University Hospitals Bristol
NHS Foundation Trust

PUBLIC TRUST BOARD

Meeting to be held on Friday 28th April 2017 2017 2017, 11:00 am - 1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Preliminary Business				
1	Apologies for absence	Information	*Chairman*	**Verbal**
2	Declarations of Interest	Information	*Chairman*	**Verbal**
3	Patient Experience Story	Information	*Chief Nurse*	**Verbal** / 3
4	Minutes of the last meetings	Approval	*Chairman*	6
5	Matters arising and Action Log	Approval	*Chairman*	21
6	Chief Executives Report	Information	*Chief Executive*	22
7	Board Assurance Framework 2016/17 (Quarter 4)	Assurance	*Chief Executive*	26
Research and Innovation				
8	Research and Innovation Report	Assurance	*Medical Director* *David Wynick Consultant attending to present*	48
Care and Quality				
9	Trust's Art Strategy	Approval	*Chief Executive*	55
10	Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Board Review – Quality, Workforce, Access	Assurance	*Chief Operating Officer and Deputy Chief Executive*	61
11	Quality and Outcomes Committee Chair's Report	Assurance	*Quality & Outcomes Committee Chair*	**To be tabled**
12	Independent Review of Children's Cardiac Services progress report	Assurance	*Chief Nurse*	117

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Financial Performance				
13	Finance Report	Assurance	*Director of Finance & Information*	152
14	Finance Committee Chair's Report	Assurance	*Finance Committee Chair*	**To be tabled**
Organisational and System Strategy and Transformation				
15	Transforming Care Programme Board	Assurance	Chief Executive	179
16	Emergency Preparedness, Resilience and Response Annual Report	Approval		185
17	Annual Operating Plan Update	Approval	Director of Strategy and Transformation	202
Governance				
18	Annual Review of Code of Conduct for Board of Directors *(including Fit and Proper Persons Self Certification)*	Assurance	*Chief Executive*	222
19	Annual Review of Directors Interests	Assurance	*Chief Executive*	242
20	Register of Seals	Assurance	*Chief Executive*	250
21	Audit Committee Chairs Report	Assurance	*Chair Audit Committee*	253
Items for Information				
22	Governors' Log of Communications	Information	Chairman	257
Concluding Business				
23	Any Other Urgent Business	Information	*Chairman*	**Verbal**
24	Date and time of next meeting **Friday 26th May 2017, 11:00am - 1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**		*Chairman*	**Verbal**

Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3
Meeting Title	Public Trust Board	**Meeting Date**	Friday, 28 April 2017
Report Title	Patient Story		
Author	Tony Watkin, Patient and Public Involvement Lead		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

The purpose of presenting a patient story to Board members is:

- To set a patient-focussed context for the meeting.
- For Board members to understand the impact of the lived experience for this patient and for Board members to reflect on what the experience reveals about our staff, morale and organisational culture, quality of care and the context in which clinicians work.

Key issues to note

Michael's story explores how his diagnosis of diabetes, and the implications of living with a long term condition, motivated him to become an active participant in improving health care services for local people. Driven by his own experiences of care, Mike was instrumental in establishing a Diabetes Support Group in Hartcliffe and is an active participant in the Trust's Rheumatology Patient Advisory Group. In November 2016 Mike was recruited to the Bristol Patient and Community Leadership Programme graduating as a Healthcare Change Maker in February 2017. In his spare time Mike is a Director at Knowle West Health Park.

By way of context, the Patient and Community Leadership Programme is a partnership

between North Bristol NHS Trust, Bristol Community Health and UH Bristol. Supported by NHS England and the King's Fund the programme is delivering a shared Patient and Public Involvement resource across the health care system. As Healthcare Change Makers, the programme graduates work together with NHS and other professionals on areas of common interest. At the moment they are beginning to support the diabetes and respiratory care pathway work streams as part of the local Sustainability and Transformation Plan.

Recommendations

Members are asked to:

- **Note** the patient story

Intended Audience
(please select any which are relevant to this paper)

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

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

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

Corporate Impact Assessment
(please tick any which are impacted on / relevant to this paper)

Quality	☐	Equality	☒	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

N/A

Resource Implications
(please tick any which are impacted on / relevant to this paper)

Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees

Audit Committee	Finance Committee	Quality and Outcomes Committee	Remuneