%	96%	96%	97%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	69	27	4	4	9	5	6	4	10	3	8	2	6	8	18	20	13	14
	S02a	Number of Confirmed Serious Incidents	55	10	1	4	8	4	5	4	5	3	6	1	-	-	16	14	10	-
	S02b	Number of Serious Incidents Still Open	5	17	1	0	1	1	1	0	0	0	2	1	6	8	2	1	3	14
	S03	Serious Incidents Reported Within 48 Hours	84.1%	88.9%	100%	100%	44.4%	100%	100%	100%	100%	66.7%	100%	100%	83.3%	87.5%	72.2%	100%	92.3%	85.7%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	-	92.6%	-	-	-	-	-	-	-	66.7%	100%	100%	100%	87.5%	-	-	92.3%	92.9%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	74.1%	100%	75%	85.7%	66.7%	60%	60%	63.6%	100%	100%	100%	100%	100%	100%	72.2%	66.7%	100%	100%
Never Events	S01	Total Never Events	3	1	0	0	1	1	0	0	0	0	0	0	1	0	2	0	0	1
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	13787	4792	1143	1142	1149	1167	1190	1196	1226	1145	1216	1258	1173	-	3458	3612	3619	1173
	S06b	Patient Safety Incidents Per 1000 Beddays	44.72	46.67	45.47	43.98	45.34	46.17	44.59	48.19	46.64	44.93	46.85	49.96	45.02	-	45.15	46.43	47.23	45.02
	S07	Number of Patient Safety Incidents - Severe Harm	97	29	8	13	8	15	5	6	3	2	8	9	10	-	36	14	19	10
Patient Falls	AB01	Falls Per 1,000 Beddays	3.94	4.22	3.9	3.54	3.79	4.15	3.56	3.59	4.15	4.24	3.93	4.57	4.57	3.81	3.83	3.77	4.24	4.19
	AB06a	Total Number of Patient Falls Resulting in Harm	30	14	1	4	3	5	2	3	5	1	4	3	3	3	12	10	8	6
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.221	0.148	0.318	0.193	0.079	0.158	0.15	0.242	0.114	0.275	0.154	0.04	0.077	0.194	0.144	0.167	0.157	0.135
	DE02	Pressure Ulcers - Grade 2	61	18	7	4	2	4	3	6	3	7	3	1	2	5	10	12	11	7
	DE03	Pressure Ulcers - Grade 3	7	1	1	1	0	0	1	0	0	0	1	0	0	0	1	1	1	0
	DE04	Pressure Ulcers - Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.2%	99.1%	99%	98.4%	98.1%	97.4%	97.1%	95.6%	96.9%	99.3%	99.1%	99%	99.1%	99.1%	98%	96.5%	99.2%	99.1%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.6%	96%	95.1%	94%	93.5%	94%	93.6%	96%	94.5%	94.8%	96.3%	96.6%	97.3%	95.7%	93.9%	94.7%	95.8%	96.5%
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	90.4%	88.9%	86.5%	91.5%	91.6%	93.2%	90.4%	89.9%	91.4%	83.6%	94%	86.3%	89.4%	89.8%	92.1%	90.6%	88.5%	89.6%
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	-	80.8%	-	-	-	-	-	-	-	-	-	80.8%	-	-	-	-	80.8%	-
Safety	Y01	WHO Surgical Checklist Compliance	99.9%	99.6%	100%	100%	99.8%	100%	99.9%	99.9%	100%	99.8%	100%	98.9%	99.6%	99.9%	99.9%	99.9%	99.6%	99.8%

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2
Patient Safety																				
Medicines	WA01	Medication Incidents Resulting in Harm	0.8%	0.25%	1.75%	0%	1.39%	1.2%	1.28%	0.42%	0.41%	0%	0.51%	0%	0.55%	-	0.91%	0.7%	0.16%	0.55%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.87%	0.65%	0.75%	0.78%	0.62%	1.03%	1.49%	0.66%	0.69%	0.93%	0.63%	0.56%	0.6%	0.38%	0.8%	0.92%	0.73%	0.49%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.1%	98%	96.2%	97.3%	95.9%	97.9%	97.2%	96.7%	97.3%	97.1%	97.7%	98.3%	98.4%	98.6%	97.1%	97.1%	97.7%	98.5%
	AK04	Safety Thermometer - No New Harms	98.6%	99%	98%	98.9%	97.9%	99.1%	98.8%	98.9%	99.4%	98.9%	98.7%	98.7%	99.2%	99.2%	98.6%	99%	98.8%	99.2%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	90%	89%	92%	92%	91%	90%	86%	86%	88%	87%	100%	79%	82%	95%	91%	86%	89%	89%
Out of Hours	TD05	Out of Hours Departures	10.7%	7.9%	11.4%	13%	11.1%	9.6%	11%	9.6%	9.6%	8.1%	7.5%	7.2%	7.8%	8.7%	11.2%	10.1%	7.6%	8.2%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	20.3%	22.6%	19.8%	19.1%	19.2%	22.1%	21.9%	22.3%	23.3%	23%	22.3%	23.4%	23.1%	21.1%	20.2%	22.5%	22.9%	22.1%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	10444	4830	845	856	836	1002	911	926	990	971	952	991	1007	909	2694	2827	2914	1916
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.1%	103.7%	103.1%	105.8%	104.8%	104.8%	105.9%	103.2%	103.1%	104.7%	104%	103.1%	104.3%	102.7%	105.1%	104.1%	103.9%	103.5%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	97.7	-	97.8	-	-	97.7	-	-	98.7	-	-	-	-	-	97.7	98.7	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	90	80.4	89.1	95.3	95.4	76.4	97.7	97	95.9	79.4	80.8	81.2	-	-	88.7	96.8	80.4	-
Readmissions	C01	Emergency Readmissions Percentage	2.74%	1.69%	2.77%	2.83%	2.82%	2.87%	2.67%	2.66%	1.5%	1.74%	1.56%	1.7%	1.76%	-	2.84%	2.27%	1.67%	1.76%
Maternity	G04	Percentage of Spontaneous Vaginal Deliveries	62.1%	61.4%	62.4%	61.3%	63.9%	63.4%	62.7%	60.1%	62.5%	66.6%	61%	56.4%	62%	61.5%	62.9%	61.8%	61.2%	61.7%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	75.9%	73%	85.7%	80.8%	76.5%	66.7%	76%	78.6%	80%	87.5%	74.1%	72%	73.5%	61.3%	74%	78.2%	77.6%	67.7%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	82.5%	75.9%	78.6%	92.3%	94.1%	86.7%	80%	78.6%	84%	83.3%	81.5%	72%	79.4%	64.5%	90.4%	80.8%	78.9%	72.3%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	63.5%	51.8%	64.3%	73.1%	70.6%	60%	60%	64.3%	68%	70.8%	59.3%	44%	52.9%	35.5%	67.1%	64.1%	57.9%	44.6%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	39.4	42.4	44.4	44.8	50.2	47.5	40.5	35.8	61.4	44.1	44.4	72.2	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	61.5%	65.7%	62.2%	57.5%	59.5%	56.8%	62.5%	77.4%	60.6%	69.2%	67.6%	65.9%	59%	-	57.9%	66.1%	67.7%	59%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	93.5%	90.5%	93.3%	90.2%	91.9%	91.9%	91.7%	96.8%	84.8%	88.5%	88.2%	93.2%	92.3%	-	91.3%	91.1%	90%	92.3%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.4%	68.1%	75%	54.5%	62.5%	47.1%	71.4%	80%	80%	58.3%	68.8%	61.5%	76.5%	71.4%	52.8%	77.3%	63.4%	74.2%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	91.6%	95.7%	91.1%	97.6%	97.2%	95%	93.4%	94.7%	96.7%	94.5%	95.8%	94.1%	98%	96.3%	96.6%	94.9%	94.8%	97.2%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	95.8%	97.7%	93.2%	98.4%	96.9%	98.4%	95.7%	96.3%	96.8%	96.8%	97.8%	98.1%	98.1%	97.8%	97.9%	96.2%	97.5%	97.9%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	92.3%	97.6%	88.9%	100%	83.3%	100%	100%	100%	100%	95.2%	100%	100%	100%	100%	91.3%	100%	97.2%	100%
	AC04	Percentage of Dementia Carers Feeling Supported	88.3%	75%	70%	100%	72.7%	72.7%	-	93.8%	100%	75%	-	-	-	-	84.2%	96.2%	75%	-
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	9588	3476	768	666	537	692	1231	788	1072	930	587	741	596	622	1895	3091	2258	1218

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	90	90	90	91	90	90	89	92	92	90	91	92	90	90	91	91
	P01g	Patient Survey - Kindness and Understanding	-	-	94	94	95	94	95	94	93	96	96	94	93	96	94	94	95	95
	P01h	Patient Survey - Outpatient Tracker Score	-	-	89	88	88	89	89	89	89	88	90	90	90	90	88	89	89	90
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	19.2%	38.3%	19.8%	19.3%	20.4%	20.6%	21.9%	22%	26.3%	35.2%	42.4%	40.5%	36.5%	36.8%	20.1%	22.7%	39.4%	36.6%
	P03b	Friends and Family Test ED Coverage	13%	14.5%	17.8%	15.9%	16.4%	13.9%	15.8%	16.7%	12.3%	14.8%	13.5%	15.5%	12%	16.8%	15.4%	14.9%	14.6%	14.3%
	P03c	Friends and Family Test MAT Coverage	22.7%	21.2%	14.6%	25.3%	20.2%	20.3%	15.7%	24%	33.7%	16.2%	26.3%	19%	24.4%	20.4%	21.8%	24.3%	20.5%	22.3%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	96.3%	96.6%	96.2%	96.2%	96.5%	95.6%	96.7%	96.1%	95.9%	97.1%	95.8%	97.2%	95.9%	97.4%	96.1%	96.2%	96.6%	96.7%
	P04b	Friends and Family Test Score - ED	75.4%	77%	76.6%	72.2%	76.2%	80%	77.7%	73.7%	71.5%	80.2%	78.1%	74.4%	71.8%	79.6%	75.9%	74.4%	77.5%	76.3%
	P04c	Friends and Family Test Score - Maternity	96.6%	97.1%	96.3%	98.2%	96.9%	97.7%	94.9%	97.6%	95.8%	96.6%	98.9%	95.5%	96.2%	97.8%	97.6%	96.2%	97.2%	97%
Patient Complaints	T01	Number of Patient Complaints	1941	875	185	182	148	116	143	183	150	176	146	198	200	155	446	476	520	355
	T01a	Patient Complaints as a Proportion of Activity	0.252%	0.269%	0.279%	0.267%	0.219%	0.19%	0.225%	0.268%	0.221%	0.272%	0.218%	0.296%	0.315%	0.246%	0.227%	0.238%	0.262%	0.28%
	T03a	Complaints Responded To Within Trust Timeframe	75.2%	81.2%	83.3%	60.7%	59.5%	50.8%	68.1%	71.8%	86.1%	81.6%	73.1%	73.8%	86.8%	90.6%	56.5%	74.6%	76.2%	89%
	T03b	Complaints Responded To Within Divisional Timeframe	91.3%	91.9%	95.8%	80.4%	81%	90.5%	91.5%	84.6%	100%	87.8%	92.3%	95.2%	89.5%	94.3%	84.5%	91.8%	91.6%	92.3%
	T04c	Percentage of Responses where Complainant is Dissatisfied	6.15%	11.19%	14.58%	8.93%	4.76%	6.35%	2.13%	7.69%	8.33%	8.16%	9.62%	16.67%	-	-	6.83%	5.74%	11.19%	-
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.03%	0.89%	0.83%	0.64%	0.86%	0.7%	1.2%	1.21%	1.84%	1.08%	0.96%	0.96%	1.03%	0.46%	0.73%	1.42%	1%	0.73%
	F01a	Number of Last Minute Cancelled Operations	713	276	50	40	51	39	68	71	108	63	59	61	63	30	130	247	183	93

RESPONSIVE

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 15/16	Annual 16/17 YTD	Monthly Totals Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Quarterly Totals 15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.3%	91.9%	90.7%	91.1%	92%	91.8%	92.4%	93.2%	92.2%	92.3%	92.6%	92.1%	92%	90.5%	91.6%	92.6%	92.3%	91.2%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3004	2772	2491	2544	2349	2083	2397	2480	2442	2753	2749	3344	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	8	0	1	0	0	0	2	0	0	0	0	0	0	0	0	2	0	0
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	471	120	28	25	22	15	15	14	26	24	22	14	27	33	62	55	60	60
	A09	Referral To Treatment Ongoing Pathways 35+ Weeks	-	-	1738	475	118	96	81	86	75	68	77	80	80	85	117	113	263	220	245	230
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	95.9%	94.5%	96.8%	97.5%	95.8%	94.8%	93.7%	98%	96.6%	94.5%	94.6%	93.5%	95.3%	-	96%	96.1%	94.2%	95.3%
	E01c	Cancer - Urgent Referrals Stretch Target	93%	93%	-	66.6%	-	-	-	-	-	-	-	64.8%	68%	65.3%	67.9%	-	-	-	66.1%	67.9%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	97.5%	95.9%	97.3%	98.7%	98.6%	97.8%	98.5%	97%	97.7%	91.5%	96.2%	96.7%	99%	-	98.4%	97.8%	94.9%	99%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.9%	98.1%	98.6%	99.1%	100%	98.9%	96.1%	100%	99%	97.7%	100%	97.3%	97.5%	-	99.3%	98.3%	98.3%	97.5%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	96.8%	91.6%	97.6%	97.9%	100%	98%	97.6%	97.9%	95%	80%	94%	97.7%	97.1%	-	98.5%	96.9%	90.2%	97.1%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.1%	97.4%	96%	96.1%	97.6%	97.4%	97.9%	96.7%	98.6%	97.9%	98.4%	96.8%	96.6%	-	97%	97.8%	97.7%	96.6%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	80.6%	72.8%	81%	79.1%	82.3%	86.7%	84.2%	74.2%	84.7%	77.2%	70.5%	70.8%	72.9%	-	82.6%	81.1%	72.7%	72.9%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	68.6%	51.1%	85.7%	14.3%	71.4%	50%	50%	60%	70%	41.7%	35.3%	85.7%	66.7%	-	51.9%	64.6%	47.2%	66.7%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	91.1%	87.9%	91.2%	93.6%	92.7%	100%	81%	92.9%	100%	75.9%	86.6%	96.9%	90%	-	95.7%	92.1%	86.8%	90%
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	1.03%	0.89%	0.83%	0.64%	0.86%	0.7%	1.2%	1.21%	1.84%	1.08%	0.96%	0.96%	1.03%	0.46%	0.73%	1.42%	1%	0.73%
	F01a	Number of Last Minute Cancelled Operations	-	-	713	276	50	40	51	39	68	71	108	63	59	61	63	30	130	247	183	93
	F02c	Number of LMCs Not Re-admitted Within 28 Days	17	17	76	34	2	5	3	2	1	6	12	23	2	2	4	3	10	19	27	7
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.28%	1.38%	0.74%	1.17%	1.67%	1.18%	1.86%	1.36%	1.68%	1.35%	1.82%	1.14%	1.5%	1.12%	1.34%	1.63%	1.43%	1.3%
	F07a	Number of Admissions Cancelled Day Before	-	-	887	428	45	73	99	66	105	80	99	79	112	72	92	73	238	284	263	165
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	75.4%	70%	76%	75.7%	78%	81.8%	75%	59.4%	63%	83.8%	55.2%	66.7%	70.5%	-	78.7%	66.7%	69.8%	70.5%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	93.3%	91.4%	92%	89.2%	95.1%	95.5%	92.5%	93.8%	85.2%	100%	93.1%	83.3%	88.6%	-	93.4%	90.9%	92.7%	88.6%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	98.97%	96.93%	99.01%	99.59%	99.37%	99.2%	98.69%	99.11%	99.2%	98.34%	98.55%	96.25%	96.09%	95.51%	99.39%	99.01%	97.68%	95.81%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	11.9%	12.6%	12%	11%	10.6%	13%	12.3%	11.8%	13.1%	14%	12.4%	12.6%	12.4%	11.8%	11.5%	12.4%	13%	12.1%
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	48	54	41	30	19	33	31	34	23	22	29	31	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	11	12	10	4	5	5	10	3	6	4	5	6	-	-	-	-
Green To Go List	AQ01	Numbers on the Green to Go List (Acute)	-	-	-	-	45	50	39	33	42	49	48	59	48	50	46	60	-	-	-	-
	AQ02	Numbers on the Green to Go List (Non-Acute)	-	-	-	-	11	11	10	9	7	9	16	8	10	10	6	9	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.16	4.13	4.51	4.2	4.11	4.12	4.04	4.03	4.3	4.23	4.16	4.14	3.89	4.24	4.14	4.13	4.18	4.06

RESPONSIVE (continued)

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	15/16	16/17 YTD	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2
ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	90.43%	89.45%	91.69%	92.16%	89.6%	88.89%	83.76%	84.23%	82.49%	87.17%	91.66%	88.99%	89.33%	90.01%	90.23%	83.47%	89.32%	89.66%
		This is measured against the national standard of 95%																				
ED - Time in Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	-	-	90.43%	89.45%	91.69%	92.16%	89.6%	88.89%	83.76%	84.23%	82.49%	87.17%	91.66%	88.99%	89.33%	90.01%	90.23%	83.47%	89.32%	89.66%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	87.4%	83.4%	87.75%	89.34%	89.43%	86.83%	75.72%	79.13%	75.11%	79.8%	87.73%	81.8%	83.73%	83.71%	88.55%	76.61%	83.17%	83.72%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	90.56%	94.47%	93.81%	93.12%	84.97%	86.7%	89.12%	84.67%	85.59%	93.02%	93.84%	95.11%	93.58%	97.29%	88.18%	86.39%	94.01%	95.21%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	99.48%	99.07%	99.77%	99.23%	99.83%	99.71%	99.83%	99.6%	98.94%	99.33%	99.54%	99.24%	98.65%	98.61%	99.59%	99.44%	99.37%	98.63%
		This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets																				
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	12	1	0	0	0	0	6	0	6	0	1	0	0	0	0	12	1	0
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	99%	96.8%	96.7%	98.4%	99.6%	99%	98.8%	99.3%	97.5%	96.2%	98.2%	94.7%	97%	97.9%	99%	98.5%	96.4%	97.5%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	93%	92.7%	92.8%	93.2%	94.1%	93.8%	92.7%	92.9%	94.1%	93.3%	94.2%	92.1%	91.7%	91.8%	93.7%	93.2%	93.2%	91.8%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.8%	53.2%	53.2%	52.8%	49.8%	53.1%	52.6%	45.3%	45.8%	55.2%	51.7%	51.7%	51.1%	56.5%	51.9%	47.8%	52.8%	53.7%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.9%	98.7%	98.7%	98.8%	99%	98.9%	98.7%	98.6%	98.6%	98.8%	98.9%	98.5%	98.3%	98.9%	98.9%	98.7%	98.7%	98.6%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	3%	2.4%	2.9%	2.7%	3.1%	3.5%	3%	3.7%	3.1%	3%	2.4%	2.3%	2.2%	2.2%	3.1%	3.3%	2.6%	2.2%
	B05	ED Left Without Being Seen Rate	5%	5%	2.4%	2.3%	2.3%	2.4%	2.4%	2.2%	2.6%	2.7%	2.5%	2.1%	2%	2.5%	2.9%	1.8%	2.3%	2.6%	2.2%	2.4%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1102	450	92	96	86	104	236	153	140	62	72	114	77	125	286	529	248	202

EFFICIENT

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2
Sickness	AF02	Sickness Rate	4.2%	3.8%	4%	4.2%	4%	4.3%	4.5%	4.6%	4.5%	3.9%	3.7%	3.8%	3.8%	3.8%	4.3%	4.5%	3.8%	
		For 2015/16, the Trust target for the year is 3.7%. Divisional targets are: 3.0% (DAT), 5.5% (FAE), 4.1% (MDC), 3.7% (SPS), 3.5% (SHN), 3.9% (WAC), 2.6% (Trust Services, excl FAE)																		
		Different targets were in place in previous years. There is an amber threshold of 0.5 percentage points above the target. These annual targets vary each quarter.																		
Staffing Numbers	AF08	Funded Establishment FTE	8258.8	8364.5	8128.9	8168.6	8197.6	8199.8	8224.1	8229.4	8258.8	8241.7	8239	8304	8334.2	8364.5	8199.8	8258.8	8304	
	AF09A	Actual Staff FTE (Including Bank & Agency)	8319.4	8398.3	8253.7	8249.7	8198	8180	8233.9	8246.6	8319.4	8339.7	8277.5	8315.7	8322.1	8398.3	8180	8319.4	8315.7	
	AF13	Percentage Over Funded Establishment	0.7%	0.4%	1.5%	1%	0%	-0.2%	0.1%	0.2%	0.7%	1.2%	0.5%	0.1%	-0.1%	0.4%	-0.2%	0.7%	0.1%	
		Green is below 0.5%. Amber is 0.5% to below 1% and Red is 1% or above																		
Bank Usage	AF04	Workforce Bank Usage	350.9	437.9	446.2	377.6	339.3	336.1	342.8	361.7	350.9	337.2	370	394.7	429.9	437.9	336.1	350.9	394.7	
	AF11A	Percentage Bank Usage	4.2%	5.2%	5.4%	4.6%	4.1%	4.1%	4.2%	4.4%	4.2%	4%	4.5%	4.7%	5.2%	5.2%	4.1%	4.2%	4.7%	
		Bank Percentage is Bank usage as a percentage of total staff (bank+agency+substantive). Target is an improvement trajectory going from 4.7% in Apr-15 to 2.7% in Mar-16																		
Agency Usage	AF05	Workforce Agency Usage	153.4	148.5	193.1	180	156.1	134	152.1	144.9	153.4	156.4	131.9	138.3	149.8	148.5	134	153.4	138.3	
	AF11B	Percentage Agency Usage	1.8%	1.8%	2.3%	2.2%	1.9%	1.6%	1.8%	1.8%	1.8%	1.9%	1.6%	1.7%	1.8%	1.8%	1.6%	1.8%	1.7%	
		Agency Percentage is Agency usage as a percentage of total staff (bank+agency+substantive). Target is an improvement trajectory going from 1.6% in Apr-15 to 0.8% in Mar-16																		
Vacancy	AF06	Vacancy FTE (Funded minus Actual)	361	452.7	436	416.4	420.1	431.3	412	422.3	361	305.8	380	439.2	494.8	452.7	431.3	361	439.2	
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.4%	5.5%	5.4%	5.1%	5.2%	5.3%	5.1%	5.2%	4.4%	3.8%	4.7%	5.3%	6%	5.5%	5.3%	4.4%	5.3%	
		For 2015/16, target is below 5% for Green, 5% or above for Red																		
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	148	340	227	146	148	120	137	154	148	229	191	137	169	340	120	148	137	
	AF10	Workforce Turnover Rate	13.4%	13.2%	13.6%	13.7%	13.9%	13.8%	13.9%	13.6%	13.4%	13.6%	13.3%	13.1%	13.4%	13.2%	13.8%	13.4%	13.1%	
		Turnover is a rolling 12 months. It's number of permanent leavers over the 12 month period, divided by average staff in post over the same period. Average staff in post is staff in post at start PLUS stafff in post at end, divided by 2.																		
		Green Target is an improvement trajectory going from 13.6% in Apr-15 to 11.5% in Mar-16.There is an Amber threshold of 10% of the Green threshold (i.e. 15% in Apr-15, falling to 12.7% in Mar-16)																		
Training	AF20	Essential Training Compliance	91%	-	89%	91%	91%	91%	92%	92%	91%	-	-	-	-	-	91%	91%	-	-
		Green is above 90%, Red is below 85%, Amber is 85% to 90%																		
Essential Training 2016/17	AF21a	Essential Training Compliance - Three Yearly Training	-	85%	-	-	-	-	-	-	-	-	88%	88%	88%	85%	-	-	88%	
	AF21b	Essential Training Compliance - Annual Training	-	67%	-	-	-	-	-	-	-	-	56%	63%	66%	67%	-	-	63%	
	AF21c	Essential Training Compliance - Induction	-	94%	-	-	-	-	-	-	-	-	96%	95%	96%	94%	-	-	95%	
	AF21d	Essential Training Compliance - Resuscitation Training	-	77%	-	-	-	-	-	-	-	-	78%	79%	79%	77%	-	-	79%	
	AF21e	Essential Training Compliance - Safeguarding Training	-	86%	-	-	-	-	-	-	-	-	88%	88%	89%	86%	-	-	88%	
		Green is above 90%, Red is below 85%, Amber is 85% to 90%																		

Appendix 1

Glossary of useful abbreviations, terms and standards

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

GI	Gastrointestinal – often used as an abbreviation in the form of Upper GI or Lower GI as a specialty or tumour site relating to that part of the gastrointestinal tract
ICU / ITU	Intensive Care Unit / Intensive Therapy Unit
LMC	Last-Minute Cancellation of an operation for non-clinical reasons
NA	Nursing Assistant
NBT	North Bristol Trust
NOF	Abbreviation used for Neck of Femur
NRLS	National Learning & Reporting System
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 August 2016:

All Essential Training

	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Three Yearly	**85%**	89%	87%	83%	86%	87%	87%	83%
Annual (Fire and IG)	**67%**	83%	57%	67%	70%	64%	71%	66%
Induction	**94%**	97%	98%	92%	94%	93%	95%	94%
Resuscitation	**77%**	74%	N/A	77%	75%	78%	82%	75%
Safeguarding	**86%**	90%	87%	86%	86%	86%	89%	80%

Safeguarding Adults and Children

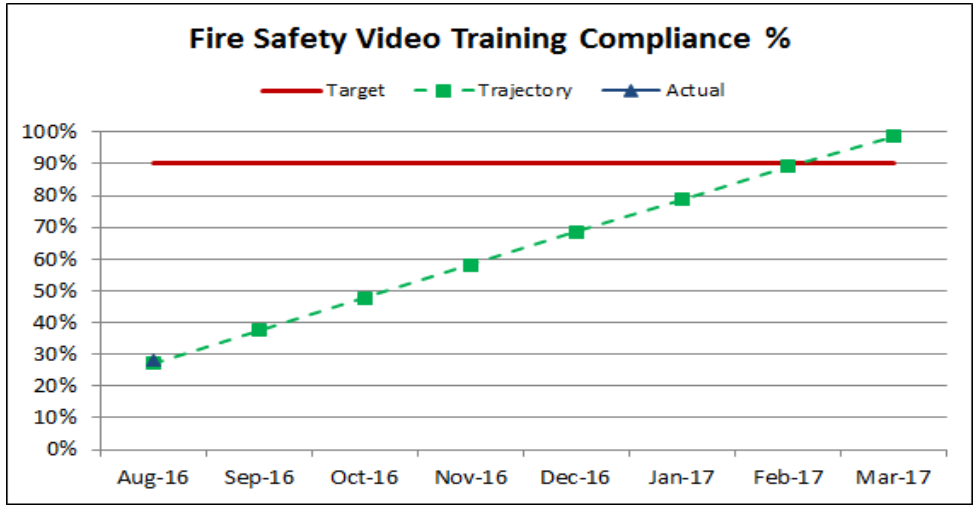
	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Safeguarding Adults L1	**89%**	94%	90%	86%	85%	87%	90%	87%
Safeguarding Adults L2	**84%**	90%	75%	87%	89%	87%	84%	77%
Safeguarding Adults L3	**63%**	100%	-	63%	78%	58%	71%	27%
Safeguarding Children L1	**91%**	93%	90%	92%	93%	87%	90%	
Safeguarding Children L2	**84%**	86%	74%	85%	83%	85%	85%	91%

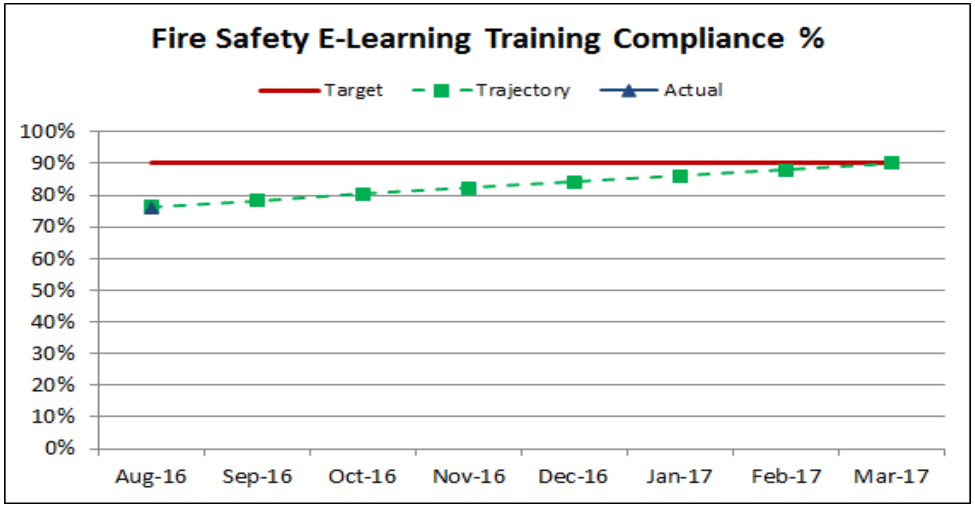
Child Protection level 3

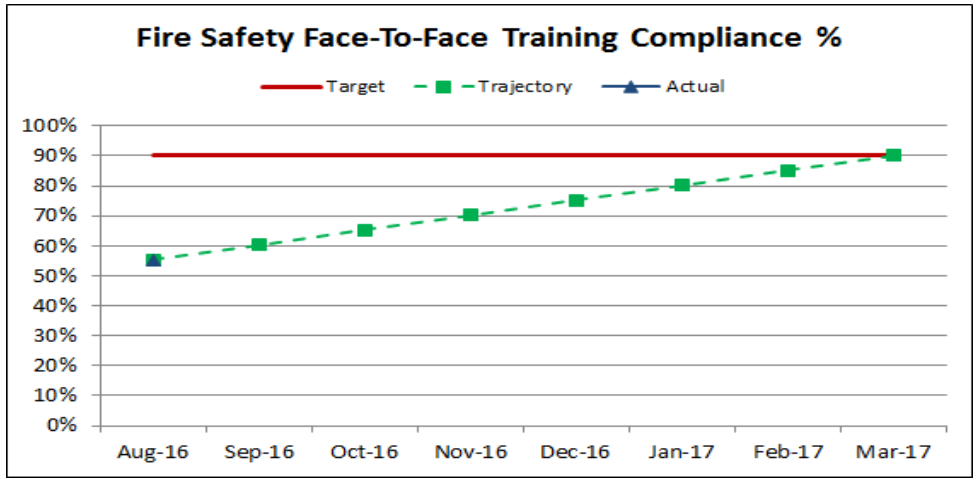
	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Core	**75%**	82%	59%	-	50%	100%	77%
Specialist	**72%**	-	-	-	-	100%	89%

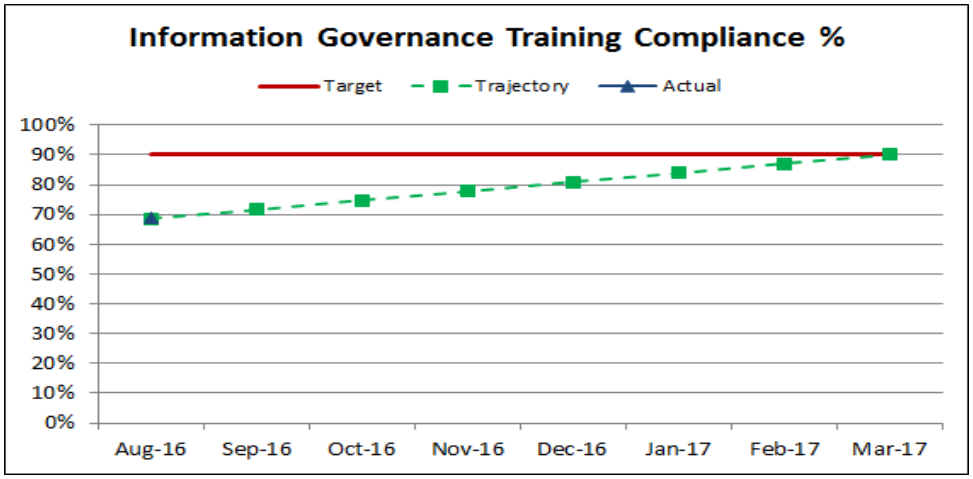
Appendix 2 (continued)

Performance against Trajectory for Fire and Information Governance









Note, there are two types of fire training represented in these trajectories, two yearly and annual fire training, with different target audiences. In addition, there are a fixed number of staff who require an additional training video under the previous fire training requirements. This will not be a requirement in the future once all are trained. The starting point for the trajectories is the same as the actual compliance figure for August 2016.

Agency shifts by staff group for 1st to 28th August 2016

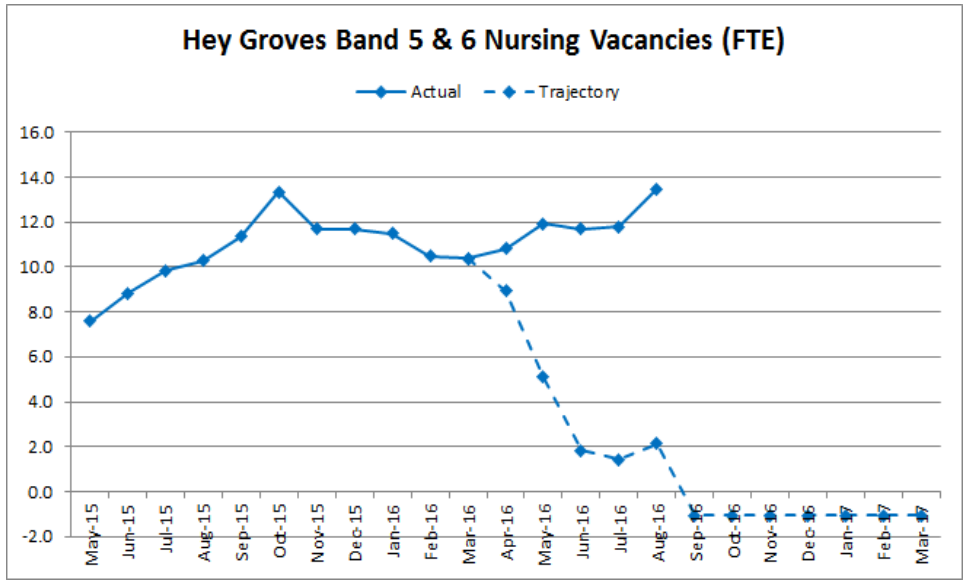
This report provides the Trust with an opportunity to do a retrospective submission to NHS Improvement of all our agency activity for the preceding four calendar week period, confirming over-rides with agency rates, worker wage rates and frameworks.

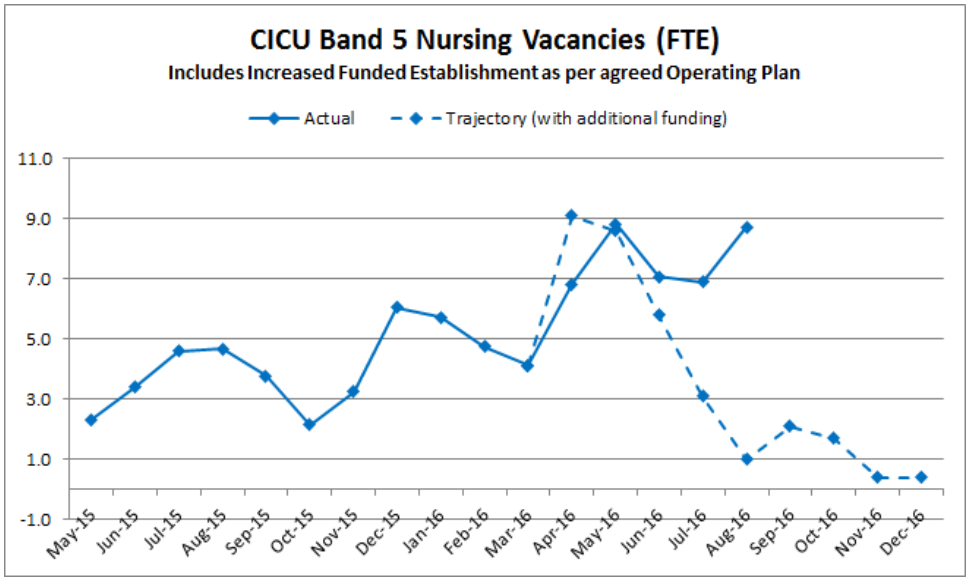
Staff Group	Within framework and price cap	Exceeds price cap	Exceeds wage cap	Non framework	Non framework and above both price and wage cap	Non framework and above price cap	Exceeds price and wage cap	Non framework and exceeds wage cap	Total
N&M /Health visiting	235	158	2	0	484	0	590	0	1469
HCA & other Support	5	11	22	0	2	0	37	0	77
Medical & Dental	0	5	16	0	0	0	90	0	111
Scientific , therapeutic and technical (AHP)	52	0	0	0	0	0	0	0	52
Healthcare Science	0	0	0	0	0	0	0	0	0
A&C and Estates	936	0	0	0	0	0	0	0	936
Other	0	0	0	0	0	0	0	0	0

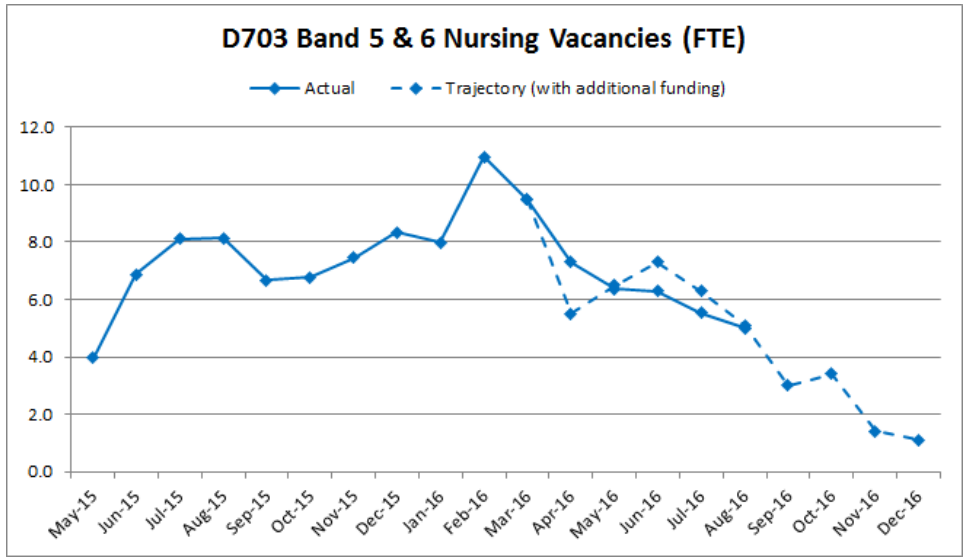
Currently reporting covers Temporary Staffing Bureau bookings only (see appendix 2). Reporting will be extended to cover all data.

Appendix 2 (continued)

Recruitment compared with trajectory for Heygroves Theatres, CICU and Ward D703







Appendix 3

Access standards – further breakdown of figures

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

Tumour Site	UH Bristol	Internal operational target	National
Breast†*	100	-	94.9
Gynaecology	42.1	85%	76.6
Haematology (excluding acute leukaemia)*	100	85%	77.5
Head and Neck	70.6	79%	65.8
Lower Gastrointestinal	36.4	79%	70.3
Lung	75.8	79%	75.5
Other*	50	-	75
Sarcoma*	100	-	66.2
Skin	87.5	96%	96.3
Upper Gastrointestinal	75.0	79%	74.1
Urology*†	33.3	-	76.0
Total (all tumour sites)	**72.9%**	**85.0%**	82.0%
Improvement trajectory	**84.7%**		
Performance for internally managed pathways	**83.3%**		
Performance for shared care pathways	**48.0%**		

*3 or fewer patients treated in accountability terms

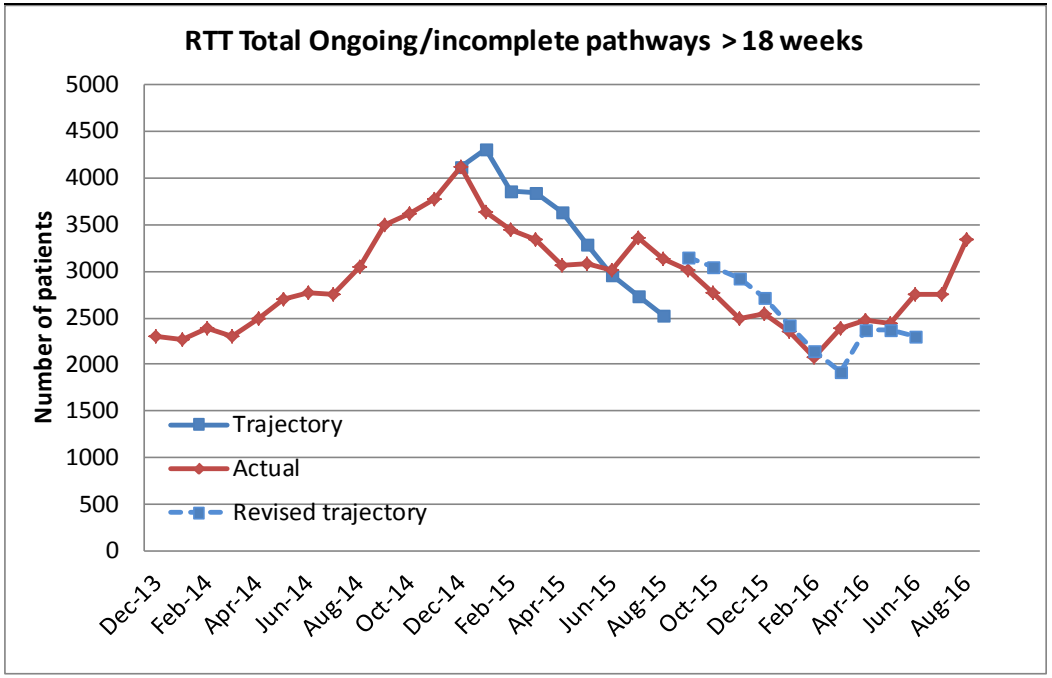
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

Appendix 3 (continued)

Access standards – further breakdown of figures

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

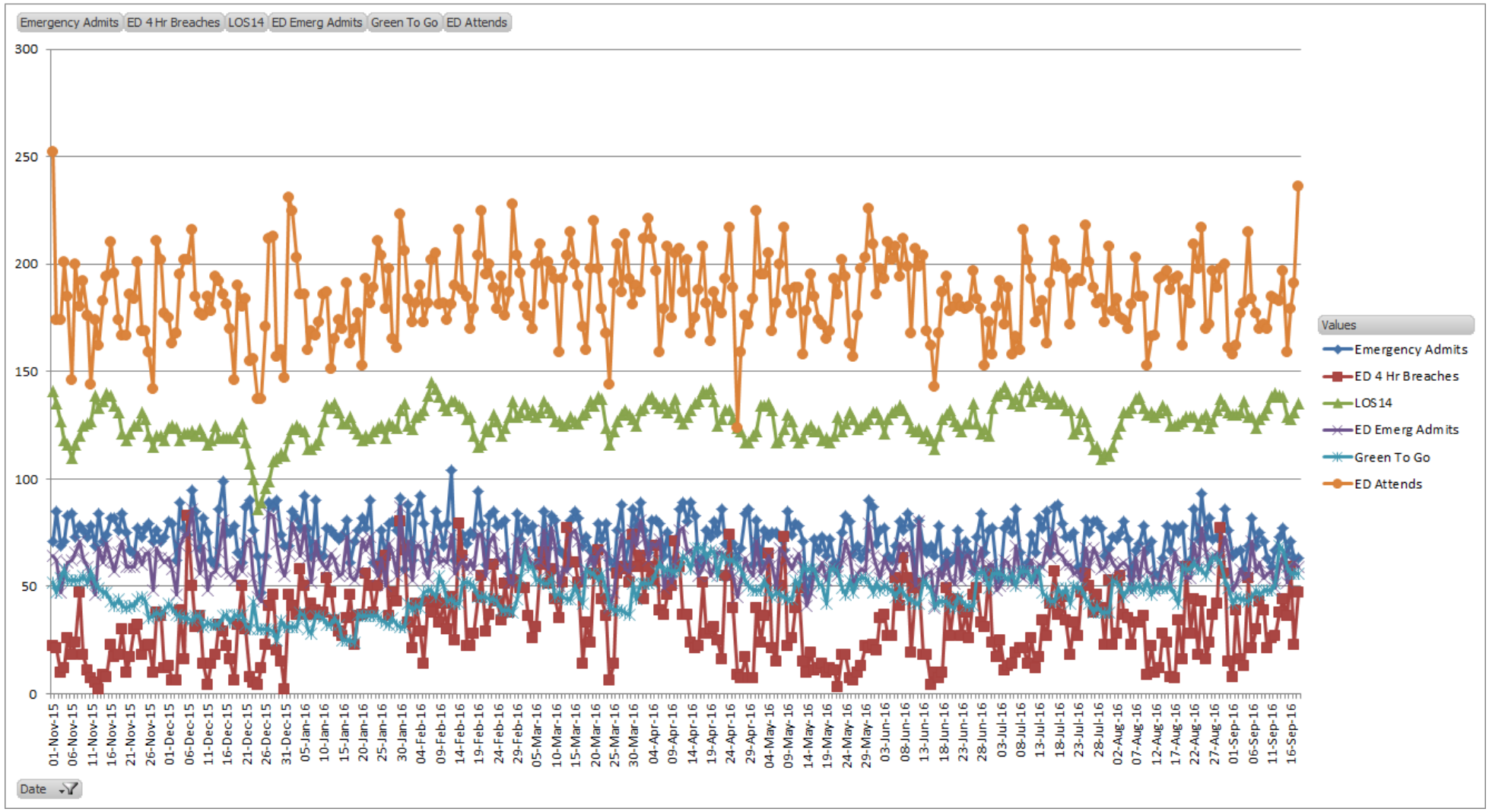
RTT Specialty	Ongoing Over 18 Weeks	Ongoing Pathways	Ongoing Performance
Cardiology	243	2,039	88.1%
Cardiothoracic Surgery	8	219	96.3%
Dermatology	184	2,391	92.3%
E.N.T.	69	2,462	97.2%
Gastroenterology	52	510	89.8%
General Medicine	0	55	100.0%
Geriatric Medicine	0	209	100.0%
Gynaecology	156	1,570	90.1%
Neurology	44	424	89.6%
Ophthalmology	227	4,755	95.2%
Oral Surgery	302	2,377	87.3%
Other	1,955	15,335	87.3%
Rheumatology	8	512	98.4%
Thoracic Medicine	16	1,014	98.4%
Trauma & Orthopaedics	80	1,157	93.1%
Grand Total	**3,344**	**35,029**	**90.5%**



	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Non-admitted pathways (target/actual)	1498/1470	1313/1222	1190/1460	1364/1479	1364/1480	1364/1796	1202/1741	1185/2189
Admitted pathways (target/actual)	931/879	832/861	735/937	1004/1001	1004/962	940/957	940/1008	940/1155
Total pathways (target/actual)	2430/2349	2145/2083	1925/2397	2368/2480	2368/2442	2304/2753	2142/2749	2125/3344
Target % incomplete < 18 weeks	92.4%	93.2%	93.9%	92.6%	92.6%	92.8%	93.2%	93.2%
Actual target % incomplete < 18 weeks	92.4%	93.2%	92.2%	92.3%	92.6%	92.1%	92.0%	90.5%

Appendix 3 (continued)

BRI Flow metrics



University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 29th September 2016 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
9. Quality and Outcomes Committee Chair's Report									
Sponsor and Author(s)									
Sponsor & Author: Alison Ryan, Non-Executive Director and Chair of the Quality and Outcomes Committee									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose To provide assurance that the Quality and Outcomes Committee are meeting in accordance with their terms of reference and to advise on the business transacted at the meeting held on 26 July 2016. Key issues to note As detailed in the report.									
Recommendations									
None.									
Impact Upon Board Assurance Framework									
Impact Upon Corporate Risk									
Implications (Regulatory/Legal)									
Equality & Patient Impact									

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

Report to the Board of Directors meeting 29 September 2016

From QOC Chair – Alison Ryan, Non-Executive Director

This report describes the business conducted at the Quality and Outcomes Committee held 26 August 2016, indicating the challenges made and the assurances received.

Item	Report/Key Points	Challenges	Assurance
Heygroves Theatres	Members received an update report on the progress against the action plan in relation to Heygroves Theatres. Members noted that the majority of the issues raised had been addressed and monitored as part of the Trust wide theatre transformation programme. Members noted that since the initial report to the CQC the Trust has received feedback that the person who contacted them raising concerns had advised of significant improvements within all aspects of the original concern.	Members received the action plan and noted the good progress that had been achieved. Assurance was required in relation to how the staff were responding to the changes and how this had been addressed.	Assurance was provided that the action plan had been addressed and significant improvements made. Members noted that the culture in care week, the workplace investigation had been integral in identifying the themes within the action plan. Assurance was provided that the team have been fully involved and supported the plan which had enabled other issues to be addressed. Members noted that additional staff were due to take up post shortly. Staff were using the 'Happy App' and it was noted the significant change in the way in which staff were feeling.
Outpatients Improvement Programme	Members received an update in relation to the Outpatients Improvement Programme.	Challenges were made in relation to the number of outpatient cancellations.	Clarification was provided in relation to the way in which cancellations were being reported

Item	Report/Key Points	Challenges	Assurance
			and it was noted that this was scheduled to be re-audited in a month. It was confirmed that whilst a number of changes are being made and that the report at the end of the next quarter will enable to under the reasons for cancellations.
	Members noted that there were some issues with the implementation of ERS.	Clarification was provided that this was a national system and there are some internal issues with the technical ability to make changes to the system.	Additional funding had been secured to recruit to fill this gap and in the interim the clinical support team are supporting these changes.
Serious Incidents and Root Cause Analysis	1 Serious Incident was reviewed.	1. The need for a reliable and consistent approach for tracking outstanding results, both in the department and more widely across the Trust. 2. 4-5 week delay between the dictation of the letter and sending it out.	Improved systems have been put in place in the Department. The wider issue is Trust wide and dependent on the roll-out of the IT Server. . Generally this has improved across the Trust. Confirmation was provided that urgent letters are actioned very quickly. Reflective learning had taken place and it was noted that the team have discussed the RCA.

Item	Report/Key Points	Challenges	Assurance
Quality Performance report	As provided to Governors	Failure of the 92% national standard for the percentage of patients waiting under 18 weeks Referral to Treatment (RTT) had been forecast due to recent rises in both the elective and outpatient waiting lists. However the national standard was achieved at the end of July, for a seventh consecutive month. Performance against the A&E 4-hour standard also continued to be above trajectory.	Pressure on RTT mounting whilst this is being handled, a recovery plan will be put in place.
		Performance against the measures of National Early Warning Scores (NEWS) continue to be disappointing, but with some improvement in the period.	These areas of patient safety and clinical effectiveness continue to be the focus of significant attention.
		Fewer patients were seen in outpatients in July than either the previous month or the same period last year, which in combination with growth in outpatient referrals for some high volume RTT specialties has led to an increase in the size of the outpatient waiting list.	Continued effort to maintain the service despite difficult challenges.
Clinical Audit Report	Members received the Clinical Audit Annual Report.		Members were assured with report as a key part of the assurance system. This would be considered at the next Audit Committee.

Item	Report/Key Points	Challenges	Assurance
Monthly Nurse staffing	The report provided the monthly and 6 monthly nurse staffing information.	Challenged the number of incidents reported for Theatres.	Clarification was provided that the figures do not include Theatres. However, all incidents are reported on Datix and there were no reported incidents for theatres in the last month. The Chief Nurse agreed to confirm the position.
Infection Control	The report provided a summary of the Infection Prevention and Control activities during the first quarter of 2016/17.	Challenged in terms of the cleaning across the Trust.	The Chief Nurse assured the Committee that she was satisfied with cleanliness across the Trust.
Quality Impact Assessment Report	The report provided an update on the Quality Impact Assessment of Cost Improvement Programme savings Schemes.		Assurance was proved that schemes have adequate mitigation of any risks to quality and safety. Agreed to receive a further update on two of the schemes at the next meeting.

Cover report to the Board of Directors meeting held in Public
To be held on 29th September 2016 in the Conference Room,
Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
11. Quarterly Complaints									
Sponsor and Author(s)									
Sponsor: Carolyn Mills, Chief Nurse **Author**: Tanya Tofts, Patient Support and Complaints Manager									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

To provide the Board with an overview of complaints received by the Trust during the first quarter of 2016/17, including any themes arising and actions taken to address.

Key issues to note

In Quarter 1:

- 520 complaints were received in Quarter 1, which equates to 0.26% of patient activity (approximately one patient in every 380).
- 76.2% of complaints were responded to within the timescales agreed with the complainant
- 11.2% of complainants were dissatisfied with our response
- None of the seven complaints closed by the PHSO in Q1 were upheld.
- Surgery Head & Neck – There was a decrease in complaints about attitude and communication and a reduction in complaints received by the Trauma and Orthopaedic service. However, the number of complaints received by the Upper and Lower GI services showed a marked increase compared with Q4. Complaints received by Bristol Eye Hospital and Bristol Dental Hospital remained high and there was an increase in the number of complaints received about appointments and admissions.
- Medicine – There was a reduction in the number of complaints received in respect of attitude and communication and the majority of complaints received in Quarter 1 were resolved via the informal process. However, the number of complaints received by the BRI Emergency Department remained high and there was an increase in complaints received by the Gastroenterology & Hepatology services. There was an increase in the number of complaints received under 'appointments and admissions' and 'clinical care'.
- Specialised Services – There was a notable reduction in complaints received by the outpatients service at Bristol Heart Institute. However, the Division saw the number of complaints received in respect of attitude and communication double to 22, compared with 11 in Q4 of 2015/16. Whilst complaints regarding the attitude of various staff groups remained low, there was an increase in complaints about waiting time for correspondence and communication with patients/relatives.
- Women's & Children's Services – significant reduction in the number of complaints received in

respect of attitude and communication, particularly with regards to communication with patients/relatives. There was, however, a sizeable increase in complaints relating to cancelled or delayed appointments and operations, with 27 complaints, compared with 12 in Q4.

- Diagnostics and Therapies - There was a notable decrease in the number of complaints received in relation to attitude and communication and also in the number of complaints received by the radiology service. However, the Division saw an increase in complaints about the audiology service.
- Training continues to be rolled out by the Patient Support & Complaints Team tailored to the theme of how to write a good response letter (sessions are currently arranged through to December 2016).

Recommendations

The Board is asked to receive the report for assurance.

Impact Upon Board Assurance Framework

Impact Upon Corporate Risk

Implications (Regulatory/Legal)

Equality & Patient Impact

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees

Quality & Outcomes Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)

University Hospitals Bristol NHS
NHS Foundation Trust

Complaints Report

Quarter 1, 2016/2017

(1st April 2016 to 30th June 2016)

Author: Tanya Tofts, Patient Support and Complaints Manager

Overview

Successes	Priorities
• None of the seven complaints closed by the PHSO in Q1 were upheld. • Surgery Head & Neck – decrease in complaints about attitude and communication and a reduction in complaints received by the Trauma and Orthopaedic service. • Medicine – reduction in number of complaints received in respect of attitude and communication and the majority of complaints received in Quarter 1 were resolved via the informal process. • Specialised Services – notable reduction in complaints received by the outpatients service at Bristol Heart Institute. • Women's & Children's Services – significant reduction in the number of complaints received in respect of attitude and communication, particularly with regards to communication with patients/relatives.	• Training continues to be rolled out by the Patient Support & Complaints Team tailored to the theme of how to write a good response letter (sessions are currently arranged through to December 2016). • Reduce the number of complaint responses that breach the agreed deadline. • Reduce the number of cases where the deadline agreed with the complainant is extended. • Finish scoping out detail of corporate quality objective for 2016/17 to reduce the number of people who complain about aspects of how we communicate with them.
Opportunities	**Risks & Threats**
• Explore potential to record severity of complaints to enable future benchmarking • Patient Support & Complaints Manager to continue working closely with Divisions in order to identify themes and trends in complaints and to share learning from complaints Trust-wide	Increases in complaints about: • Upper and Lower GI surgery • Gastroenterology • Hepatology • Audiology • Attitude and communication in Specialised Services • Cancelled of delayed appointments and operations in Women's & Children's Services Levels of complaints remained high in the following areas: • Bristol Eye Hospital • Bristol Dental Hospital • BRI Emergency Department

1. Complaints performance – Trust overview

The Board monitors three indicators of how well the Trust is doing in respect of complaints performance:

- Total complaints received as a proportion of activity;
- Proportion of complaints responded to within timescale; and
- Numbers of complainants who are dissatisfied with our response.

1.1 Total complaints received

The Trust's preferred way of expressing the volume of complaints it receives is as a proportion of patient activity, i.e. total inpatient admissions and outpatient attendances in a given month.

We received 520 complaints in Q1, which equates to 0.26% of patient activity. This includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1]. This figure does not include concerns which may have been raised by patients and dealt with immediately by front line staff. The number of complaints received in Q1 represents an increase of approximately 9% compared to Q4 and a 13% increase on the corresponding period one year previously.

Figure 1 shows the pattern of complaints received in the last 15 months. Figure 2 shows the complaints received as a percentage of patient activity and Figure 3 shows the numbers of complaints dealt with via the formal investigation process compared to those dealt with via the informal investigation process.

1.2 Complaints responses within agreed timescale

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

The Trust's target is to respond to at least 95% of complaints within the agreed timescale. The end point is measured as the date when the Trust's response is posted to the complainant. In Q1, 76.2% of responses were posted within the agreed timescale, compared to 74.6% in Q4 (2015/16) and 56.5% in Q3. This represents 34 breaches out of 143 formal complaints which were due to receive a response during Q1[2]. Figure 4 shows the Trust's performance in responding to complaints since April 2015.

[1] Informal complaints are dealt with quickly via direct contact with the appropriate department, whereas formal complaints are dealt with by way of a formal investigation via the Division.

[2] Note that this will be a different figure to the number of complainants who *made* a complaint in that quarter.

Figure 1: Number of complaints received

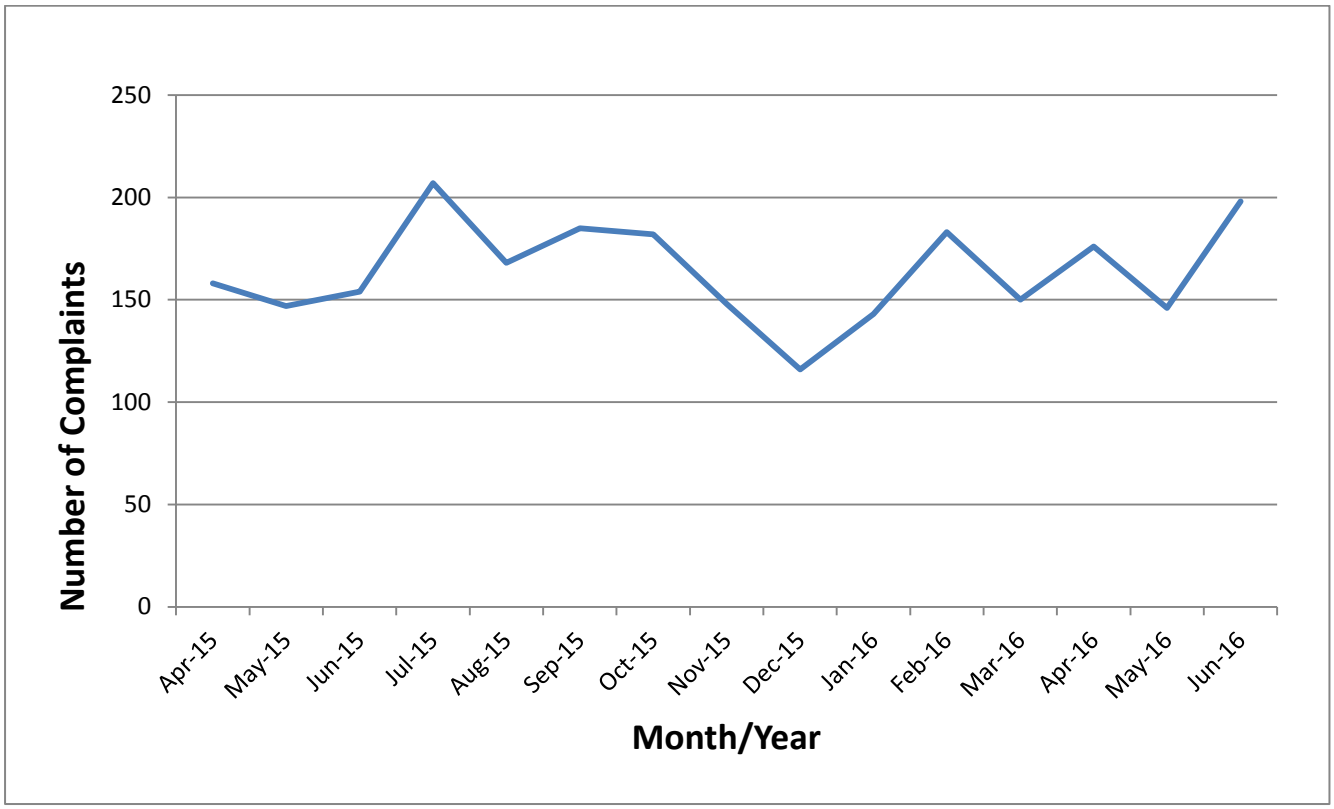


Figure 2: Complaints received, as a percentage of patient activity

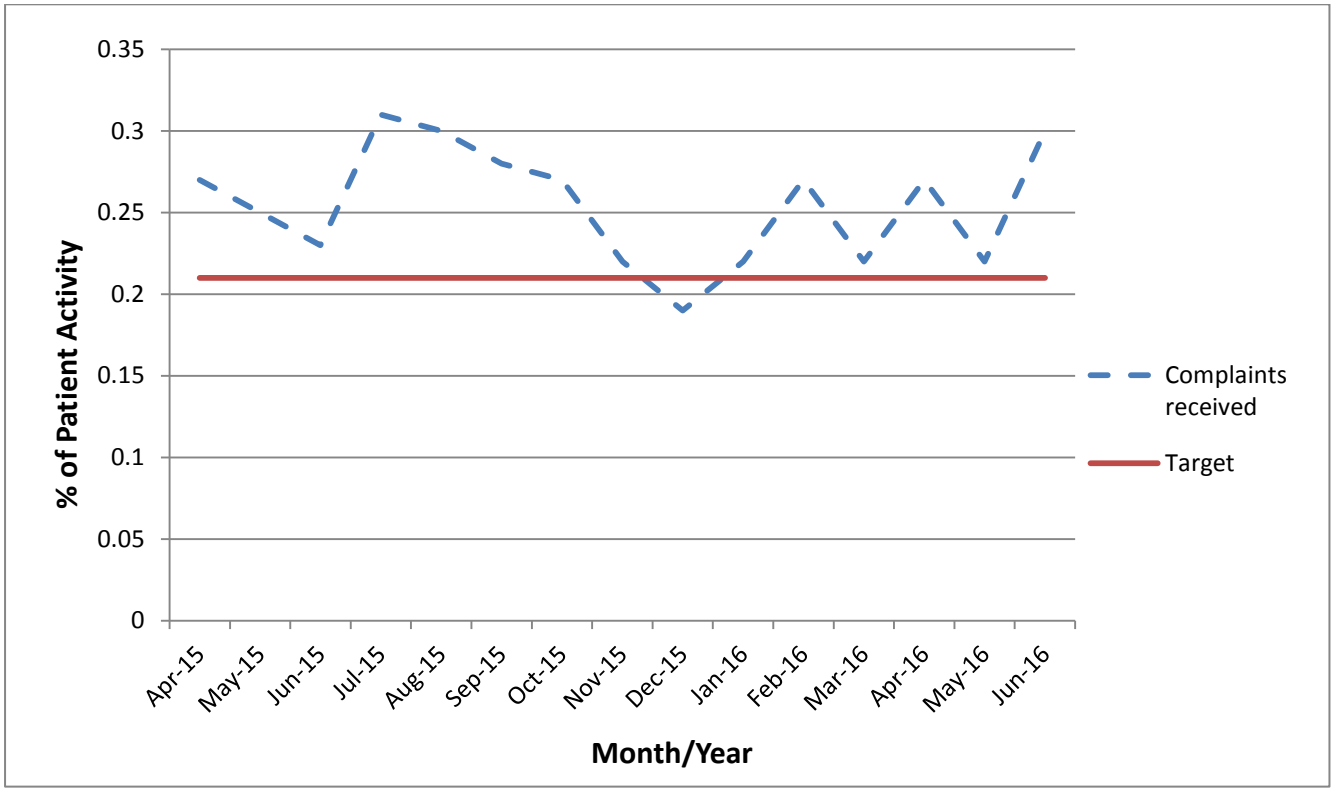


Figure 3: Numbers of formal v informal complaints

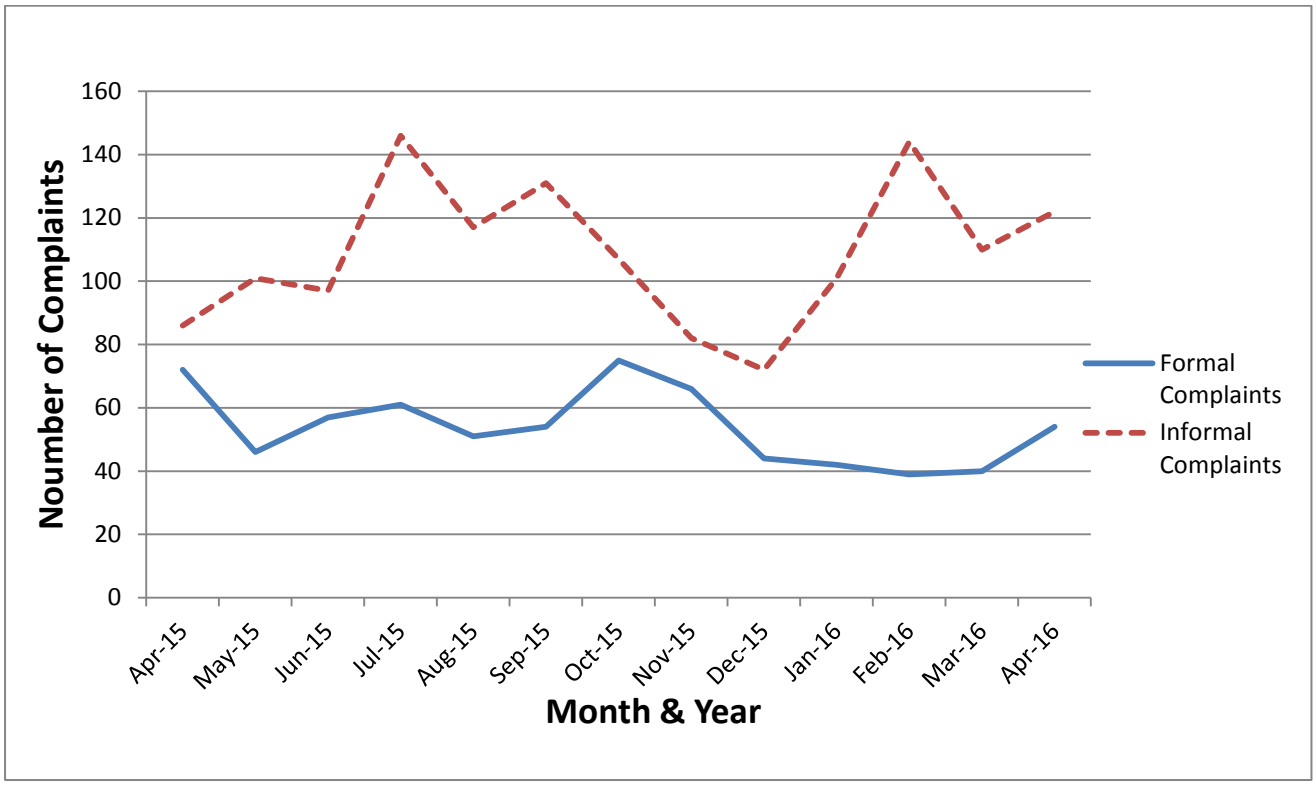


Figure 4: Percentage of complaints responded to within agreed timescale

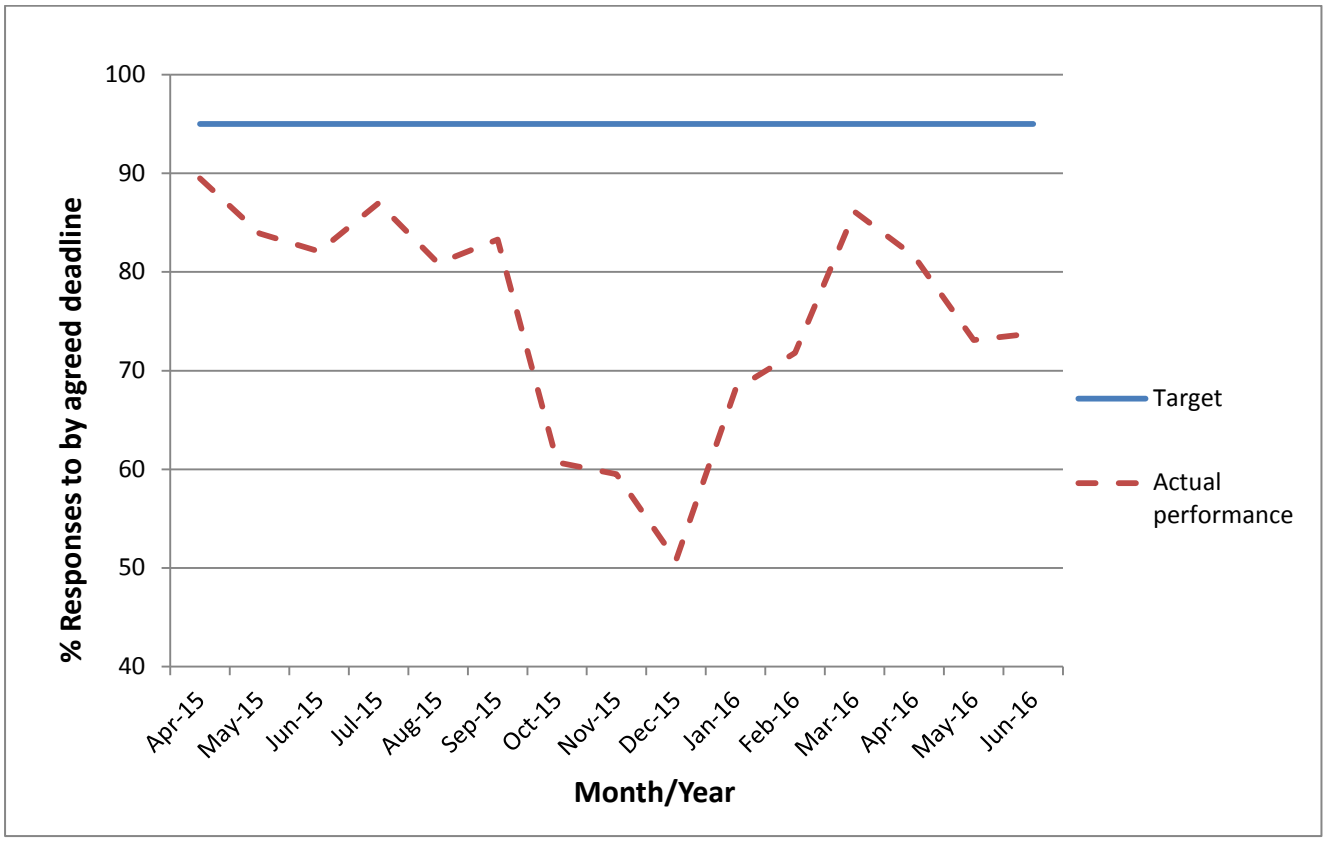


Table 1: Complaints performance

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

		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Total complaints received (inc. TS and F&E from April 2013)	TOTAL	154	207	168	185	182	148	116	143	183	150	176	146	198
	Formal	57	61	51	54	75	66	44	42	39	40	54	35	57
	Informal	97	146	117	131	107	82	72	101	144	110	122	111	141
Number and % of complaints per patient attendance in the month	%	0.23%	0.31%	0.30%	0.28%	0.27%	0.22%	0.19%	0.22%	0.27%	0.22%	0.27%	0.22%	0.30%
	Complaints	154	207	168	185	182	148	116	143	183	150	176	146	198
	Attendances	66,548	65,810	55,657	66,285	68,131	67,434	61,126	63,582	68,391	67,932	64,750	66,973	66,816
% responded to within the agreed timescale (i.e. response posted to complainant)	%	82.1%	87.0%	80.9%	83.3%	60.7%	59.5%	50.8%	68.1%	71.8%	86.1%	80.0%	73.1%	73.8%
	Within timescale	55	47	38	40	34	25	32	32	28	31	40	38	31
	Total	67	54	47	48	56	42	63	47	39	36	49	52	42
% responded to by Division within required timescale for executive review	%	94.0%	98.1%	93.6%	95.8%	80.4%	81.0%	90.5%	91.5%	84.6%	100.0%	86.0%	92.3%	92.9%
	Within timescale	63	53	44	46	45	34	57	43	33	36	43	48	39
	Total	67	54	47	48	56	42	63	47	39	36	50	52	42
Number of breached cases where the breached deadline is attributable to Division	Attributable to Division	6	6	3	2	7	7	20	12	10	5	3	8	7
	Total Breaches	12	7	9	8	22	17	31	15	11	5	9	14	11
Number of extensions to originally agreed timescale (formal investigation process only)		16	11	14	10	23	13	26	21	14	25	21	8	11
% of complainants dissatisfied with response and case re-opened	%	9.0%	13.0%	12.8%	16.7%	10.7%	4.8%	7.9%	6.4%	7.7%	8.3%	8.0%	-	-
	Reopened Dissatisfied	6	7	6	8	6	2	5	3	3	3	4	-	-
	Total Responses Due	67	54	47	48	56	42	63	47	39	36	50	-	-

1.3 Dissatisfied complaints

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

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

The way in which dissatisfied cases are reported is expressed as a percentage of the responses the Trust has sent out in any given month. From Q3 2015/16 onwards, our target has been for less than 5% of complainants to be dissatisfied. This data is now reported two months' in arrears in order to capture the majority of cases where complainants tell us they were not happy with our response.

In Q1, 143 responses were sent out and by the cut-off point of mid-September 2016 (the date on which the dissatisfied data for June 2016 was finalised); 16 people had contacted us to say they were dissatisfied. This represents 11.2% of the responses sent out during this period.

In Q4, a total of 122 responses were sent out. By the cut-off point of mid-May 2016 (the date on which the dissatisfied data for March 2016 was finalised), nine people had contacted us to say they were dissatisfied with our response. This represented 7.4% of the responses sent out and was an increase on the 6.2% (10 of 161) reported in Q3.

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

Each case where a complainant advises they are dissatisfied, the case is reviewed by the Patient Support and Complaints Manager. This review leads to one of the following courses of action, according to the complainant's preference:

- The lead Division is asked to reinvestigate the outstanding concerns and send a further response letter to the complainant addressing these issues;

- The lead Division is asked to reinvestigate the outstanding concerns and arrange to meet with the complainant to address these issues

- On rare occasions, a letter may be sent to the complainant advising that the Trust feels that it has already addressed all of the concerns raised and reminding the complainant that if they remain unhappy, they have the option of asking the Ombudsman to independently review their complaint. This option might be appropriate if, for example, if a complainant

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

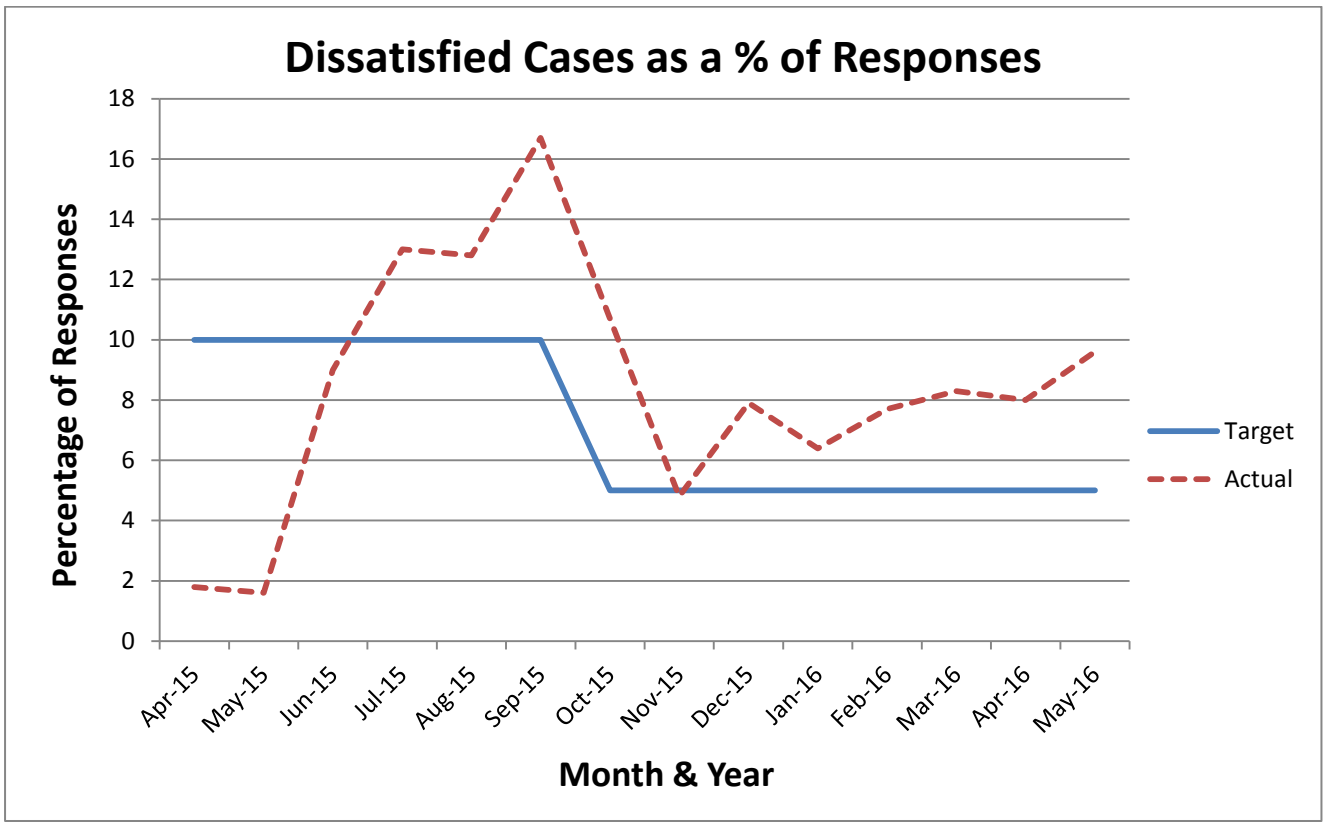
was disputing certain events that had been captured on CCTV and were therefore incontrovertible.

In the event that we do not have enough information to initiate the process outlined above, the allocated caseworker from the Patient Support and Complaints Team will contact the complainant to clarify which issues remain unresolved and, where possible, identify some specific questions that the complainant wishes to be answered. Following this, the process noted above would then be followed.

In all cases where a further written response is produced, the draft is reviewed by the Patient Support and Complaints Manager and by the Head of Quality (Patient Experience and Clinical Effectiveness) before sending it to an Executive Director for signing.

In the event that a complainant comes back to us again, having received two responses (whether in writing or by way of a meeting), the case will be escalated to the Chief Nurse for review.

Figure 5: Percentage of complainants dissatisfied with complaint response



2. Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of eight major categories, or themes. Two of these categories are new and have not been reported on prior to this Q1 report – they are 'discharge/transfer/transport' and 'documentation'. Table 2 provides a breakdown of complaints received in Q1 2016/17 compared to Q4 2015/16. Complaints in the categories of 'appointments and admissions', clinical care' and information and support' have all increased in Q1 in real terms. Complaints that fall under the category of access would include, for example, complaints about physical access to our hospitals, services not being available and dissatisfaction with visiting hours.

Table 2: Complaints by category/theme

Category/Theme	Number of complaints received in Q1 (2016/17)	Number of complaints received in Q4 (2015/16)
Access	5 (0.9% of total complaints) ↓	7 (1% of total complaints) ↓
Appointments & Admissions	169 (32.5%) ↑	150 (32%) ↑
Attitude & Communication	135 (26%) ↓	154 (33%) ↑
Clinical Care	128 (24.7%) ↑	112 (23%) ↓
Discharge/Transfer/Transport	26 (5%)	[4]
Documentation	2 (0.4%)	
Facilities & Environment	22 (4.2%) ↓	25 (5%) ↑
Information & Support	33 (6.3%) ↑	28 (6%) ↑
Total	**520**	**476**

Each complaint is also assigned to a more specific sub-category, for which there are over 100. Table 3 lists the eight most consistently reported sub-categories. In total, these sub-categories account for approximately 68% of the complaints received in Q1 (353/520).

Table 3: Complaints by sub-category

Sub-category	Number of complaints received in Q1 (2016/17)	Q4 2015/16	Q3 2015/16	Q2 2015/16
Cancelled/delayed appointments and operations	142 (27.9% increase compared to Q4) ↑	111	103	151
Communication with patient/relative	34 (45.2% decrease) ↓	62	41	31
Clinical Care (Medical/Surgical)	70 (70.7% increase) ↑	41	54	48
Failure to answer telephones/failure to respond	34 (17.2% increase) ↑	29	17	22
Clinical Care (Nursing/Midwifery)	22 (12% decrease) ↓	25	18	20
Attitude of Medical Staff	23 (27.8% increase) ↑	18	16	24
Attitude of Admin/Clerical Staff	16 (23.1% increase) ↑	13	9	10
Attitude of Nursing Staff	12 (50% increase) ↑	8	13	14

Complaints about cancelled or delayed appointments or operations/procedures have increased from 111 in Q4 to 142 in Q1. This consists of 88 complaints about cancelled or delayed appointments and 54 complaints about cancelled or delayed operations/procedures.

[4] Discharge/Transfer/Transport and Documentation are new reporting categories, added at the end of Q4 2015/16.

Most notably however, was the increase in the number of complaints received in respect of clinical care (medical/surgical), with 70 complaints received in Q1, compared to 41 in Q4.

There were increases in the number of complaints received about the attitude of administrative, nursing and medical staff, with a total of 51 complaints across these three sub-categories in Q1, compared with 39 in Q4.

Complaints in respect of failure to answer telephones or to respond to patients saw a further increase from 29 complaints in Q4 (2015/16) to 34 in Q1 (2016/17).

Figures 6, 7, and 8 show the four most commonly recorded sub-categories of complaint as detailed above, tracked since April 2015. These graphs suggest a deteriorating pattern in respect of complaints about cancelled or delayed appointments and operations since December 2015 and a similar rise in complaints about clinical care (medical/surgical). However, complaints about communication with patients/relatives have fallen significantly from a previous high point in February 2016 (one of the Trust's corporate quality objectives for 2016/17 is to reduce complaints about failures in communication).

Figure 6: Cancelled or delayed appointments and operations

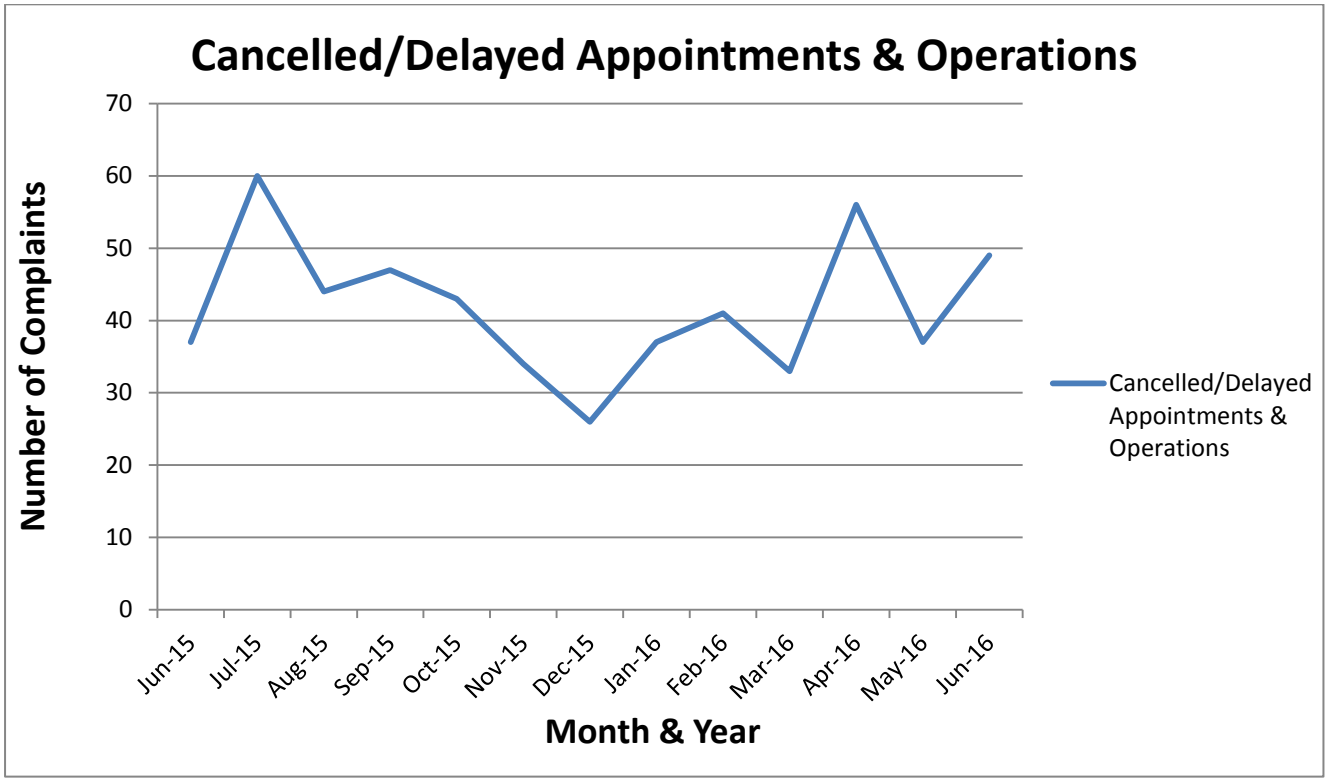


Figure 7: Clinical care – medical/surgical

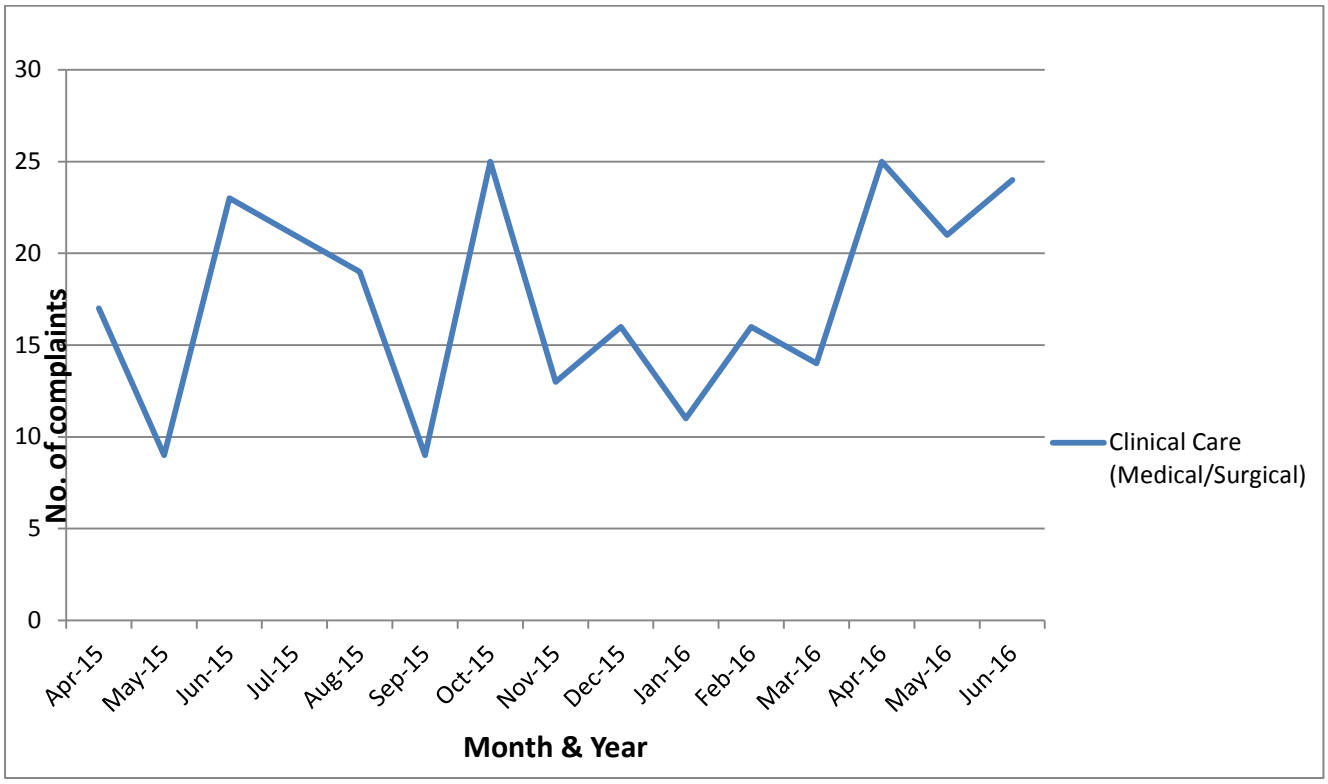
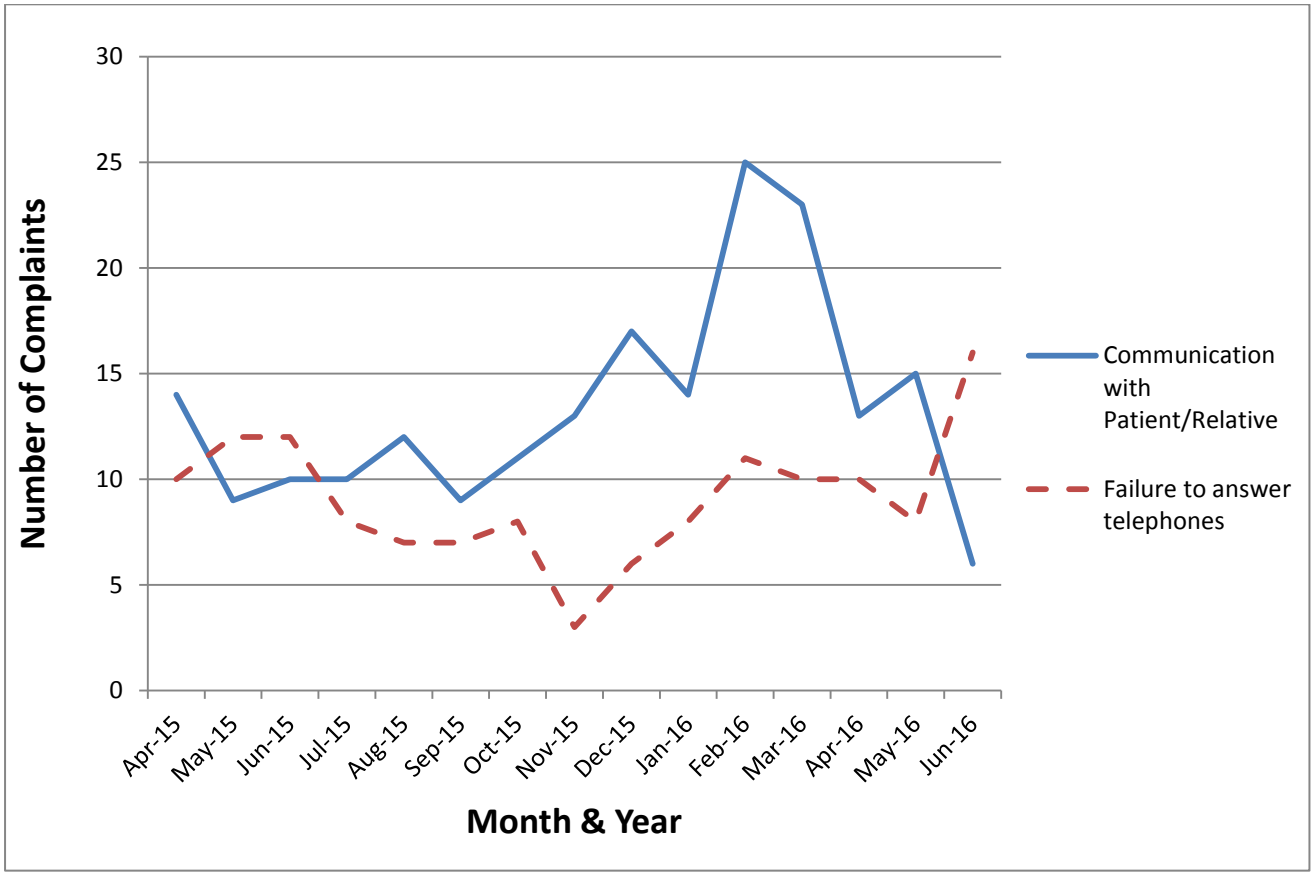


Figure 8: Communication with patient/relative and telephone answering

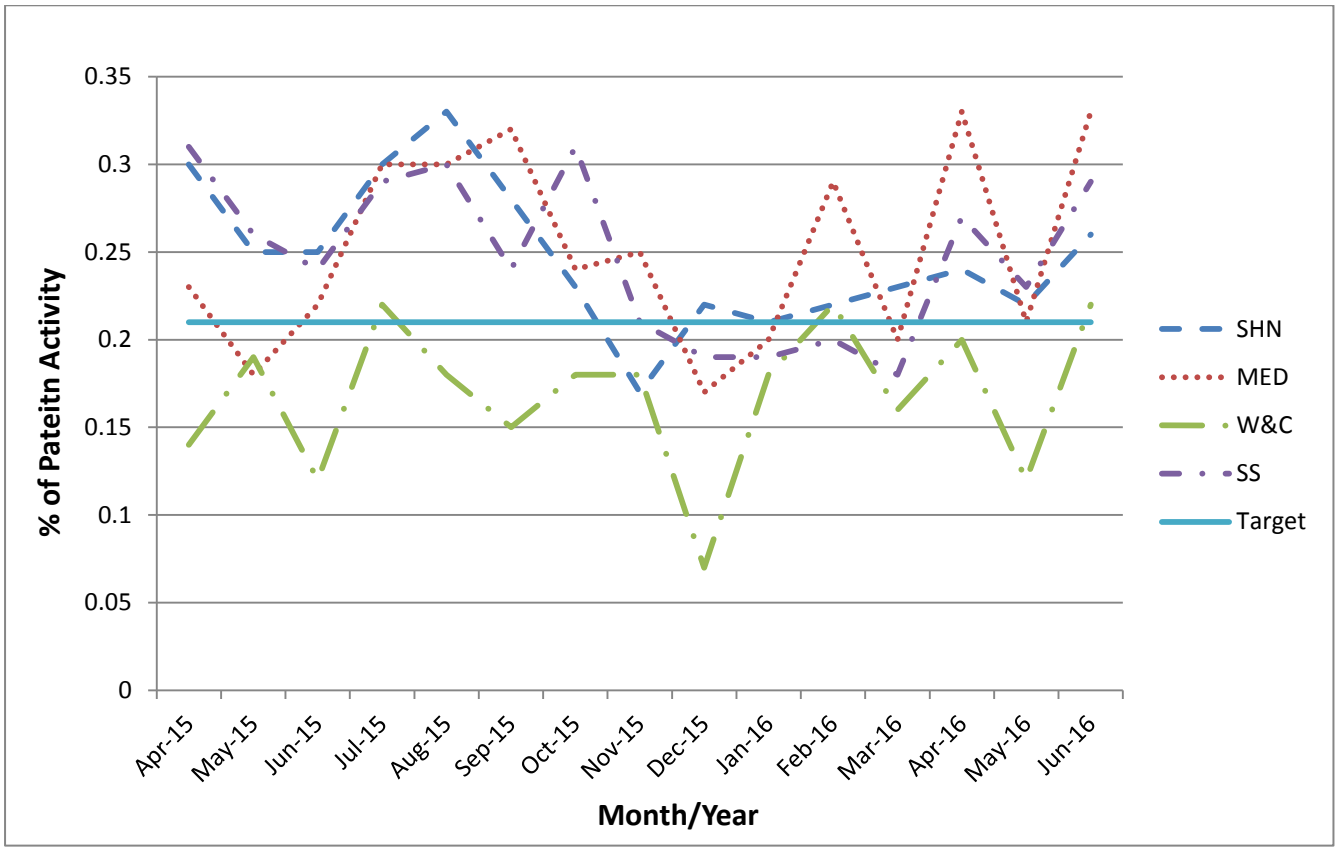


3. Divisional performance

3.1 Total complaints received

A divisional breakdown of the percentage of complaints per patient attendance is provided in Figure 9. This shows an overall increase in the volume of complaints received in the bed holding Divisions during Q4, with only Specialised Services showing a decrease in the number of complaints received.

Figure 9: Complaints by Division as a percentage of patient attendance



It should be noted that data for the Division of Diagnostics and Therapies is excluded from Figure 9 because this Division's performance is calculated from a very small volume of outpatient and inpatient activity. Overall, reported Trust-level data includes Diagnostics and Therapies complaints, but it is not appropriate to draw comparisons with other Divisions. For reference, numbers of reported complaints for the Division of Diagnostics and Therapies since April 2015 have been as follows:

Table 4: Complaints received by Division of Diagnostics and Therapies

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
No. of complaints received	2	5	7	10	4	5	12	5	7	5	13	6	5	7	12

3.2 Divisional analysis of complaints received

Table 5 provides an analysis of Q1 complaints performance by Division[5]. In addition to providing an overall view, the table includes data for the three most common reasons why people complain: concerns about appointments and admissions; concerns about staff attitude and communication; and concerns about clinical care.

Table 5	**Surgery, Head & Neck**	**Medicine**	**Specialised Services**	**Women & Children**	**Diagnostics & Therapies**
Total number of complaints received	198 (182) ↑	122 (102) ↑	66 (49) ↑	84 (87) ↓	24 (24) =
Total complaints received as a proportion of patient activity	0.24% (0.22%) ↑	0.29% (0.23%) ↑	0.26% (0.19%) ↑	0.18% (0.18%) =	N/A
Number of complaints about appointments and admissions	93 (80) ↑	26 (19) ↑	18 (21) ↓	28 (23) ↑	7 (6) ↑
Number of complaints about staff attitude and communication	50 (56) ↓	38 (40) ↓	22 (11) ↑	17 (30) ↓	6 (11) ↓
Number of complaints about clinical care	38 (35) ↑	32 (28) ↑	18 (14) ↑	31 (29) ↑	7 (6) ↑
Area where the most complaints have been received in Q1	Bristol Eye Hospital - 46 (52) Bristol Dental Hospital – 46 (44) Trauma & Orthopaedics – 21 (34) ENT – 17 (17) Upper GI – 15 (6) Lower GI – 12 (4)	Emergency Department (BRI) – 25 (25) Gastroenterology & Hepatology - 20 (11) Dermatology – 14 (19) Ward A300 (AMU) - 9 (7)	BHI Outpatients - 8 (15) GUCH Services – 8 (9) Chemo Day Unit/Outpatients – 7 (2) Ward C708 – 7 (5) Ward D603 – 6 (0)	Paediatric Orthopaedics – 7 (7) Paediatric Plastic Surgery – 7 (2) Gynae Outpatients – 6 (9) ED/Ward 39 – 6 (4) ENT (BRHC) – 5 (3)	Radiology – 8 (12) Audiology – 6 (3) Pharmacy – 5 (7) Physiotherapy – 4 (3)
Notable deteriorations compared to Q4	Upper GI – 15 (6) Lower GI – 12 (4)	Gastroenterology & Hepatology - 20 (11)	Ward D603 – 6 (0)	Paediatric Plastic Surgery – 7 (2)	Audiology – 6 (3)
Notable improvements compared to Q4	Trauma & Orthopaedics – 21 (34)	None	BHI Outpatients – 8 (15)	None	None

[5] It should be noted that the overall percentage of complaints against patient activity as shown in Table 5 differs slightly from the overall Trust percentage of 0.24% as the latter includes complaints from non-bed-holding Divisions.

3.2.1 Division of Surgery, Head & Neck

In Q1, the number of complaints received by the Upper and Lower GI services showed a marked increase compared with Q4. Complaints received by Bristol Eye Hospital and Bristol Dental Hospital remained high and there was an increase in the number of complaints received about appointments and admissions. However, complaints remained low in respect of complaints relating to attitude of medical and nursing/midwifery staff.

Table 6: Complaints by category type

Category Type	Number and % of complaints received – Q1 2016/17	Number and % of complaints received – Q4 2015/16
Access	0 (0% of total complaints) ↓	2 (1.1% of total complaints) =
Appointments & Admissions	90 (45.6%) ↑	80 (44%) ↑
Attitude & Communication	53 (26.7%) ↓	56 (30.8%) ↑
Clinical Care	40 (20%) ↑	35 (19.2%) ↓
Facilities & Environment	2 (1.1%) ↓	4 (2.2%) ↑
Information & Support	8 (3.8%) ↑	5 (2.7%) ↓
Discharge/Transfer/ Transport	5 (2.8%)	
Documentation	0	
Total	**198**	**182**

Table 7: Top sub-categories

Category	Number of complaints received – Q1 2016/17	Number of complaints received – Q4 2015/16
Cancelled or delayed appointments and operations	73 ↑	69 ↑
Clinical Care (Medical/Surgical)	18 ↑	14 =
Communication with patient/relative	10 ↓	24 ↑
Attitude of Medical Staff	6 ↓	9 ↑
Attitude of Nursing/Midwifery	4 ↑	0 ↓
Attitude of Admin/Clerical Staff	5 ↑	4
Clinical Care (Nursing/Midwifery)	4 ↑	0 ↓
Failure to answer telephones	18 ↑	9 ↑

Table 8: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
There was an increase in the number of complaints received by the Upper GI service in Q1, with 15 complaints compared to six in Q4. Of the 15 complaints received, 10 were in respect of cancelled or delayed appointments or operations.	Cancelled/delayed appointments were due to lack of capacity.	A focus on improving the discharge of patients from the Upper GI and Lower GI service will be commenced in October as part of wider transformation activity aimed at reducing length of stay to enhance the capacity for ward beds.
There was also an increase in the number of complaints received by the Lower GI service, with 12 complaints received in Q1, compared with four in Q4. Of the 12 complaints received, six were in in respect of cancelled or delayed appointments or operations. There were no other discernible trends identified for the remaining six complaints, although three related to attitude and communication.	Whilst an increase was seen in Q1, the numbers of formal complaints has reduced so far in Q2. Cancelled/delayed appointments were due to lack of capacity.	As above – focus on improving the discharge process for patients within the Lower GI appointment areas.
There has been an increase in the number of complaints received in respect of appointments and admissions; 93 complaints compared to 80 in Q4. The majority of these were in respect of cancelled or delayed appointments or operations. Of these complaints, 20 were received by the Bristol Eye Hospital; 15 by the Bristol Dental Hospital and 10 by the Upper GI service.	There has been an increase in complaints received by the Bristol Dental Hospital. This has been due to staff sickness and vacancies. The Bristol Eye Hospital and Upper GI complaints are related to cancelled appointments due to lack of capacity.	Weekly meetings have been implemented between the dental management team, Divisional Director and divisional human resources team to focus on reducing sickness and enhancing retention.
Complaints received about the Bristol Dental Hospital increased from 44 in Q4 to 46 in Q1, with 24 of these being about Adult Restorative Dentistry and 11 in respect of Oral Surgery.	This was a theme in Q4 of 2015/16 and the complaints continue to relate to diagnosis and the treatment plan presented to the patient.	In conjunction with the weekly meetings detailed above, there is a great deal of work ongoing to improve staff retention and reduce sickness levels amongst administrative staff at the Dental Hospital.

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

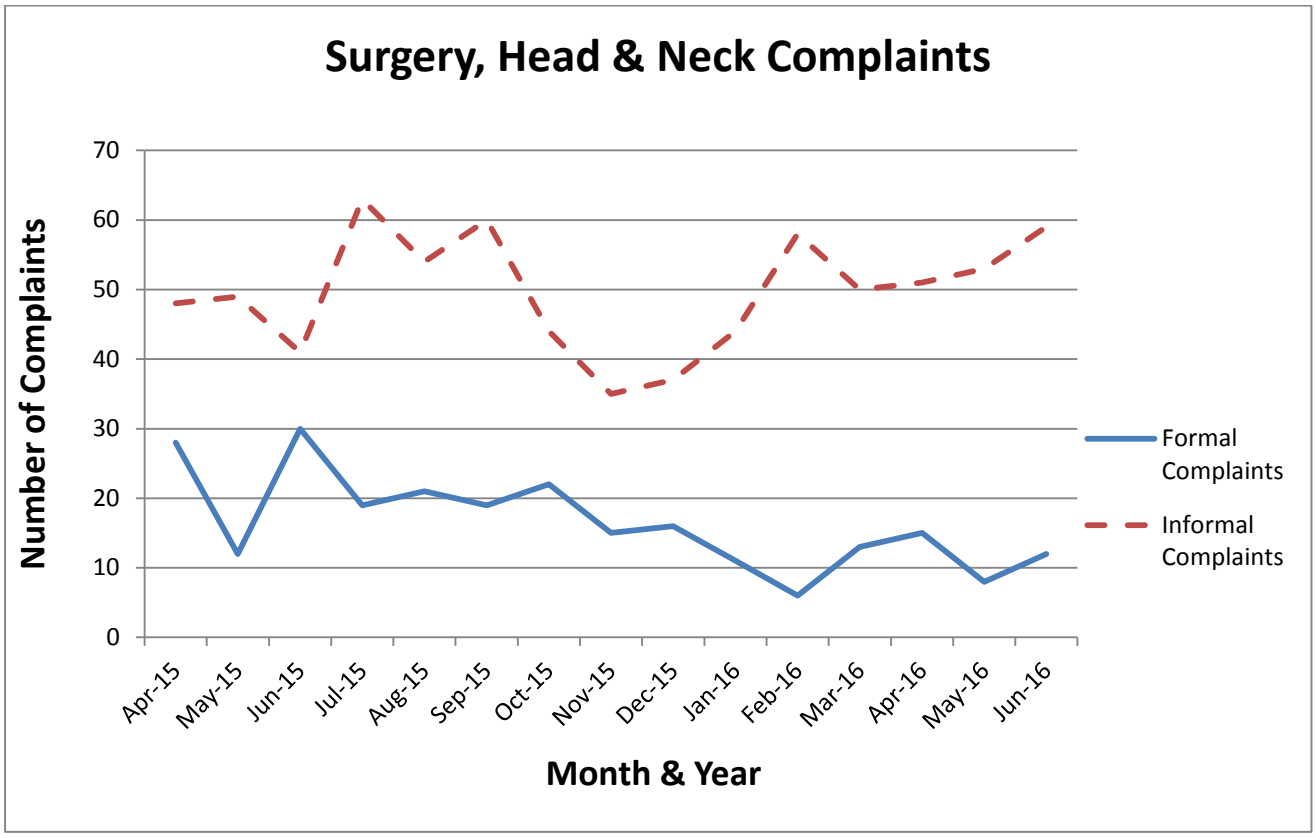
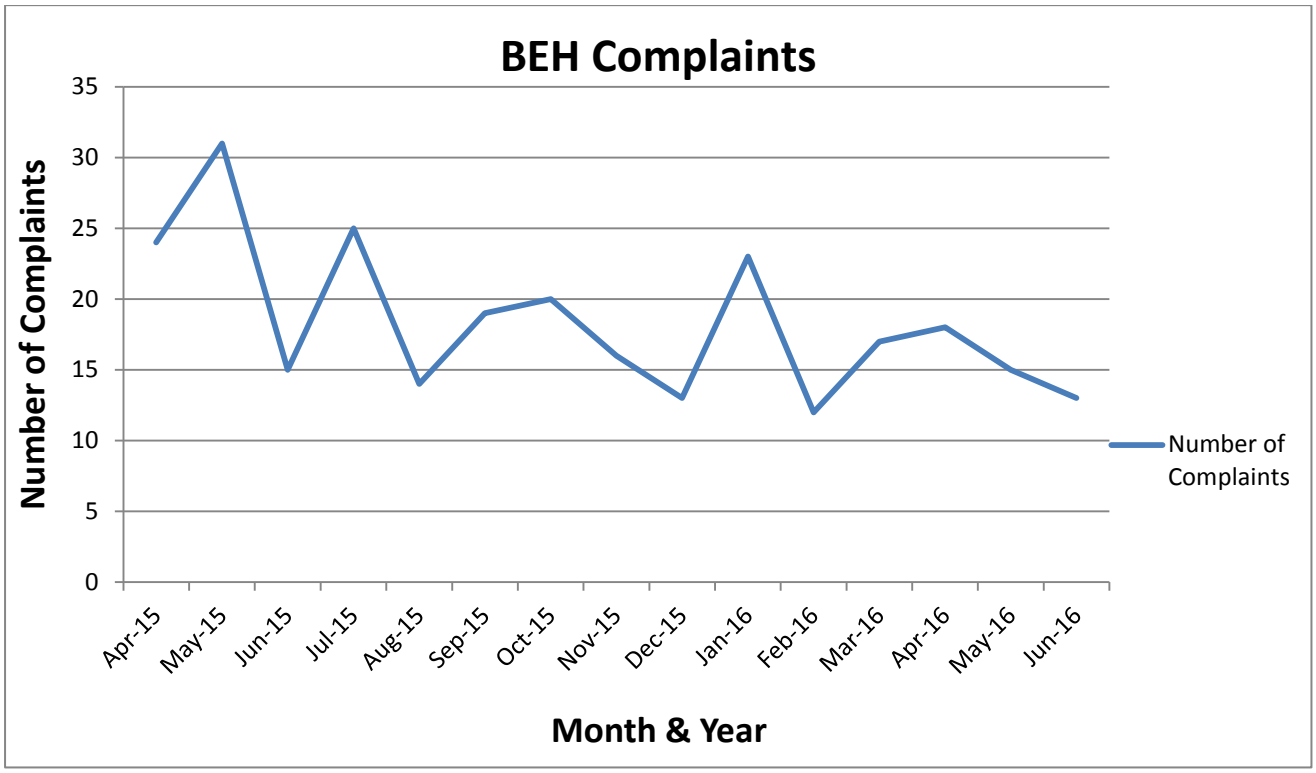


Figure 11: Complaints received by Bristol Eye Hospital



3.2.2 Division of Medicine

In Q1, the number of complaints received by the BRI Emergency Department remained high and there was an increase in complaints received by the Gastroenterology & Hepatology services. There was an increase in the number of complaints received under 'appointments and admissions' and 'clinical care'. The majority of complaints continued to be resolved via the informal process (87 compared to 35 managed formally).

Table 9: Complaints by category type

Category Type	Number and % of complaints received – Q1 2016/17	Number and % of complaints received – Q4 2015/16
Access	1 (0.8% of total complaints) =	1 (1% of total complaints) ↑
Appointments & Admissions	28 (23.1%) ↑	19 (18.6%) ↑
Attitude & Communication	38 (31.1%) ↓	40 (39.2%) ↑
Clinical Care	32 (26.2%) ↑	28 (27.5%) ↓
Facilities & Environment	7 (5.7%) ↓	8 (7.8%) ↑
Information & Support	3 (2.5%) ↓	6 (5.9%) ↑
Discharge/Transfer/ Transport	12 (9.8%)	
Documentation	1 (0.8%)	
Total	**122**	**102**

Table 10: Top sub-categories

Category	Number of complaints received – Q1 2016/17	Number of complaints received – Q4 2015/16
Cancelled or delayed appointments and operations	17 ↑	12 ↑
Clinical Care (Medical/Surgical)	17 ↑	8 ↓
Communication with patient/relative	12 =	12 ↓
Attitude of Medical Staff	8 ↑	6 ↑
Attitude of Nursing/Midwifery	5 ↑	4 ↓
Attitude of Admin/Clerical Staff	5 ↑	2
Clinical Care (Nursing/Midwifery)	9 ↓	12 ↑
Failure to answer telephones	5 ↓	9 ↑

Table 11: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
The ED received 25 complaints in Q1, in line with the 25 received in Q4. Of these 25 complaints, 10 were in respect of clinical care and nine related to attitude and communication.	Although this looks like a large number of complaints, it represents a very small proportion of the 17,000 patients who accessed the service during this period. One complaint about clinical care is subject to an RCA investigation.	Continue to monitor numbers of complaints and review for any emerging themes.
There was an increase in complaints received by the Gastroenterology and Hepatology service in Q1, with 20 complaints compared with 11 in Q4 of 2015/16. 11 of the complaints received by the service were in respect of appointments and admissions, with nine of those relating to cancelled or delayed appointments or procedures. Five complaints were received in respect of attitude and communication.	Patients complained about cancelled appointments and delays getting a follow up appointment following the industrial action by junior doctors. Some patients who had been booked onto the earlier strike dates were rebooked onto future strike dates (unknown at the time), therefore resulting in more than one cancellation for the same reason. Complaints were also received about delays in starting treatment for Hepatitis C treatment. The majority of the complaints received related to failure to respond to or answer telephone messages. This issue was highlighted as clinic coordinators' extension numbers had changed and the divert had been removed. There were also low staffing levels for a short period of time, resulting in delays returning calls.	Additional clinics requested and added where possible. There will be an additional Specialist Registrar running clinics from September 2016, increasing capacity for follow ups. Patients have been updated that we are currently restricted by NHS England on the number of patients the network can treat on a monthly basis – this is being challenged by the Trust. Telecoms have put the divert back on and have since removed an extension number so that messages cannot be left on it.

There was an overall increase in complaints received regarding clinical care, most notably with 17 of these being medical/surgical compared with eight in Q4 2015/16. Of the 17 cases, seven were in respect of the Emergency Department, with the remainder spread across a variety of departments.	All of these complaints have been analysed and no themes or trends emerged. Issues varied in nature and involved different medical and nursing teams.	Continue to monitor numbers of complaints and review for any emerging themes.

Figure 12: Medicine – formal and informal complaints received

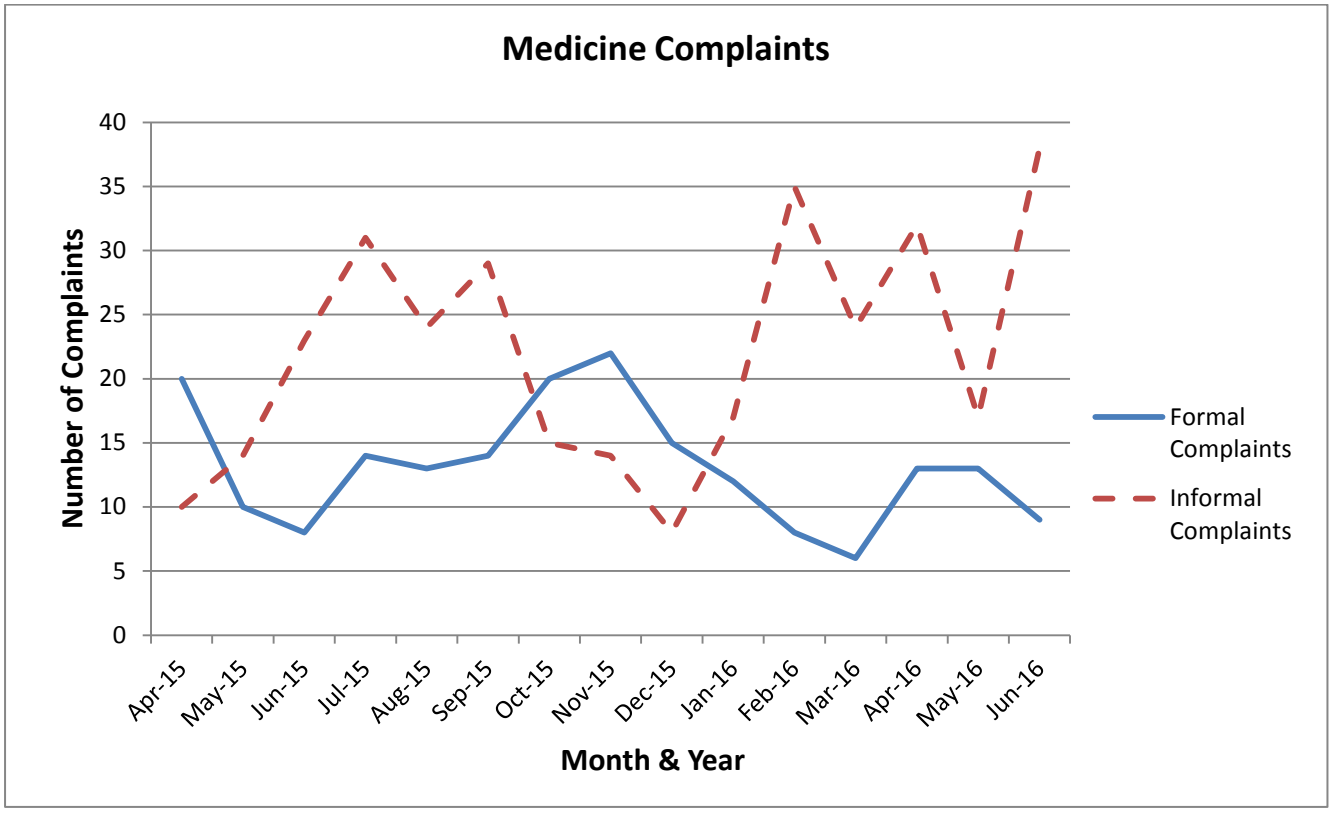
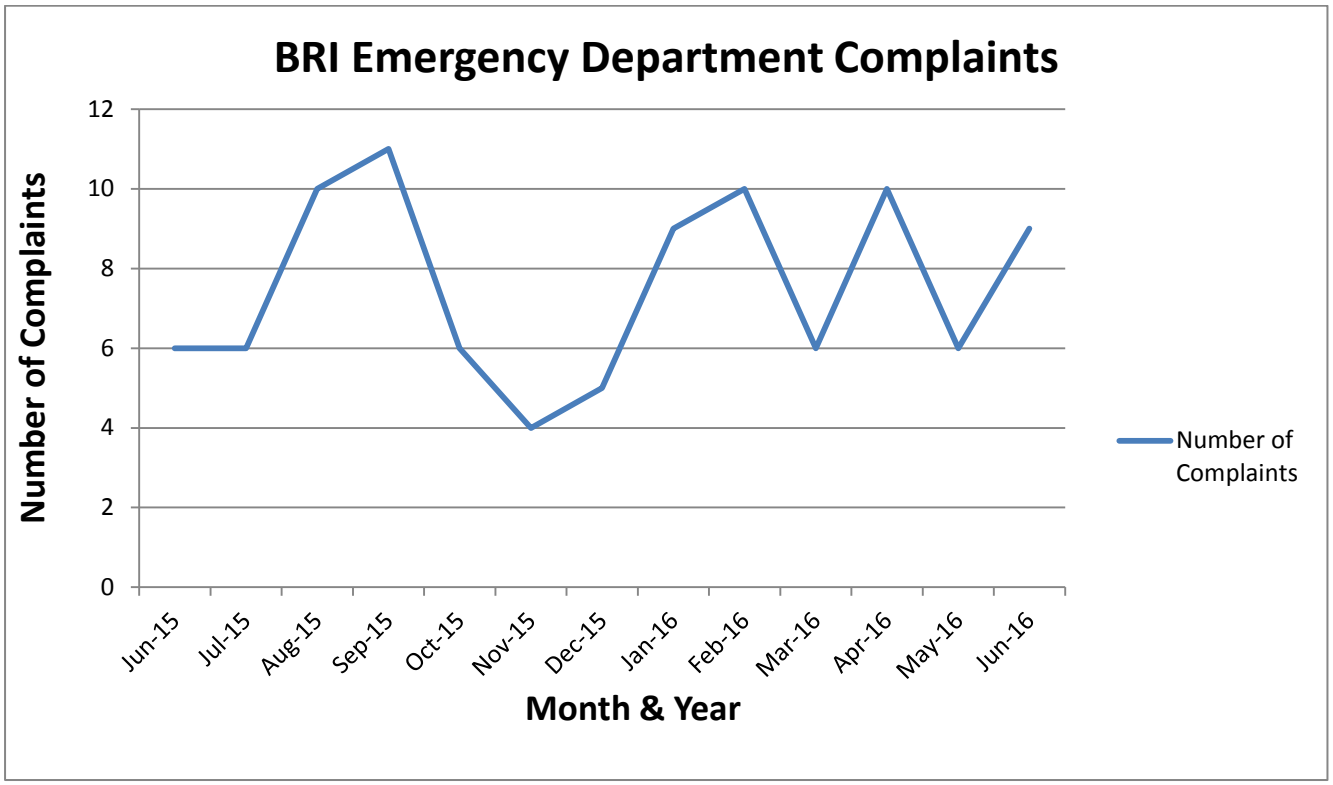


Figure 13: Complaints received by BRI Emergency Department



3.2.3 Division of Specialised Services

In Q1, the Division saw the number of complaints received in respect of attitude and communication double to 22, compared with 11 in Q4 of 2015/16. Whilst complaints regarding the attitude of various staff groups remained low, there was an increase in complaints about waiting time for correspondence and communication with patients/relatives.

Table 12: Complaints by category type

Category Type	Number and % of complaints received – Q1 2016/17	Number and % of complaints received – Q4 2015/16
Access	0 (0% of total complaints) =	0 (0% of total complaints) =
Appointments & Admissions	18 (27.3%) ↓	21 (42.9%) =
Attitude & Communication	22 (33.3%) ↑	11 (22.4%) ↓
Clinical Care	18 (27.3%) ↑	14 (28.6%) ↓
Facilities & Environment	1 (1.5%) ↑	0 (0%) ↓
Information & Support	1 (1.5%) ↓	3 (6.1%) =
Discharge/Transfer/Transport	5 (7.6%)	
Documentation	1 (1.5%)	
Total	**66**	**49**

Table 13: Top sub-categories

Category	Number of complaints received – Q1 2016/17	Number of complaints received – Q4 2015/16
Cancelled or delayed appointments and operations	17 ↑	16 ↑
Clinical Care (Medical/Surgical)	9 ↑	5 ↓
Communication with patient/relative	8 ↑	3 ↓
Attitude of Medical Staff	1 ↑	0 ↓
Attitude of Nursing/Midwifery	2 ↑	0 =
Attitude of Admin/Clerical Staff	0 ↓	1
Clinical Care (Nursing/Midwifery)	3 =	3 =
Failure to answer telephones	5 ↑	3 =

Table 14: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
The number of complaints received in relation to attitude and communication increased from 11 in Q4 2015/16 to 22 in Q1. Of these 22 complaints, 10 were received by the Bristol Haematology & Oncology Centre and 12 were received by the Bristol Heart Institute.	Themes within the 22 complaints include: • delays in communication of test results to patients; • unanswered telephone calls across Bristol Haematology and Oncology Centre and Bristol Heart Institute; and • concerns raised regarding the communication of plans of care from nursing staff to patients during their cardiac surgery pathway and communication between medical staff and patients within oncology	A typing delay report is produced for each team of medical secretaries, detailing any typing tasks that are outstanding or overdue. These reports will be reviewed by the appropriate team leaders to ensure that typing takes place in a timely fashion within the Bristol Heart Institute so that test results are communicated in a more timely way. The Division is currently considering ways in which the Trust's telecommunications team and the Division can and highlight telephone numbers which are patient-facing within its records. This will help to identify which specific numbers are not being answered in a timely manner and any issues to be addressed. Patient stories within cardiac surgery will be shared and discussed at the Sisters'

		meeting and within clinical areas to facilitate reflection; medical staff have received feedback regarding the complaints which reflect their communication. The Division is also currently working with the patient experience team to roll out a patient-focused programme to improve communication between clinical staff and patients across the Division. It is proposed that this will be trialed within cardiac surgery.
There was an increase in the number of complaints received by Ward D603 at the Bristol Haematology & Oncology Centre, from zero complaints in Q4 of 2015/16 to six complaints in Q1. Of these six complaints, three were in respect of clinical care (medical/surgical), with one complaint each in respect of attitude of medical staff, clinical care (nursing) and communication with patient/relative.	Of the six complaints received by Ward D603, one related to the way in which medical staff communicated a patient's diagnosis and deteriorating condition and three reflected concerns raised regarding clinical care or decisions made by the medical staff. The two concerns categorised as nursing clinical care were respectively about cold conditions on the ward and the manner in which a patient was discharged.	The complaints which highlight concerns surrounding the communication and clinical care of medical staff are being addressed through specific action plans relating to the complaints. In addition, they are being reviewed and reflected upon by the clinical and managerial teams within Bristol Haematology and Oncology Centre to facilitate some reflection for individuals concerned. Nursing related concerns are being addressed through a project to be undertaken within the Division to improve discharge processes, and Estates have undertaken work upon the windows on Ward D603 to improve the temperature during the winter.

Figure 14: Specialised Services – formal and informal complaints received

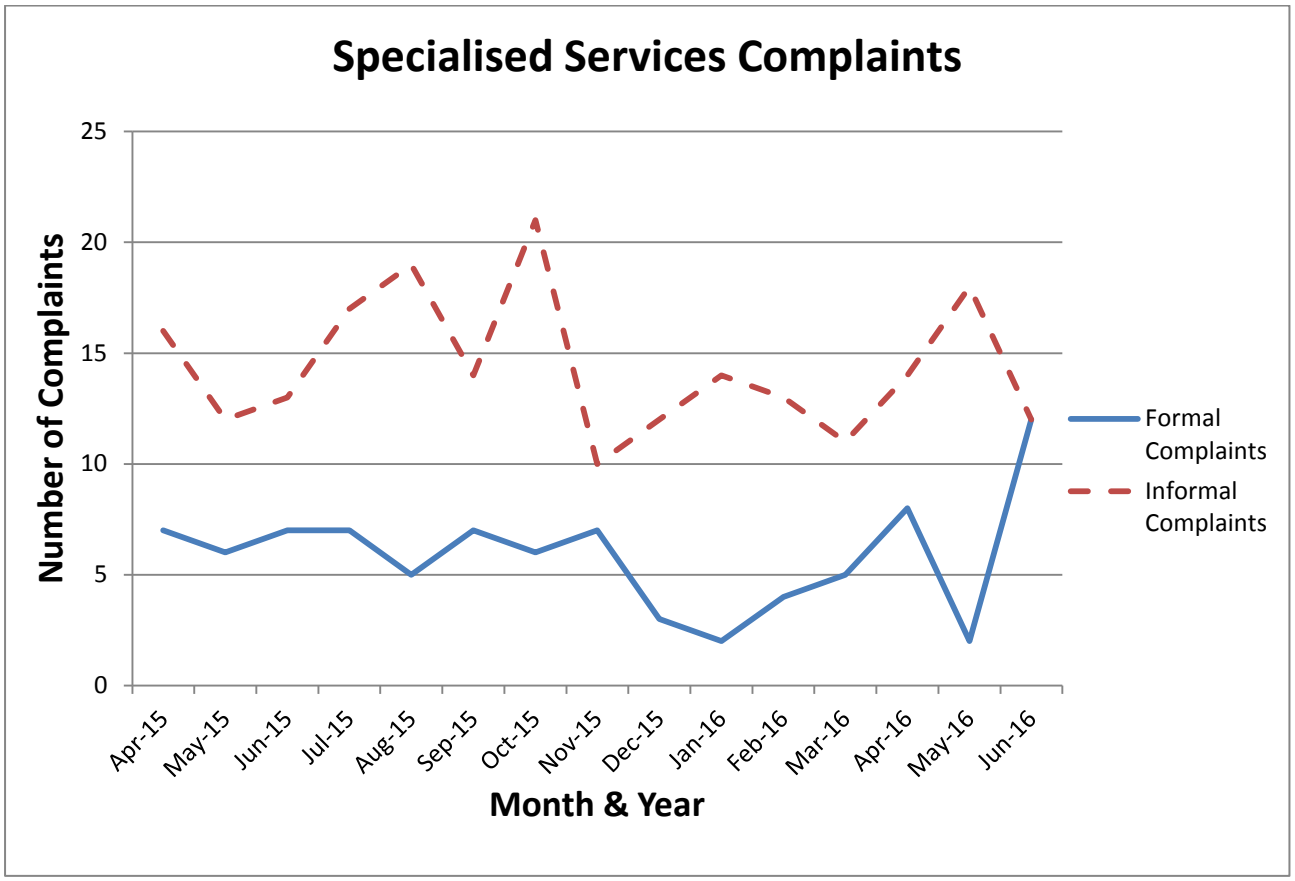
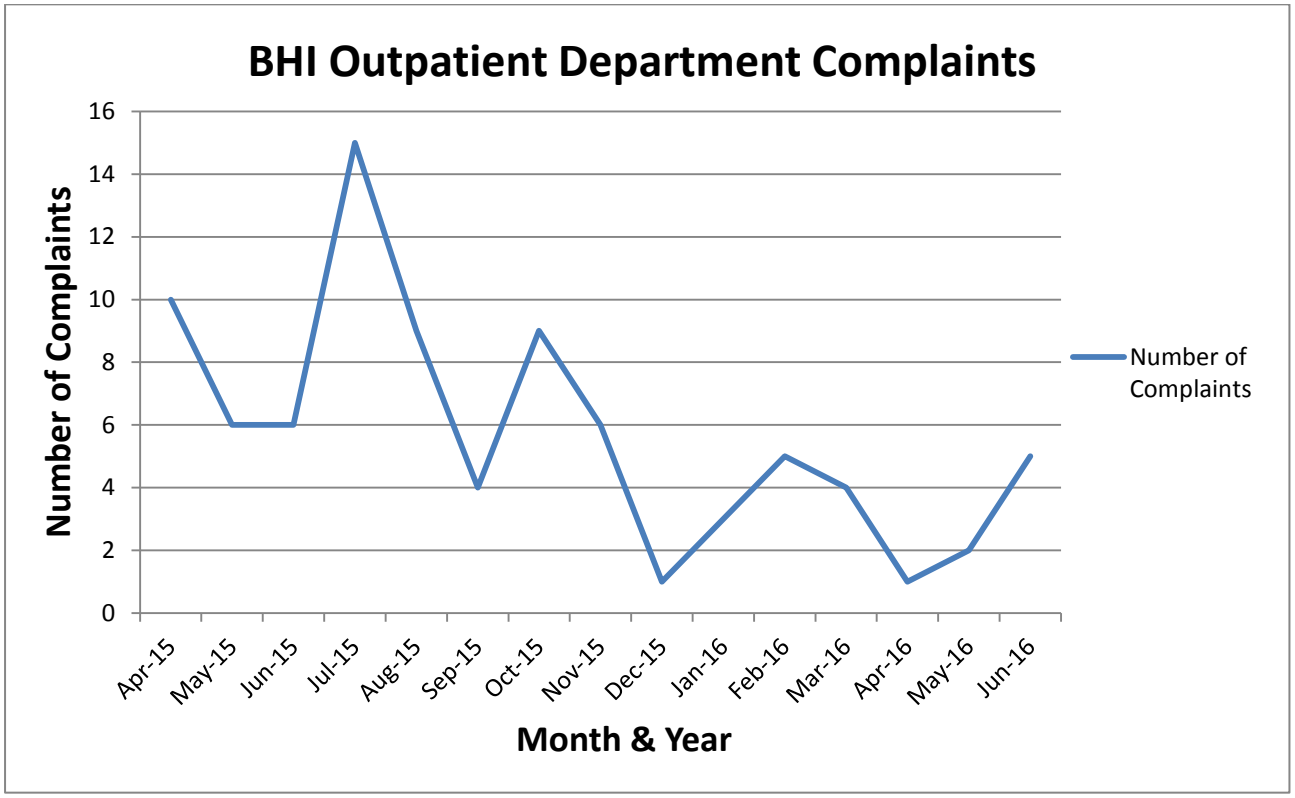


Figure 15: Complaints received by BHI Outpatients



3.2.4 Division of Women's and Children's Services

In Q1, the Division saw a significant decrease in complaints about attitude and communication; with 17 complaints under this category, compared with 30 in Q4 of 2015/16. There was however a sizeable increase in complaints relating to cancelled or delayed appointments and operations, with 27 complaints, compared with 12 in Q4. Whilst the number of complaints received under the category of 'appointments and admissions' has remained similar to Q4, a larger proportion of complaints in this category were about cancelled or delayed appointments and operations. Other sub-categories in this category - for example, administrative issues and admission arrangements - decreased in Q1.

Table 15: Complaints by category type

Category Type	Number and % of complaints received – Q1 2016/17	Number and % of complaints received – Q4 2015/16
Access	0 (0% of total complaints) =	0 (0% of total complaints) =
Appointments & Admissions	29 (34.5%) ↑	23 (26.4%) ↓
Attitude & Communication	17 (20.2%) ↓	30 (34.5%) ↑
Clinical Care	31 (36.9%) ↑	29 (33.3%) ↑
Facilities & Environment	1 (1.2%) ↓	2 (2.3%) =
Information & Support	4 (4.8%) ↑	3 (3.4%) ↑
Discharge/Transfer/Transport	2 (2.4%)	
Documentation	0 (0%)	
Total	**84**	**87**

Table 16: Top sub-categories

Category	Number of complaints received – Q1 2016/17	Number of complaints received – Q4 2015/16
Cancelled or delayed appointments and operations	27 ↑	12 ↓
Clinical Care (Medical/Surgical)	15 ↑	12 =
Communication with patient/relative	3 ↓	18 ↑
Attitude of Medical Staff	5 ↑	2 ↓
Attitude of Nursing/Midwifery	1 ↓	3 ↑
Attitude of Admin/Clerical Staff	2 ↑	1
Clinical Care (Nursing/Midwifery)	5 ↓	10 ↑
Failure to answer telephones	2 ↑	1 =

Table 17: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
In Q1, the Division experienced an increased number of complaints relating to cancelled or delayed appointments and procedures. The number of complaints received was 27, compared with 12 in Q4 of 2015/16. Of these 27 complaints, 25 were received by the Bristol Royal Hospital for Children (BRHC) and two were received by St Michael's Hospital (STMH).		
Of the 25 complaints received by the BRHC, 20 were in respect of cancelled or delayed outpatient appointments, with six of these being received by the Paediatric Plastic Surgery service.	A recent review of the burns service (part of paediatric plastic surgery) has identified that demand for the service has exceeded capacity, leading to delays in appointments or treatment.	A monthly theatre list was implemented in July 2016 and should significantly reduce waiting times.

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

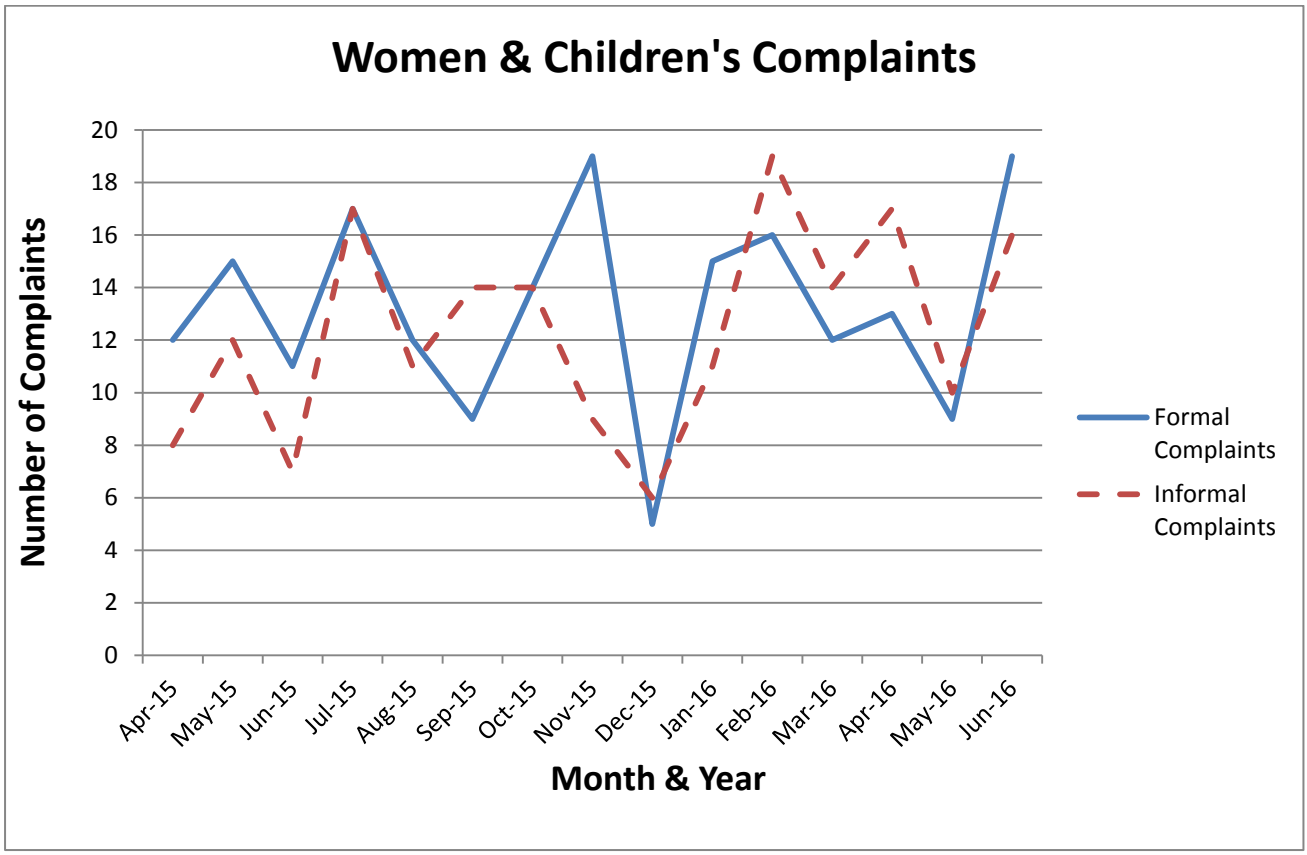
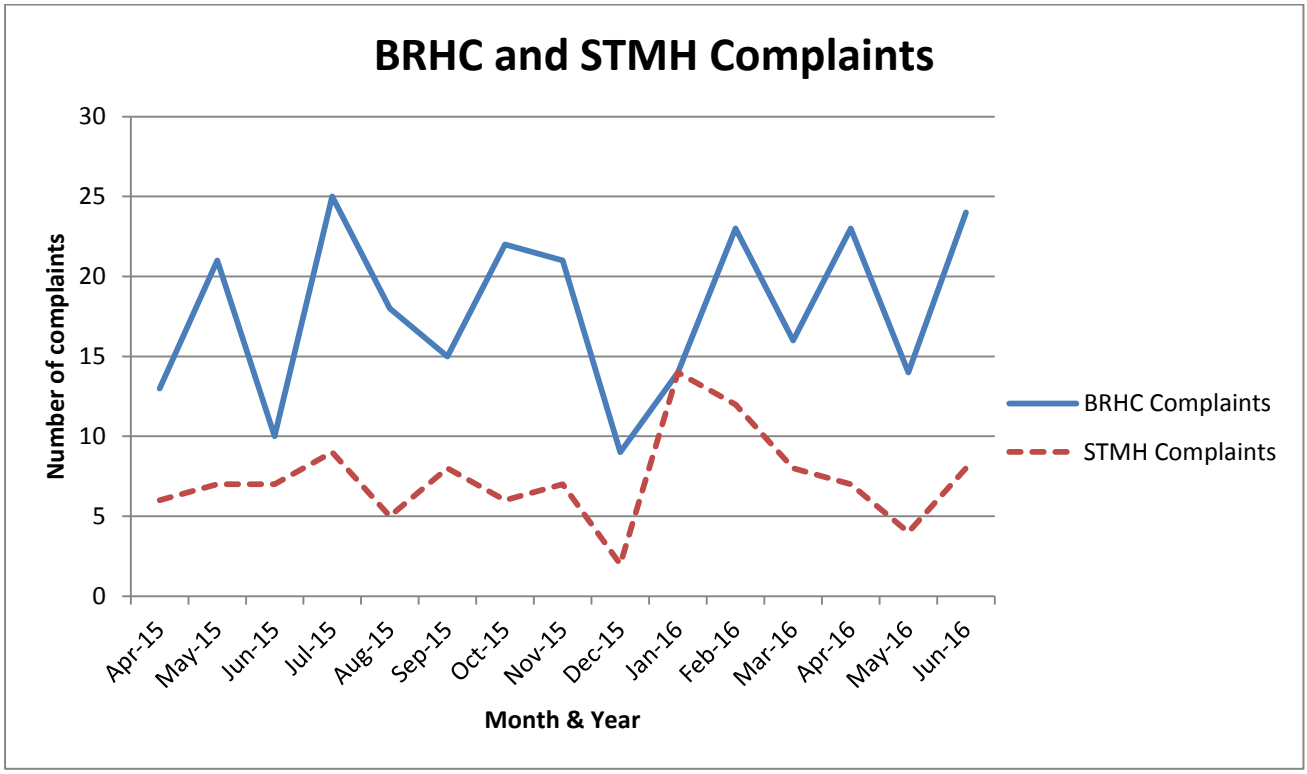


Figure 17: Complaints received by Bristol Royal Hospital for Children and St Michael's Hospital



3.2.5 Division of Diagnostics & Therapies

In Q1, the Division saw an increase in complaints about the audiology service. There was a notable decrease in the number of complaints received in relation to attitude and communication and also in the number of complaints received by the radiology service.

Table 18: Complaints by category type

Category Type	Number and % of complaints received – Q1 2016/17	Number and % of complaints received – Q4 2015/16
Access	1 (4.2% of total complaints) ↑	0 (0% of total complaints)
Appointments & Admissions	7 (29.2%) ↑	6 (25%) =
Attitude & Communication	6 (25%) ↓	11 (45.8%) ↑
Clinical Care	7 (29.2%) ↑	6 (25%) ↓
Facilities & Environment	3 (12.5%) ↑	0 (0%) ↓
Information & Support	0 (0%) ↓	1 (4.2%) =
Discharge/Transfer/Transport	0 (0%)	
Documentation	0 (0%)	
Total	**24**	**24**

Table 19: Top sub-categories

Category	Number of complaints received – Q1 2016/17	Number of complaints received – Q4 2015/16
Cancelled or delayed appointments and operations	5 ↓	6 ↑
Clinical Care (Medical/Surgical)	3 ↑	2 ↑
Communication with patient/relative	0 ↓	4 ↑
Attitude of Medical Staff	1 ↑	0 ↓
Attitude of Nursing/Midwifery	0 =	0 ↓
Attitude of Admin/Clerical Staff	0 ↓	1
Clinical Care (Nursing/Midwifery)	1 ↑	0 =
Failure to answer telephones	4 ↑	2 ↑

Table 20: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
The audiology service received six complaints in Q1, compared with three in Q4 of 2015/16. Three of these complaints were in respect of failure to answer telephones/failure to respond and there was one each in respect of cancellation of an appointment, access to premises and attitude of medical staff.	Of the six complaints received, one was formal and related to wheelchair access at Southmead Hospital (part of North Bristol NHS Trust), where some UH Bristol audiology clinics are hosted.	The complainant had raised an informal complaint during Q4 and at that time, the Audiology Department had raised the issues with NBT. This matter was raised again with NBT following receipt of the formal complaint. The access issue relates to the door access and NBT are reviewing potential solutions with their building contractor.
	In terms of the complaints relating to unanswered calls, in one of those cases the complainant did not have up to date contact details for the department and had contacted the North Bristol Trust (NBT) switchboard, who registered the complaint with the UH Bristol complaints team.	The Audiology Department contacted the complainant and advised that the web page needed to be updated at NBT – they also contacted NBT to request that they update their web page (having previously already requested this).
	The two other complaints related to issues in contacting the department following an NBT network crash. The department's whole system went down, resulting in the phone line being unavailable for several hours.	Normal service resumed when the telephone system came back on-line. The issue was outside the control of the Audiology Department.

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

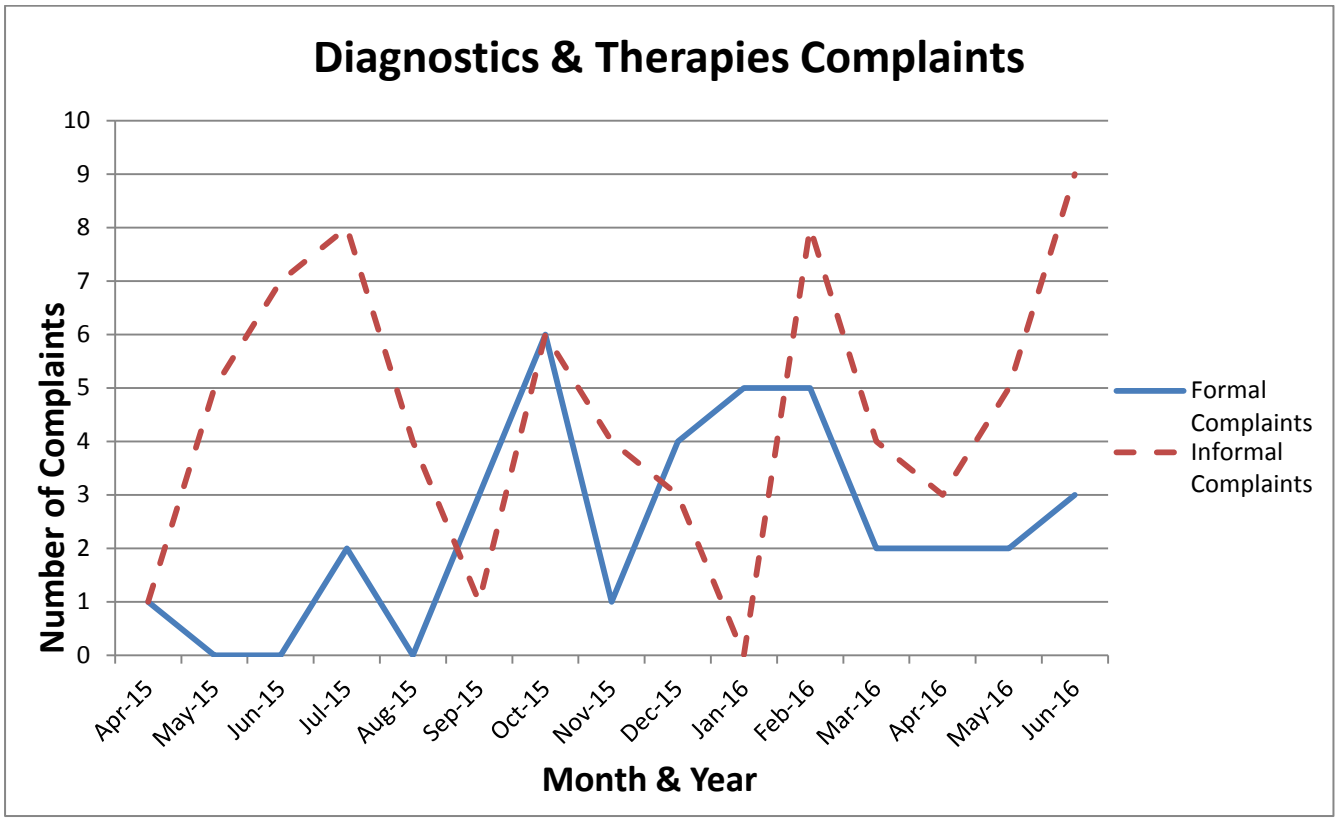
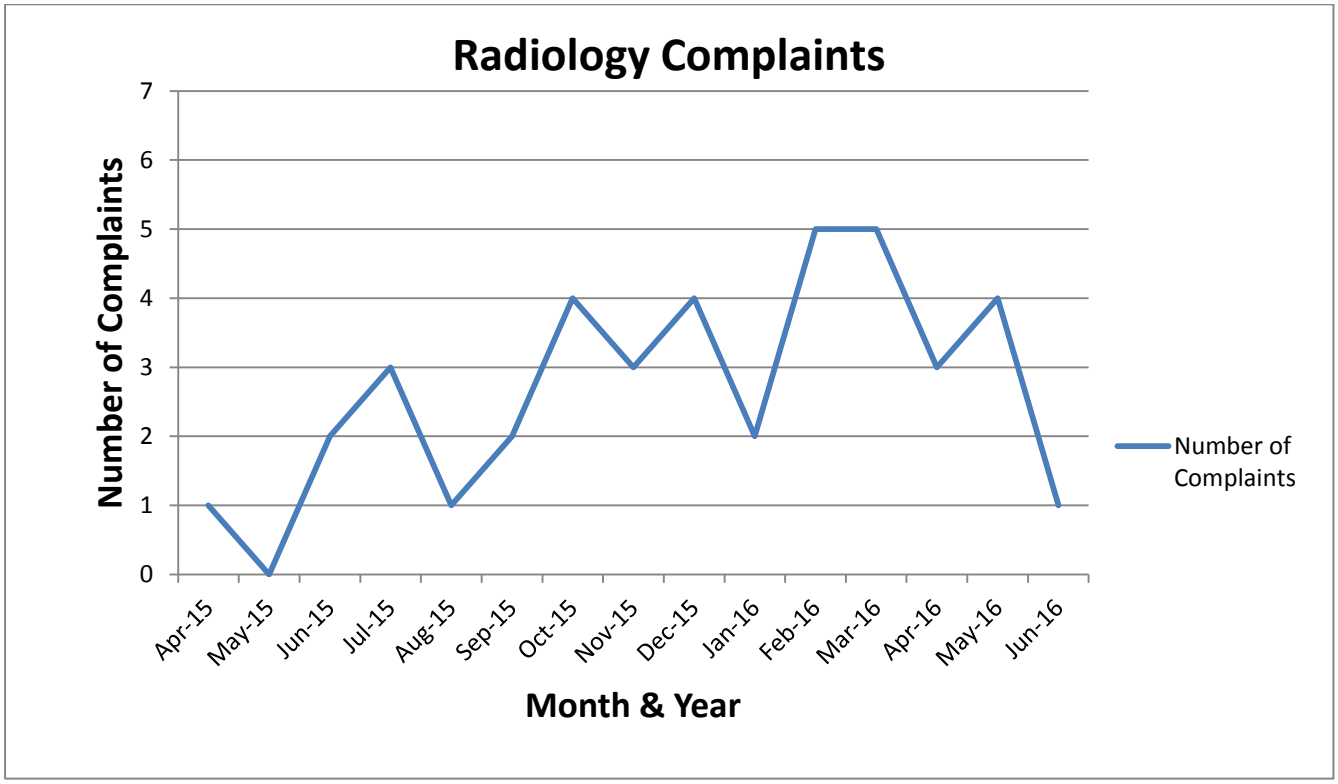


Figure 19: Complaints received by Radiology (Trustwide)



3.3 Complaints by hospital site

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

Table 21: Breakdown of complaints by hospital site

Hospital/Site	Number and % of complaints received in Q1 2016/17	Number and % of complaints received in Q4 2015/16
Bristol Royal Infirmary (BRI)	228 (43.8% of total complaints)	209 (43.9% of total complaints)
Bristol Eye Hospital (BEH)	46 (8.9%)	52 (10.9%)
Bristol Dental Hospital (BDH)	46 (8.9%)	44 (9.2%)
St Michael's Hospital (StMH)	37 (7.1%)	52 (10.9%)
Bristol Heart Institute (BHI)	50 (9.6%)	45 (9.5%)
Bristol Haematology & Oncology Centre (BHOC)	22 (4.2%)	10 (2.1%)
Bristol Royal Hospital for Children (BRHC)	62 (11.9%)	59 (12.4%)
South Bristol Community Hospital (SBCH)	10 (1.9%)	5 (1.1%)
UH Bristol off site services[6]	19 (3.7%)	0
Total	**520**	**476**

Table 22 below breaks this information down further, showing the complaints rate as a percentage of patient activity for each site and whether the number of complaints each hospital site receives is broadly in line with its proportion of attendances. For example, in Q1, BRI accounted for 30.6% of all attendances and 43.8% of all complaints.

Table 22: Complaints rates by hospital site

Site	No. of complaints	No. of attendances	Complaints rate	Proportion of all attendances	Proportion of all complaints
BRI	228	60,667	0.38%	30.6%	43.8%
BEH	46	31,946	0.14%	16.1%	8.8%
BDH	46	20,987	0.22%	10.6%	8.8%
StMH	37	21,654	0.17%	10.9%	7.1%
BHI	50	4,924	1.02%	2.5%	9.6%
BHOC	22	18,400	0.12%	9.3%	4.2%
BRHC	62	32,639	0.19%	16.5%	11.9%
SBCH	10	7,100	0.14%	3.6%	1.9%
Total	**501**	198,317	0.25%		

This analysis shows that Bristol Royal Infirmary and Bristol Heart Institute continue to receive the highest rates of complaints and that they both receive a disproportionately high volume of complaints compared to their share of patient activity.

[6] UH Bristol off site services includes clinics held at other sites, e.g. the ENT clinic at Southmead and community services such as community midwifery. These complaints are not included in Table 22 as patient attendance data is not available for them.

3.4 Complaints responded to within agreed timescale

All of the clinical Divisions reported breaches in Q1, totalling 34 breaches, which is a slight increase on the 31 breaches recorded in Q4 and a significant improvement on the 65 breaches reported in Q3. The table below shows how these breaches were broken down by Division. Table 23 indicates a recent pattern of reductions in breached deadlines in the Divisions of Surgery, Head & Neck and Specialised Services.

Table 23: Breakdown of breached deadlines

Division	Q1 (2016/17)	Q4 2015/16	Q3 2015/16	Q2 2015/16
Surgery, Head & Neck	6 (14.6%)	10 (24.4%)	16 (31.4%)	12 (22.6%)
Medicine	12 (36.4%)	10 (28.6%)	18 (48.6%)	3 (8.8%)
Specialised Services	2 (15.4%)	3 (23.1%)	8 (36.4%)	6 (30%)
Women & Children	12 (30.8%)	8 (34.8%)	21 (65.6%)	2 (5.1%)
Diagnostics & Therapies	2 (18.2%)	0 (0%)	2 (22.2%)	0 (0%)
All	**34 breaches**	**31 breaches**	**65 breaches**	**23 breaches**

(So, as an example, there were 12 breaches of timescale in the Division of Medicine in Q1, which constituted 36.4% of the complaints responses that had been due in that Division in Q1).

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

Table 24: Source of delays

	Source of delays in Q1 2016/17				Totals
	Division	PSCT	Executive sign-off	Other	
Surgery, Head & Neck	5	1	0	0	**6**
Medicine	5	5	1	1	**12**
Specialised Services	2	0	0	0	**2**
Women & Children	8	2	2	0	**12**
Diagnostics & Therapies	0	1	0	1	**2**
All	**20**	**9**	**3**	2	**34 breaches**

Although the majority of responses were prepared by the Division within the time agreed (130 out of 144 responses or 90.3%), the need for changes/improvements following executive review led to 20 cases breaching the deadline by which they were sent to the complainant. Therefore only 75.7% of responses were actually sent out on time, against a target of 95%.

The nine breaches of deadline by the PSCT in Q1 have been reviewed by the PSCT Manager and are attributable to service capacity.

Actions being taken to improve the quality of responses and reduce the number of breaches include:

- All response letters received from Divisions are checked by the caseworker managing the complaint and then reviewed by the Patient Support & Complaints Manager prior to Executive sign-off.

- A random selection of complaint responses are also reviewed by the Head of Quality (Patient Experience & Clinical Effectiveness) prior to Executive sign-off.
- Training aimed at improving the quality of written complaint responses is being rolled out to all Divisions, with two sessions having already been delivered at the time of writing this report.
- Standard Operating Procedures (SOPs) have been produced in respect of the process for checking and signing off response letters and for the escalation of more serious or complex complaints for Executive review.
- During Q4, the process was changed to allow seven working days for the review and sign-off process. This has resulted in a reduction in the number of breaches from 65 in Q3 to 31 in Q4 and 34 in Q1.

4. Information, advice and support

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

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

In Q1, the team dealt with 257 such enquiries, compared to 135 in Q4. These enquiries can be categorised as:

- 121 requests for advice and information (95 in Q4)
- 129 compliments (37 in Q4)[7]
- 7 requests for support (3 in Q4)

The table below shows a breakdown of the 128 requests for advice, information and support dealt with by the team in Q4.

Table 25: Enquiries by category

Category	Number of enquiries
Information about patient	19
Hospital information request	16
Medical records requested	13
Clinical information request	12
Signposting	9
Freedom of information request	6
Emotional support	5
Clinical care	5
Support with access	5
Accommodation enquiry	4
Expenses claim	3
Transport request	3
Employment and volunteering	3

[7] In Q1, this figure includes compliments added directly to the Datix system by Divisions.

Admissions arrangements	2
Benefits and social care	2
Transfer arrangements	2
Attitude of staff	2
Car parking	2
Discharge arrangements	2
Laundry	1
Disability support	1
Communication with patient/relative	1
Travel arrangements	1
Complaints handling	1
Wayfinding	1
Appointment letter not received	1
Appointments administration issues	1
Follow-up treatment	1
Medication not received	1
Personal property	1
Waiting time for correspondence	1
Patient choice information	1
Total	**128**

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

One of the Key Performance Indicators (KPIs) used by the Patient Support and Complaints Team is the length of time between receipt of a complaint and sending an acknowledgement.

The Trust's Complaints and Concerns Policy states that when the Patient Support and Complaints Team reviews a complaint following receipt:

- a risk assessment will be carried out;
- agreement will be reached with the complainant about how we will proceed with their complaint and a timescale for doing so;
- The appropriate paperwork will be produced and sent to the Divisional Complaints Coordinator for investigation; and
- an acknowledgement letter confirming how the complaint will be managed will be sent to the complainant.

In line with the NHS Complaints Procedure (2009), the Trust's policy states that this review will take place within three working days of receipt of written complaints (including emails), or within two working days of receipt of verbal complaints (including PSCT voicemail).

In Q1, 270 complaints were received verbally and 250 were received in writing.

Of the 270 verbal complaints, 256 (94.8%) were acknowledged within two working days. The remaining 14 cases were all acknowledged within three working days.

Of the 250 written complaints, 239 (95.6%) were acknowledged within three working days. The remaining 11 cases were all acknowledged within four working days.

6. PHSO cases

During Q1, the Trust has been advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in any seven complaints, compared to five in Q4 and five in Q3. It should be noted however that four of these cases have been investigated and closed quickly by the PHSO and have not been upheld; these cases are therefore shown in Table 28 as closed cases (18986, 20474, 18248 and 18055). Tables 26 to 28 list these new cases, cases with existing PHSO interest and cases now closed by the PHSO. Of the seven cases that were closed in Q1, none were upheld.

Table 26: New PHSO cases

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
17763	AP-S	CW	16/01/2015	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Copy of complaint file and medical records sent to PHSO. Draft report received. UH Bristol consultants currently in discussion with PHSO's clinical adviser regarding the draft report and a difference of opinion within the report.						
18479	NK		09/04/2015	BEH	Outpatients	Surgery, Head & Neck
Copy of complaint file and medical records sent to PHSO. Currently awaiting further contact/report from PHSO.						
14561	HB	PB	05/12/2013	STMH	ENT	Surgery, Head & Neck
Copy of complaints file and medical records sent to PHSO. Further information/records requested by PHSO on 16 August 2016, which will be sent to them as soon as available.						

Table 27: Existing PHSO cases

16474		CM	05/08/2014	BRI	Ward A604	Surgery, Head & Neck
PHSO draft report received 9 August 2016 advising that they are not upholding the complaint. The Trust has confirmed its agreement with the report and we are currently awaiting the final report.						
17173	DF	DJ	29/10/2014	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Currently awaiting further contact from the PHSO.						
18315	SOC		19/03/2015	BRI	Rheumatology	Medicine
The complainant has added further to his complaint to the PHSO. Currently awaiting further contact from the PHSO.						
18318	SOC		27/03/2015	BRI	Adult Therapy	Diagnostics & Therapies
See case 18315 above – complaints being dealt with together by PHSO.						
18856	SC	VP	22/05/2015	BRI	Ward B501	Medicine
Contacted by PHSO in February 2016. Copy of complaints file and medical records sent to PHSO. Further information requested by and sent to PHSO in July 2016. Currently waiting to hear further from PHSO.						
19541	AA	LA	13/08/2015	BRI	Gastroenterology	Medicine

					& Hepatology	
Contacted by PHSO in March 2016. Copy of complaints file and medical records sent to PHSO. Further information requested by and sent to PHSO in July 2016. Currently waiting to hear further from PHSO.						
15534	AN		22/04/2014	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Contacted by PHSO in March 2016. Copy of complaints file and medical records sent to PHSO. Advised in July 2016 by PHSO that they expect to be in a position to provide their draft report by early September 2016.						

Table 28: Closed PHSO cases

18986	NT	ST	08/06/2015	BRI	Ward A900	Medicine
PHSO's final report received 4 August 2016 advising that they were not upholding the complaint and that they have advised the complainant accordingly.						
20474	NH		04/12/2015	BRI	X-ray (Adult)	Diagnostics & Therapies
PHSO's report received 27 June 2016 confirming that they were not upholding the complaint. Recommendation that all future correspondence with patient is in large font and this has been noted on patient's records.						
18248	LH	SH	10/03/2015	BHOC	Chemo Day Unit/Outpatients	Specialised Services
Notification received from PHSO on 21 June 2016 that patient had decided that she was happy with the Trust's response to her complaint and they have therefore closed the case.						
18055	DH		18/02/2015	BEH	Outpatients	Surgery, Head & Neck
PHSO report received 8 August 2016 confirming that they were not upholding the complaint and that they have notified the complainant accordingly.						
18420	MW		31/03/2015	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
PHSO draft report received 14 March 2016 stating that they did not uphold the complaint. However, the patient appealed this decision. The PHSO confirmed on 9 June 2016 that they had reviewed the case and stood by their decision not to uphold the complaint. The Trust subsequently wrote to the complainant explaining the current situation with regards to his ongoing treatment.						
16977	LG	KG	30/09/2014	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
PHSO's final report received 18 July 2016 advising that they were not upholding the complaint and that they have notified the complainant accordingly.						
16841	JA	RA	17/09/2014	BHOC	Ward D603	Specialised Services
PHSO's final report received 3 June 2016 confirming that they were not upholding the complaint and that they have advised the complainant of their decision.						

7. Protected Characteristics

We are unable to report on protected characteristics in Q1 2015/16 as the information held on the new Datix system, which is now used to record complaints, does not match the information held on Medway and is therefore not transferring across. This issue is currently being investigated by the Trust's Risk Management Team, which is responsible for the Datix system.

Cover report to the Board of Directors meeting held in Public
To be held on 29th September 2016 in the Conference Room,
Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
12. Quarterly Patient Experience Report									
Sponsor and Author(s)									
Sponsor: Carolyn Mills, Chief Nurse **Author**: Paul Lewis, Patient Experience and Involvement Team Manager									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

To provide the Board with an overview of patient feedback received by the Trust in the first quarter of 2016/17, including any themes arising and actions taken to address.

In addition to Quarter 1 survey data and, as a new development, this quarterly report incorporates a summary of recent current Patient and Public Involvement activity. For the first time, the report also includes detailed division-level outpatient survey data.

Key issues to note

- The Trust's key patient-reported experience indicators remained "green" in Quarter 1 – demonstrating the continued provision of a high quality patient experience at UH Bristol.
- The Trust successfully achieved its improvement trajectory for the inpatient and day case Friends and Family Test survey response rate. The improvement notice issued by the Clinical Commissioning Group in January 2016 has therefore now been closed.
- The Friends and Family Test response rate in the Trust's Emergency Departments was slightly below the 15% target for two out of three months during Quarter 1 (achieving 14.6% for the Quarter overall). This was primarily a result of lower uptake of the survey touchscreens in the Emergency Departments by patients. The Patient Experience and Involvement Team continues to explore methods of collecting feedback in this challenging setting, including a current trial of SMS (text message) survey technology.
- South Bristol Community Hospital again achieved relatively low scores on the headline inpatient postal survey measures. Previous investigation has concluded that the difference in scores is likely to reflect the challenges of caring for patients with complex, long-term conditions. However, to provide additional assurance, the Trust has invited Healthwatch Bristol to carry out an "enter and view" inspection of South Bristol Community Hospital during October 2016.

The report highlights lower than expected patient survey scores on ward A518, and in the outpatient department at Bristol Haematology and Oncology Centre – however neither location appears as an outlier in the corresponding quarterly complaints report (i.e. no read-across)

Recommendations

The Board is asked to receive the report for assurance.

Impact Upon Board Assurance Framework

Impact Upon Corporate Risk							
Implications (Regulatory/Legal)							
Equality & Patient Impact							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	
Date the paper was presented to previous Committees							
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**		

University Hospitals Bristol NHS
NHS Foundation Trust

Quarterly Patient Experience and Involvement Report

Incorporating current Patient and Public Involvement activity and patient survey data received during Quarter 1 (April-June) 2016/17

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

Patient Experience and Involvement Team

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1. Patient-reported experience at UH Bristol: Quarter 1 overview

Successes	Priorities
• The Trust's key patient-reported experience indicators remained "green" in Quarter 1 – demonstrating the continued provision of a high quality patient experience at UH Bristol. • The Trust successfully achieved its improvement trajectory for the inpatient and day case Friends and Family Test. The improvement notice issued by the Clinical Commissioning Group in January 2016 has therefore now been closed. • Information about the Trust's successful maternity "Patient Experience at Heart" workshops, where staff attend a reflective session on delivering a positive patient experience, has been shared with colleagues at NHS England who are now exploring how this might be shared more widely with other trusts. • Following significant improvement activity within UH Bristol's cancer services, the latest National Cancer Patient Experience Survey showed an improvement in UH Bristol's position against the national average.	• Use insight from patients via the *Face2Face* interview survey to inform improvement plans around the Trust's corporate quality objectives relating to keeping patients informed about their care in hospital, and ensuring that patients are asked about the quality of their care during their stay (research report to be completed in September 2016 by the Patient Experience and Involvement Team). • In light of the recent National Inpatient Survey results, to ensure that each ward has a "Tell us About Your Care" poster on display, informing patients and visitors about how to give feedback and / or complain (these posters have been distributed to wards by the Patient Experience and Involvement Team and are currently being put in place by the Divisions). • An "audit" of outpatient clinics will be carried out during September and October by the Patient Experience and Involvement Team, to ensure that all outpatient areas have the tools to collect patient feedback (comments cards and boxes, and Friends and Family Test posters), and wherever possible have a professionally presented / up to date "you said we did" display in response to feedback.
Opportunities	**Risks & Threats**
• To incorporate Patient and Public Involvement activity in the Quarterly Patient Experience report (see Section 2 of the current report) • To design a formal engagement strategy for the Trust's developing Involvement Network (this will be in place by Quarter 3 2016/17) • In light of the Trust's new Quality Strategy (which will be presented to the Trust Board in October 2016), to enhance the collection and use of patient feedback via the procurement of a new "real-time feedback" IT system • To share the positive patient feedback in this Quarterly Report with staff delivering care and users of our services	• The Friends and Family Test response rate in the Trust's Emergency Departments was slightly below the 15% target for two out of three months during Quarter 1 (achieving 14.6% for the Quarter overall). This was primarily a result of lower uptake of the survey touchscreens in the Emergency Departments by patients. The Trust continues to explore methods of collecting feedback in this challenging setting, including a current trial of SMS (text message) technology. • Although the vast majority of feedback about UH Bristol staff is positive, where a negative experience occurs, this is often related to the way a member of staff behaved. These "human factors" are usually the determinant of a positive or negative patient experience. • South Bristol Community Hospital (SBCH) and the Trust's Care of the Elderly wards continued to receive lower survey ratings, primarily on questions relating to "communication". This is likely to reflect the complex, long-term health and social care needs of this patient group. However, a number of actions are outlined in the current report in response to these results, including inviting Healthwatch Bristol to carry out an "enter and view" of SBCH in October 2016.

2. Patient and Public Involvement (PPI) Activity

The UH Bristol Patient Experience and Involvement Team carries out a range of activities to ensure that patients and the public can influence and shape the services that the Trust provides. The Patient Experience Group receives an update on this Patient and Public Involvement (PPI) activity at each of its meetings via the Trust's "PPI Log". There are three broad areas of activity:

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

This new section of the Quarterly Patient Experience Report provides an overview of recent and current PPI activity at the Trust:

The corporate PPI programme

The Trust's Involvement Network consists of a network of patients, carers and communities of interest willing to contribute to discussions about service development at UH Bristol. The network adopts a "hub and spoke" model, with the Trust at the centre linking out to leaders and groups in the community who, in turn, engage their own networks / members in the topic under discussion. The Involvement Network is currently involved in a review of the Trust's Carers Policy.

The *Face2Face* interview programme trains volunteers (members of staff, governors and the public) to elicit feedback from patients whilst they are still in UH Bristol's care. Recently these interviews have been used to generate insight into two of the Trust's corporate quality objectives for 2016/17: how to ensure that patients are kept informed about the progress of their care whilst in hospital, and ensuring that patients are asked about the quality of their care. The information generated from these interviews will be used to develop the service improvement plans associated with the quality objectives.

The Trust's 15 Steps Challenge programme, again carried out by trained volunteers, is a way of capturing the initial impression that visitors have of a ward or clinic environment. The Challenges consider how welcoming a ward is, whether the ward is well organised and calm, how caring and involving the ward is, and whether the ward is safe. Feedback is given directly to the ward sister or matron at the end of the Challenge, for local action as required. There have been two recent 15 Step Challenges - on A515 (Stroke unit) and in the Bristol Eye Hospital outpatient areas. The Challenge teams commented positively on these areas and reported some relatively minor improvements back to the appropriate service leads to action.

Service-level PPI activity

In collaboration with staff delivering care, the corporate Patient Experience and Involvement Team supports a wide range of "local" PPI activity across the Trust. Recent projects include:

- Working with the paediatric cardiac service to carry out listening events for parents and patients
- A focus group with parents whose children were treated by the Paediatric Intensive Care Unit
- Working with the Postgraduate Medical Education Team, to bring together patients and Foundation Level 2 doctors in educational workshops, to enable medics to view their work from a patient perspective

- Focus groups with patients and relatives who are receiving palliative care. This is being used to inform the development of training and support for staff involved in providing end of life care

Engaging with partner organisations

These projects aim to ensure that key external partners (particularly those that have a broad "patient advocacy" role) are able to contribute to the work of the Trust, and that UH Bristol provides both local and national leadership in the PPI agenda. Recent and current examples include:

- Supporting Healthwatch to carry out an "enter and view" of the Trust's Discharge Lounge. Positive feedback was received from Healthwatch, with a small number of useful but relatively minor recommendations now being taken forward by the service lead
- Partnering with North Bristol Trust, Bristol Community Health, NHS England, People in Health West of England and the Kings Fund, to develop and deliver a Bristol Patient and Community Leadership Programme. This programme will produce a cohort of "patient leaders", to support service change across the health care system in Bristol
- Exploring effective governance around PPI conducted in relation to research projects, with the Trust's Research and Innovation Team, University of the West of England and National Institute of Health Research (NIHR)
- Working with colleagues on the West of England Evaluation Strategy group to develop PPI guidance for service evaluation projects. This project is supported by funding from the UK Evaluation Society.

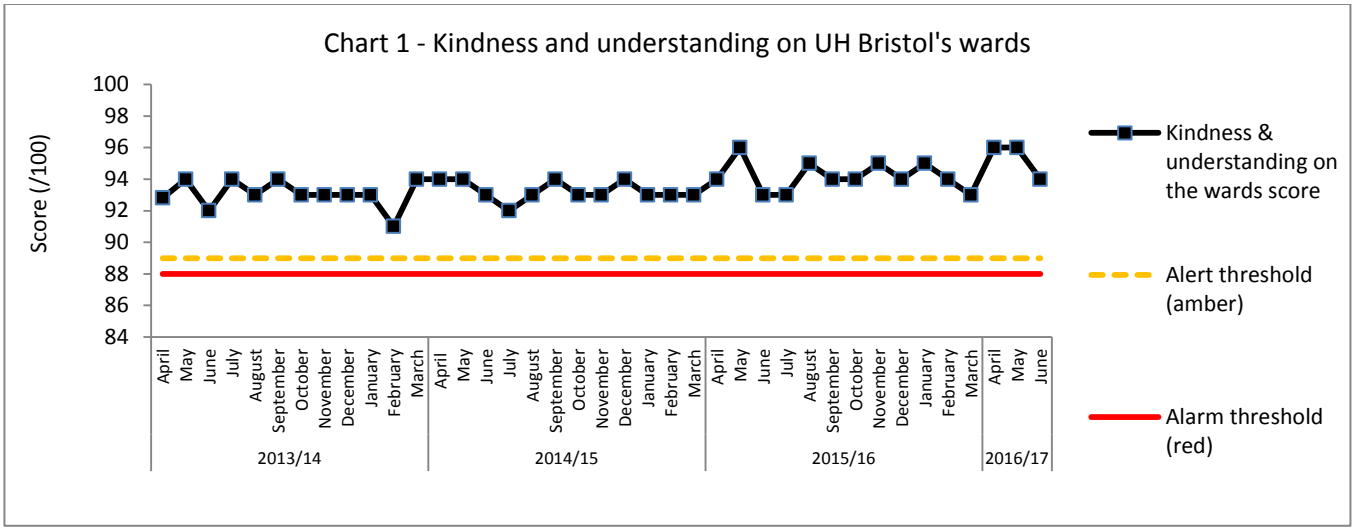
3. Patient-reported experience

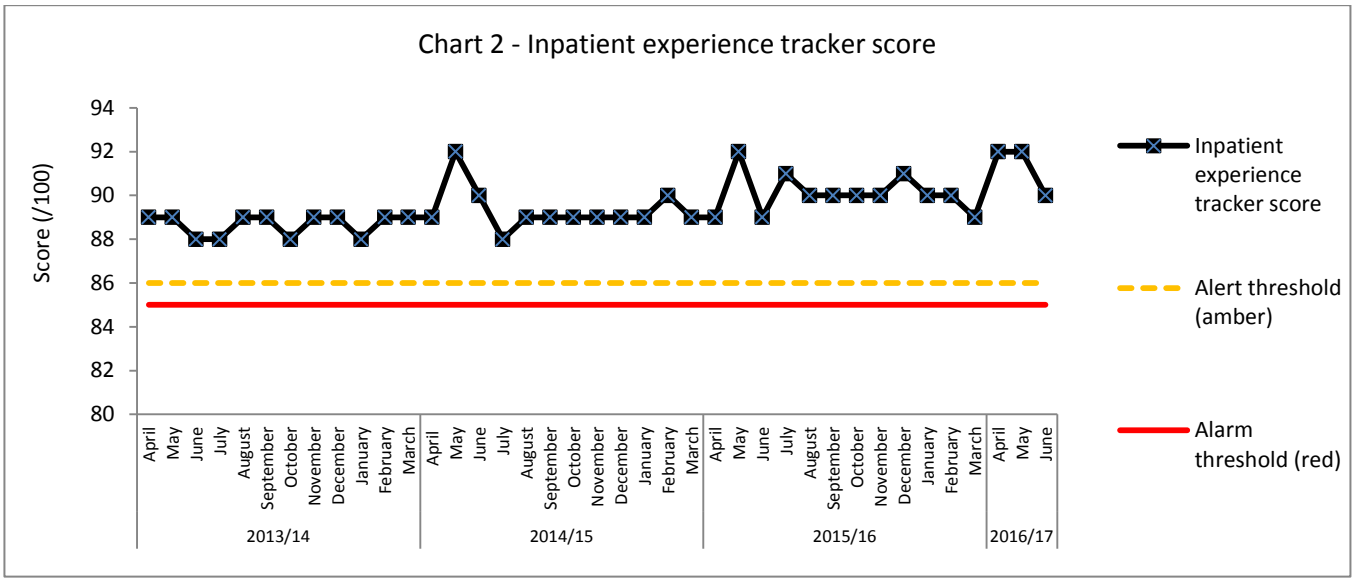
The Trust's Patient Experience and Involvement Team is also responsible for measuring patient-reported experience, primarily via the Trust's patient survey programme[1]. This ensures that the quality of UH Bristol's care, as perceived by service-users themselves, can be monitored on an ongoing basis to ensure that high standards are maintained. In Quarter 1 (April to June 2016), the Trust maintained positive scores in the headline patient survey measures (see Charts 1-6). A description of these data sources is provided in Appendix B. It should be noted that the postal survey methodology changed in April 2016 (to provide the data a month earlier than had previously been the case). Although at this stage we do not think the data has been significantly affected by this change, at present some caution is needed in directly comparing Quarter 1 data with previous quarters.

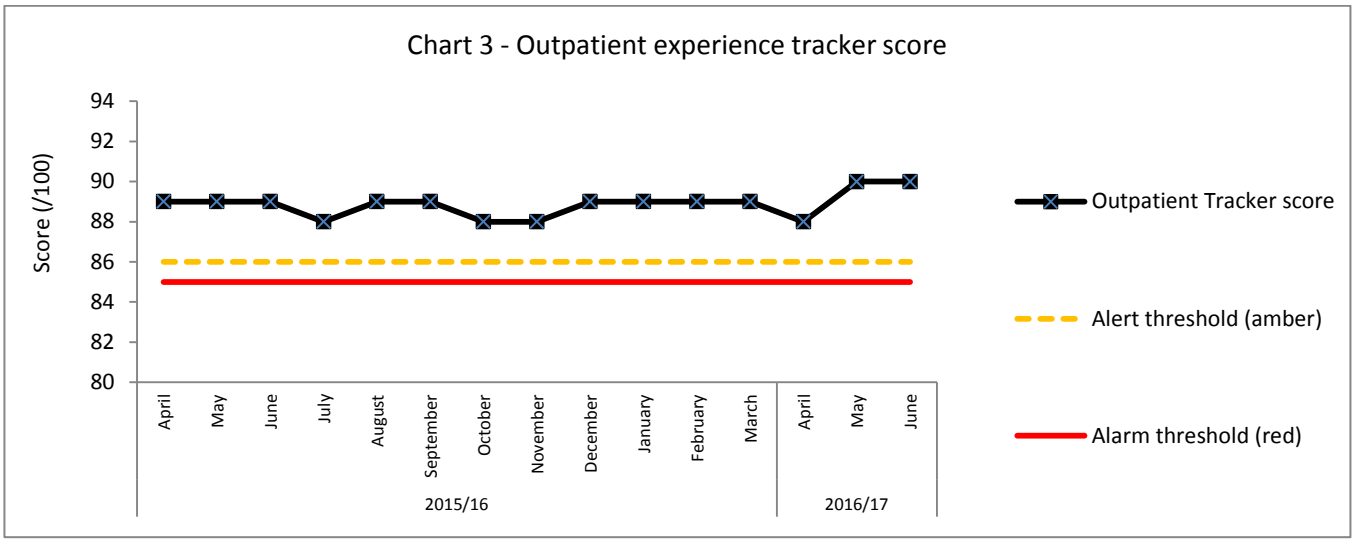
The Trust has a series of response rate targets in relation to the Friends and Family Test. Performance against these is shown in Charts 7-9. In Quarter 1, the Trust has significantly improved its response rate to the inpatient and day case Friends and Family Test (Chart 8), having previously been served with an improvement notice by the Clinical Commissioning Group in January 2016 for under-performance in this area. The improvement trajectory was met and this improvement notice is now closed. However, in Quarter 1 the Trust was slightly below the 15% response rate target for its Emergency Departments (14.6% - see Chart 9). This was primarily due to lower numbers of respondents giving feedback via the survey touchscreens located in the Departments (although the underlying reasons for this aren't clear). An SMS (text message) Emergency Department Friends and Family Test is currently being trialled by the Patient Experience and Involvement Team, in collaboration with the Division of Medicine, to assess whether this can significantly boost the number of responses. The outcomes of this trial will

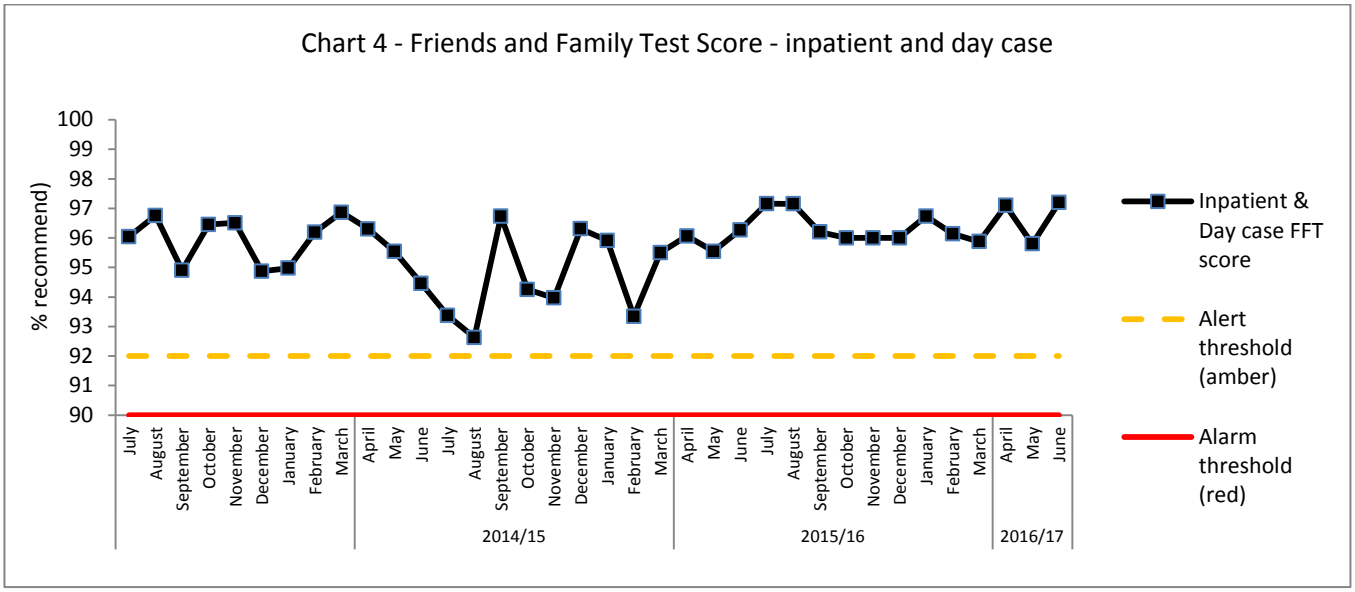
[1] A description of the key Trust surveys is provided in Appendix B. The headline metrics that are used to track patient-reported experience are: being treated with kindness and understanding, the inpatient and outpatient trackers (which combine several scores across the surveys relating to cleanliness, respect and dignity, communication, and waiting times), and the Friends and Family Test score. The postal survey target thresholds are set to detect a deterioration of around two standard deviations below the Trust's average (mean) score, so that these measures can act as an "early warning" if the quality of patient experience significantly declines, and action can be taken in response.

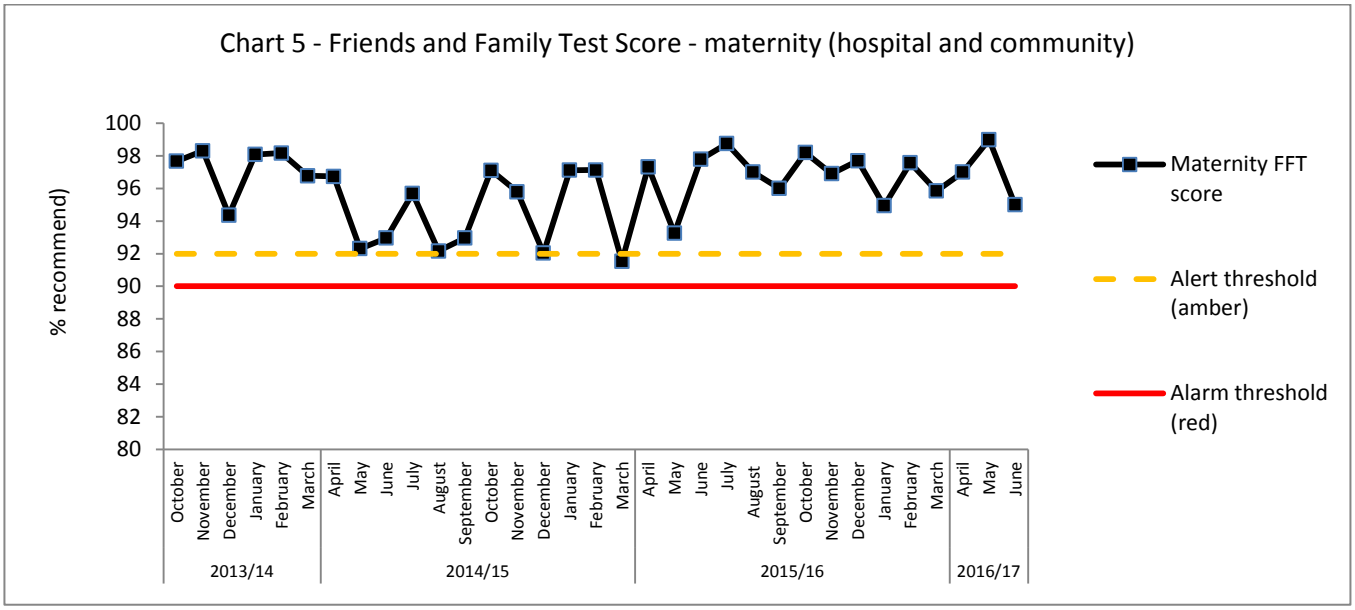
be assessed in early Quarter 3, with a view to continuing this approach and potentially expanding the survey to the Trust's other Emergency Departments.

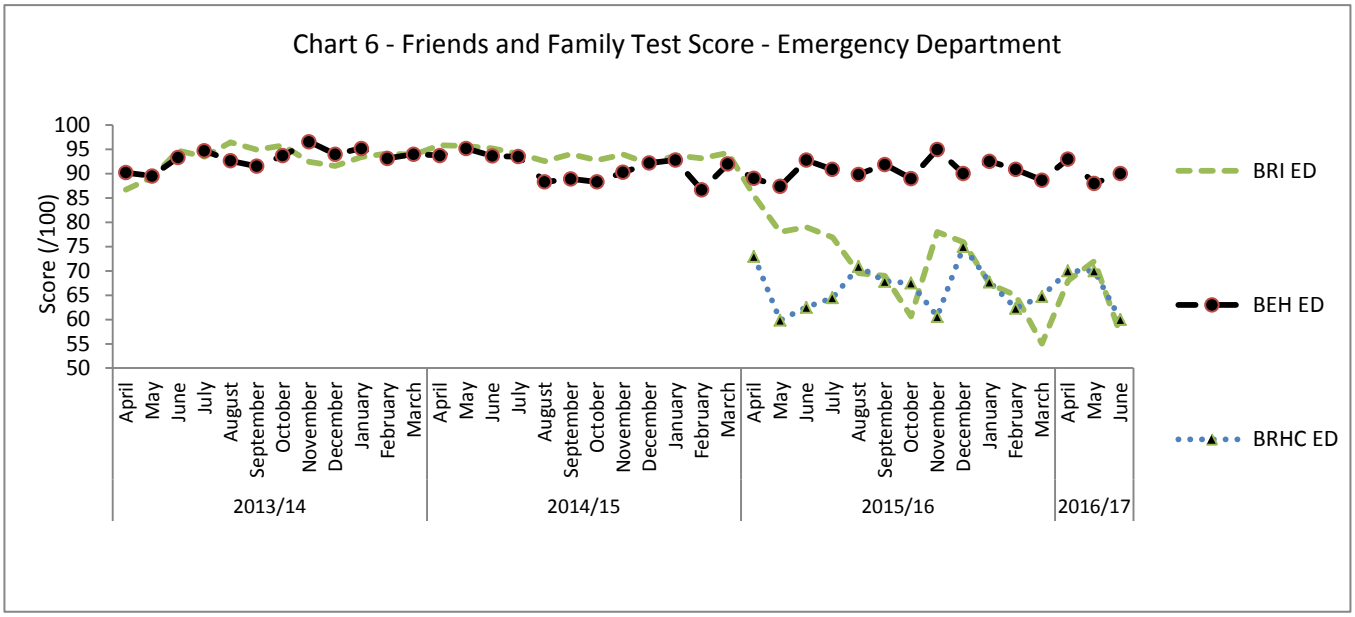




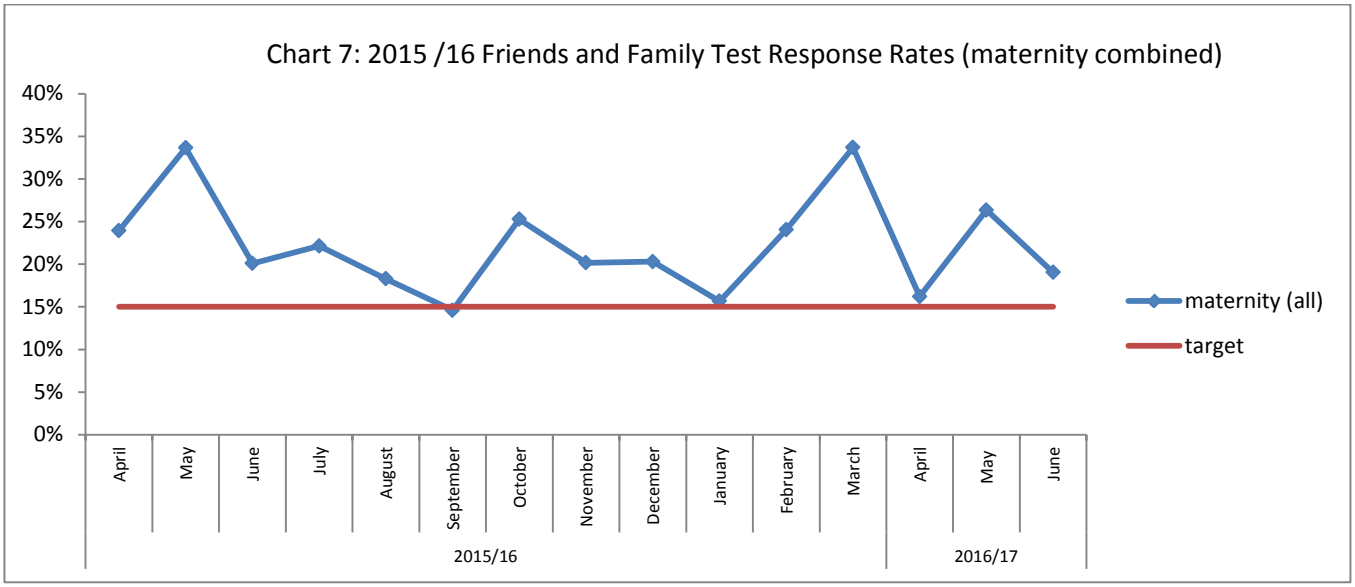


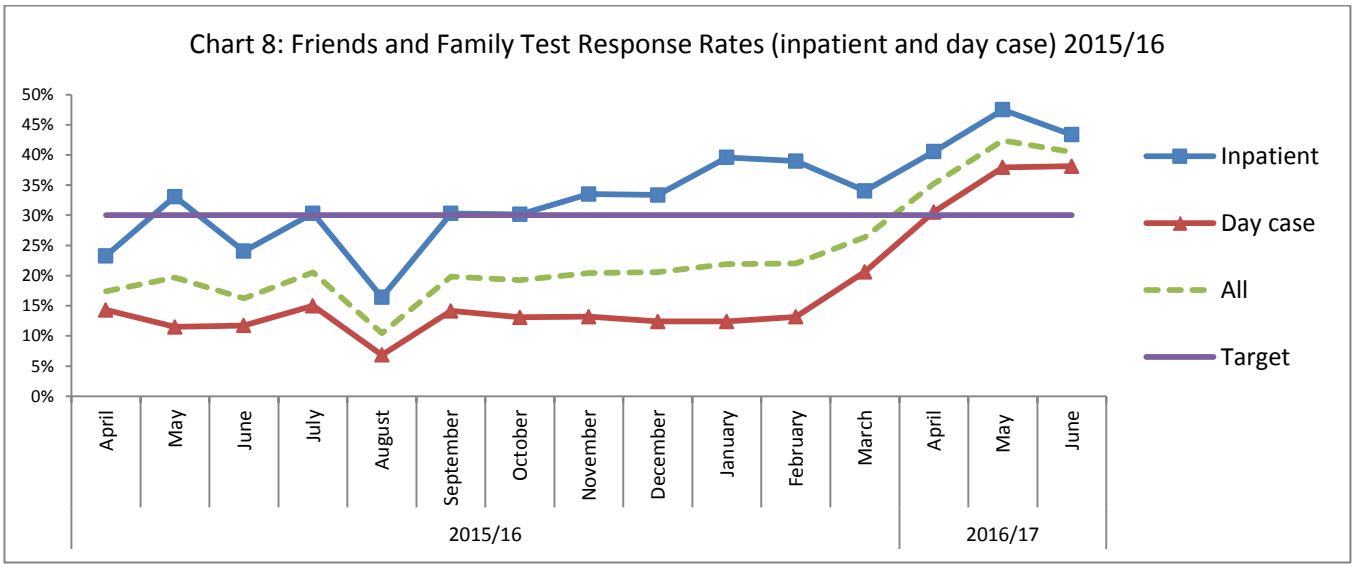


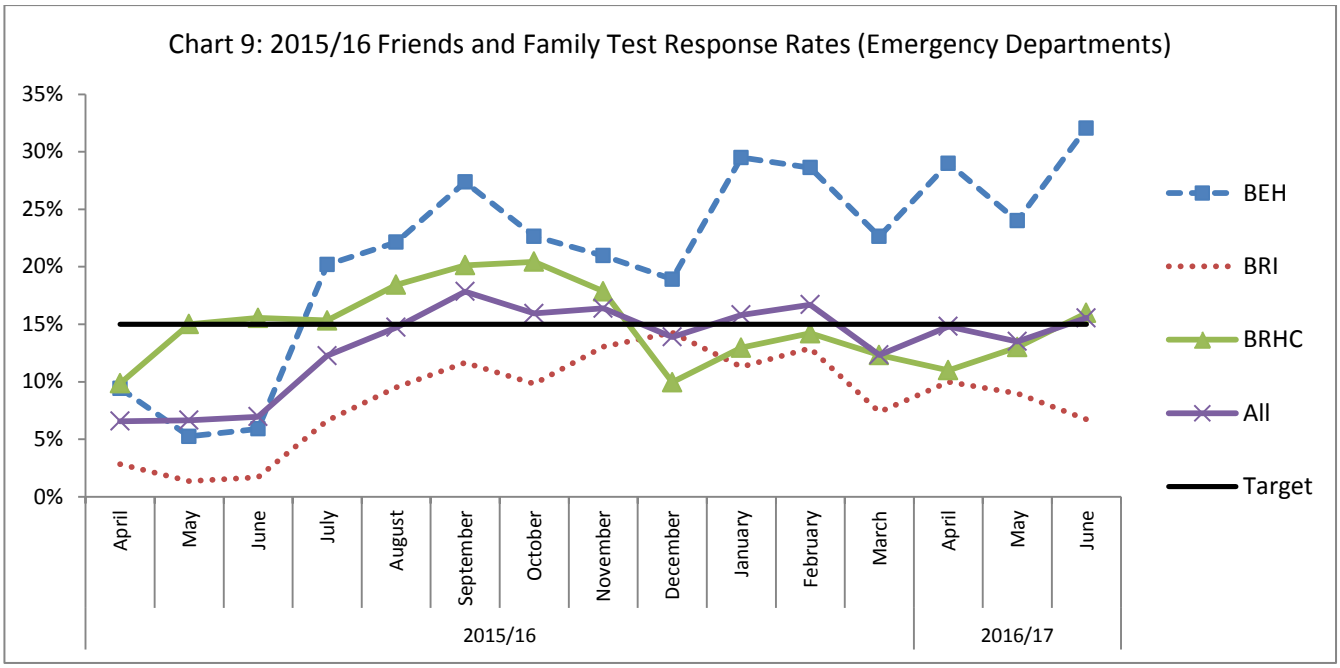




(Key: BRI = Bristol Royal Infirmary; BEH = Bristol Eye Hospital; BRHC = Bristol Royal Hospital for Children; ED = Emergency Department)







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

4. Divisional, hospital and ward-level patient-reported experience

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

Division of Medicine – inpatient experience

South Bristol Community Hospital (wards 100 and 200)

This hospital had relatively low scores on the headline inpatient experience scores in Quarter 1 (Charts 14 and 15) - although it should be noted that the majority of feedback remains very positive. The reliability of the kindness and understanding score (Chart 14) for South Bristol Community Hospital is affected by the relatively small sample sizes for this site, which is likely to be causing the large fluctuations in the score between each quarter: although the score was slightly below the target in Quarter 1 (though within margin of error), over the course of the full year this score is above this level. As noted in previous Quarterly Patient Experience reports, the elements of the inpatient tracker (Chart 15) relating to communication and involving patients in care decisions tend to pull down the overall score for South Bristol Community Hospital. This is likely to be a realistic reflection of the challenges in caring for patients with long-term / complex health and social care needs (a view that is also supported by research at a national level). However, it is important to test these ideas and to recognise that the scores can still be improved. The Trust has therefore invited Healthwatch Bristol to carry out an "enter and view" inspection of South Bristol Community Hospital during October 2016. There is also ongoing improvement work around patient experience at the hospital, particularly in respect of communication, and recent examples include:

- The employment of a "carer's link worker" for two days per week
- Further development of the "Integrated Discharge Hub", which brings together relevant health and social care professionals to facilitate a patient's discharge out of hospital
- Revising patient leaflets to ensure that patients/families/carers understand that the majority of care is managed by nursing and therapy staff (rather than doctor-led), to ensure that expectations are appropriately managed

Ward A518

In Quarter 1, ward A518 had the lowest Friends and Family Test score (Chart 20) and the second lowest inpatient tracker score (Chart 19). A review of the Friends and Family Test survey comments has been undertaken but these were generally positive and no specific negative themes emerged. The Head of Nursing has also triangulated these results with other quality data and has not found a similar decline in performance. Therefore, the ward team has been notified of these scores and the scores will continue to be closely monitored by the Patient Experience and Involvement Team and Division of Medicine (note: in July 2016 the ward received a 100% score in the Friends and Family Test).

Wards C808 and A528

These wards, which primarily focus on care of the elderly, have been noted as negative outliers in previous Quarterly Patient Experience Reports. The Patient Experience and Involvement Team are working with the Matron to carry out "Patient Experience at Heart" staff workshops in Quarter 3. These will be modelled on the successful workshops undertaken in the Trust's maternity services, which contributed to a significant improvement of survey scores in that setting, and will be an opportunity for staff to reflect on their personal role

in delivering a positive patient experience. In addition, there are local projects underway to improve communication with patients and visitors, including the piloting of a "dementia diary" and evaluating the potential roll-out of a trial carried out on ward A400 which involves staff proactively contacting relatives/carers on a daily basis.

Communication (theme)
As noted above, effective communication with patients is a particular challenge for the Division of Medicine. This is reflected in the full breakdown of survey results shown in Table 2, where three Division of Medicine scores are flagged as negative outliers (telling patients about operations, procedures and potential side effects). As noted in the previous Quarterly Patient Experience and Involvement report, the Division of Medicine has formed a patient experience and involvement group, comprising key staff from across the Division. This group will have a particular focus on developing initiatives / sharing learning around effective communication with patients, with a view to improving this aspect of patient and carer experience. Further updates will be provided in the next Quarterly Patient Experience and Involvement report as this work develops.

Outpatient experience[2]

Bristol Royal Hospital for Children (tracker score - Chart 13)
In Quarter 1, the Bristol Royal Hospital for Children had a relatively low score on the composite outpatient experience tracker, which combines survey questions relating to the clinic environment, waiting times, communication, and being treated with respect and dignity. The main reason for this is that patients reported relatively long waits in clinic, which dragged down the overall score. The Women's and Children's Division has made the outpatient teams aware of this score. The management team is currently developing a comprehensive response to the recent Paediatric Cardiac Review – a section of which is focussed purely on improvements in outpatient services. Further updates on the patient experience elements of this improvement work will be provided in future Quarterly Patient Experience and Involvement Reports.

Bristol Haematology and Oncology Centre (tracker score - Chart 17)
Waiting times in clinic were also the reason why the Bristol Haematology and Oncology Centre scored below the target score on the outpatient experience tracker. Ensuring that clinics run to time is a constant challenge given the high demand for services and because patients with cancer often have complex clinical needs. This aspect of patient experience is subject to ongoing improvement work, including recent examples such as:

- Reviewing clinic templates and introducing a "look ahead" to ensure that clinics are booked appropriately (e.g. to take account of annual leave)
- Implementation of a new room rota to help ensure that clinics can be set up in good time, and to increase flexibility on the day of clinics (e.g. if one clinic overruns then it is easier to identify a new location for other clinics to start on time)
- Ensuring that doctors are made aware when their clinic starts to run behind schedule

[2] Please note that sample sizes are relatively low at hospital level in the outpatient survey. The survey also takes a sample from one day of attendances per month, so a Quarter reflects three days of outpatient experience across the Division. The outpatient data shown in Table 3 (which comprises the full set of Divisional-level survey questions) takes a six-monthly view, in order to add stability to the data.

In response to the Quarter 1 survey data, the Bristol Haematology and Oncology management team is carrying out an audit to identify whether specific clinics are particularly prone to delays. If patterns of delay are identified then specific actions will be developed to support those areas.

It should also be noted that in recognition of the challenges around reducing waiting times in clinics, this has been chosen as a corporate quality objective by the Trust in 2016/17.

Division of Diagnostics and Therapies (outpatient information boards – Table 2)
A relatively low proportion of patients in the Diagnostics and Therapies Division reported that they saw an information board in their outpatient clinic, which provided information about any delays being experienced that day. The Division acknowledges that this is an accurate reflection of their clinics, most of which do not have these boards, but a key reason is that clinics generally run to time (this is corroborated by the survey data, where 91% of patients said that they were seen on time or within fifteen minutes – far higher than the other Divisions). Clinic staff in the Division are required to tell patients if there is a delay, and again the Division scores relatively well in this respect (In Quarter 1, 58% of the 9% of patients who wait over fifteen minutes were told that there was a delay). However, there is clearly room for improvement here for all Divisions. Ensuring that patients are kept informed of delays is currently a corporate quality objective, which means that it is a key focus of improvement for the Trust during 2016/17 (a separate report about progress against these objectives is provided to the Trust Board each quarter).

Further note: outpatient clinics – providing feedback opportunities for service-users
The Trust's Delivering Best Care Week[3] in outpatient services found that a number of clinics did not have all of the basic tools needed to collect and use feedback (comments cards, boxes, and posters to publicise this opportunity). In addition, whilst a number of clinics displayed comments cards and put a response against these where necessary, in some cases these displays were out of date and could have been presented more professionally. As a result of these findings, the Patient Experience and Involvement Team provided a number of clinics with cards / boxes etc, and issued guidance on how to use and present feedback. In September 2016 an audit will be carried out by the Patient Experience and Involvement Team to check that these issues have been addressed and to identify any further support needs.

[3] This was an in-house inspection of the Trust's outpatient clinics, which covered a number of aspects of "quality" – including patient experience.

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

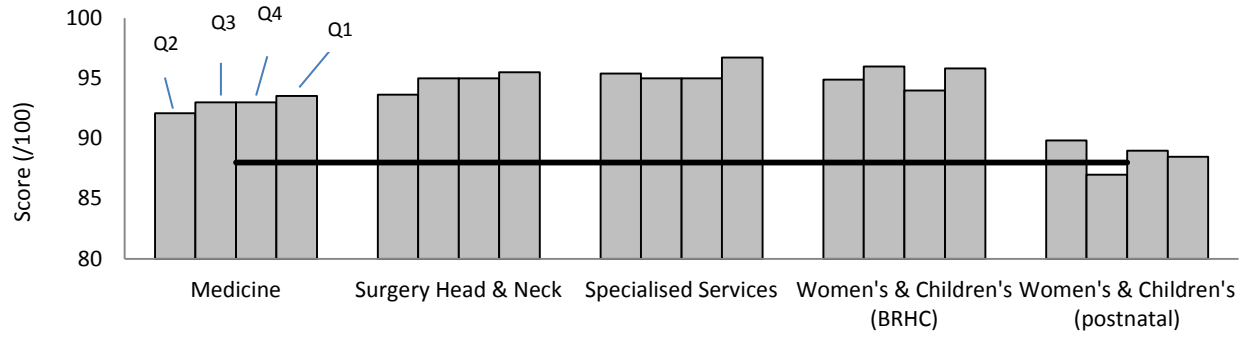


Chart 11 - Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)

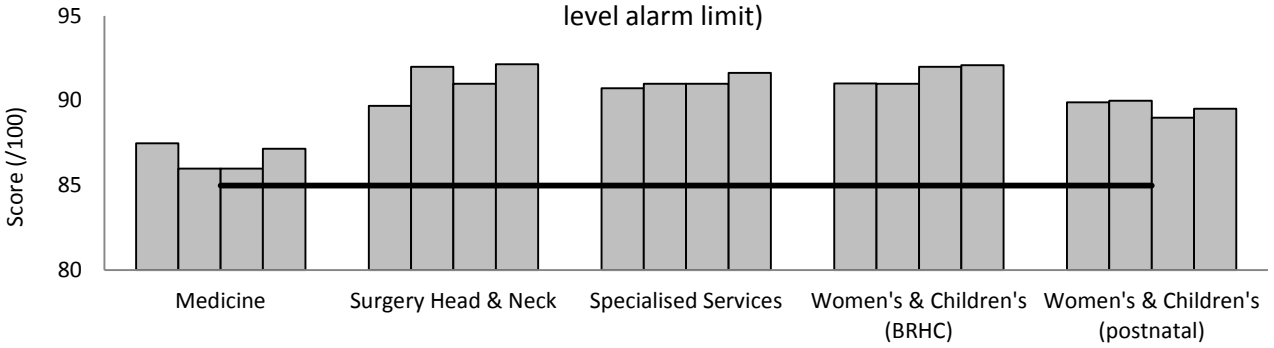


Chart 12 - Inpatient Friends and Day Case Family Test score - last four quarters by Division (with Trust-level alarm limit)

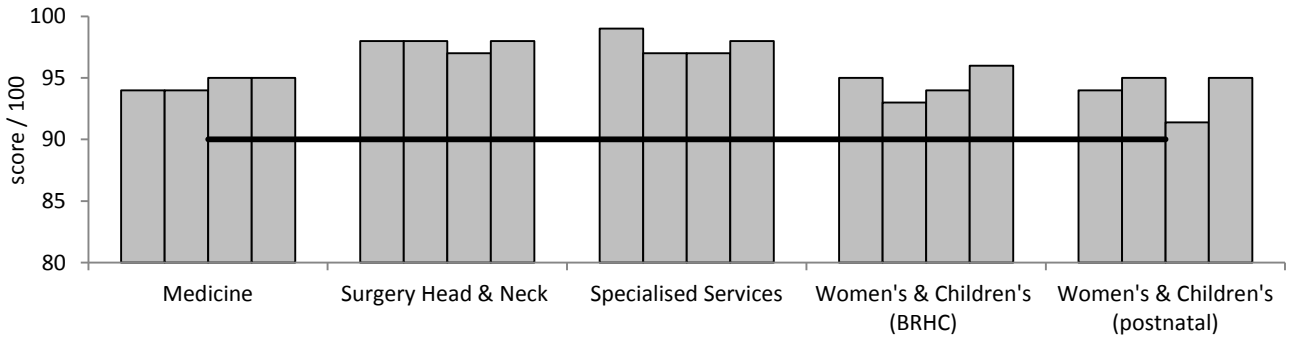


Chart 13 - Outpatient experience tracker score by Division - with Trust-level alarm limit

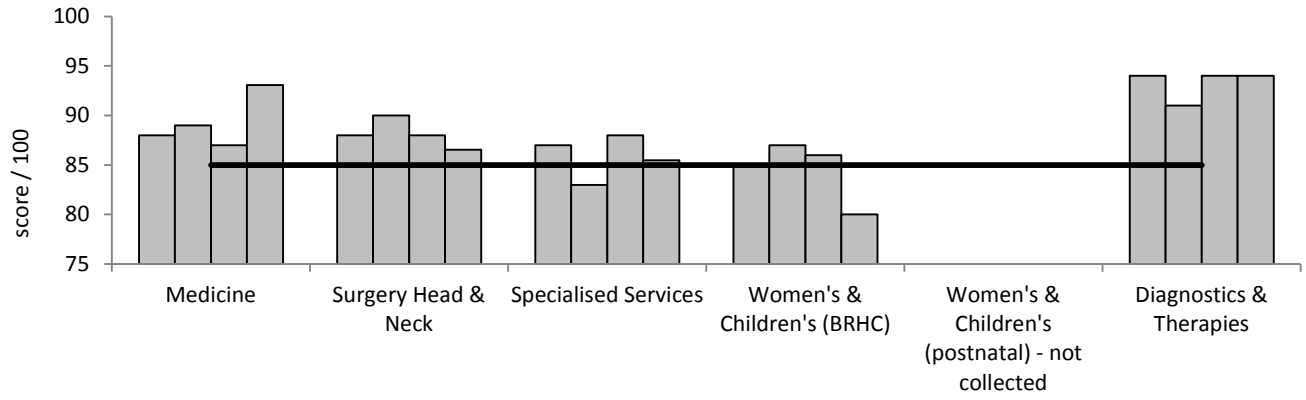


Chart 14: Kindness and understanding score by hospital (last four quarters; with Trust-level alert limit)

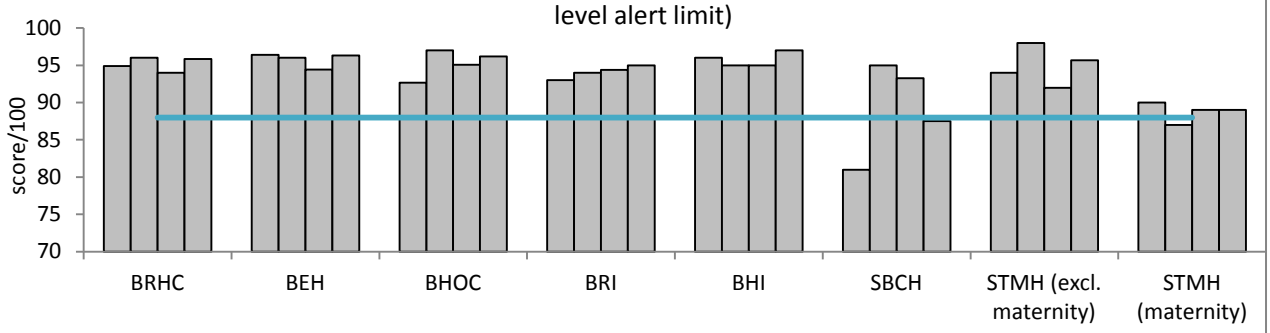


Chart 15: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)

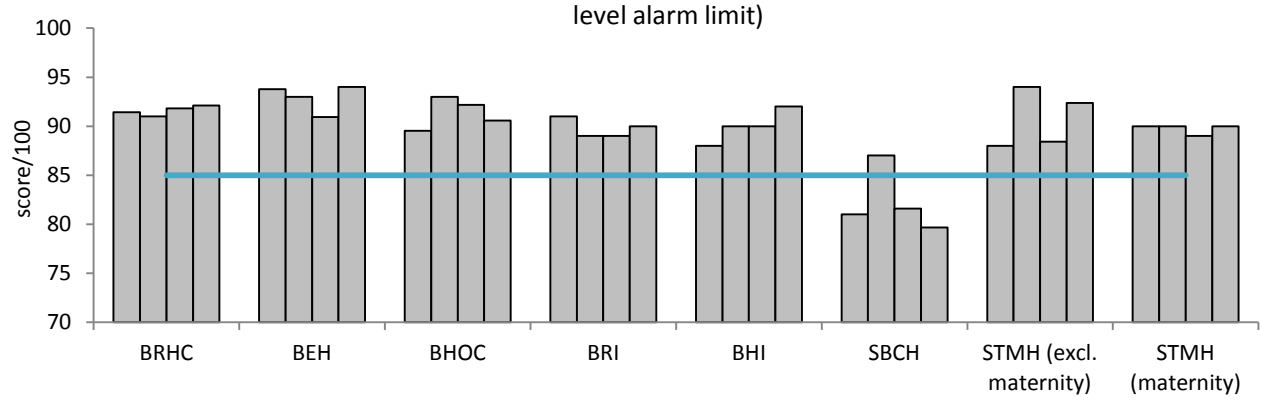


Chart 16: Inpatient and day case Friends and Family Test (last four quarters; with Trust-level alarm limit)

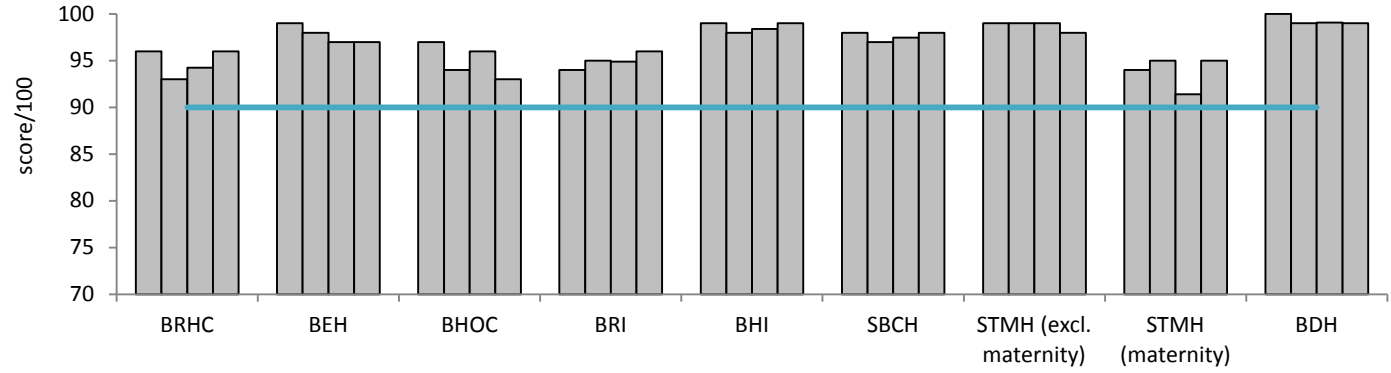
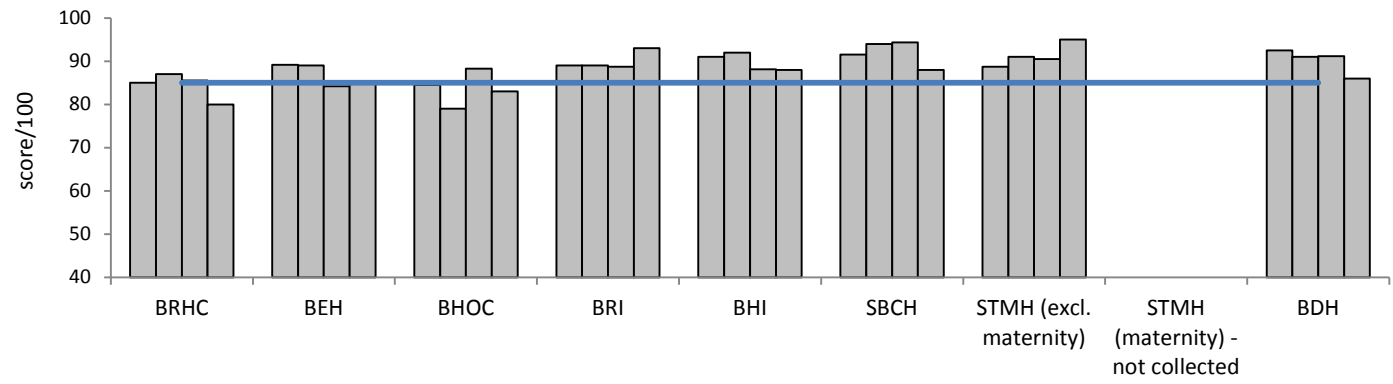


Chart 17: Outpatient experience tracker score by hospital (with Trust-level alarm limit)



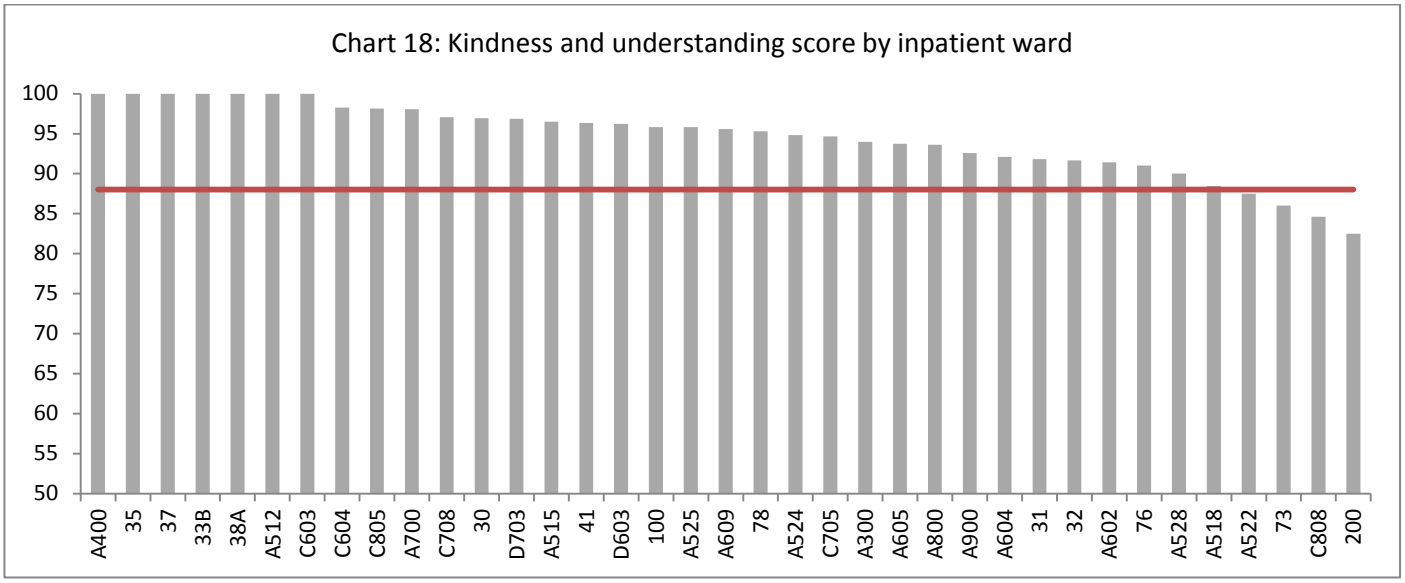


Chart 18: Kindness and understanding score by inpatient ward
100
95
90
85
80
75
70
65
60
55
50
A400 35 37 33B 38A A512 C603 C604 C805 A700 C708 30 D703 A515 41 D603 100 A525 A609 78 A524 C705 A300 A605 A800 A900 A604 31 32 A602 76 A528 A518 A522 73 C808 200

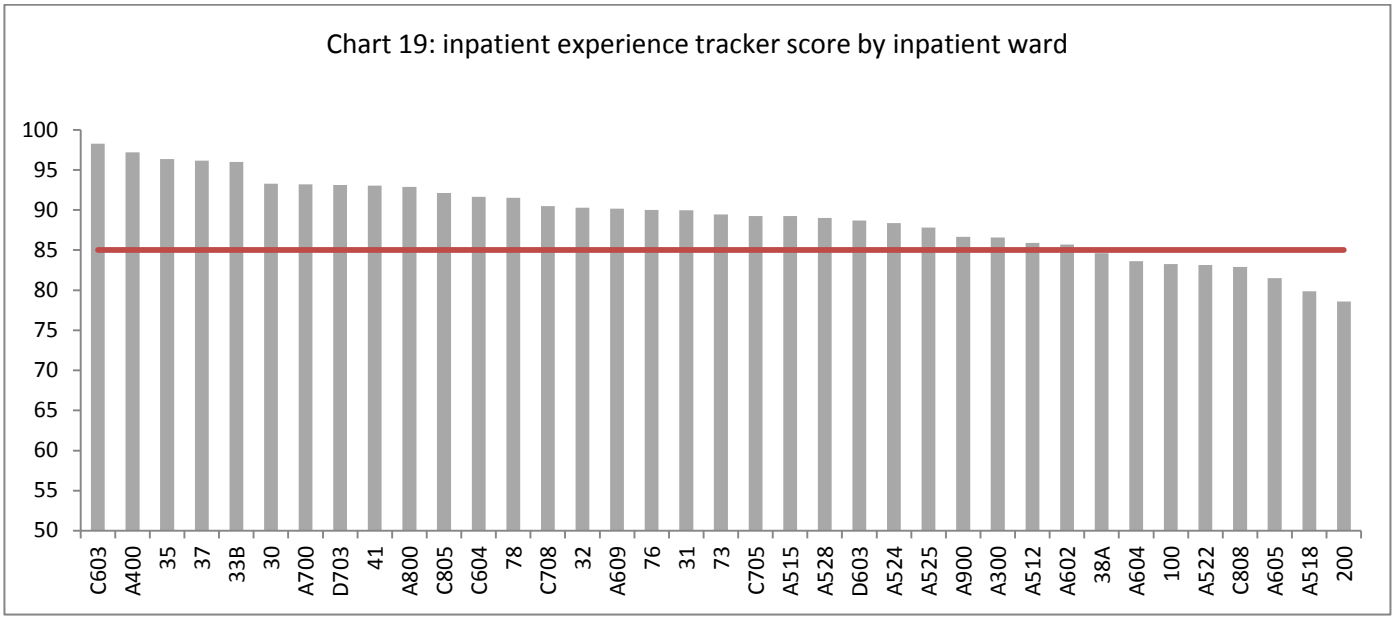


Chart 19: inpatient experience tracker score by inpatient ward
100
95
90
85
80
75
70
65
60
55
50
C603 A400 35 37 33B 30 A700 D703 41 A800 C805 C604 78 C708 32 A609 76 31 73 C705 A515 A528 D603 A524 A525 A900 A300 A512 A602 38A A604 100 A522 C808 A605 A518 200

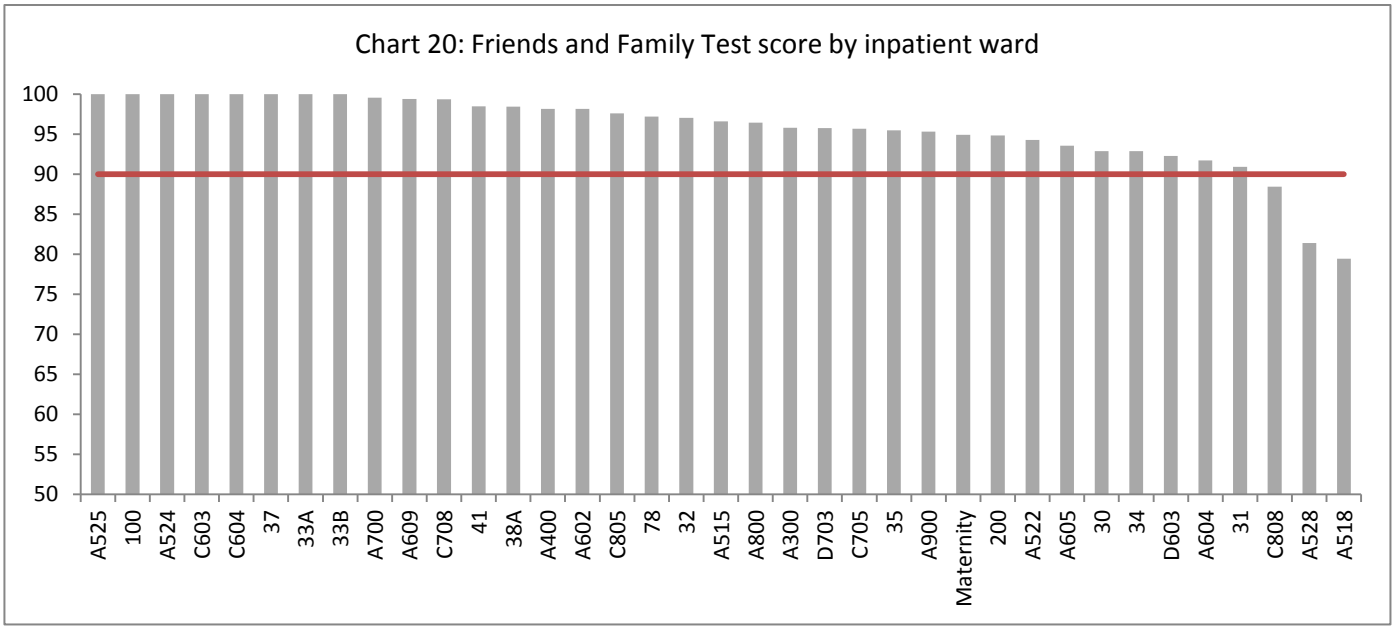


Chart 20: Friends and Family Test score by inpatient ward
100
95
90
85
80
75
70
65
60
55
50
A525 100 A524 C603 C604 37 33A 33B A700 A609 C708 41 38A A400 A602 C805 78 32 A515 A800 A300 D703 C705 35 A900 Maternity 200 A522 A605 30 34 D603 A604 31 C808 A528 A518

Table 1: Full Quarter 1 Divisional scores from UH Bristol's monthly **inpatient** postal survey (cells are highlighted if they are 10 points or more below the Trust score)

	Medicine	Surgery, Head and Neck	Specialised Services	Women's & Children's (excl. maternity)	Maternity (postnatal ward)	Trust
Were you / your child given enough privacy when discussing your condition or treatment?	92	95	92	92	n/a	93
How would you rate the hospital food you / your child received?	62	63	59	64	52	61
Did you / your child get enough help from staff to eat meals?	79	83	88	82	n/a	83
In your opinion, how clean was the hospital room or ward you (or your child) were in?	94	97	96	92	91	95
How clean were the toilets and bathrooms that you / your child used on the ward?	90	93	92	92	85	92
Were you / your child ever bothered by noise at night from hospital staff?	77	85	83	85	n/a	83
Do you feel you / your child was treated with respect and dignity on the ward?	95	97	97	98	93	97
Were you / your child treated with kindness and understanding on the ward?	94	96	97	96	89	96
How would you rate the care you / your child received on the ward?	85	90	90	92	86	90
When you had important questions to ask a doctor, did you get answers you could understand?	84	91	89	90	89	89
When you had important questions to ask a nurse, did you get answers you could understand?	85	90	90	92	91	89
If you / your family wanted to talk to a doctor, did you / they have enough opportunity to do so?	70	75	74	78	83	74
If you / your family wanted to talk to a nurse, did you / they have enough opportunity to do so?	83	87	87	92	89	87
Were you involved as much as you wanted to be in decisions about your / your child's care and treatment?	78	86	85	91	86	85
Do you feel that the medical staff had all of the information that they needed in order to care for you / your child?	86	90	90	89	n/a	89
Did you / your child find someone to talk to about your worries and fears?	69	76	75	80	82	75

(inpatient survey data continued..)	**Medicine**	**Surgery, Head and Neck**	**Specialised Services**	**Women's & Children's (excl. maternity)**	**Maternity (postnatal ward)**	**Trust**
Staff explained why you needed these test(s) in a way you could understand?	82	87	87	93	n/a	87
Did hospital staff keep you informed about what would happen next in your care and treatment during your stay?	76	85	84	92	n/a	84
Were you told when this would happen?	77	81	80	84	n/a	81
Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	74	93	93	96	n/a	92
Did a member of staff explain how you / your child could expect to feel after the operation or procedure?	68	80	75	85	n/a	78
Staff were respectful any decisions you made about your / your child's care and treatment	91	94	94	95	n/a	93
During your hospital stay, were you asked to give your views on the quality of your care?	28	33	35	35	51	33
Do you feel you were kept well informed about your / your child's expected date of discharge?	85	92	90	92	n/a	90
On the day you / your child left hospital, was your / their discharge delayed for any reason?	63	65	56	72	69	63
% of patients delayed for more than four hours at discharge	21	15	16	29	30	18
Did a member of staff tell you what medication side effects to watch for when you went home?	43	65	57	67	n/a	59
Total number of patients / parents responding to the survey in Quarter 1	*310*	*617*	*483*	*242*	*102*	*1754*

Table 2: Full six-monthly Divisional-level scores from UH Bristol's monthly **outpatient** postal survey (cells are highlighted if they are 10 points or more below the Trust score)

(Quarter 1 and 2: January-June 2016. Data combined to increase same sizes / reliability)	***Division***					
	Diagnostics & Therapies	**Medicine**	**Surgery Head & Neck**	**Specialised Services**	**Women's & Childrens (excl. Maternity)**	**All**
	Pre-appointment and booking					
Patient / parent given a choice of appointment time if they wanted one (%)	87	68	72	75	72	76
Patients / parents not experiencing a cancelled appointment (%)	88	81	83	88	86	85
Ease of contacting the hospital (score / 100)	72	62	58	77	63	67
	At the clinic					
Courtesy of the receptionist in the clinic (score/100)	94	97	94	96	89	95
Able to find a seat in the waiting area (%)	99	98	99	100	99	99
Cleanliness of the clinic (% very or fairly clean)	100	100	100	100	99	100
Seen within 15 minutes of scheduled appointment (%)	91	70	71	64	61	72
If waiting over 15 minutes - told how long delay would be (%)	58	49	41	37	18	39
If waiting over 15 minutes - told why there was a delay (%)	53	46	61	44	35	48
Patient / parent saw an information board with waiting time information on it (%)	30	66	46	59	44	50

(Outpatient survey data continued)	**Diagnostics & Therapies**	**Medicine**	**Surgery Head & Neck**	**Specialised Services**	**Women's & Childrens (excl. Maternity)**	**All**
	In the appointment					
The medical professional had all of the information needed to care for the patient (score / 100)	86	91	91	93	89	90
Medical professional listened to the patient / parent (score / 100)	95	96	95	96	95	95
Patient / parent got understandable answers to important questions (score /100)	93	93	90	91	91	92
The patient / parent had enough time with the medical professional (score / 100)	93	95	92	92	96	93
The patient / parents was treated with respect and dignity (score/100)	99	98	98	98	96	98
Risks and benefits of treatment explained (score/100)	88	87	84	85	86	86
Test results explained (score/100)	75	83	80	78	82	79
Potential medication side effects explained (score/100)	61	71	63	80	61	70
	Overall experience					
Overall care rating (% excellent, very good, good)	98	99	98	99	96	98
% extremely likely or likely to recommend the department to friends and family	94	93	91	94	93	93
Total number of respondents	308	296	333	426	151	1514

5. Specific issues raised via the Friends and Family Test in Quarter 1

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

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

Division	Ward	Issue raised	Response from Division
Division of Medicine	A528	Three comments about poor quality food were received during a short period of time during May 2016.	The feedback was shared with the Facilities Department, who could not find substantiating evidence in their local survey and audits. No further negative comments of this nature were received during Quarter 1. Scores will continue to be monitored for this ward by the Facilities Department.
	A300	A member of staff used the hospital telephone for a personal call, and the respondent witnessed the internet being used by a member of staff to access a dating website.	We could not identify the member(s) of staff being referred to in this comment, but all staff on the ward have been reminded that inappropriate use of telephones, email and internet will result in disciplinary action.
Division of Specialised Services	C705 (Bristol Heart Institute)	A comment was received about the difficulties of being on the ward if you have a visual impairment. In particular, the patient struggled to see / use their water jug.	This comment has been given to the nutrition and hydration steering group and discussed with occupational therapy colleagues to consider if there are any opportunities to make the water jugs more accessible to patients with a visual impairment. This comment has also been shared with the Sisters in the Division to raise awareness of this issue.
	D703 (Bristol Haematology and Oncology Centre)	A comment was made about needing more nurses on the ward.	There have been a number of vacancies on D703 and this is an area where focussed recruitment is taking place. On a day-to-day basis, staffing levels are reviewed to ensure that they are at safe levels for each shift.
	D603 (Bristol Haematology and Oncology Centre)	Delays at discharge, which the patient attributed to delays in the pharmacy department.	This comment has been shared with the relevant teams / staff, and discussed at key hospital governance meetings, for staff to reflect on and identify areas where these processes and communication can be improved.

Division	Ward	Issue raised	Response from Division
Women's and Children's Division *(Bristol Royal Hospital for Children)*	31	Two patients commented that on arrival they were not shown where anything was on the ward (e.g. where to get refreshments).	Parents are usually given a "Welcome to Ward 31" leaflet, along with a notice board for families, and nursing staff usually show families around the ward. It is unclear why this didn't happen on this occasion, but the ward have been notified of these comments to ensure they proactively provide an orientation for all families.
	31	Negative comment about the cleanliness of the ward floors, as the parent had a baby who was crawling around on the floor and felt that they were unhygienic.	The comments have been shared with the housekeepers on the ward. On average the ward receives a high score (95%) in its cleanliness audit. Within the comment the respondent also noted that other areas of the ward were very clean - but the floors have a high foot fall, making it difficult to resolve this issue completely.
	30A	Negative comment which raised concerns about staff attitude on the ward, and that the parent had to ask staff for the patient to be given breakfast.	This feedback has been shared directly with the ward sister, who will share it with the ward team. In respect of breakfast provision - a member of staff goes into each room every morning between 0800 and 0900 to ask for breakfast choices, so it may have been that there was a misunderstanding (i.e. that the member of staff hadn't yet arrived at the patient's room).
	30B	Comment about the lack of play facilities for children.	Due to health, safety and security the playroom is closed out of hours, but the ward now keeps a selection of craft activities and toys.
	34	A long time taken to respond to the call button.	This feedback has been shared with the ward Sister to remind staff that call buttons are a priority. A number of new staff have been recruited to the ward, which should also help to improve this issue.
	Emergency Department	A comment noted the negative attitude of reception staff.	An email has been sent to all reception staff reminding them of appropriate behaviours and values.
Division of Surgery, Head and Neck	Bristol Eye Hospital Emergency Department (BEH ED)	Several negative comments relating to staff attitude.	Although the great majority of comments about staff are positive, we need to ensure that every patient experiences this high level of care and compassion. We will therefore put in place increased monitoring around the delivery of a positive patient experience, including observations of care, unannounced visits and a formal letter to the BEH ED Sisters outlining the negative patient feedback.

Division	Ward	Issue raised	Response from Division
Division of Surgery, Head and Neck (continued)	Bristol Eye Hospital Emergency Department	Difficulties in getting through to the Emergency Department by telephone.	The Head of Nursing is currently exploring this issue with the Matron for the service. An update will be provided in the next Quarterly Patient Experience Report
	Bristol Eye Hospital Emergency Department	Ensuring that patients are kept informed of waiting times in clinics.	The Ward Sister has reminded her staff about the importance of keeping patients informed about waiting times.
	Queen's Day Unit and South Bristol Community Hospital Day case wards	Some criticism was received about the system whereby several patients are all asked to attend at the same time, so then some have to wait a relatively long time for their procedure.	Process mapping of the Division's day case services in the Queen's Day Unit and South Bristol Community Hospital is planned for January 2017. This should identify opportunities to improve the current appointments system / process.

6. Update on survey scores identified as key issues in the previous Quarterly report

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

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

Issue / area	*Main action(s) cited*	*Outcome*
Low survey scores on Ward 38b (paediatric neurology).	A member of the LIAISE Team to visit Ward 38b and talk to parents about their levels of satisfaction with their experience, and identify improvements where necessary.	This action has been deferred as the ward is currently closed for refurbishment. The visit will take place when the ward re-opens.
Low survey scores on wards C808 / A528 (Care of the Elderly) and at South Bristol Community Hospital (rehabilitation).	See Section 4 of this report.	
Below-target Friends and Family Test response rate in the day case element of this survey.	Visit each ward to put in place a robust process for collecting this feedback (complete).	The improvement trajectory agreed with the Bristol Clinical Commissioning Group has been achieved.
Waiting times in outpatient clinics at the Bristol Eye Hospital.	Patients often see several specialists during a single appointment. The management team are developing a process to track patients through this "pathway" via the Medway system. This will help clinic staff to manage the flow of patients through their appointment and to identify / prioritise patients who have been waiting a relatively long time.	Although this score improved in Quarter 1, and overall the outpatient "tracker" score reached the target for this hospital (Chart 17), waiting times in clinic are likely to remain a major challenge and focus for the Bristol Eye Hospital and other outpatient services. This is reflected in the Trust's decision to focus on this issue as a corporate quality objective in 2016/17.

7. Themes arising from inpatient free-text comments in the monthly inpatient survey

At the end of the Trust's postal survey questionnaires, patients are invited to comment on any aspect of their stay. The themes from these comments are provided in Table 5 (inpatients) and Table 6 (outpatients). (Please note that "sentiment" is a term that identifies whether a comment theme is positive (i.e. praise) or negative (improvement needed)). The themes are broad, but it can be seen that they are reasonably consistent across Divisions. By far the most frequent type of feedback is praise for staff, with the key improvement issues being around communication, staff behaviour and waiting times. Although these categories do not directly overlap with the way that the Trust classifies complaints, there are similarities between these issues (see accompanying Quarter 1 complaints report). Please note that the coding of the outpatient survey comments is a relatively recent development, and therefore we do not currently have a Divisional breakdown of these themes. However, these should be available for the next Quarterly Patient Experience and Involvement report.

Table 5: inpatient survey comments by theme (Quarter 1 2016/17)

	Theme	*Sentiment*	*Percentage of comments containing this theme*
Trust (excluding maternity[4])	Staff	Positive	57%
	Communication / information	Negative	14%
	Food / catering	Negative	9%
	Waiting / delays	Negative	8%
	Staff	Negative	8%
Division of Medicine	Staff	Positive	48%
	Food / catering	Negative	9%
	Communication / information	Negative	8%
Division of Specialised Services	Staff	Positive	53%
	Communication / information	Negative	17%
	Food / catering	Negative	14%
Division of Surgery, Head and Neck	Staff	Positive	56%
	Communication / information	Negative	15%
	Waiting / delays	Negative	9%
Women's and Children's Division (excluding Maternity)	Staff	Positive	75%
	Communication / information	Negative	12%
	Communication / information	Positive	12%
Maternity	Staff	Positive	71%
	Care during labour and birth	Positive	32%
	Communication / information	Negative	16%

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

Positive		*Negative*	
Staff	54%	Waiting / Delays	13%
Time spent with medical professional	9%	Communication and information	11%
Clinic coordination / efficiency	7%	Clinic environment / facilities	8%
Waiting / Delays	6%	Staff	8%
Clinic environment / facilities	6%	Administration (letters etc)	7%

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

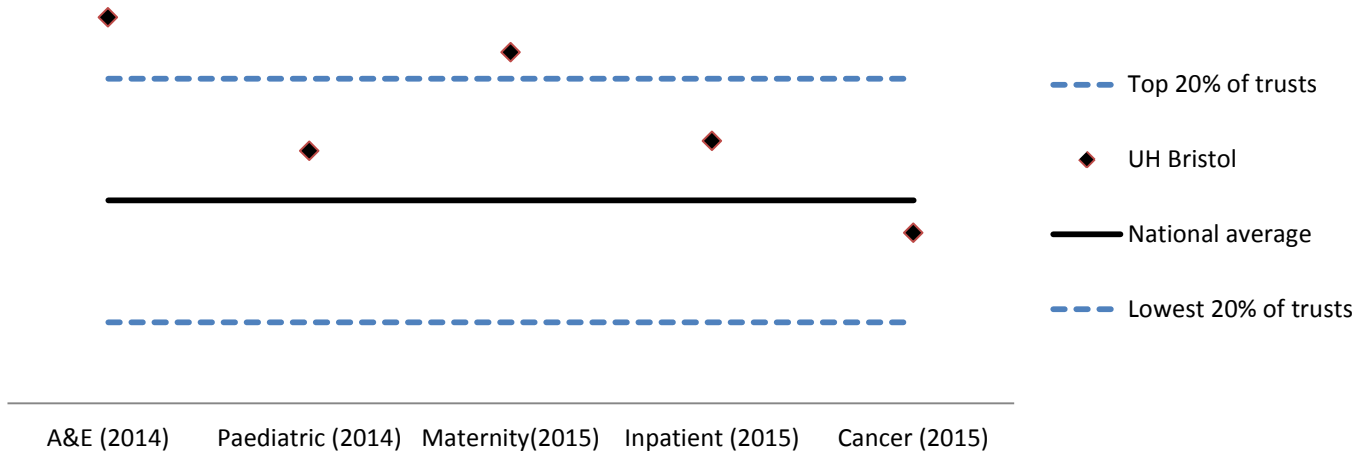
8. National Patient Surveys

The Care Quality Commission's (CQC's) National Patient Survey programme is a mandatory survey programme for acute English trusts. It provides a robust national benchmark against which the patient experience at UH Bristol can be compared to other organisations. Chart 21 provides a broad summary of the Trust's position[5]. The Trust Board receives a full report containing an analysis of each national survey and UH Bristol's response to these results (see Appendix A for a summary).

Two sets of results have recently been received - one for the national inpatient survey and the other for the national cancer survey. As in previous years, UH Bristol broadly performed in line with the national average in the national inpatient survey. There was one score that was better than this benchmark (relating to privacy as an inpatient) and one that was worse (availability of hand gels – but this was still a very good score in itself). A key area for improvement related to ensuring that patients and visitors knew how to give feedback about their care, including how to make a complaint. Each ward has now been provided with a large "Tell Us About Your Care" framed poster, which highlights how to give feedback. The Divisions are currently arranging for these posters to be put in place on the wards.

In previous years, UH Bristol performed below expectations in the national cancer survey. As a result, in 2014/15 a comprehensive and far reaching service improvement plan was developed in collaboration with patients, staff and other key stakeholders. The latest (2015) set of results for this survey were released in Quarter 1, and suggest that the effects of these improvements are beginning to be felt, with the Trust moving closer to the national average. The action plan was not fully implemented at the point in time that these survey respondents were receiving care, and therefore our expectation is for further improved scores in the next national cancer survey (results due in 2017). The current focus continues to be implementing the improvements in the Trust's cancer survey action plan. This action plan is on target for completion and is reviewed regularly by the Trust's Cancer Steering Group.

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



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

Appendix A: summary of national patient survey results and key actions arising for UH Bristol (note: progress against action plans is monitored by the Patient Experience Group)

Survey	*Headline results for UH Bristol*	*Report and action plan approved by the Trust Board*	*Action plan review*	*Key issues addressed in action plan*	*Next survey results due (approximate)*
2015 National Inpatient Survey	61/63 scores were in line with the national average. One score was below (availability of hand gels) and one was (privacy when discussing the patients treatment or condition)	July 2016	Six-monthly	• Availability of hand gels • Awareness of the complaints / feedback processes • Asking patients about the quality of their care in hospital	July 2017
2015 National Maternity Survey	9 scores were in line with the national average; 10 were better than the national average	March 2016	Six-monthly	• Continuity of antenatal care • Partners staying on the ward • Care on postnatal wards	January 2018
2015 National Cancer Survey	45/50 scores were in line with the national average; one score was above the national average (being assigned a nurse specialist); four were worse (related to holistic care)	September 2016	Six-monthly	• Support from partner health and social care organisations • Providing patients with a care plan • Coordination of care with the patient's GP	September 2017
2014 National Accident and Emergency surveys	33/35 scores in line with the national average; 2 scores were better than the national average	February 2015	Six-monthly	• Keeping patients informed of any delays • Taking the patient's home situation into account at discharge • Patients feeling safe in the Department • Key information about condition / medication at discharge	December 2014
2015 National Paediatric Survey	All scores in line with the national average, except one which was better than this benchmark	November 2015	Six-monthly	• Information provision • Communication • Facilities / accommodation for parents	November 2017
2011 National Outpatient Survey	All scores in line with the national average	March 2012	n/a	• Waiting times in the department and being kept informed of any delays • Telephone answering/response • Cancelled appointments	No longer part of the national programme

Appendix B – UH Bristol corporate patient experience programme

The Patient Experience and Involvement Team at UH Bristol manage a comprehensive programme of patient feedback and engage activities. If you would like further information about this programme, or if you would like to volunteer to participate in it, please contact Paul Lewis (paul.lewis@uhbristol.nhs.uk) or Tony Watkin (tony.watkin@uhbristol.nhs.uk). The following table provides a description of the core patient experience programme, but the team also supports a large number of local (i.e. staff-led) activities across the Trust.

Purpose	Method	Description
Rapid-time feedback	The Friends & Family Test	Before leaving hospital, all adult inpatients, day case, Emergency Department patients, and maternity service users should be given the chance to state whether they would recommend the care they received to their friends and family.
	Comments cards	Comments cards and boxes are available on wards and in clinics. Anyone can fill out a comment card at any time. This process is "ward owned", in that the wards/clinics manage the collection and use of these cards.
Robust measurement	Postal survey programme (monthly inpatient / maternity surveys, annual outpatient and day case surveys)	These surveys, which each month are sent to a random sample of approximately 1500 patients, parents and women who gave birth at St Michael's Hospital, provide systematic, robust measurement of patient experience across the Trust and down to a ward-level. A new monthly outpatient survey commenced in April 2015, which is sent to around 500 patients / parents per month.
	Annual national patient surveys	These surveys are overseen by the Care Quality Commission allow us to benchmark patient experience against other Trusts. The sample sizes are relatively small and so only Trust-level data is available, and there is usually a delay of around 10 months in receiving the benchmark data.
In-depth understanding of patient experience, and Patient and Public Involvement	Face2Face interview programme	Every two months, a team of volunteers is deployed across the Trust to interview inpatients whilst they are in our care. The interview topics are related to issues that arise from the core survey programme, or any other important "topic of the day". The surveys can also be targeted at specific wards (e.g. low scoring areas) if needed.
	The 15 steps challenge	This is a structured "inspection" process, targeted at specific wards, and carried out by a team of volunteers and staff. The process aims to assess the "feel" of a ward from the patient's point of view.
	Focus groups, workshops and other engagement activities	These approaches are used to gain an in-depth understanding of patient experience. They are often employed to engage with patients and the public in service design, planning and change. The events are held within our hospitals and out in the community.

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

Appendix C: survey scoring methodologies

Postal surveys

For survey questions with two response options, the score is calculated in the same was as a percentage (i.e. the percentage of respondents ticking the most favourable response option). However, most of the survey questions have three or more response options. Based on the approach taken by the Care Quality Commission, each one of these response options contributes to the calculation of the score (note the CQC divide the result by ten, to give a score out of ten rather than 100).

As an example: Were you treated with respect and dignity on the ward?

	Weighting	**Responses**	**Score**
Yes, definitely	1	81%	81*100 = 81
Yes, probably	0.5	18%	18*50= 9
No	0	1%	1*0 = 0
Score			*90*

Friends and Family Test Score

The inpatient and day case Friends and Family Test (FFT) is a card given to patients at the point of discharge from hospital. It contains one main question, with space to write in comments: How likely are you to recommend our ward to Friends and Family if they needed similar care or treatment? The score is calculated as the percentage of patients who tick “extremely likely” or “likely”.

The Emergency Department (A&E) FFT is similar in terms of the recommend question and scoring mechanism, but at present UH Bristol operates a mixed card and touchscreen approach to data collection.

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 29 September 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
13. Finance Report									
Sponsor and Author(s)									
Sponsor & Author: Paul Mapson, Director of Finance & Information									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

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

Key issues to note
The summary income and expenditure statement shows a surplus of £6.722m (before technical items) for the first five months of the year. This includes £5.308m of sustainability funding – the position represents a surplus of £1.414m without this funding. At month five the Trust is £0.883m adverse against plan. The deterioration from last month reflects the continued run rate in Clinical Divisions, particularly driven by the reduced level of activity over the summer months and high levels of pay expenditure. The agreed NHS Improvement plan required a surplus of £6.719m at month 5, the Trust has just achieved this.

Recommendations
None.
Impact Upon Board Assurance Framework
Impact Upon Corporate Risk
Implications (Regulatory/Legal)
Equality & Patient Impact

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
	26/09/16				

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £6.722m (before technical items) for the first five months of the year. This includes £5.308m of sustainability funding – the position represents a surplus of £1.414m without this funding. At month five the Trust is £0.883m adverse against plan. The deterioration from last month reflects the continued run rate in Clinical Divisions, particularly driven by the reduced level of activity over the summer months and high levels of pay expenditure. The agreed NHS Improvement plan required a surplus of £6.719m at month 5, the Trust has just achieved this and therefore is able to receive the sustainability and transformation funding subject to activity performance.

The run rate overspend in Clinical Divisions and Corporate Services for August was at its highest level this year. The adverse variance was £1.508m compared with £0.812m in June. The year to date overspend is now £5.021m compared with the operating plan trajectory to date of £1.143m.

In addition the Corporate share of the income under-performance adds £0.378m to the adverse movement in August, £0.302m in July and £0.030m in June.

The subjective analysis is shown below:

(Adverse)/Favourable	August £m	July £m	June £m	May £m	April £m	2016/17 to date £m
Nursing & midwifery pay	(0.350)	(0.162)	(0.251)	(0.555)	(0.348)	(1.666)
Medical & dental staff pay	(0.235)	(0.015)	0.025	(0.321)	(0.123)	(0.669)
Other pay	0.144	0.143	0.109	0.346	0.175	0.917
Non-pay	(0.190)	(0.246)	(0.212)	(0.444)	(0.270)	(1.362)
Income	(0.877)	(0.532)	(0.785)	0.372	(0.419)	(2.241)
Totals	**(1.508)**	**(0.812)**	**(1.114)**	**(0.602)**	**(0.985)**	**(5.021)**

The Divisional position is of significant concern and, unless the run rate substantially improves this could compromise the delivery of the Control Total agreed with NHS Improvement.

The current level of Divisional overspend is supported by non-recurrent savings which cannot be repeated in 2017/18. The Trust has benefitted from additional non-recurring gains in the last month whilst finalising the contracts with the CCG and Health Education England.

The Service Level Agreement (SLA) with the CCG is close to agreement and is expected to be signed by 23rd September. The NHS England Specialist Commissioning SLA has now been agreed and signed.

The August position is particularly concerning as it represents one of the biggest monthly deteriorations experienced in recent years. Whilst there was some deterioration in spending (mainly Nursing and Medical) the big issue is the substantial drop off in clinical activity in July and August.

In particular the cumulative income under-performance on activity based SLA lines is now over £2.5m, of which £1.6m relates to elective activity (mainly out-patients). This has accrued almost entirely in June, July and August – this position is bound to affect the delivery of the Trust's

Referral to Treatment (RTT) performance in the coming months. If the RTT performance drops below the cumulative required trajectory then this will also result in loss of sustainability funding.

The level of adverse variance against the Divisional Operating plans (i.e. £5m versus the planned £1.1m to Month 5) suggests that the agreed Divisional Plans were not soundly based and a critical review for 2017/18 is essential. For the October Finance Committee an analysis of the variances from Operating Plans will be produced which may be extended to workforce indicators.

In particular the prospect of cumulative failure of cancer, A&E and RTT is very real and hence the delivery of the control total of a £15.9m surplus is now very much in doubt due to the consequential loss of S&T fines.

As for previous months, the five significant financial drivers remain as below – they are key to controlling the Trust's financial position to achieve the 2016/17 financial plan.

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

These are described in the following sections.

a) Sustainability Funding

The Trust's financial position to date includes £5.308m of sustainability funding, £0.107m behind the plan to date of £5.415m. Earning sustainability funding in quarter 1 only required the agreement of the access standards trajectories with NHS Improvement / NHS England.

For August, the Trust assessed its delivery of the net surplus Control Total excluding STF. The year to date net surplus of £1.414m exceeded the Control Total net surplus requirement of £1.303m. Therefore, delivery of the net surplus Control Total in August earned STF of £0.759m and triggers the Trust's eligibility for the remaining 30% of the STF available based on the Trust's performance against the access trajectories. To date, the Trust delivered the A&E and RTT access trajectories, each worth £0.135m. The Trust did not deliver the Cancer access standard meaning the Trust did not earn the £0.054m available. The position is summarised in the table below. Further detail is provided in Appendix 9.

Trajectory to date	Quarter 1	July	August	Total YTD
Control Total delivery	Achieved	Achieved	Achieved	
STF earned	£3.250m	£0.759m	£0.759m	£4.768m
A&E trajectory delivery	Achieved	Achieved	Achieved	
STF earned	£0.135m	£0.135m	£0.135m	£0.270m
Cancer trajectory delivery	Failed	Failed*	Failed*	
STF earned	£0.000m	£0.000m	£0.000m	£0.000m
RTT National target delivery	Achieved	Achieved	Achieved**	
STF notionally earned	£0.135m	£0.135m	£0.135m	£0.270m
Total	£3.250m	£1.029m	£1.029m	£5.308m

* subject to validation. ** estimated

Italics represents notional values

Although performance remains below the 95% national standard, cumulative A&E performance was 89.5% compared with the agreed trajectory of 85.6%. The Trust is currently forecasting ongoing achievement of the A&E access trajectory for the remainder of the financial year. However, performance to date in September is lower than trajectory, and the trajectory becomes more challenging during quarter 3. So this forecast may be revised next month.

Performance against the 62-day GP standard is forecast to improve to 82.6% in August (to be confirmed on final reporting), compared with 72.9% in July. This is above the trajectory for the month of 81.7%. Current predictions indicate that cumulative performance will continue to improve this quarter, with the trajectory being met in quarters 3 and 4.

RTT performance in August dipped to 90.4%. This took cumulative delivery for the period to 91.9%, compared with a trajectory of 91.9% after the application of the 1% tolerance. Going forward, the trajectory increases from 92.0% forecast for the end of September to 93.0% from January, with the minimum requirement for securing monthly funds being achievement of the national standard (i.e. 92%) on a cumulative basis. The Trust now needs to achieve 92.7% for the month of September in order to achieve the trajectory at month-end, and for this reason the Trust is now forecasting failure of the 92% standard going forward.

b) Nursing & Midwifery

The nursing and midwifery pay variance for the month is £0.350m adverse. The table below shows the analysis between substantive, bank and agency for each month and year to date. The 2015/16 position is shown for comparison.

	August £m	July £m	Quarter 1 £m	2016/17 to date £m	2015/16 outturn £m
Substantive	0.725	0.955	1.264	3.909	10.099
Bank	(0.591)	(0.520)	(1.438)	(2.550)	(6.684)
Agency	(0.484)	(0.598)	(1.945)	(3.027)	(7.691)
Totals	**(0.350)**	**(0.163)**	**(1.155)**	**(1.668)**	**(4.276)**

Whilst agency improved by £0.114m in the month, this was offset by £0.071m on bank staff and £0.230m on substantive staff.

The following table shows the Nursing and ODP price and volume variance for August. Overall, it shows that Nursing and ODPs were £0.383m adverse with £0.262m due to volume above the funded establishment (wte) and £0.121m due to adverse variance on price. The table also shows that the wards in the Clinical Divisions are responsible for the overspend (£0.390m).

There has been a notable improvement in Surgery, Head and Neck, but the position in Medicine and Women's and Children's remains concerning.

Table: Nursing & ODP Variance

Division	Nursing Category	Price Variance fav/ (adv) £'000	Volume Variance fav/ (adv) £'000	Total Variance fav/ (adv) £'000	Lost Time % (Wards/ED/ Theatres)
Medicine	Ward	(14)	(96)	(109)	
	Other	10	(50)	(39)	
	ED	16	(6)	10	
Medicine Total		**13**	**(151)**	**(138)**	**128%**
Surgery, Head & Neck	Ward	70	(115)	(45)	
	Theatres	(37)	37	0	
	Other	(41)	59	18	
	ED	2	1	2	
Surgery, Head & Neck Total		**(6)**	**(19)**	**(25)**	**124%**
Specialised Services	Ward	8	(63)	(55)	
	Other	(45)	23	(22)	
Specialised Services Total		**(36)**	**(40)**	**(76)**	**127%**
Women's & Children's Services	Ward	(110)	(27)	(137)	
	Theatres	(30)	14	(15)	
	Other	29	(18)	12	
	ED	(10)	0	(10)	
Women's & Children's Services Total		**(121)**	**(30)**	**(151)**	**129%**
Clinical Division Total	Ward	(40)	(306)	(346)	
	Theatres	(66)	51	(15)	
	Other	(40)	8	(32)	
	ED	7	(4)	3	
CLINICAL DIVISIONS TOTAL		**(138)**	**(252)**	**(390)**	**127%**
NON CLINICAL DIVISIONS	Other	18	(10)	7	
NON CLINICAL DIVISIONS TOTAL		**18**	**(10)**	**7**	
TRUST TOTAL		**(121)**	**(262)**	**(383)**	**127%**

The HR Nursing Controls dashboard is attached at appendix 3 and shows the registered nursing position for each Division against eight Key Performance Indicators (KPIs). Highlights from the KPIs are as follows:

- Sickness –Surgery, Head and Neck and Women's and Children's Divisions continue to be above trajectory for their sickness levels, and in August Medicine is also above trajectory;
- Vacancies – all but the Women's and Children's Division are above the Trust target of 5% for vacancies with the Division of Medicine being the highest at 10.6% (which is a continued increase in trajectory);
- Operating Plan for nursing agency wte – all Divisions are above their Operating Plan position with the Division of Surgery, Head and Neck being the most concerning with an actual position of 30.2wte against a target of 8.6wte. This is also reflected in their percentage of nursing agency against total nursing spend, 8.8% against a target of 2.5%; and
- Nursing assistant, 1:1 and RMN usage – the Medicine Division continues to be above the funded level for NA 1:1's and RMN's, as are Specialised Services in month 5.

c) Medical and Dental

The medical and dental pay variance for the month is £0.235m adverse. The table below shows the analysis between substantive, locum and agency each month and year to date. The 2015/16 position is shown for comparison.

	August £m	July £m	Quarter 1 £m	2016/17 to date £m	2015/16 Outturn £m
Substantive	(0.002)	0.255	0.645	0.899	2.387
Locum	(0.197)	(0.142)	(0.630)	(0.967)	(1.803)
Agency	(0.036)	(0.129)	(0.434)	(0.600)	(2.389)
Totals	**(0.235)**	**(0.015)**	**(0.419)**	**(0.668)**	**(1.805)**

The increase in substantive pay was due to the successful recruitment to a number of consultant posts and a reduction in gaps in the rota following the most recent rotation of junior medical staff.

NHS Improvement Agency Ceiling

NHS Improvement has set an agency expenditure ceiling of £12.793m for the Trust. In 2015/16 this was referred to as an agency and locum ceiling and therefore the Trust included medical staff on zero hour contracts paid through the payroll in information provided to Monitor. This information was used to set the Trust's ceiling. The Operational Plan submitted by the Trust to NHS Improvement for 2016/17 had a forecast outturn of £11.755m.

Following the change in terminology by NHS Improvement, the Trust has split out the medical locums on zero hour contracts (in effect the Trust's medical bank staff). NHS Improvement support this approach and are now considering whether this will require a change to the Trust's ceiling.

At the end of August the Trust is currently showing an adverse variance against the NHS Improvement ceiling of £0.384m, an improvement in month of £0.138m. Against the Trust's operational plan the variance is £0.870m adverse, due to nursing expenditure being higher than planned.

The tables below show a summary of both the current month and year to date position against the NHS Improvement agency ceiling and the Trust's Operating Plan by staff group.

Spending versus NHS Improvement Agency Ceiling

	Current month position (August)			Year to date position		
Staff category	NHS I Ceiling £m	Actual £m	Variance fav/(adv) £m	NHS I Ceiling £m	Actual £m	Variance fav/(adv) £m
Medical Agency	-	0.085	-	-	0.870	-
Medical Locum – Zero Hours		0.098			0.370	
Medical Locum – Fixed Term		0.177			1.208	
Nursing Agency (RNs and NAs)	-	0.556	-	-	3.154	-
Other Agency	-	0.159	-	-	0.764	-
Totals	**1.213**	**1.075**	**0.138**	**5.982**	**6.366**	**(0.384)**

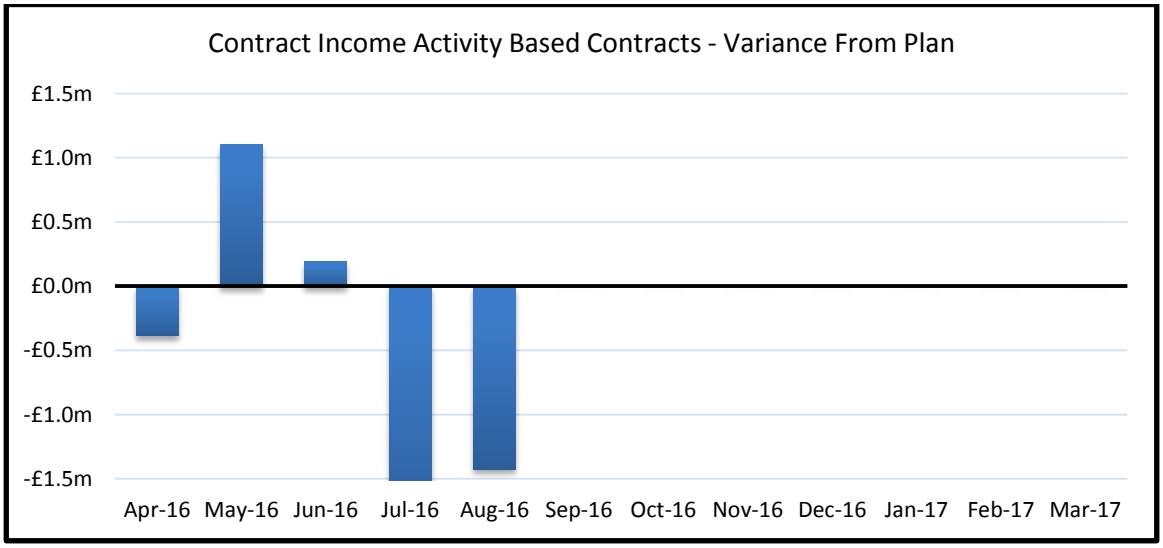
Spending versus UH Bristol Operating Plan

	Current month position (August)			Year to date position		
Staff category	Operational Plan £m	Actual £m	Variance fav/(adv) £m	Operational Plan £m	Actual £m	Variance fav/(adv) £m
Medical	0.582	0.359	0.223	2.972	2.448	0.524
Nursing (RNs and NAs)	0.345	0.556	(0.211)	1.622	3.154	(1.532)
Other	0.188	0.159	0.029	0.902	0.764	0.138
Totals	**1.115**	**1.074**	**0.041**	**5.496**	**6.366**	**(0.870)**

d) Clinical Activity

Activity based contract performance worsened by £1.424m in August to give a cumulative under performance of £2.518m. The position worsened in August for all Divisions. Performance at Clinical Divisional level is shown at appendix 5a.

The graphs below show the monthly performance for all activity based activity and for elective activity. Whilst the April underperformance for elective work was recovered in May, the position has deteriorated for each month thereafter.



A significant amount of August's under-performance is due to a continuation of the reduced activity over the summer months possibly reflecting the level of Divisional planning over this period.

The table below summarises the overall clinical income by work type, which is described in more detail under agenda item 5.2.

	In Month Variance Fav/(Adv) £m	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance Fav/(Adv) £m
Activity Based				
Accident & Emergency	0.04	6.49	6.71	0.22
Bone Marrow Transplants	0.02	3.45	3.60	0.15
Critical Care Bed days	(0.14)	18.39	18.09	(0.30)
Day Cases	(0.12)	16.41	16.25	(0.16)
Elective Inpatients	(0.02)	21.32	21.15	(0.17)
Emergency Inpatients	0.01	32.37	33.44	1.07
Excess Bed days	(0.05)	2.91	2.66	(0.25)
Non – Elective Inpatients	(0.33)	11.44	9.91	(1.53)
Other	(0.18)	39.00	38.72	(0.27)
Outpatients	(0.65)	34.53	33.26	(1.27)
Sub Totals	**(1.42)**	**186.31**	**183.79**	**(2.52)**
Contract Penalties	(0.03)	(0.39)	(0.42)	(0.03)
Contract Rewards	0.00	3.92	3.92	0.00
Pass through payments	0.41	36.29	34.44	(1.85)
2016/17 Totals	**(1.04)**	**226.13**	**221.73**	**(4.40)**
Prior year income	0.34	-	1.68	1.68
Overall Totals	**(0.70)**	**226.13**	**223.41**	**(2.72)**

Outpatient activity, both new and follow ups, accounted for £0.646m of the deterioration in the month and was reflected across all Divisions; Medicine (£0.107m), Specialised Services (£0.116m), Surgery, Head and Neck (£0.234m) and Women's and Children's (£0.091m). In particular Ophthalmology and Dental specialties were both £0.120m behind plan. The year to date performance of £1.27m below plan includes Dental (£0.34m), Ophthalmology (£0.54m) and Haematology/Oncology (£0.23m).

Non-elective inpatient under performance increased in August by £0.332m, particularly within Specialised Services (£0.107m), Surgery, Head and Neck (£0.087m). Emergency inpatients were broadly in line with plan this month. Taken together they are £0.46m lower than plan to date, with medical and cardiac specialities below plan and surgical specialties above plan.

CQUINs have now been agreed including the Hepatitis C CQUIN with NHS England Specialised Commissioning (worth c£2.6m). However the delays in finalising the agreements and quarterly monitoring for most indicators means that rewards performance will commence at quarter two and is currently set to plan.

Performance against penalties was £0.03m below plan this month, moving the cumulative performance to £0.03m below plan. The cumulative position is predominately due to Remedial Action Plan (RAP) penalties for cancelled operations readmissions within 28 days.

Pass through payments were £0.41m higher than plan in August, reducing the adverse cumulative position to £1.85m. The year to date adverse variance relates to drugs (£1.43m), devices (£0.52m) and blood products (£0.13m).

e) Savings Programme

The savings requirement for 2016/17 is £17.420m. Savings of £5.262m have been realised to date, a shortfall of £1.971m against divisional plan. The shortfall is a combination of unidentified schemes of £1.323m and a further £0.648m for scheme slippage. The 1/12th phasing adjustment increases the shortfall to date by £0.026m.

The year-end forecast outturn has improved slightly this month to £13.945m, a shortfall of £3.475m, which represents delivery of 80%.

A summary of progress against the Savings Programme for 2016/17 is summarised below. A more detailed report is given under item 5.4 on this month's agenda.

	Savings Programme to 31st August 2016				
	Plan £m	Actual £m	Variance fav / (adv) £m	Phasing adjustment fav/(adv) £m	Total variance Fav/(adv) £m
Diagnostics and Therapies	0.637	0.693	0.056	(0.047)	0.009
Medicine	0.672	0.518	(0.154)	(0.030)	(0.184)
Specialised Services	0.603	0.464	(0.139)	(0.027)	(0.166)
Surgery, Head and Neck	1.997	1.083	(0.914)	(0.068)	(0.982)
Women's and Children's	2.018	1.126	(0.892)	0.085	(0.807)
Estates and Facilities	0.280	0.302	0.022	(0.047)	(0.025)
Corporate Services	0.406	0.379	(0.027)	0.108	0.081
Other Services	0.620	0.697	0.077	-	0.077
Totals	**7.233**	**5.262**	**(1.971)**	**(0.026)**	**(1.997)**

The performance for the year by category is also shown below.

	Year to Date			Variance Against Adjusted Plan £m	Forecast Outturn		
	Plan £m	Actual £m	Variance £m		Plan £m	Actual £m	Variance £m
Pay	1.044	0.935	(0.109)	(0.146)	2.597	2.591	(0.006)
Drugs	0.528	0.526	(0.002)	0.091	1.044	1.078	0.034
Clinical Supplies	1.278	1.384	0.106	0.103	3.073	3.519	0.446
Non Clinical Supplies	1.699	1.449	(0.250)	(0.319)	4.241	3.835	(0.406)
Other Non Pay	0.024	0.024	-	-	0.057	0.057	-
Income	1.049	0.656	(0.393)	(0.403)	2.543	2.175	(0.368)
Capital Charges	0.288	0.288	-	-	0.690	0.690	-
Unidentified	1.323	-	(1.323)	(1.323)	3.175	-	(3.175)
Totals	**7.233**	**5.262**	**(1.971)**	**(1.997)**	**17.420**	**13.945**	**(3.475)**

2. Divisional Financial Position

Clinical Divisions and Corporate Services overspend against budget increased by £1.508m in August to a cumulative position of £5.021m adverse to plan. The table below summarises the financial performance in August for each of the Trust's management divisions against their budget and against their August Operating Plan trajectory. Further analysis of the variances against budget by pay, non-pay and income categories is provided in Appendix 2.

	Budget Variance favourable/(adverse)			Operating Plan Trajectory favourable/(adverse)	
	To 31 July £m	August £m	To 31 Aug £m	Trajectory To Aug £m	Variance £m
Diagnostic & Therapies	0.112	(0.052)	0.060	(0.047)	0.107
Medicine	(1.167)	(0.398)	(1.565)	(0.224)	(1.341)
Specialised Services	(0.240)	(0.198)	(0.438)	(0.164)	(0.274)
Surgery, Head & Neck	(1.306)	(0.507)	(1.813)	(0.434)	(1.379)
Women's & Children's	(1.021)	(0.374)	(1.395)	(0.240)	(1.155)
Estates & Facilities	(0.023)	(0.013)	(0.036)	(0.047)	0.011
Trust Services	0.012	(0.019)	(0.007)	0.013	(0.020)
Other corporate	0.120	0.053	0.173	0	0.173
Totals	**(3.513)**	**(1.508)**	**(5.021)**	**(1.143)**	**(3.878)**

Variance to Budget:

The table below shows the Clinical Divisions and Corporate Services budget variances against the four main income and expenditure headings.

	Budget Variance favourable/(adverse)		
	To 31 July £m	August £m	To 31 August £m
Pay	(0.880)	(0.391)	(1.271)
Non Pay	(0.068)	0.149	0.081
Operating Income	(0.067)	(0.117)	(0.184)
Income from Activities	(0.842)	(0.809)	(1.651)
Sub Total	(1.857)	(1.168)	(3.025)
Savings programme	(1.656)	(0.340)	(1.996)
Totals	**(3.513)**	**(1.508)**	**(5.021)**

Pay budgets have an adverse variance in month of £0.391m increasing the cumulative adverse variance to £1.271m. The significant adverse movements in the month were within Medicine (£0.166m), Specialised Services (£0.165m) and Women's and Children's (£0.227m), offset by a favourable variance in Diagnostic and Therapies (£0.115m). Cumulative adverse variances are within Women's and Children's (£1.129m), Surgery, Head and Neck (£0.239m), Medicine (£0.555m), and Specialised Services (£0.360m) offset by favourable variances in Diagnostic & Therapies (£0.623m) and Trust Services (£0.307m).

For the Trust as a whole, agency spend is £4.788m to date. The monthly average spend of £0.958m compares with a monthly average spend in 2015/16 of £1.260m. Agency spend to date is £1.324m in Medicine, £0.951m in Women's and Children's, £1.060m in Surgery, Head and Neck and £0.869m in Specialised Services. Waiting List Initiatives (WLIs) costs to date are £1.322m of which £0.543m is within Surgery, Head and Neck, £0.224m in Women's and Children's and £0.202m in Specialised Services.

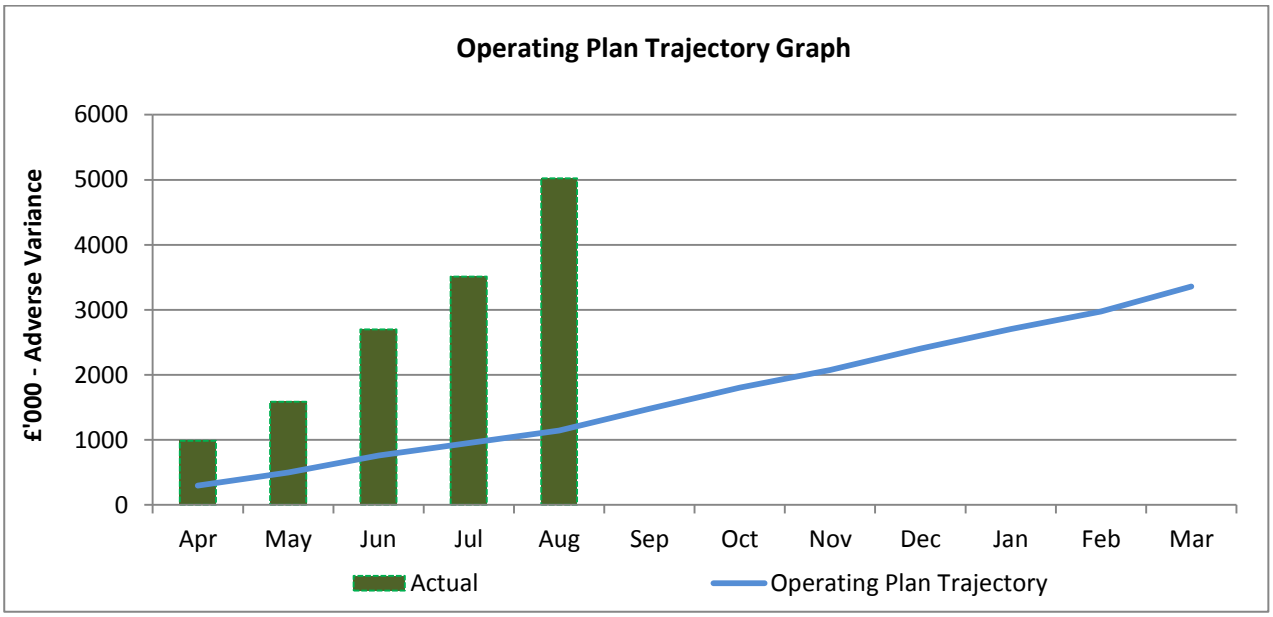
N**on-pay budgets** have a favourable variance of £0.149m in the month changing the cumulative variance to £0.081m favourable.
The movement in the month was primarily within Women's and Children's which improved by £0.198m.
Cumulative adverse variances are within Diagnostic & Therapies (£0.484m), Surgery, Head and Neck (£0.215m), and Specialised Services (£0.155m) offset by a favourable variance in Women's and Children's of £1.048m.

Operating Income budgets have an adverse variance in the month of £0.117m increasing the cumulative adverse variance to £0.184m. Both the movement in month and cumulative variance is primarily outside of the Clinical Divisions and is offset by non pay.

Income from Activities budgets have an adverse variance in month of £0.809m increasing the cumulative adverse variance to £1.651m.
The most significant adverse variances in month were in Medicine (£0.245m) Surgery, Head and Neck (£0.265m) and Women's and Children's (£0.206m).
The principal areas of under achievement to date are within Medicine (£0.829m), Women's and Children's (£0.532m) and Surgery, Head and Neck (£0.412m) offset by a favourable variance in Specialised Services (£0.150m).

Variance to Operating Plan:

Clinical Divisions and Corporate Services have an adverse variance of £5.021m against a combined Operating Plan trajectory of £1.143m. The August position is £3.878m above trajectory as shown in the graph below.



Further detail is given under agenda item 5.3 in the Finance Committee papers.

3. Divisional Reports

The following is intended to provide a brief update on the Divisional positions including reasons for variances and actions being taken to address adverse positions. As requested at the previous Finance Committee, the divisional reports at item 5.3 provide further detail on the impact of actions being taken and the new actions that have been introduced since the last report.

Five Divisions are red rated for their financial performance for the year to date:

3.1 Division of Medicine

The Division reports an adverse variance to month 05 of £1.565m; the Division is £1.341m adverse to its Operating Plan trajectory to date. The Division is reporting a savings programme year to date adverse variance of £0.184m and a savings programme forecast outturn favourable variance of £0.256m.

The key reasons for the variance are:

<u>Adverse variances</u>

- An adverse pay variance of £0.555m which represents an in month deterioration of £0.166m. The pay expenditure in August was the highest recorded this year. Nursing budgets were adverse by £0.437m; within this, total nursing expenditure was £0.058m higher in August than July. Agency expenditure was higher in August than in July, and bank spend was higher than in July due to a further increase in the associated costs of 1:1 nursing.
- An adverse variance on non-pay of £0.018m, although an improvement in month of £0.016m.The overspend to date includes, drugs £0.061m and clinical supplies £0.078m.
- An adverse variance on SLA income of £0.829m which represents a deterioration in month of £0.245m, the main reason being lower than planned Outpatient activity £0.107m, and lower than planned emergency activity £0.051m.

Favourable variances

- A favourable variance on income from operations of £0.021m.

Actions being taken and mitigation to restore performance include:

Ongoing actions

- Reductions in nursing costs – this is being managed via a programme of close controls with respect to the booking of shifts out of hours, the continued close scrutiny of all agency use and the introduction of dementia 'night clubs' aimed at reducing the number of 1:1 shifts required. The Division will also explore the possibility of cost recovery from Commissioners where appropriate (i.e. where accountability clearly lies with Commissioners); the ability to control and manage this action is severely constrained by the lack of mobilisation in the community and the lack of community beds.
- The rolling out of 'Discharge to Assess' for 'Pathway 3' patients, to understand the impact upon both length of stay and ultimately occupancy rates;
- Development of Emergency Nurse Practitioners (ENPs) and Advanced Nurse Practitioners (ANPs) within the ED.
- Medical Staff Payments – including the review of all WLI and additional payments in accordance with Trust guidance. A capacity planning exercise, in conjunction with refreshed job plans and the recruitment of acute physicians is also underway.
- The full management of the ORLA programme – a detailed description is provided in the Medicine divisional report.
- Ensure the planned recovery of non-elective and emergency activity and deliver at marginal rates. It will be important not to react to any increased activity volumes following the closure of A518. Managing occupancy and discharge is the key priority, not the seeking of escalation capacity.
- Increasing and retaining elective activity volumes and delivering at a margin through the cessation of outsourcing arrangements and better use of existing resources.
- The ownership, accountability and responsibility for community bed placements have passed to Commissioners with immediate effect. It is the Division's recommendation that Commissioners seek to utilise Care Home Select's existing resources in the absence of an appropriate replacement programme of service. Indeed, the closure of ward A518 (unfunded post September 2016) is predicated on the re-provision of this service.

New actions

- Specialties have been identified that are able to over-perform against contract, in respect of elective, outpatient activity. These opportunities have been identified with consideration given to the requirement for waiting list initiatives. The planned over-performance will allow assist the Division in its overall recovery of outpatient performance but can also assist in the achievement of trust wide RTT targets, facilitating, in turn an ability to earn the STF

Proposed actions

- To work with Commissioners to ensure that the front door pilot, encompassing the Urgent Care Centre, is progressed and rolled out in tandem with the 'high impact users' initiative – to progress one initiative without the other would be contradictory to the wider aims of managing pressures in the ED.
- All patients, following a decision to admit (DTA) in ED, to be referred on ICE to ORLA for consideration – it is hoped that in doing this, referrals accepted by ORLA directly from the ED can be increased, improving both cost and operational efficiency.

Risks

The 2016/17 financial plan forecasts a deficit of c. £0.94m but contains a number of risks and assumptions. These include:

- The consultation for and closure of Ward A518, independent of ORLA Healthcare Ltd.
- The mobilisation and careful management of the ORLA Healthcare Ltd initiative.
- Recruitment to the Enhanced Supervision Team.
- Community and social care initiatives including the ownership of a bed placement scheme.

3.2 Division of Surgery, Head and Neck

The Division reports an adverse variance to month 05 of £1.813m; The Division is £1.379m adverse to its Operating Plan trajectory to date. The key reasons for the variance are:

Adverse variances

- An underachievement of savings resulting in an adverse variance to date of £0.983m. The majority relates to unidentified plans £0.625m the rest relates to schemes having been removed with regards to outsourcing savings and other slippage on schemes.
- An adverse variance on pay of £0.239m primarily due to high nursing agency and bank usage as well as high levels of waiting list expenditure within Medical Staff.
- An adverse variance on non-pay of £0.215m this has been caused by spend on outsourcing work and overspends on clinical supplies offset by underspends relating to support funding.
- An adverse variance on income from activities of £0.412m after a significant deterioration this month of £0.265m, the most significant adverse year to date variances are within Ophthalmology due mainly to a low number of follow up outpatients £0.202m driven by vacancies in key posts. Oral/Dental services £0.503 and Colorectal services £0.148m. These being offset by a significant favourable variances within Upper GI services £0.200m, ENT services £0.038m and Private/Overseas Patients £0.169m.

Favourable variances

- A favourable variance on income from operations of £0.036m due to higher than planned research and development income.

The key reasons for the variance against the Operating Plan trajectory are:

- Higher than planned nursing spend of £0.211m.
- Higher than planned medical staff spend including WLI payments of £0.151m.
- Higher than planned expenditure on outsourcing of £0.249m.
- Lower than planned income from activities of £0.411m.
- Higher than planned spend on drugs and clinical supplies of £0.1219m.
- Slippage on recruitment to vacancies of £0.1149m favourable.
- Higher than planned blood spend £0.189.
- Slippage on CIP delivery.

Key risks to delivery of the Operating Plan and ongoing improvement include:

- There remains risk around delivery of service level agreement income which has the potential to be substantial; there is an increased reliance on outsourcing) and recovery is dependent on swift and successful recruitment particularly around oral and dental services. The income forecast will be fully refreshed at Month 06.
- The division is continuing to develop plans to recover and deliver service level agreement income and the key performance targets required. These plans come at a cost. The team is clear that the financial implications of these plans require close management control.
- Lost activity due to bed pressures and lack of anaesthetic cover remain risks to divisional performance although recruitment has now succeeded in the anaesthetic workforce
- Failure to deliver the required improvements in both recruitment and retention of staff, in particular in the registered nursing and operating department practitioner workforce will drive additional costs in terms of agency spend into the position. (Particularly an issue for the orthopaedic wards, across all theatres and intensive care).

- The Junior Medical and Dental workforce is vulnerable to changes in trainee levels and difficulty has been found in recruitment particularly in Trauma and Orthopaedics. The need to maintain cover on the wards is driving agency costs albeit there has now been a successful round of recruitment to this team.
- The division has been notified that there will be reductions in training numbers into Intensive Care in the autumn which will produce further cost pressures
- Failure to address the appropriate need for 1:1 nursing.
- Failure to work up additional cost improvement.

Actions being taken and mitigation to restore performance include:

Ongoing Actions

- The Division is holding fortnightly Finance and Performance Meetings where Service Line Managers are held to account for finance and service performance.
- The Division is holding fortnightly CIP meetings where service lines are clear on their individual savings targets and are presenting news plans and pipeline ideas to meet those targets.
- Review meetings are being held with Divisional Director, Divisional Finance Manager and General Manager, reviewing actual expenditure and challenging spend.
- The Managed Inventory System Project has been approved and there have been further meetings in to date in order to progress the contract terms. This is proving difficult but progress is being made.
- Recruitment plans are under way. The investment in a recruitment/training manager for theatres has been made and is delivering real improvements.
- Reduction of turnover is being approached with additional provision of training and staff development, and career progression opportunities.
- The Division continues to work with other divisions in understanding bed modelling and planning going forward.
- The monthly nursing performance and finance meetings are in place and the first meeting havs been held with the "hotspots" of the T&O wards, Theatres, ITU and Ward 700. The new terms of reference for these meetings will be reviewed to ensure the focus on recovery of the position is a key agenda item.
- The new Head of Nursing is working closely with Matron colleagues to improve controls and reduce spend on agency and bank staffing. New agency tracking and monitoring paperwork is in use.
- Re-Launch of Divisional Non Pay group to review and progress savings ideas on non-pay

New Actions

- The Division is beginning a formal process of re-engaging with the service teams, the clinical, management and nursing staff. This engagement is required to identify further actions that can be taken to move the results back towards planned outturn and outcomes for 16/17 and will also be valuable in planning for 2017/18.
- Nurse performance meetings are being extended to encompass all nursing teams, with the "hotspots" being reviewed monthly and other departments rotating through.

Proposed Actions

- Review of delivery plans to mitigate high cost solutions in ENT and Endoscopy.
- Project underway in Dental Hospital to understand and resolve major issues within the admin processes to try and deliver significant improvements in clinic utilisation ahead of recruitment cost impacts.

- Substantive General Manager appointed to the Dental Hospital, starting during September. This is a vital appointment as these services have struggled to deliver improvements with interim management in post.

3.3 The Division of Women's and Children's Services

The Division reports an adverse variance to month 05 of £1.395m. The Division is £1.155m adverse to the Operating Plan trajectory to date.

The key reasons for the variance are:

Adverse variances:

- An adverse variance on pay of £1.129m including higher than planned nursing agency costs above NHS Improvement cap rate, mental health nurse specialling for three highly dependent children £0.095m in the first two months has now ceased. Medical staff overspends £0.448m including costs associated with non-compliant junior rotas and significant agency spend for consultants, there is significant levels of maternity leave and sickness in key junior medical rotas with 11 posts on maternity leave.
- An underperformance on the savings programme resulting in an adverse variance to date of £0.806m. The majority of which relates to the level of unidentified savings in the plan £0.755m.
- An adverse performance on SLA income of £0.532m including deterioration in month of £0.206m particularly in Neurosurgery, Cardiac, PICU and Paediatric Surgery.

Favourable variances

- A significant favourable variance on non-pay of £1.048m which includes a share of support funding and capacity growth reserves which offset the underachieved of income and slippage on developments.

Actions being taken and mitigation to restore performance:

Ongoing Actions

- Nurse rostering KPI metrics continuing to improve.
- Nursing up to full establishment by autumn.
- Spinal Surgery Investment Plan and re-profiled activity plan developed by Spinal Pathway Transformation Group with first additional lists in June.
- Children's Hospital Flow Programme budget signed off by multi-disciplinary team.
- Outpatient productivity manager started in post.
- Specialty Productivity Reviews beginning with Paediatric T&O.
- Review of theatres productivity metrics and improving data capture to ensure effective utilisation of operating theatres.
- Meeting UK Specialist Children's Alliance colleagues in July to attempt a "mini-Carter Review" process.
- Supplier re-engagement meetings held with cochlear implant suppliers.
- Numerous controls being implemented with regards to nursing being driven by the Nursing Controls Finance Meeting
- Peer review benchmarking against the Evelina Children's Hospital.

New actions:

The main challenges to the delivery of the Division's Operating Plan moving forward are:

- Identifying mitigations for the significant adverse pay variances including nurse 'specialling', and agency cost premiums.

- Identifying a way of ensuring agency usage, where unavoidable, is within NHS Improvement capped rates.
- Ensuring that emergency demand does not disrupt elective throughput.
- Converting savings pipeline ideas into cash releasing savings and identifying new opportunities from the Carter Review and Model Hospital Programme.

3.4 Division of Specialised Services

The Division reports an adverse variance to month 05 of £0.438m. The Division is £0.274m adverse to the Operating Plan trajectory to date.

The key reasons for the variances are:

Adverse variances:
- Cardiac Surgery activity - the Division reports an adverse variance to date of £0.112m after a significant improvement this month of £0.090m.
- Medical pay budgets show an adverse variance of £0.112m due to agency and WLI costs.
- Non Pay budgets report an adverse variance of £0.155m mainly within Clinical Supplies but also spread across a number of areas.
- Pay budgets are reporting an adverse variance of £0.360m with nursing reporting an adverse variance of £0.239m.
- A year to date shortfall on the savings programme of £0.165m.

Favourable variances
- Operating income reports a favourable variance of £0.092m.
- Cardiology now reports a favourable SLA variance of £0.67m although there was deterioration in month of £0.019m.
- A favourable variance on Private Patients of £0.21m, an improvement of £0.005m in month.
- Clinical Genetics budgets are reporting a favourable variance of £0.014m; this is down £0.059m from last month.

Actions being taken and mitigation to restore performance:

Ongoing Actions
- Reductions in nursing overspends
  Ambitious plans have been identified for reducing nursing costs; the following actions have taken place:

  - Appointment of Nursing recruitment lead
  - Appointment of new training lead
  - Development of retention plans
  - Increased focus on tackling sickness levels, with success having been achieved in CICU where levels have halved
  - Review of one to one practices
  - Reviews of annual leave allocations

- Agency expenditure
  - Recruiting as quickly as possible once vacancies are known
  - Recruiting permanently into nursing maternity vacancies
  - Replacing long term agency with substantive posts
  - Developing and growing in house staff to fill hard to recruit to areas.

- Drugs
  - In month, a financial loss has been experienced in the division due to a high cost drugs usage date expiring. The divisional pharmacist is to review pharmacy practices to ensure that any future items that are coming up to expiry are notified in advance so as to give the trust the opportunity to try and prevent the loss.

New actions

- Significant activity planning has been put in place to maintain activity levels during the summer period. The division is focused on continuing to plan its activity effectively to maximise its throughput and maintain high volumes of treatment through the coming months.

- A plan has been completed within Cardiac Surgery to replace high cost junior doctor agency with Nurse Practitioners and Surgical Care Practitioners in addition to amending existing medical rotas. The output of this change will be to provide a more sustainable and stable service as well as to reduce expenditure on high cost agency. Implementation is planned for September with FYE savings totalling £300k having been added to the divisional Cost Improvement Programme.

- Clinical Genetics
  Plans are in development to address the current waiting list backlogs in this area. Due to the service line being profitable for this area favourable margins are expected. This will enable resolution of a clinical issue whilst contributing to the divisional financial position.

- Perfusion Workforce
  Agency usage has been relied upon and has been increasing for a significant period. A review of the perfusion workforce is to be undertaken to ensure workforce planning is working effectively in this area.

Proposed Actions

- National Commissioning changes to pass through items have been identified posing a significant risk to device income through increased bureaucracy. The division has:
  - Held meetings with NHS Supply chain.
  - Developing catalogues for products moving to supply chain.
  - Advised medical colleagues of changes.
  - Is revising processes and support for purchasing and billing of high cost devices.

The main challenges to the delivery of the Division's Operating Plan moving forward are:

- Delivery of Cardiac Surgery Activity.
- Meeting contracted levels of activity across other specialties.
- Controlling and reducing Nursing expenditure to deliver a breakeven year end out turn.
- Reducing agency staffing across all staff groups through; improved retention, reduced sickness, improving recruitment to posts that have been covered for longer than a short term period with temporary staff, improved training and development of staff.
- Delivering the savings programmes identified and continuing to develop new schemes.
- Maintaining controls on non-pay expenditure.
- Developing procedures to ensure no adverse impacts will be incurred as a result of national commissioning arrangements e.g. prior approval for devices

3.5 Trust Services

The Division reports an adverse variance to month 05 of £0.007m. The Division is £0.020m adverse to the Operating Plan trajectory to date.

Two Divisions are rated Green for their performance to date

3.6 Diagnostic and Therapies Division

The Division reports a favourable variance to month 05 of £0.060m. The Division is £0.107m favourable compared to the Operating Plan trajectory to date.

The key reasons for the variance are:

Adverse variances

- An adverse variance on non-pay of £0.484m which includes double running costs associated with LIMS £0.105m, Radiology outsourcing costs £0.208m, and adverse variances on clinical supplies and drugs including £0.144m due to drug wastage.
- An adverse variance on operating income of £0.061m.
- An adverse variance on SLA income of £0.027m, there is a favourable variance on services hosted by Diagnostics and Therapies of £0.197m offset by adverse variances associated with services hosted by other divisions of £0.220m

Favourable variances

- A favourable variance on pay of £0.623m, primarily the result of vacancies in clinical staff
- The savings programme is £0.009m favourable year to date.
- Adverse variances on non-pay above are offset by a balance of contract transfer funding.

Actions being taken and mitigation to restore performance:

Existing actions

- Rolling programme of Service Line Reporting meetings being set up with Heads of Service, Radiology have started, order of other services was determined at Divisional Finance Committee.
- Review of Radiology contract income data post HRG move underway, with support from information analyst.
- Specialty review of Radiology taking place for August Savings Board, including WLIs.

New actions

- Division is working on response to Lord Carter's team regarding Pathology services.

Key risks to delivery of the operating plan and future performance include:

- Other Division's under-performance on contracted activity.
- Non-delivery or under-delivery of savings schemes currently forecast to achieve.
- Employing high cost agency and or locum staff into hard to recruit to posts to ensure delivery of key performance targets and resilience in services such as Radiology.

3.7 Facilities and Estates Division

The Division reports an adverse variance to month 05 of £0.036m. The Division is £0.011m favourable to the Operating Plan trajectory to date.

4. Risk Rating

The Trust achieved an overall Financial Sustainability Risk Rating (FSRR) of 4 (actual 4.00) against a plan of 4 for the period to August.

Each of the four FSRR metrics are in line with the plan to date with actual metric scores of 4. A summary is provided in the table below.

		31st August 2016		31st March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		12.64	14.39	11.96	11.96
Metric Rating	25%	4	4	4	4
Capital Servicing Capacity					
Metric Result – times		2.66	2.61	2.77	2.77
Metric Rating	25%	4	4	4	4
Income & expenditure margin					
Metric Result		3.10%	3.12%	2.70%	2.70%
Metric Rating	25%	4	4	4	4
Variance in I&E margin					
Metric Result		0.32%	0.02%	0.32%	0.00%
Metric Rating	25%	4	4	4	4
Overall FSRR		**4.0**	**4.0**	**4.0**	**4.0**
Overall FSRR (rounded)		**4**	**4**	**4**	**4**

5. Capital Programme

A summary of income and expenditure for the five months ending 31st August 2016 is provided in the table below. The Operational Plan of £35.0m shows a profiled planned spend to date of £14.285m. A review of the capital programme has identified a number of delays resulting in a re-profiled internal plan, although the forecast outturn remains at £35.0m.

Operational Plan £m			Period ended 31st August 2016			
		Operational Plan to date £m	Internal Plan £m	Actual £m	Variance £m	Forecast Out turn £m
	Sources of Funding					
0.273	PDC	0.273	0.273	0.272	(0.001)	0.273
3.049	Donations	2.170	2.170	2.169	(0.001)	2.732
	Cash:					
22.054	Depreciation	8.907	8.907	8.886	(0.021)	22.054
9.624	Cash balances	2.935	1.484	0.817	(0.667)	9.915
35.000	**Total Funding**	**14.285**	**12.834**	**12.144**	**(0.690)**	**34.974**
	Expenditure					
(14.244)	Strategic Schemes	(7.659)	(7.477)	(7.543)	(0.066)	(10.805)
(11.142)	Medical Equipment	(2.617)	(1.393)	(0.850)	0.543	(10.128)
(4.659)	Information Technology	(1.601)	(1.663)	(1.390)	0.273	(4.486)
(2.815)	Estates Replacement	(0.828)	(0.704)	(0.638)	0.066	(2.755)
(13.191)	Operational Capital	(2.580)	(2.383)	(1.723)	0.660	(9.722)
(46.051)	**Gross Expenditure**	**(15.285)**	**(13.620)**	**(12.144)**	**1.476**	**(37.896)**
2.706	Planned Slippage	1.000	0.786	-	(0.786)	2.922
8.345	I&E Variation from Plan		-	-	-	-
(35.000)	**Net Expenditure**	**(14.285)**	**(12.834)**	**(12.144)**	**0.690**	**(34.974)**

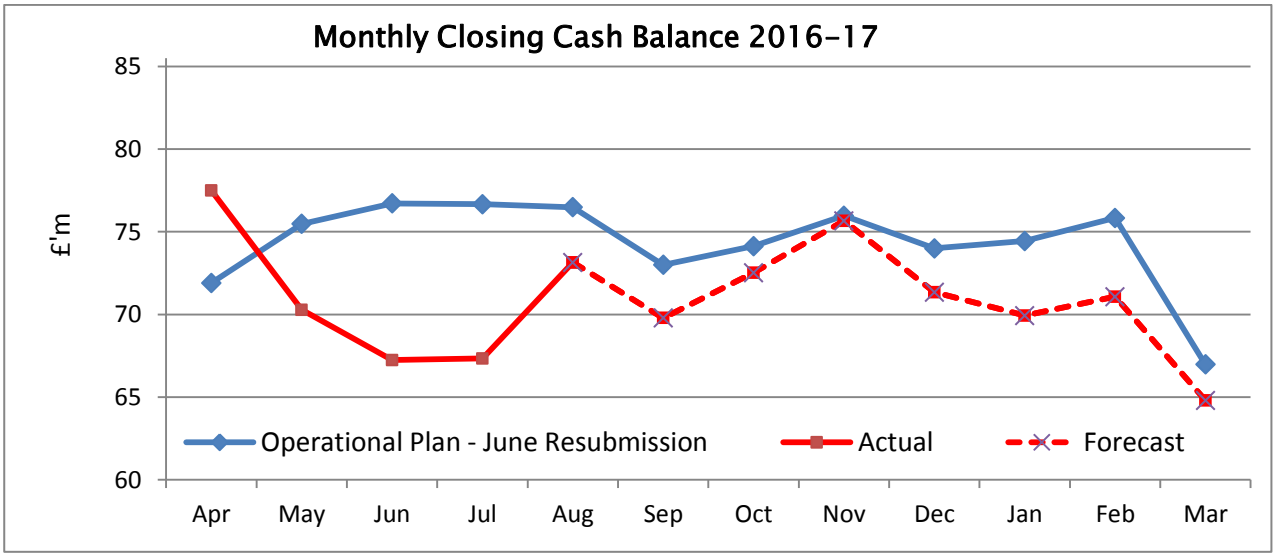
Capital expenditure for the period is £12.144m against an internal plan of £12.834m, a variance of £0.690m. This is largely due to timing issues, particularly medical equipment purchases for which procurement is underway. Further information is provided under agenda item 6.1.

6. Statement of Financial Position and Cashflow

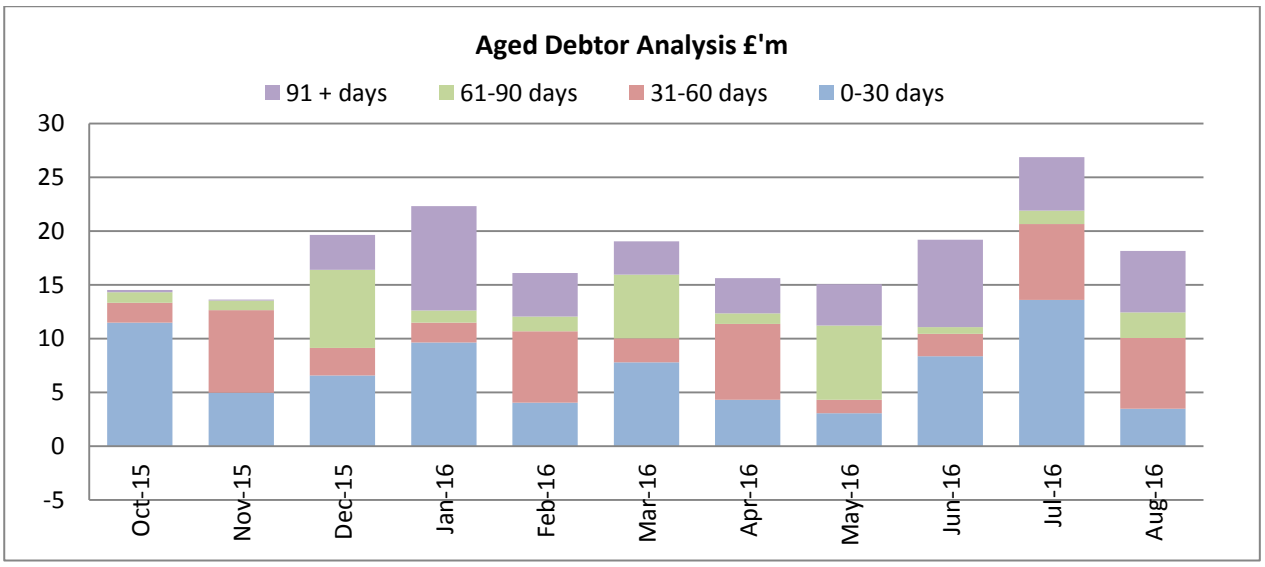
Overall, the Trust had a strong statement of financial position as at 31st August 2016 with net current assets of £33.473m, £2.273m higher than plan.

The Trust held cash and cash equivalents of £73.331m at the end of August, £5.889m higher than last month. Payment has now been received for the prior year activity and sustainability and transformation funds delayed from last month. The cash balance remains below the plan (£3.152m) whilst Commissioners continue to pay at 2015/16 contract levels pending signing of the 2016/17 contracts.

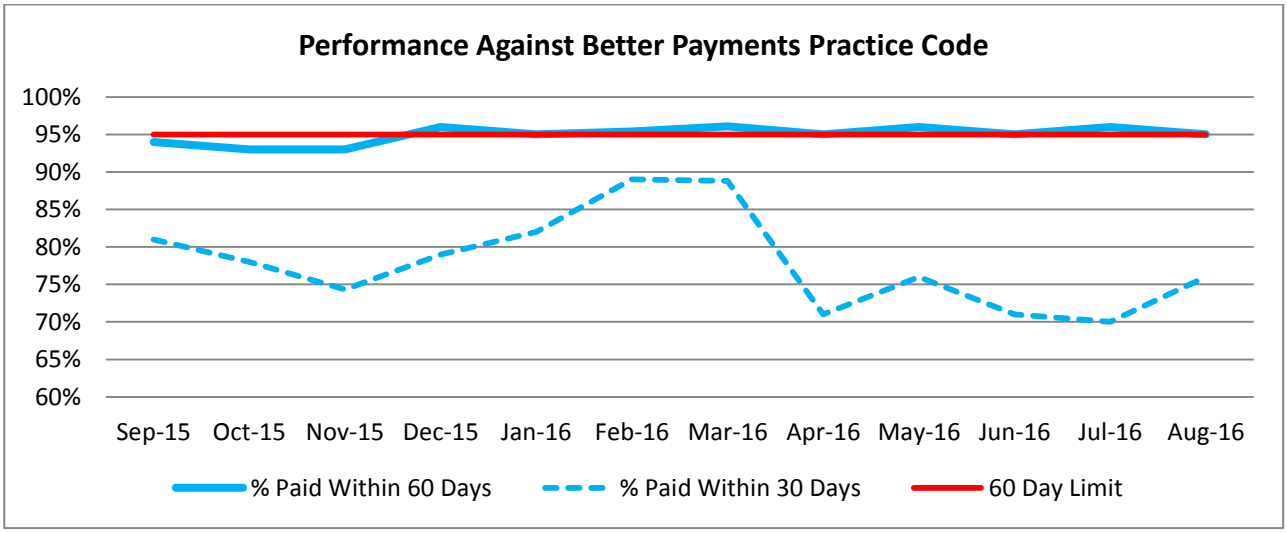
The forecast year end cash balance is £64.801m. The graph below shows the month end cash balance trajectory for the financial year.



The total value of debtors decreased by £8.708m in August to £18.169m. SLA debtors decreased by £8.719m and non SLA debtors increased by £0.011m. The SLA decrease reflects payment of activity invoices and quarter 1 sustainability funding. The total value of debtors over 60 days old increased by £1.907m to £8.120m. £1.710m increase related to SLA invoices, primarily due to Wessex Specialist Commissioning Cancer Drugs Fund (payment is expected in September) and maternity pathways. The increase in non SLA debtors of £0.197m relates to North Bristol Trust and Avon and Wiltshire Mental Health Partnership NHS Trust. The position is summarised in the chart below. Further details are provided in agenda item 7.1.



In August the Trust's performance against the 60 day limit was 95%. The number of invoices paid within 30 days was 76%. A chart plotting performance is provided below.



Attachments

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

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

Approved Budget / Plan 2016/17	Heading	Position as at 31st August Plan	Actual	Variance Fav / (Adv)	Actual to 31st July
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
542,283	From Activities	225,046	224,486	(560)	178,428
88,782	Other Operating Income	37,423	37,116	(307)	29,620
631,065	**Sub totals income**	**262,469**	**261,602**	**(867)**	**208,048**
	Expenditure				
(359,291)	Staffing	(150,822)	(152,240)	(1,418)	(121,527)
(212,940)	Supplies and Services	(87,595)	(88,935)	(1,340)	(70,295)
(572,231)	**Sub totals expenditure**	**(238,417)**	**(241,175)**	**(2,758)**	**(191,822)**
(8,782)	Reserves	(2,500)	-	2,500	-
50,052	**EBITDA**	**21,552**	**20,427**	**(1,125)**	**16,226**
7.93	**EBITDA Margin - %**		**7.81**		**7.80**
	Financing				
(22,472)	Depreciation & Amortisation - Owned	(9,081)	(8,886)	195	(7,103)
244	Interest Receivable	102	112	10	98
(291)	Interest Payable on Leases	(121)	(122)	(1)	(98)
(3,124)	Interest Payable on Loans	(1,302)	(1,233)	69	(987)
(8,509)	PDC Dividend	(3,545)	(3,576)	(31)	(2,861)
(34,152)	**Sub totals financing**	**(13,947)**	**(13,705)**	**242**	**(10,951)**
15,900	**NET SURPLUS / (DEFICIT) before Technical Items**	**7,605**	**6,722**	**(883)**	**5,275**
	Technical Items				
-	Profit/(Loss) on Sale of Asset	-	(20)	(20)	(20)
2,732	Donations & Grants (PPE/Intangible Assets)	2,170	2,169	(1)	2,145
(6,436)	Impairments	(1,273)	(1,296)	(23)	(1,296)
385	Reversal of Impairments	-	-	-	-
(1,610)	Depreciation & Amortisation - Donated	(668)	(665)	3	(531)
10,971	**SURPLUS / (DEFICIT) after Technical Items**	**7,834**	**6,910**	**(924)**	**5,573**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report August 2016- Divisional Income & Expenditure Statement

Approved Budget / Plan 2016/17	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 31st July	Operating Plan Trajectory Year to Date	Variance from Operating Plan Year to Date
				Pay	Non Pay	Operating Income	Income from Activities	CIP				
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income											
541,417	Contract Income	226,133	226,133	-	-	(23)	23	-	-	-		
-	Overheads, Fines & Rewards	-	1,396	-	24	-	1,372	-	1,396	1,457		
36,017	NHSE Income	15,024	15,024	-	-	-	-	-	-	-		
577,434	**Sub Total Corporate Income**	**241,157**	**242,553**	**-**	**24**	**(23)**	**1,395**	**-**	**1,396**	**1,457**		
	Clinical Divisions											
(51,377)	Diagnostic & Therapies	(21,453)	(21,393)	623	(484)	(61)	(27)	9	60	112	(47)	107
(75,989)	Medicine	(31,945)	(33,510)	(555)	(18)	21	(829)	(184)	(1,565)	(1,167)	(224)	(1,341)
(102,135)	Specialised Services	(42,520)	(42,958)	(360)	(155)	92	150	(165)	(438)	(240)	(164)	(274)
(105,453)	Surgery Head & Neck	(43,838)	(45,651)	(239)	(215)	36	(412)	(983)	(1,813)	(1,306)	(434)	(1,379)
(119,434)	Women's & Children's	(49,878)	(51,273)	(1,129)	1,048	24	(532)	(806)	(1,395)	(1,021)	(240)	(1,155)
(454,388)	**Sub Total - Clinical Divisions**	**(189,634)**	**(194,785)**	**(1,660)**	**176**	**112**	**(1,650)**	**(2,129)**	**(5,151)**	**(3,622)**	**(1,109)**	**(4,042)**
	Corporate Services											
(36,245)	Facilities And Estates	(14,928)	(14,964)	30	(3)	(16)	(21)	(26)	(36)	(23)	(47)	11
(25,422)	Trust Services	(10,967)	(10,974)	307	(306)	(92)	2	82	(7)	12	13	(20)
(2,545)	Other	(1,576)	(1,403)	52	214	(188)	18	77	173	120	-	173
(64,212)	**Sub Totals - Corporate Services**	**(27,471)**	**(27,341)**	**389**	**(95)**	**(296)**	**(1)**	**133**	**130**	**109**	**(34)**	**164**
(518,600)	**Sub Total (Clinical Divisions & Corporate Services)**	**(217,105)**	**(222,126)**	**(1,271)**	**81**	**(184)**	**(1,651)**	**(1,996)**	**(5,021)**	**(3,513)**	**(1,143)**	**(3,878)**
(8,782)	Reserves	(2,500)	-	-	2,500	-	-	-	2,500	1,600		
-	NHS Improvement Plan Profile	-	-	-	-	-	-	-	-	288	-	-
(8,782)	**Sub Total Reserves**	**(2,500)**	**-**	**-**	**2,500**	**-**	**-**	**-**	**2,500**	**1,888**		
50,052	**Trust Totals Unprofiled**	**21,552**	**20,427**	**(1,271)**	**2,605**	**(207)**	**(256)**	**(1,996)**	**(1,125)**	**(168)**		
	Financing											
(22,472)	Depreciation & Amortisation - Owned	(9,081)	(8,886)	-	195	-	-	-	195	140		
244	Interest Receivable	102	112	-	10	-	-	-	10	17		
(291)	Interest Payable on Leases	(121)	(122)	-	(1)	-	-	-	(1)	(1)		
(3,124)	Interest Payable on Loans	(1,302)	(1,233)	-	69	-	-	-	69	54		
(8,509)	PDC Dividend	(3,545)	(3,576)	-	(31)	-	-	-	(31)	(25)		
(34,152)	**Sub Total Financing**	**(13,947)**	**(13,705)**	**-**	**242**	**-**	**-**	**-**	**242**	**185**		
15,900	**NET SURPLUS / (DEFICIT) before Technical Items**	**7,605**	**6,722**	**(1,271)**	**2,847**	**(207)**	**(256)**	**(1,996)**	**(883)**	**17**		
	Technical Items											
-	Profit/(Loss) on Sale of Asset	-	(20)	-	(20)	-	-	-	(20)	(20)		
2,732	Donations & Grants (PPE/Intangible Assets)	2,170	2,169	-	-	(1)	-	-	(1)	(25)		
(6,436)	Impairments	(1,273)	(1,296)	-	(23)	-	-	-	(23)	(23)		
385	Reversal of Impairments	-	-	-	-	-	-	-	-	-		
(1,610)	Depreciation & Amortisation - Donated	(668)	(665)	-	3	-	-	-	3	-		
(4,929)	**Sub Total Technical Items**	**229**	**188**	**-**	**(40)**	**(1)**	**-**	**-**	**(41)**	**(68)**		
10,971	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**7,834**	**6,910**	**(1,271)**	**2,807**	**(208)**	**(256)**	**(1,996)**	**(924)**	**(51)**		

REGISTERED NURSING - NURSING CONTROL GROUP AND HR KPIs

Graph 1 **Sickness**

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

Source: HR

Graph 2 **Vacancies**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Medicine	Actual	7.5%	8.7%	8.3%	9.4%	10.6%							
Specialised Services	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Specialised Services	Actual	6.5%	7.7%	7.0%	7.0%	6.8%							
Surgery, Head & Neck	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Surgery, Head & Neck	Actual	3.9%	5.9%	8.1%	8.2%	8.1%							
Women's & Children's	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Women's & Children's	Actual	1.5%	2.6%	3.0%	4.8%	2.5%							

Source: HR

Graph 3 **Turnover**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*
Medicine	Actual	16.9%	16.7%	16.0%	17.4%	15.8%							
Specialised Services	*Target*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*
Specialised Services	Actual	15.6%	14.2%	13.2%	13.1%	12.8%							
Surgery, Head & Neck	*Target*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*
Surgery, Head & Neck	Actual	14.6%	13.6%	13.3%	13.9%	11.9%							
Women's & Children's	*Target*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*
Women's & Children's	Actual	9.3%	10.0%	10.5%	10.9%	11.5%							

Source: HR
Note: M4 figs restated

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*145.0*	*115.0*	*131.0*	*140.0*	*150.0*	*150.0*	*80.0*	*90.0*	*90.0*	*75.0*	*80.0*	*75.0*
Medicine	Actual	244.6	132.0	169.6	160.6	163.0							
Specialised Services	*Target*	*54.7*	*54.7*	*54.7*	*36.7*	*36.7*	*32.1*	*32.1*	*27.5*	*18.3*	*18.3*	*18.3*	*18.3*
Specialised Services	Actual	95.0	108.4	107.8	75.1	88.6							
Surgery, Head & Neck	*Target*	*38.6*	*38.3*	*54.6*	*56.9*	*53.6*	*25.8*	*12.5*	*12.5*	*12.5*	*12.5*	*12.5*	*12.5*
Surgery, Head & Neck	Actual	215.0	201.7	183.4	157.9	163.2							
Women's & Children's	*Target*	*36.9*	*50.8*	*71.8*	*37.7*	*50.7*	*79.5*	*122.1*	*29.1*	*29.1*	*25.3*	*25.3*	*25.3*
Women's & Children's	Actual	158.8	134.0	109.2	188.3	140.7							

Source: Finance GL (excludes NA 1:1)

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*28.5*	*18.5*	*20.5*	*21.3*	*26.3*	*15.7*	*10.5*	*11.3*	*18.5*	*8.4*	*9.4*	*8.4*
Medicine	Actual	31.3	18.8	24.9	27.9	32.4							
Specialised Services	*Target*	*8.0*	*8.0*	*8.0*	*8.0*	*8.0*	*7.0*	*7.0*	*6.0*	*4.0*	*4.0*	*4.0*	*4.0*
Specialised Services	Actual	10.6	13.2	13.6	11.7	14.7							
Surgery, Head & Neck	*Target*	*6.0*	*6.1*	*8.6*	*9.1*	*8.6*	*4.1*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*
Surgery, Head & Neck	Actual	27.5	29.6	25.9	27.1	30.2							
Women's & Children's	*Target*	*7.8*	*10.8*	*15.3*	*7.8*	*10.6*	*16.8*	*25.8*	*5.8*	*5.8*	*4.8*	*4.8*	*4.8*
Women's & Children's	Actual	15.4	11.3	10.7	19.7	15.4							

Source: Finance GL (excludes NA 1:1)

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*7.9%*	*6.4%*	*7.2%*	*7.7%*	*8.3%*	*8.1%*	*4.6%*	*5.1%*	*5.2%*	*4.4%*	*4.6%*	*4.4%*
Medicine	Actual	13.4%	7.1%	9.5%	9.0%	9.0%							
Specialised Services	*Target*	*4.3%*	*4.3%*	*4.3%*	*2.9%*	*2.9%*	*2.5%*	*2.5%*	*2.1%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*
Specialised Services	Actual	7.3%	7.7%	7.9%	5.7%	6.4%							
Surgery, Head & Neck	*Target*	*1.8%*	*1.8%*	*2.6%*	*2.7%*	*2.5%*	*1.2%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*
Surgery, Head & Neck	Actual	11.5%	10.5%	10.0%	8.8%	8.8%							
Women's & Children's	*Target*	*1.2%*	*1.6%*	*2.3%*	*1.2%*	*1.6%*	*2.5%*	*3.7%*	*0.9%*	*0.9%*	*0.8%*	*0.8%*	*0.8%*
Women's & Children's	Actual	4.7%	3.8%	3.2%	5.5%	4.0%							

Source: Finance GL (RNs only)

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

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

Source: Info web: KPI Bed occupancy

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*
Medicine	Actual	70	66	78	82	95							
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	23	27	14	24	32							
Surgery, Head & Neck	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery, Head & Neck	Actual	25	21	31	34	33							
Women's & Children's	*Target*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
Women's & Children's	Actual	87	31	10	29	10							

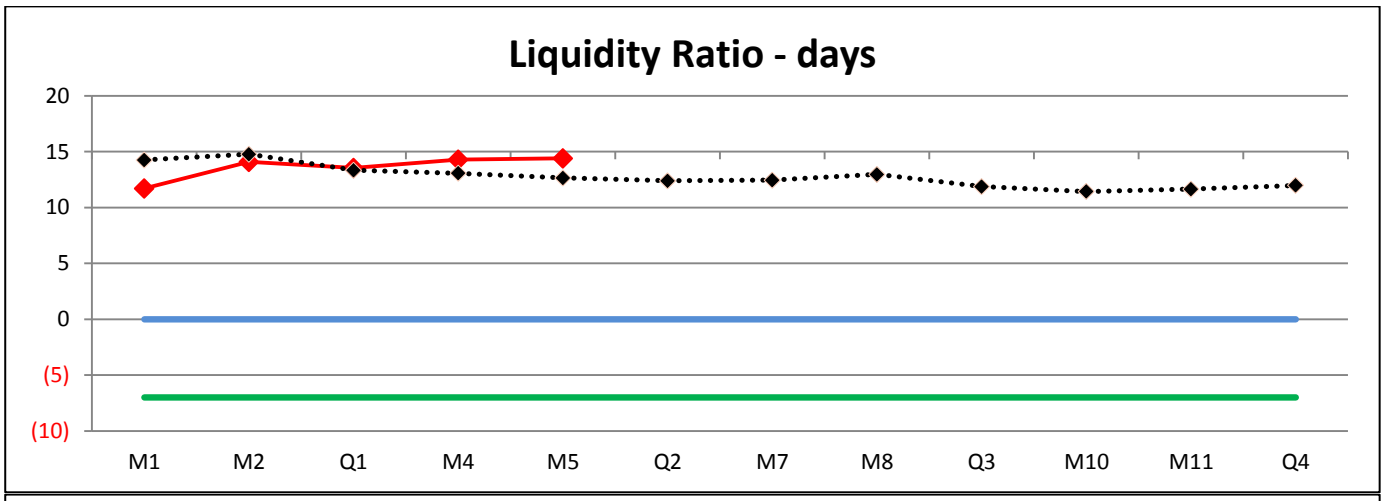
Financial Sustainability Risk Rating – August 2016 Performance

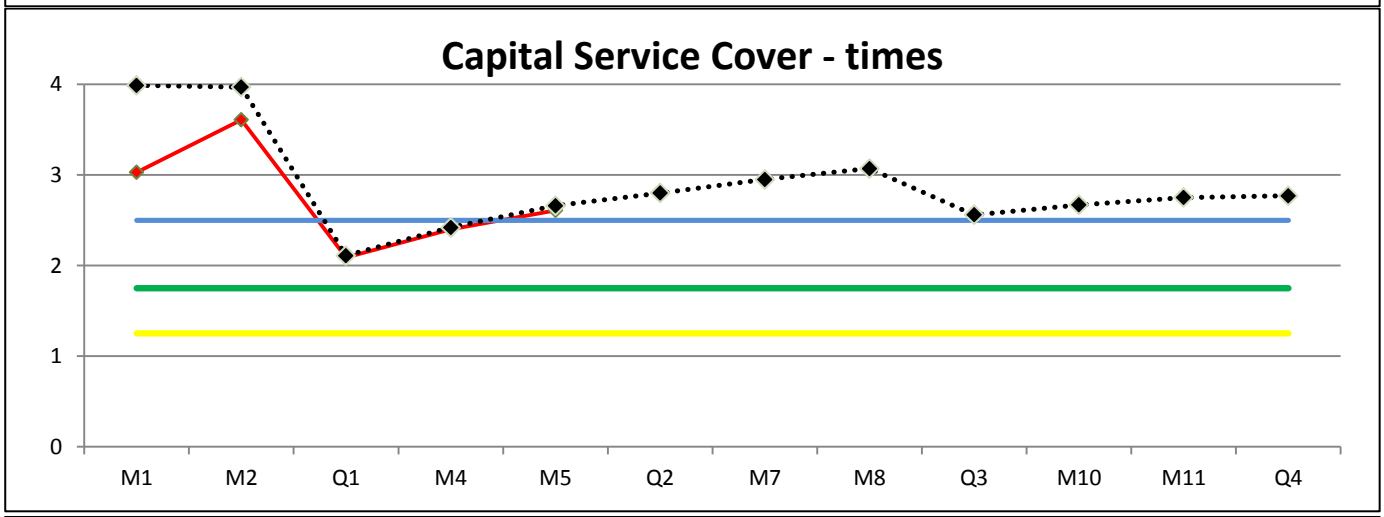
The graphs overleaf show performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For the period to the end of August, the Trust achieved an overall FSRR of 4 (actual 4.00) against a plan of 4.

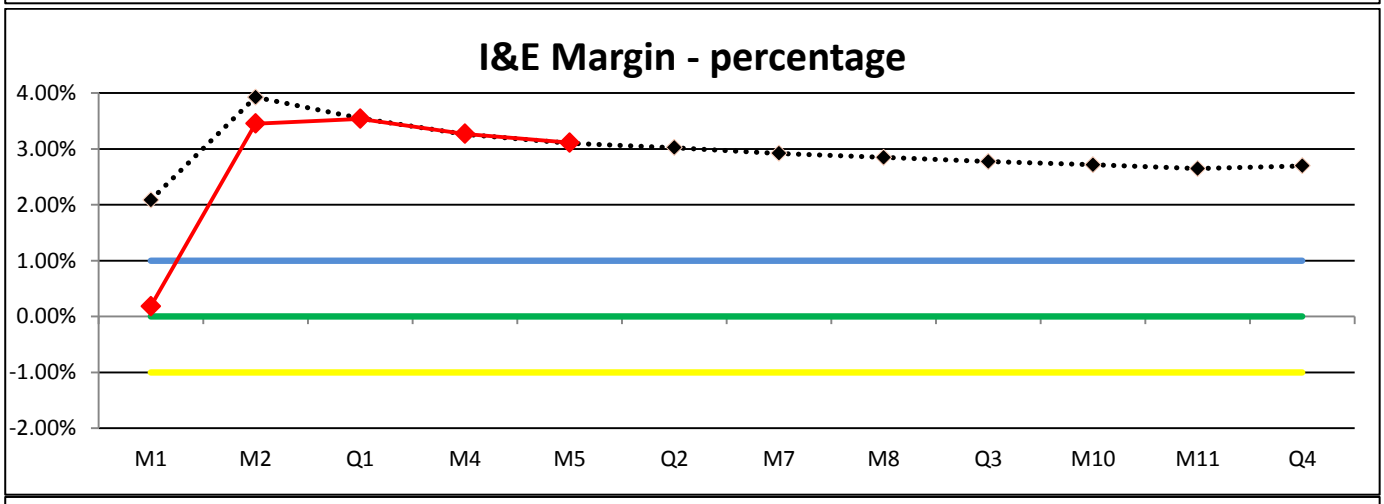
All of the FSRR metrics are in line with the plan to date with actual metric scores of 4. A summary is provided in the table below.

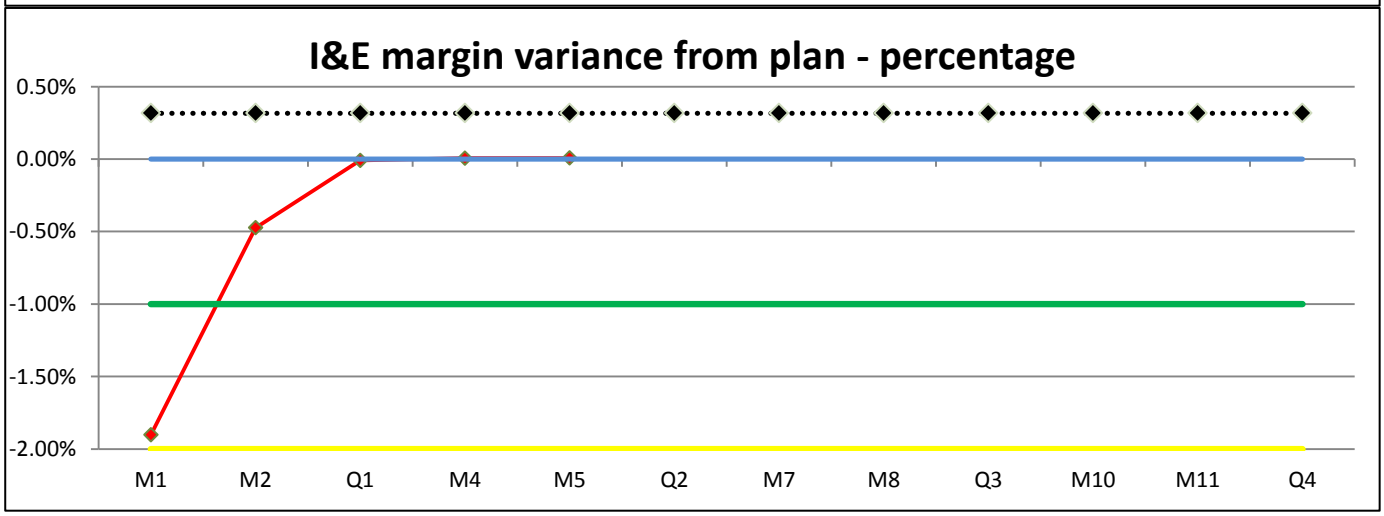
		31st August 2016		31st March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		12.64	14.39	11.96	11.96
Metric Rating	25%	4	4	4	4
Capital Servicing Capacity					
Metric Result – times		2.66	2.61	2.77	2.77
Metric Rating	25%	4	4	4	4
Income & expenditure margin					
Metric Result		3.10%	3.12%	2.70%	2.70%
Metric Rating	25%	4	4	4	4
Variance in I&E margin					
Metric Result		0.32%	0.02%	0.32%	0.00%
Metric Rating	25%	4	4	4	4
Overall FSRR		**4.0**	**4.0**	**4.0**	**4.0**
Overall FSRR (rounded)		**4**	**4**	**4**	**4**

The charts presented overleaf show the trajectories for each of the four metrics. The revised 2016/17 Operational Plan submitted to Monitor on 29th June 2016 is shown as the black dotted line against which actual performance is plotted in red. The metric ratings are shown for **4 (blue line)**; **3 (green line)** and **2 (yellow line)**.


Liquidity Ratio - days
20
15
10
5
0
(5)
(10)
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


Capital Service Cover - times
4
3
2
1
0
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E Margin - percentage
4.00%
3.00%
2.00%
1.00%
0.00%
-1.00%
-2.00%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E margin variance from plan - percentage
0.50%
0.00%
-0.50%
-1.00%
-1.50%
-2.00%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4

Key Financial Metrics - August 2016

Appendix 5a

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Contract Income - Activity Based									
Current Month									
Budget	3,357	4,457	5,271	7,104	8,823	314		8,896	38,222
Actual	3,318	4,216	5,168	6,884	8,391	302		8,518	36,797
Variance Fav / (Adv)	(39)	(241)	(103)	(220)	(432)	(12)	-	(378)	(1,425)
Year to date									
Budget	16,630	21,858	25,126	34,588	43,420	1,541		43,151	186,314
Actual	16,680	21,157	25,333	34,034	42,371	1,514		42,706	183,795
Variance Fav / (Adv)	50	(701)	207	(554)	(1,049)	(27)	-	(445)	(2,519)

Women's and Children's identified £0.221m of activity related income due for August which was not able to be included due to delayed information. This was brought into their financial position and reduces the in-month deterioration to £0.212m.

Contract Income - Penalties									
Current Month									
Plan	-	(82)	(12)	(28)	(8)			(51)	(181)
Actual	(1)	(82)	(11)	(42)	(7)			(70)	(213)
Variance Fav / (Adv)	(1)	0	1	(14)	1	-	-	(19)	(32)
Year to date									
Plan	-	(82)	(12)	(33)	(13)			(254)	(394)
Actual	(1)	(83)	(11)	(133)	(104)			(89)	(421)
Variance Fav / (Adv)	(1)	(1)	1	(100)	(91)	-	-	165	(27)

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

Contract Income - Rewards									
Current Month									
Plan								797	797
Actual								797	797
Variance Fav / (Adv)	-	-	-	-	-	-	-	-	-
Year to date									
Plan								3,922	3,922
Actual								3,922	3,922
Variance Fav / (Adv)	-	-	-	-	-	-	-	-	-

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

Cost Improvement Programme									
Current Month									
Plan	126	159	123	442	401	57	78	126	1,512
Actual	126	126	76	246	246	63	74	154	1,111
Variance Fav / (Adv)	0	(33)	(47)	(196)	(155)	6	(4)	28	(401)
Year to date									
Plan	637	672	602	1,997	2,018	280	406	620	7,232
Actual	693	518	464	1,082	1,126	302	380	696	5,261
Variance Fav / (Adv)	56	(154)	(138)	(915)	(892)	22	(26)	76	(1,971)

Key Workforce Metrics **Appendix 5b**

Diagnostic & Therapies

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	355	196	36	(11)	18	39	32								114	82
Nursing agency expenditure (£'000)	7	3	12	(6)	-	4	(4)								6	(3)
Overall																
Sickness (%)	2.8%		2.4%	2.4%	2.5%	2.4%	2.8%								2.5%	
Turnover (%)	12.5%		13.3%	13.5%	12.6%	12.5%	11.7%								11.7%	
Establishment (wte)			1,000.69	958.00	966.08	975.98	979.73									
In post (wte)			961.64	927.00	928.24	928.28	930.20									
Under/(over) establishment (wte)			39.05	31.00	37.84	47.70	49.53	-	-	-	-	-	-	-		
Nursing:																
Sickness - registered (%)			1.7%	0.0%	0.2%	0.2%	4.10%								1.2%	
Sickness - unregistered (%)			0.0%	0.0%	10.0%	0.0%	0.00%								2.0%	
Turnover - registered (%)	4.1%		19.9%	19.2%	13.2%	13.3%	13.30%								13.3%	
Turnover - unregistered (%)			0.0%	0.0%	0.0%	0.0%	0.0								0.0%	
Starters (wte)			1.00	1.00	-	-	-								2.00	
Leavers (wte)			-	-	-	-	-								-	
Net starters (wte)			1.00	1.00	-	-	-	-	-	-	-	-	-	-	2.00	
Establishment (wte)			17.66	17.66	17.66	17.66	17.66									
In post - Employed (wte)			16.57	18.75	18.24	18.24	17.57									
In post - Bank (wte)			0.16	1.41	2.35	2.80	3.24									
In post - Agency (wte)			3.46	0.10	-	0.60	-									
In post - total (wte)			20.19	20.26	20.59	21.64	20.81	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(2.53)	(2.60)	(2.93)	(3.98)	- 3.15	-	-	-	-	-	-	-		

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

Medicine

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,965	1,206	334	239	290	249	214								1,326	(120)
Nursing agency expenditure (£'000)	1,395	717	256	140	176	168	167								907	(190)
Overall																
Sickness (%)	4.6%		4.4%	3.7%	3.9%	4.4%	5.2%								4.3%	
Turnover (%)	13.2%		14.9%	15.2%	14.6%	15.4%	14.7%								14.7%	
Establishment (wte)			1,215.16	1,209.00	1,221.06	1,215.64	1,222.99									
In post (wte)			1,253.43	1,230.00	1,246.58	1,256.53	1,272.56									
Under/(over) establishment (wte)			(38.27)	(21.00)	(25.52)	(40.89)	(49.57)	-	-	-	-	-	-	-		
Nursing:																
Sickness - registered (%)	4.1%		3.1%	1.9%	2.2%	3.1%	5.2%								3.1%	
Sickness - unregistered (%)	6.5%		7.8%	7.3%	6.2%	6.0%	6.7%								6.8%	
Turnover - registered (%)	15.1%		16.9%	16.7%	16.0%	17.4%	15.8%								15.8%	
Turnover - unregistered (%)	25.6%		18.1%	19.4%	19.2%	20.7%	19.6%								19.6%	
Starters (wte)			11.19	16.94	4.64	7.00	11.60								26.04	
Leavers (wte)			13.26	9.16	7.72	12.99	10.31								21.42	
Net starters (wte)			(2.07)	7.78	(3.08)	(5.99)	1.29	-	-	-	-	-	-	-	4.62	
Establishment (wte)			769.87	767.62	768.14	772.12	767.57									
In post - Employed (wte)			695.64	686.14	686.33	678.04	674.82									
In post - Bank (wte)			82.62	88.69	97.90	111.08	100.27									
In post - Agency (wte)			36.20	21.30	27.03	30.29	35.69									
In post - total (wte)			814.46	796.13	811.26	819.41	810.78	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(44.59)	(28.51)	(43.12)	(47.29)	(43.21)	-	-	-	-	-	-	-		

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

Key Workforce Metrics **Appendix 5b**

Specialised Services

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,332	651	182	196	177	156	158								869	(218)
Nursing agency expenditure (£'000)	410	240	100	110	109	81	86								486	(246)
Overall																
Sickness (%)	3.6%		3.4%	3.3%	3.2%	3.8%	3.7%								3.5%	
Turnover (%)	12.4%		14.2%	13.4%	12.7%	12.1%	11.40%								11.4%	
Establishment (wte)			908.17	937.00	932.51	934.93	946.17									
In post (wte)			901.55	933.00	938.46	943.79	968.61									
Under/(over) establishment (wte)			6.62	4.00	(5.95)	(8.86)	(22.44)	-	-	-	-	-	-	-		
Nursing:																
Sickness - registered (%)	4.1%		3.2%	3.5%	3.0%	2.7%	3.9%								3.2%	
Sickness - unregistered (%)	7.4%		7.0%	5.4%	6.6%	9.9%	11.3%								8.0%	
Turnover - registered (%)	13.3%		15.6%	14.2%	13.2%	13.1%	12.8%								12.8%	
Turnover - unregistered (%)	18.0%		12.2%	12.3%	14.3%	11.8%	14.4%								14.4%	
Starters (wte)			7.80	4.60	6.80	8.00	7.13								12.40	
Leavers (wte)			6.37	3.00	5.05	4.71	9.55								9.37	
Net starters (wte)			1.43	1.60	1.75	3.29	- 2.42	-	-	-	-	-	-	-	3.03	
Establishment (wte)			480.47	486.02	482.51	483.04	487.18									
In post - Employed (wte)			441.23	438.90	442.49	444.68	457.84									
In post - Bank (wte)			27.30	37.55	42.33	40.77	34.03									
In post - Agency (wte)			12.07	14.14	13.93	13.01	15.54									
In post - total (wte)			480.60	490.59	498.75	498.46	507.41	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(0.13)	(4.57)	(16.24)	(15.42)	(20.23)	-	-	-	-	-	-	-		

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

Key Workforce Metrics

Appendix 5b

Surgery, Head and Neck

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	978	507	263	251	193	195	158								1,060	(553)
Nursing agency expenditure (£'000)	343	242	219	207	186	161	164								937	(695)
Overall																
Sickness (%)	3.7%		3.8%	3.6%	3.9%	3.7%	3.1%								3.6%	
Turnover (%)	12.1%		14.1%	13.7%	13.6%	14.3%	14.3%								14.3%	
Establishment (wte)			1,741.45	1,756.00	1,796.48	1,810.54	1,818.49									
In post (wte)			1,785.03	1,772.00	1,773.35	1,775.68	1,782.64									
Under/(over) establishment (wte)			(43.58)	(16.00)	23.13	34.86	35.85	-	-	-	-	-	-	-		
Nursing:																
Sickness - registered (%)	3.8%		3.8%	3.9%	5.1%	4.9%	4.0%								4.3%	
Sickness - unregistered (%)	3.7%		7.7%	5.4%	4.9%	4.3%	5.6%								5.6%	
Turnover - registered (%)	12.1%		14.6%	13.6%	13.3%	13.9%	11.9%								11.9%	
Turnover - unregistered (%)	21.8%		17.1%	18.1%	16.7%	19.6%	18.8%								18.8%	
Starters (wte)			4.00	6.37	7.81	4.53	12.80								10.37	
Leavers (wte)			8.00	4.50	6.77	10.62	9.59								12.50	
Net starters (wte)			(4.00)	1.87	1.04	(6.09)	3.21	-	-	-	-	-	-	-	- 2.13	
Establishment (wte)			695.49	699.86	726.18	739.12	748.05									
In post - Employed (wte)			662.80	658.55	662.38	661.93	666.11									
In post - Bank (wte)			49.28	44.54	49.13	58.93	43.57									
In post - Agency (wte)			28.85	30.80	27.61	28.22	31.37									
In post - total (wte)			740.93	733.89	739.12	749.08	741.05	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(45.44)	(34.03)	(12.94)	(9.96)	7.00	-	-	-	-	-	-	-		

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

Key Workforce Metrics

Appendix 5b

Women's and Children's

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	775	324	255	162	131	238	165								951	(627)
Nursing agency expenditure (£'000)	662	281	217	141	117	198	144								817	(536)
Overall																
Sickness (%)	3.8%		3.9%	3.9%	3.6%	4.0%	3.8%								3.8%	
Turnover (%)	10.8%		10.9%	11.0%	11.2%	11.7%	12.1%								12.1%	
Establishment (wte)			1,899.46	1,878.00	1,884.05	1,886.26	1,885.88									
In post (wte)			1,932.95	1,898.00	1,890.48	1,894.56	1,884.31									
Under/(over) establishment (wte)			(33.49)	(20.00)	(6.43)	(8.30)	1.57	-	-	-	-	-	-	-		
Nursing:																
Sickness - registered (%)	4.0%		3.9%	4.0%	3.5%	3.8%	4.1%								3.9%	
Sickness - unregistered (%)	5.0%		8.6%	9.5%	9.6%	13.3%	10.2%								10.3%	
Turnover - registered (%)	10.6%		9.3%	10.0%	10.5%	10.9%	11.5%								11.5%	
Turnover - unregistered (%)	15.3%		15.3%	12.7%	11.9%	12.6%	11.5%								11.5%	
Starters (wte)			4.91	10.22	4.03	5.61	13.60								15.13	
Leavers (wte)			10.46	11.27	11.91	12.39	21.49								21.73	
Net starters (wte)			(5.55)	(1.05)	(7.88)	(6.78)	(7.89)	-	-	-	-	-	-	-	(6.60)	
Establishment (wte)			1,112.90	1,118.77	1,122.66	1,123.22	1,118.16									
In post - Employed (wte)			1,078.77	1,075.80	1,075.11	1,067.06	1,072.54									
In post - Bank (wte)			32.38	42.04	37.18	43.56	39.42									
In post - Agency (wte)			29.91	19.07	11.44	22.66	17.82									
In post - total (wte)			1,141.06	1,136.91	1,123.73	1,133.28	1,129.78	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(28.16)	(18.14)	(1.07)	(10.06)	(11.62)	-	-	-	-	-	-	-		

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

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UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report August 2016 - Risk Matrix

Datix Risk Register Ref.	Description of Risk	Inherent Risk (if no action taken)		Action to be taken to mitigate risk	Lead	Current Risk		Target Risk	
		Risk Score & Level	Financial Value			Risk Score & Level	Financial Value	Risk Score & Level	Financial Value
959	Risk that Trust does not deliver future years financial plan due to under delivery of recurrent savings in year. Only 82% of the required savings have been identified at 30th April 2016, leaving a savings gap of £3.2m.	16 - Very High	£3.2m	Trust is working to develop savings plans to meet 2016/17 target of £17.4m and close the current savings gap of £3.475m. Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes.	OA	12 - High	£3.475m	4 - Low	£0.0m
416	Risk that the Trust's Financial Strategy may not be deliverable in changing national economic climate.	9 - High	-	Maintenance of long term financial model and in year monitoring on financial performance through monthly divisional operating reviews and Finance Committee and Trust Board.	PM	9 - High	-	9 - High	-
951	Risk of national contract mandates financial penalties on under-performance against key indicators.	9 - High	£4.0m	30% of the agreed Sustainability & Transformation Funding is subject to forfeit if core targets are not delivered. The current risk of loss is high.	PM	9 - High	£3.0m	3 - Low	£0.0m
50	Risk of Commissioner Income challenges	6 - Moderate	£3.0m	The Trust has strong controls of the SLA management arrangements.	PM	6 - Moderate	£2.0m	3 - Low	£0.0m
408	Risk to UH Bristol of fraudulent activity.	3 - Low	-	Local Counter Fraud Service in place. Pro active counter fraud work. Reports to Audit Committee.	PM	3 - Low	-	3 - Low	-

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17									2014/15	2014/15
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Diagnostic & Therapies	Pay budget	10,357	10,483	10,432	10,413	41,686	3,474		3,580	3,350	3,370	10,299	3,365	3,491	17,155	3,431		3,373	
	Bank	82	109	93	88	371	31	0.9%	20	21	25	66	29	32	128	26	0.8%	26	0.8%
	Agency	377	242	186	168	972	81	2.4%	36	(11)	18	42	39	32	114	23	0.7%	87	2.6%
	Waiting List initiative	98	54	95	95	342	29	0.8%	62	35	53	150	72	35	257	51	1.6%	22	0.7%
	Overtime	147	94	100	110	450	38	1.1%	47	37	36	120	30	33	183	37	1.1%	34	1.0%
	Other pay	9,572	9,648	9,788	9,920	38,927	3,244	94.8%	3,310	3,119	3,049	9,478	3,082	3,244	15,805	3,161	95.9%	3,198	95.0%
	Total Pay expenditure	10,276	10,146	10,261	10,382	41,063	3,422	100.0%	3,475	3,201	3,181	9,857	3,253	3,376	16,486	3,297	100.0%	3,367	100.0%
	Variance Fav / (Adverse)	82	337	172	31	623	52		105	149	189	443	112	115	669	134		5	
Medicine	Pay budget	12,841	12,458	12,400	12,606	50,305	4,192		4,306	4,290	4,258	12,853	4,219	4,282	21,354	4,271		4,108	
	Bank	897	935	905	1,039	3,775	315	7.2%	243	319	318	880	338	358	1,575	315	7.1%	297	7.1%
	Agency	826	875	814	1,119	3,634	303	7.0%	333	239	290	861	249	214	1,324	265	6.0%	291	7.0%
	Waiting List initiative	51	45	56	42	194	16	0.4%	30	30	17	77	3	16	96	19	0.4%	16	0.4%
	Overtime	16	21	35	32	105	9	0.2%	8	9	7	23	8	5	36	7	0.2%	8	0.2%
	Other pay	11,212	10,941	10,982	11,308	44,443	3,704	85.2%	3,789	3,850	3,796	11,435	3,726	3,890	19,052	3,810	86.3%	3,568	85.4%
	Total Pay expenditure	13,002	12,817	12,792	13,539	52,151	4,346	100.0%	4,403	4,447	4,428	13,278	4,324	4,483	22,083	4,417	100.0%	4,180	100.0%
	Variance Fav / (Adverse)	(161)	(359)	(391)	(933)	(1,846)	(154)		(97)	(157)	(170)	(424)	(105)	(201)	(729)	(146)		(72)	
Specialised Services	Pay budget	10,135	10,245	10,342	10,557	41,279	3,440		3,657	3,968	3,834	11,459	3,819	3,838	19,115	3,823		3,266	
	Bank	402	404	352	423	1,581	132	3.7%	94	159	172	425	151	176	752	150	3.8%	108	3.2%
	Agency	671	710	582	689	2,651	221	6.3%	182	196	177	555	156	158	869	174	4.4%	228	6.7%
	Waiting List initiative	125	144	156	103	528	44	1.2%	42	58	36	136	21	45	202	40	1.0%	42	1.3%
	Overtime	29	29	30	25	114	9	0.3%	8	11	13	32	16	11	58	12	0.3%	12	0.4%
	Other pay	9,189	9,222	9,395	9,674	37,480	3,123	88.5%	3,329	3,644	3,515	10,487	3,532	3,635	17,654	3,531	90.4%	2,995	88.5%
	Total Pay expenditure	10,415	10,510	10,516	10,913	42,354	3,529	100.0%	3,654	4,068	3,913	11,635	3,876	4,025	19,535	3,907	100.0%	3,386	100.0%
	Variance Fav / (Adverse)	(280)	(265)	(174)	(356)	(1,075)	(90)		3	(100)	(79)	(176)	(57)	(187)	(420)	(84)		(120)	
Surgery Head and Neck	Pay budget	19,366	19,669	19,708	19,855	78,598	6,550		6,588	6,629	6,673	19,890	6,696	6,762	33,349	6,670		6,030	
	Bank	559	683	488	624	2,355	196	3.0%	172	176	194	542	229	261	1,032	206	3.1%	169	2.7%
	Agency	603	908	738	752	3,000	250	3.8%	262	251	193	707	195	158	1,060	212	3.2%	106	1.7%
	Waiting List initiative	407	387	371	249	1,414	118	1.8%	98	154	130	382	90	71	543	109	1.6%	139	2.2%
	Overtime	38	47	45	41	171	14	0.2%	11	12	9	33	8	11	52	10	0.2%	32	0.5%
	Other pay	17,853	17,860	18,200	18,209	72,122	6,010	91.2%	6,144	6,165	6,159	18,467	6,083	6,286	30,836	6,167	92.0%	5,859	92.9%
	Total Pay expenditure	19,461	19,885	19,844	19,875	79,062	6,589	100.0%	6,687	6,758	6,685	20,130	6,605	6,786	33,523	6,705	100.0%	6,305	100.0%
	Variance Fav / (Adverse)	(95)	(215)	(136)	(20)	(466)	(39)		(99)	(129)	(12)	(240)	91	(24)	(174)	(35)		(275)	

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17									2014/15	2014/15
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Women's and Children's	Pay budget	22,562	22,828	23,290	23,780	92,460	7,705		7,944	7,602	7,919	23,465	7,868	7,911	39,244	7,849		7,178	
	Bank	533	582	487	611	2,213	184	2.3%	141	185	172	498	181	194	873	175	2.2%	181	2.5%
	Agency	703	840	866	719	3,128	261	3.3%	255	162	131	548	238	165	951	190	2.4%	154	2.1%
	Waiting List initiative	205	169	203	206	783	65	0.8%	33	73	40	146	48	30	224	45	0.6%	33	0.5%
	Overtime	23	19	26	35	102	9	0.1%	9	15	17	42	13	11	66	13	0.2%	30	0.4%
	Other pay	21,492	21,695	22,409	22,958	88,554	7,379	93.4%	7,749	7,623	7,575	22,947	7,561	7,737	38,246	7,649	94.8%	6,793	94.5%
	Total Pay expenditure	22,956	23,305	23,991	24,530	94,780	7,898	100.0%	8,188	8,058	7,935	24,181	8,041	8,137	40,360	8,072	100.0%	7,190	100.0%
	Variance Fav / (Adverse)	(393)	(477)	(701)	(750)	(2,320)	(193)		(244)	(456)	(16)	(716)	(173)	(226)	(1,116)	(223)		(12)	
Facilities & Estates	Pay budget	5,057	5,113	5,142	5,070	20,382	1,699		1,708	1,788	1,744	5,239	1,740	1,770	8,750	1,750		1,618	
	Bank	296	320	278	246	1,140	95	5.6%	45	78	72	195	82	107	383	77	4.4%	89	5.5%
	Agency	145	189	249	154	738	62	3.6%	32	27	37	96	26	29	151	30	1.7%	42	2.6%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	225	244	207	200	876	73	4.3%	68	68	65	201	66	82	349	70	4.0%	80	5.0%
	Other pay	4,406	4,373	4,371	4,499	17,649	1,471	86.5%	1,572	1,609	1,592	4,773	1,546	1,567	7,887	1,577	89.9%	1,394	86.9%
	Total Pay expenditure	5,072	5,126	5,106	5,100	20,403	1,700	100.0%	1,717	1,782	1,766	5,265	1,720	1,785	8,770	1,754	100.0%	1,605	100.0%
	Variance Fav / (Adverse)	(16)	(12)	36	(30)	(21)	(2)		(9)	6	(22)	(26)	20	(16)	(20)	(4)		13	
(Including R&I and (Incl R&I and Support Services)	Pay budget	6,487	6,496	6,977	7,438	27,398	2,283		2,327	2,532	2,398	7,257	2,382	2,218	11,856	2,371		2,478	
	Bank	179	211	232	223	846	70	3.2%	60	61	92	213	70	71	354	71	3.1%	57	2.4%
	Agency	69	177	390	367	1,002	83	3.7%	26	98	116	239	35	44	318	64	2.8%	59	2.5%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	22	23	20	16	81	7	0.3%	4	5	3	13	5	9	27	5	0.2%	9	0.4%
	Other pay	6,029	5,967	6,201	6,662	24,859	2,072	92.8%	2,190	2,213	2,191	6,594	2,194	1,997	10,785	2,157	93.9%	2,223	94.7%
	Total Pay expenditure	6,299	6,378	6,843	7,268	26,788	2,232	100.0%	2,280	2,377	2,403	7,059	2,305	2,120	11,484	2,297	100.0%	2,348	100.0%
	Variance Fav / (Adverse)	188	118	134	169	610	51		47	155	(5)	197	77	97	371	74		130	
Trust Total	Pay budget	86,805	87,293	88,292	89,718	352,109	29,342		30,109	30,158	30,194	90,462	30,089	30,271	150,822	30,164		28,050	
	Bank	2,949	3,244	2,834	3,254	12,281	1,023	3.4%	774	998	1,046	2,818	1,080	1,199	5,098	1,020	3.3%	927	3.3%
	Agency	3,393	3,941	3,824	3,967	15,126	1,260	4.2%	1,127	961	961	3,049	938	801	4,788	958	3.1%	967	3.4%
	Waiting List initiative	886	799	881	695	3,261	272	0.9%	265	350	276	891	234	197	1,322	264	0.9%	252	0.9%
	Overtime	499	478	463	460	1,899	158	0.5%	156	157	150	463	146	160	770	154	0.5%	204	0.7%
	Other pay	79,752	79,705	81,348	83,230	324,035	27,003	90.9%	28,083	28,223	27,876	84,183	27,725	28,355	140,263	28,053	92.1%	26,031	91.7%
	Total Pay expenditure	87,480	88,166	89,352	91,607	356,602	29,717	100.0%	30,405	30,690	30,310	91,404	30,123	30,712	152,240	30,448	100.0%	28,381	100.0%
	Variance Fav / (Adverse)	(674)	(873)	(1,058)	(1,889)	(4,493)	(374)		(296)	(532)	(115)	(942)	(35)	(441)	(1,418)	(284)		(331)	

NOTE: Other Pay includes all employer's oncosts.

	Significant Reserve Movements							Divisional Analysis								
	Contingency Reserve	Inflation Reserve	Operating Plan	Savings Programme	Other Reserves	Non Recurring	Totals	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Estates & Facilities	Trust Services	Other including income	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Resources Book	700	11,709	38,455	(690)	2,426	3,194	55,794									
April movements	(120)	(8,993)	(31,315)	-	166	(208)	(40,470)	3,694	9,102	8,756	7,388	9,590	1,238	1,749	(1,047)	40,470
May movements	(28)	(6)	(3,529)	7	(588)	(217)	(4,361)	(119)	(22)	1	1,914	47	26	194	2,320	4,361
June movements	97	(9)	87	-	(160)	(366)	(351)	10	165	28	40	83	99	141	(215)	351
July movements	(20)	(45)	447		(119)	(207)	56	9	91	45	27	103	98	218	(647)	(56)
August																
MPET					64		64								(64)	(64)
SLA Adjustment			288				288								(288)	(288)
Spend to Save						(32)	(32)			16	12	4				32
CQUINs			10				10	15		6	5			(36)		(10)
Strategic Schemes Costs						(33)	(33)						21	12		33
CSIP						(39)	(39)							39		39
EWTD					(144)		(144)	9	31	20	25	55	2	1	1	144
Other		(6)	(64)			(14)	(84)	34					14	106	(70)	84
Month 5 balances	629	2,650	4,379	(683)	1,645	2,078	10,698	3,652	9,367	8,872	9,411	9,882	1,498	2,424	(10)	45,096

2016/17 Sustainability & Transformation Fund – August trajectory performance

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

Net surplus Control Total

The cumulative net surplus Control Total (excluding STF) was achieved for the period to August with an actual cumulative net surplus excluding STF of £1.414m against a Control Total of £1.303m. Please see Table 1 below.

Table 1: Net surplus Control Total and performance to date

Control Total	Q1 £m	July £m	August £m	Sept £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m
Planned net surplus	3.858	5.258	6.719	8.135	9.486	10.850	12.084	13.383	14.475	15.900
Less planned STF	(3.250)	(4.333)	(5.416)	(6.500)	(7.583)	(8.666)	(9.750)	(10.833)	(11.916)	(13.000)
Planned net surplus exc STF	**0.608**	**0.925**	**1.303**	**1.635**	**1.903**	**2.184**	**2.334**	**2.550**	**2.559**	**2.900**
Actual reported net surplus	3.871	5.275	6.722							
Less STF	(3.250)	(4.279)	(5.308)							
Actual net surplus exc STF	**0.621**	**0.996**	**1.414**							
Control Total delivered / Eligible for STF?	Yes	Yes	Yes							

A&E waiting times

The Trust delivered the A&E waiting times standard trajectory in August with performance of 90.0%. Cumulative performance was also 89.5%, ahead of the agreed trajectory of 85.6%. Therefore, the Trust was eligible for funding of £0.135m for August.

The Trust is forecasting cumulative delivery of the A&E trajectory for the remainder of the second quarter. For quarters 3 and 4 delivery of the trajectory is still currently assumed based on the estimated potential scale of underperformance against the monthly trajectory being offset by cumulative over-performance to date (currently running at 3.9%). The forecast will be re-assessed at the end of September. Table 2 below summarises the position.

Table 2: A&E waiting times trajectories and performance to date

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
National standard	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Agreed in month trajectory	81.9%	84.4%	85.9%	87.6%	88.4%	89.2%	89.8%	91.0%	89.3%	88.5%	87.4%	89.7%
Actual performance	87.2%	91.7%	89.0%	89.3%	90.0%							
Agreed cumulative trajectory	81.9%	83.2%	84.1%	85.0%	85.6%	86.2%	86.7%	87.3%	87.5%	87.6%	87.6%	87.8%
Actual - cumulative performance	87.2%	89.5%	89.3%	89.3%	89.5%							
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory delivered	Yes	Yes	Yes	Yes	Yes							
STF due	*£135k*	*£135k*	*£135k*	£135k	£135k							

Italics represent notional values relating to quarter 1 only.

Cancer waiting times

The Trust delivered the Cancer waiting standard in April and May cumulatively. In month and cumulative performance for quarter 1 were not met. The draft position for August is 82.6% compared with the in month trajectory of 81.7%. Underperformance for the quarter as a whole continues to be driven by a combination of histopathology reporting delays, following the transfer of the service to North Bristol NHS Trust, and above plan levels of late referrals from other providers. Therefore, the Trust forfeited STF funding of £0.054m in August.

Although the Trust is expected to report improving performance in quarter 2, with the in-month trajectory being met for August, the trajectory will not be met for the quarter as a whole due to the continued impact of histopathology reporting delays and late referrals impacting in July, forfeiting a further £0.054m. Forecasting for quarters 3 and 4 is particularly difficult due to the number of factors influencing performance which are outside of the control of the Trust. The expectation is performance will improve for the final two quarters due to a reduction in histopathology reporting delays and the implementation of a local CQUIN agreed with North Bristol NHS Trust and Weston Area Healthcare NHS Trust which will result in the automatic reallocation of breaches of the cancer standard when referrals are received beyond agreed acceptable milestones for referral. The impact of the latter alone could be in the region of a 5% improvement in performance. At this point, the Trust is assuming receipt of the Cancer access monies for the remainder of the year. Table 3 summarises the position.

Table 3: Cancer waiting times trajectories and performance to date

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
National standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Agreed in month trajectory	72.7%	73.2%	81.8%	84.7%	81.7%	85.0%	85.2%	85.1%	86.9%	83.6%	85.7%	85.9%
Actual performance	77.2%	70.5%	70.8%	72.9%	82.6%							
Agreed cumulative trajectory	72.7%	73.0%	76.3%	84.7%	83.3%	83.8%	85.2%	85.1%	85.7%	83.6%	84.7%	85.1%
Actual - cumulative performance	77.2%	73.7%	72.7%	72.9%	78.5%							
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory delivered	Yes	Yes	No	No	No							
STF due	*£55k*	*£55k*	*£55k*	£0k	£0k							

Italics represent notional values relating to quarter 1 only.
Please note: July and August figures are still subject to final reporting for the quarter

Referral to Treatment Time (RTT)

The Trust failed to achieve the 92% national standard in August, following achievement each month to date in 2016/17. However, final reporting is expected to confirm that whilst performance dipped in August to 90.4% the cumulative trajectory, with the 1% tolerance applied, was achieved. Hence the Trust is entitled to STF funding of £0.135m for the month.

The Trust is forecasting non-delivery of the RTT standard again in September, with likely forfeit therefore of £0.135m. It continues to be difficult to forecast beyond the second quarter due to the volatility in demand, the dates of key appointments to dental posts not yet being known, and unpredictable levels of staff uptake of waiting list initiatives. However, a RTT Recovery Plan with a projected backlog for quarters three and four is in the process of being finalised, from which a forecast for achievement of the cumulative trajectory will be provided next month.

Table 4 overleaf summarises the position.

Table 4: RTT waiting times trajectories and performance to date

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
National standard	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Agreed in month trajectory	92.6%	92.6%	92.8%	93.2%	93.2%	93.4%	93.4%	93.4%	92.8%	92.8%	92.8%	93.0%
Actual performance	92.3%	92.6%	92.1%	92.0%	90.4%							
Agreed cumulative trajectory	92.6%	92.6%	92.7%	92.8%	92.9%	93.0%	93.0%	93.1%	93.0%	93.0%	93.0%	93.0%
Actual - cumulative performance	92.3%	92.5%	92.3%	92.3%	91.9%							
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory / national standard delivered	Yes	Yes	Yes	Yes	Yes							
STF due	*£135k*	*£135k*	*£135k*	£135k	£135k							

Italics represent notional values relating to quarter 1 only.

Diagnostics

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

Summary

The Trust will need to understand delivery going forward and more importantly, the actions and response required to ensure delivery the trajectories for the remainder of the financial year. Operational plans should be formulated to ensure timely action is taken to secure the STF funding included in the Trust's planned net surplus of £15.9m. Failure to do so, will compromise the Trust's ability to deliver the Control Total recently agreed with NHS Improvement.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 29 September 2016 at 11.00 am in the Conference Room,
Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
16. NHS Improvement feedback on Quarter 1 Risk Assessment Framework Submission									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive **Author**: Pam Wenger, Trust Secretary									
Intended Audience									
Board members	**X**	Regulators	**X**	Governors	**X**	Staff	**X**	Public	**X**

Executive Summary

Purpose

The purpose of this report is to inform the Trust Board of Directors of NHS Improvement's analysis of the Trust's Quarter 1 submission.

Key issues to note

NHS Improvement's analysis of the quarter 1 submission is based on the Trust's risk ratings relating to Continuity of Services and Governance, which the Trust submitted as follows:

- Continuity of Services Risk Rating – 4
- Governance Risk Rating – Green

NHS Improvement has formally confirmed these ratings, which will be published on NHS Improvement's website during September 2016.

The Trust has failed to meet the following targets which have triggered consideration for further regulatory action:

- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge target since Q3 2013/14;
- All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer target (C62-day GP referral) since Q4 2013/14; and
- All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral target since Q3 2014/15.

Following the conclusion of NHS Improvement's review of whether the Trust's target failures indicate underlying governance concerns, NHS Improvement have decided to keep the Trust on a governance rating of Green. NHS Improvement have however, requested a meeting with the Trust to discuss the Trust's cancer performance; primarily to understand what is continuing to prevent the Trust from achieving its improvement trajectory.

NHS Improvement has decided not to open an investigation to assess whether the trust could be in breach of its licence at this stage, however, they will reconsider this following the meeting in September.

Recommendations
The Board is recommended to receive the report to note
Impact Upon Board Assurance Framework
Principal Risk 11: Failure to comply with targets, statutory duties and functions.
Impact Upon Corporate Risk
801 - Risk that the Trust does not maintain a GREEN Monitor Governance Rating
Implications (Regulatory/Legal)
There are potential regulatory implications if the Trust fails to achieve the targets applicable to it could indicate that the trust is providing health care services in breach of its licence, which could lead to consideration of enforcement action 1.
Equality & Patient Impact
There are no equality implications as a result of this report. Potential impact on patient experience as a result of the Trust's failure to meet targets.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	✓

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 29th September 2016 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
16 Freedom to Speak Up									
Sponsor and Author(s)									
Sponsor: Alex Nestor, Acting Director of Workforce and OD **Author:** Pam Wenger, Trust Secretary									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

The purpose of this report is to inform the Trust Board of the requirement to appoint the Freedom to Speak Up Local Guardian by 1 October 2016.

Recommendations

The priorities of the Local Guardian for the next 6 months will be:

- Further review and update of the Trust's Speaking Out Policy;
- Establishment of reporting through to the Audit Committee and the Trust Board;
- Consider the need to establish a network of Freedom to Speak Out Guardians to roll out across the organisation, in such a way as to reflect the organisation's need and staff confidence to raise Speaking Out concerns;
- To align this work with the processes in place regarding staff engagement;
- Complete the organisational self-assessment and identify areas for action and develop a Trust wide action plan;
- Develop and agree a communication plan which may include: Newsbeat, leaflets, trust wide emails, dedicated section of Internet and Intranet, increase the profile using social media highlighting the importance of raising concerns and that it's normal to speak up;
- Join the NHS Employers raising concerns virtual expert network to keep up to date with national development; and
- Launch of Datix anonymised reporting functionality for potential whistleblowing matters.

There are a number of different approaches being considered by different organisations. The time commitment for this role has not yet quantified and estimates are based on Local Guardians in post in other organisations suggest that this could be approximately 1-2 days per week. The initial phase will be the set up and in light of the independence required, access to the Trust Board, establishment of the governance and assurance arrangements; it is recommended that the Trust Secretary undertakes this role.

There will be a requirement to consider additional resources to back fill the Trust Secretary to enable her to undertake this role and discharge her responsibilities as set out in the role profile. Whilst at this stage the impact cannot be quantified it is anticipated that this will approximately be 1-2 days per week.

Members are asked to:

- **Note** the report;
- **Support** the action being taken following the Freedom to Speak Up Review; and
- **Agree** to appoint the Trust Secretary as the Local Guardian and note the agreement to back fill the

Trust Secretary to enable the functions to be discharged as outlined in this report; and

- **Review** these arrangements in 6 months.

Impact Upon Board Assurance Framework
Impact Upon Corporate Risk
Implications (Regulatory/Legal)
Equality & Patient Impact

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval	✓	For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

FREEDOM TO SPEAK UP LOCAL GUARDIAN

SITUATION

The purpose of this report is to inform the Trust Board of the requirement to appoint the Freedom to Speak Up Local Guardian by 1 October 2016.

BACKGROUND

The need for an independent National Guardian for the National Health Service (NHS) was highlighted in Sir Robert Francis's *Freedom to Speak Up* review in February 2015. It found that patients could be put at risk of harm because vital information about mistakes and concerns was not being raised routinely by NHS staff. The creation of the National Guardian was one of the key recommendations from the review for which the Secretary of State for Health confirmed his support in July 2015.

2.1 Freedom to Speak Up Review

A full copy of the report into the Freedom to Speak Up Review can be found on the Freedom to Speak Up website: https://freedomtospeakup.org.uk/.

The two over-arching recommendations are:

- All organisations should implement the Principles and Actions set out in in the report in line with good practice described in the report; and
- The Secretary of State for Health should review, at least annually, the progress made in the implementation of these Principles and Actions.

2.2 National Policy

The 'National Freedom to Speak Up: raising concerns (whistleblowing) for the NHS Policy' came into force from April 2016.

The current Trust policy is clear that the leads for the Speaking are the Director of Workforce and Organisational Development and the Trust Secretary who will ensure that concerns are investigated effectively and are in line with the formal procedure described within this Policy.

The current Policy requires the Audit Committee to receive a report of all Speaking Out cases raised within the Trust, via the Trust Secretary in order to monitor progress of investigations and summary outcomes of individual cases on a regular basis. An annual report will be presented to The Board.

Overall the Trust's policy exceeds the requirements of the national policy, however there are some areas that now necessitate an update of our local policy and procedure, as follows:

- Inclusion of the Freedom to Speak Up Guardian role and responsibilities;
- How the Contact Links will work with the FTSU guardian role; and
- Review of these roles.

National Guardian
The set-up of the national guardian's office is well underway and the new national guardian, practicing GP and medical director Dr Henrietta Hughes, will provide overarching leadership and support to local guardians and staff who have raised a concern that has then not been effectively dealt with by the employer. In her new role, Dr Hughes will also lead on cultural change, ensuring healthcare staff always feel confident and supported to raise public interest concerns. She is due to take up the national guardian post, four days a week from October 2016.

The priorities of the national guardian's office over the next few months include:

- Establish and support a strong network of local **Freedom to Speak Up** guardians
- Highlight NHS providers that are successful in creating the right environment for staff to speak up safely and share this best practice across the NHS
- Independently review cases where NHS providers may have failed to follow good practice, working with statutory bodies to take action where needed.

The National Guardian will also share good practice, report on national or common themes and identify any barriers that are preventing the NHS from having a truly safe and open culture.

Local Guardian
Every Trust will be required to have a *Freedom To Speak Up (FTSU)* guardian in place by the end of the 2016/17 financial year. Trusts are expected to have plans in place by end September 2016, based on local needs and how confident staff are about raising concerns and speaking up. The title of these roles will be the same across the NHS to ensure clarity and consistency.

These new local roles are being supported through a network by the newly established office of the National Guardian. FTSU Guardians typically report to the Chief Executive and will lead on the creation of the material to share with the wider organisation and with support from Communication, Workforce and Organisational Development Department, the Clinical Divisions to ensure that a learning organisation culture is developed.

Guardians do not get involved in investigations or complaints, but help to facilitate the process where needed, ensuring organisational policies in relation to raising concerns are followed correctly.

There are various examples of how other Trusts have appointed to Guardian roles, including shared roles. Whilst the Senior Independent Director is the designated Non Executive Director, the guidance requires a lead role put in place, with the contact links as a network supporting the FTSU guardian thereby ensuring accessibility of the service.

The priorities of the Local Guardian for the next 6 months will be:

- Further review and update of the Trust's Speaking Out Policy;
- Establishment of reporting through to the Audit Committee and the Trust Board;
- Consider the need to establish a network of Freedom to Speak Out Guardians to roll out across the organisation, in such a way as to reflect the organisation's need and staff confidence to raise Speaking Out concerns;
- To align this work with the processes in place regarding staff engagement;
- Complete the organisational self-assessment and identify areas for action and develop a Trust wide action plan;
- Develop and agree a communication plan which may include: Newsbeat, leaflets, trust wide emails, dedicated section of Internet and Intranet, increase the profile using social media highlighting the importance of raising concerns and that it's normal to speak up;
- Join the NHS Employers raising concerns virtual expert network to keep up to date with national development; and
- Launch of Datix anonymised reporting functionality for potential whistleblowing matters.

ASSESSMENT

There are a number of different approaches being considered by different NHS Trusts. The time commitment for this role has not yet quantified and estimates are based on Local Guardians in post in other organisations suggest that this could be approximately 1-2 days per week. The initial phase will be the set up and in light of the independence required, access to the Trust Board, establishment of the governance and assurance arrangements; it is recommended that the Trust Secretary undertakes this role.

There will be a requirement to consider additional resources to back fill the Trust Secretary to enable her to undertake this role and discharge her responsibilities as set out in the role profile. Whilst at this stage the impact cannot be quantified it is anticipated that this will approximately be 1-2 days per week.

The detailed role profile is attached to the report and a high level summary of the main functions are summarised below:

- The Freedom to Speak Up Guardian (Guardian) will work closely with the Senior Independent Director to develop a robust governance and assurance process including reporting mechanism to the Trust Board and the Audit Committee.

- The Guardian will act in an independent capacity and provide support and supervision to the organisation working closely with the Head of Workforce to ensure that any issues are directed to the most appropriate process and actioned in a timely manner.

- The Guardian will attend the nationally arranged network of Freedom to Speak Up Guardians and bring best practice and learning back into the organisation.

- The Guardian will accountable for bringing regular reports on concerns raised for the Trust Board and appropriate formal sub-committees to consider.

- The Guardian will lead on the creation of the material to share with the wider organisation and with support from Communication, Workforce and Organisational Development Department, the Clinical Divisions to ensure that a learning organisation culture is developed.

RECOMMENDATIONS
Members are asked to:

- **Note** the report;
- **Support** the action being taken following the Freedom to Speak Up Review; and
- **Agree** to appoint the Trust Secretary as the Local Guardian and note the agreement to back fill the Trust Secretary to enable the functions to be discharged as outlined in this report; and
- **Review** these arrangements in 6 months.

Freedom to Speak Up Local Guardian

Role Profile

Purpose of the role
The Freedom to Speak Up (FTSU) Guardian will work alongside trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

Role Description
The role of the FTSU Guardian is to:

Culture

- Develop and deliver communication and engagement programmes to increase visibility of the Freedom to Speak Up Guardian amongst all staff.
- Promote local speaking up processes and sources of support and guidance, demonstrate the impact that speaking up is having in the organisation, and celebrate speaking up.
- Ensure that all 'frontline' staff are aware of, and have access to, support to help them speak up.
- Where appropriate, develop and support a network of 'advocates' to ensure that Freedom to Speak Up reaches all parts of the organisation and everyone has easy access to someone outside their immediate line-management chain who can advise and support them.

Process improvement

- Work with HR professionals and others to ensure that speaking up guidance and processes are clear and accessible, reflect best practice, and address any local issues that may hinder the speaking up process.
- Assess the effectiveness of Freedom to Speak Up processes and the handling of individual cases, intervening when these are failing people who speak up, and making recommendations for improvement.

Capability

- Assess the knowledge and capability of staff to speak up and to support people when they speak up.
- Ensure that all staff have the relevant skills and knowledge to enable them to speak up effectively, and those supporting, managing or investigating speaking up issues have the capability and knowledge to do this effectively.
- Ensure that appropriate items on speaking up are incorporated into induction programmes for all staff.
- Ensure that groups of staff and individuals who may find it difficult to speak up are given particular support.

Supporting staff

- Ensure that information and data are handled appropriately, and personal and confidential data are protected.
- Ensure that individuals receive appropriate feedback on how issues that they speak up about are investigated, and the conclusion of any investigation.
- Where necessary, give extra support, including 1-2-1 support, to people who are experiencing difficulty with speaking up, or those who are experiencing difficulty in handling or supporting someone who is speaking up.

Working with and challenging the Board

- Develop strong and open working relationships with the CEO, NEDs and other Directors, with direct access to Trust leaders as required.
- Attend board meetings regularly to report on Freedom to Speak Up activities. Reports should include assessment of issues that people are speaking up about (and trends in those issues), and barriers affecting ability of people to speak up. Particular attention should be given to concerns which may suggest a link to patient safety and quality.
- Hold the Board to account for taking appropriate action to create a Freedom to Speak Up culture, assess trends, and respond to issues that are being raised.

Safety and quality

- Take immediate appropriate action when matters that people are speaking up about indicate that safety and quality may be compromised.
- Develop measures, data sets, and indicators to monitor trends and identify linkages between issues raised through people speaking up, and issues raised through other safety and quality routes.

NHS culture

- Take part in National Guardian Office activities and training, actively supporting fellow Freedom to Speak Up Guardians, developing personal networks and peer-to-peer relationships, contributing to wider networking events, and sharing and learning from best practice.
- Raise issues that cannot be resolved locally with the National Guardian's Office, including where Trusts appear to be failing in their obligations.
- Keep abreast of developments and best practice, assessing their own development and training needs, and seeking support in addressing these.

Personal qualities:

FTSU Guardians are expected to have the qualities and experience that will enable them to uphold these key principles:

Key principles	**…what this means**
Independent	… in the advice they give to staff and trust's senior leaders, and free to prioritise their actions to create the greatest impact on speaking up culture … and able to hold trusts to account for: creating a culture of speaking up; putting in place processes to support speaking up; taking action to make improvements where needed; and displaying behaviours that encourage

	speaking up
Impartial	… and able to review fairly how cases where staff have spoken up are handled
Empowered	… to take a leading role in supporting staff to speak up safely and to independently report on progress on behalf of a local network of 'champions' or as the single role holder
Visible	… to all staff, particularly those on the frontline, and approachable by all, irrespective of discipline or grade
Influential	… with direct and regular access to members of trust boards and other senior leaders
Knowledgeable	…in Freedom to Speak Up matters and local issues, and able to advise staff appropriately about speaking up
Inclusive	… and willing and able to support people who may struggle to have their voices heard
Credible	… with experience that resonates with frontline staff
Empathetic	… to people who wish to speak up, especially those who may be encountering difficulties
	… and able to listen well, facilitate constructive conversations, and mediate to help resolve issues satisfactorily at the earliest stage possible
Trusted	… by all to handle issues fairly, take action as necessary, act with integrity and maintain confidentiality as appropriate
Resilient	… and able to handle difficult situations professionally, setting boundaries and seeking support where needed
Forward thinking	… and able to make recommendations and take action to improve the handling
	of cases where staff have spoken up, and freedom to speak up culture more generally
Supported	… with sufficient designated time to carry out their role, participate in external Freedom to Speak Up activities, and take part in staff training, induction and other relevant activities
	… with access to advice and training, and appropriate administrative and

	other support
Effective	… monitoring the handling and resolution of concerns and ensuring clear action, learning, follow up and feedback.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 29th September 2016 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
17. Governors' Log of Communications									
Sponsor and Author(s)									
Sponsor: John Savage, Chairman **Author:** Kate Hanlon, Head of Membership & Governance									
Intended Audience									
Board members	✓	Regulators		Governors	✓	Staff	✓	Public	✓
Executive Summary									
Purpose: The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous Board. The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust. The log is distributed to all Board members, including Non-executive Directors when new items are received and when new responses have been provided.									
Recommendations									
None.									
Impact Upon Board Assurance Framework									
Impact Upon Corporate Risk									
Implications (Regulatory/Legal)									
Equality & Patient Impact									
Resource Implications									
Finance				Information Management & Technology					
Human Resources				Buildings					
Action/Decision Required									
For Decision		For Assurance		For Approval		For Information	✓		

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

ID	Governor Name		
163	Clive Hamilton	***Theme:*** Risk Management Policy and guidance	***Source:*** Governor Direct

Query **14/09/2016**

Page 386 of the July 2016 Board report sets out some of the duties, roles and responsibilities of those involved in the risk management process as follows:

"6.14 Wards and department leads
Each manager is responsible for ensuring Risk Assessments are completed with implementation of suitable and sufficient control measures and for communicating the risk assessment to those affected.

Line managers must allocate sufficient time for the risk assessor to ensure that they have enough time to complete their assessor responsibilities within normal working hours."

Firstly, is there a need to define the Ward and Departmental Leads responsibilities more directly?

i.e. "...Risk Assessments are completed and that the resulting control measures are implemented within the agreed time frame and communicated to all staff responsible for implementation."

and

"...Where the Ward Manager or Departmental Lead is unable to ensure suitable and sufficient control measures are implemented, the risk, control measures and time frame target must be escalated to the next in line of supervision and documented to that effect."

Secondly, one of the findings of the Review of Cardiac Services at the Bristol Children's hospital was the inadequate escalation of risks to higher levels of management for mitigation, especially in relation to safe staffing levels on Ward 32.

Are we assured that the current Risk Management policy and guidance is now in place to reduce the likelihood of inadequate risk control escalation procedures?

Division: Trust Services ***Executive Lead:*** *Trust Secretary* ***Response requested:***

Response

ID	Governor Name
Status:	*Assigned to Executive Lead*

162 **Clive Hamilton** ***Theme:*** VTE ***Source:*** Governor Direct

Query **14/09/2016**

On page 133 of the July 2016 Board Report it was reported that there were two incidences of venous thromboembolism in the Children's Hospital and that this was unusual so validation was needed.

Were these cases valid, and if so, is there a case for VTE assessment in the Children's Hospital?

Division: Women's & Children's Services ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **19/09/2016**

The validation of the two venous thromboembolism (VTE) cases in the July Board report (June data) has taken place. One of the cases was not validated and one was. For the case that was validated the young person had had the appropriate VTE risk assessments completed and thrombo-prophylaxsis treatment given as per Trust policy.

The current policy states that clinicians should consider thrombo-prophylaxis in paediatric patients over 40kg, the rationale for that is that they are more physiologically akin to an adult.

Status: *Awaiting Governor Response*

ID	Governor Name		
161	Clive Hamilton	***Theme:*** Inpatient Food Safety and Nutritional Standards	***Source:*** Governor Direct

Query **14/09/2016**

The Trust recently took on a new contract for the supply of frozen meals/food.

Microbiological safety and nutritional quality are important for reducing the risk of harm and as aids to enhanced recovery.

Do we have independent assurance that all food supplied to patients meets microbiological safety requirements and adequate nutritional content?

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **20/09/2016**

Yes. The Trust is undertaking a vigorous procurement process, which encompasses microbiological safety requirements. Our quality in-house dieticians secure and monitor the nutritional standards set by the Trust.

Status: *Awaiting Governor Response*

ID	Governor Name		
160	Clive Hamilton	***Theme:*** Safe Staffing Levels	***Source:*** Chairman's Counsel

Query **14/09/2016**

The 'Safe Staffing Levels' report for June 2016 indicates that the Women's and Children's Division had a deficit of 1,084 hours from expected levels of staff amounting to 99% cover.

Three wards were showing more substantial deficits:
Ward 32 - 296 hours or 93% of expected
Ward 34 - 803 hours or 84% of expected
Ward 38 - 278 hours or 94% of expected

Can we have assurance that patient safety was not put at risk as a result of these deficiencies and that High Dependency Care was not compromised?

Division: Women's & Children's Services ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **22/09/2016**

The UH Bristol 'Monthly Staffing Report of Nursing and Midwifery Levels June 2016' reported that the Women's and Children's Division had a deficit of 1,084 hours from the expected 77,449 nursing hours planned. The Women's and Children's Division report on staffing levels across 15 clinical areas and in June 2016, 3 of these clinical areas (wards 32, 34, 38) reported a negative variance. The reasons for this are explained as follows:

Ward 32
Ward 32 has 16 beds (11 cardiac speciality and 5 High Dependency beds) and to staff these as planned, if all beds are fully occupied 7 days of the week, requires 6 registered nurses and 1 nursing assistant on the day shift. Throughout June, the number of patients who occupied these beds were on average 10/11 patients meaning that 4/5 beds were 'empty' and therefore required less staffing than planned. The negative balance of 296 hours (or 93% fill rate) is appropriate as the bed occupancy was lower than expected in June, and the number of nurses required to staff 16 beds was reduced in response to this. There were no lower than expected staffing level incidents reported in June and the correct ratio of nurse to patient was provided. Therefore assurance is given that patient safety was not put at risk and High Dependency Care not compromised.

Ward 34
Ward 34, has 16 beds (6 Bone Marrow Transplant and 10 Oncology/Haematology) and to staff these as planned, if all beds are fully occupied all of the week, plans to roster 7 registered nurses and 1 nursing assistant on the day shift and 6 registered nurses and 1 nursing assistant on the night shift. Ward 34 temporarily reduced its beds from 16 to 14 over the summer months. Throughout June, the number of patients who occupied the 14 beds available were on average 10/11 patients meaning that 3/4 beds were 'empty' and therefore required less staffing than planned for the 14 beds. The negative balance of 803 hours (or 84% fill rate) is appropriate. There were no lower than expected staffing level incidents reported in June and the correct ratio of nurse to patient was provided. Therefore

ID **Governor Name**

assurance is given that patient safety was not put at risk or compromised.

Ward 38
Ward 38 has 22 beds (16 neurosurgery and neurology and 6 neuro rehabilitation) and to staff these as planned, if all beds are fully occupied 7 nights of the week, requires 5 registered nurses and 2 nursing assistants on the night shift. Throughout June, the number of patients who occupied these beds were on average 13/14 patients meaning that 8/9 beds were 'empty'. The negative balance of 278 hours (or 94% fill rate) is appropriate at weekends/weekend nights the number of nurses required is less as some of the rehabilitation patients go home as part of their recovery plan. There were no lower than expected staffing level incidents reported in June and the correct ratio of nurse to patient was provided. Therefore assurance is given that patient safety was not put at risk or compromised.

Status: *Awaiting Governor Response*

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159 **Andy Coles-Driver** ***Theme:*** Renewing our hospitals ***Source:*** Governor Direct

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Query **30/08/2016**

There have been discussions about the redevelopment of Trust Headquarters and the staff car park. How is this work to be funded? Will any new car park be for staff and/or patients and visitors?

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **13/09/2016**

We are currently undertaking a competitive tender exercise to find a private operator to design, build and operate a car park on the site of the existing staff car park. The new car park would be for patients and visitors, however we would seek to re-provide the existing staff car parking spaces. Any proposals resulting from the tender exercise would still be subject to planning.

Status: *Awaiting Governor Response*

ID	Governor Name		
158	Andy Coles-Driver	***Theme:*** Renewing our hospitals	***Source:*** Governor Direct

Query **30/08/2016**

Since the facade work was completed the front of the BRI looks superb, however the top levels under the helideck look unattractive and spoil the whole look. Are there any plans to refurbish the very top of the Queen's Building?

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **13/09/2016**

There are no plans at present to refurbish the top of the Queen's Building, due mainly to funding.

Status: *Awaiting Governor Response*

ID	Governor Name		
157	Garry Williams	***Theme:*** Cataract surgery	***Source:*** Governor Direct

Query **25/08/2016**

It could be thought that the scheme to refer 'post op' cataract patients to CCG approved community optometrists could increase the risk of delay and a break in continuity of care, with the associated possibility of errors in clerical/admin aspects, and also for sales pressure upon patients using commercial premises.

If such schemes to relieve pressure on hospital lists are to be urged, they must also proffer rigorous validation and evaluation of the impact on patients and existing professional/clerical back-up within the Trust.

Is evidence being urgently sought of numbers involved, reaction of patients, especially to possible exposure to sales pressure, and as to the way Trust staff are managing this delegation of patient care and associated scrutiny of record-keeping?

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **13/09/2016**

The CCG has commissioned community optometrists to provide cataract follow-up appointments in place of the Bristol Eye Hospital (BEH) and therefore the new arrangements fall outside of that which the BEH can directly manage. However, while the BEH is not party to the nature of the contract between the CCG and these community providers, it would be highly unusual for any such contract not to include an instance on collecting and acting upon patient feedback. In terms of securing ongoing patient care, through administrative systems put in place, the BEH is able to see which of the patients discharged have booked their follow-up appointment. The BEH will then contact any patient who has not made their appointment within the appropriate clinical timescale to either support them in making a follow-up appointment with their optometrist, or arrange an appointment at the BEH if deemed clinically necessary.

Status: *Awaiting Governor Response*

ID	Governor Name		
156	**Angelo Micciche and Mo Schille**	***Theme:*** Impact of service changes	***Source:*** From Constituency/ Members

Query **20/07/2016**

At a recent Health Matters event, a Foundation Trust member raised the question of how the Trust effectively manages the impact of changes to services, from the point of view of the patients and staff involved. The member had raised this question at the last annual members meeting and was awaiting a more detailed response, and has also since completed a freedom of information request in relation to this matter.

Please can we be assured that this question will be dealt with urgently, and that processes are in place to capture members' questions from public meetings that require follow up.

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **30/08/2016**

The FOI response to the Foundation Trust member, and related documents, were circulated by email to the Trust Board and Council of Governors with the response.

In terms of members' questions raised at the Annual Members Meeting, these are recorded in the minutes. Any actions will be added to the action log for the next Council of Governors meeting so that they can be followed up and closed.

Status: *Closed*

ID	Governor Name		
155	Mo Schiller	***Theme:*** Contacting patients	***Source:*** From Constituency/ Members

Query **11/07/2016**

Elderly people cannot always get to the phone in time to pick up a call, the problem being most phones have a limited ring before going to an answerphone system. Also the existing hospital phone system says caller number withheld, so some people avoid picking up calls if they don't know who is on the other end – if the call is from the hospital is to cancel an appointment this could be a problem. If the call is following up from a message left with the OPD line/co-ordinator and no message is left then the patient thinks they have not been called back.

When you call the outpatient appointment co-ordinators you frequently get, "I am not at my desk/am on another call, leave your name, hospital number and telephone number and we will call you back." Should there be a message saying who called, why they called /a number to call back? Why is the caller number withheld? We need to consider a lot of our patients are now old.

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 11/07/2016

Response **21/07/2016**

The outpatient standards outline that answerphone messages with minimal information can be left when contacting patients on either a landline or mobile phone. An example of a standard message that can be left on a machine to protect patient confidentiality is: 'This is a call for Joe Smith about your admission date, please ring us on 0117 342 ….' . In terms of the caller ID, organisations such as hospitals and the police used to be encouraged to withhold their numbers, however with the public now able to request a block on undeclared numbers this stance has changed. When the Trust moves to a new external line provider (which we anticipate will be in the next 12 months) we will then have the capability to declare a Trust ID on outbound calls. How the Trust then deals with the returned calls to that declared ID has still to be decided, as has the timeframe for implementation.

Comment from Mo Schiller: Can governors ensure we track this and return to it in six and then 12 months, as I know our members want an improvement here. I will not be a governor after May 2017, so governors need to keep it on the horizon for if/when the new line commences.

Status: *Closed*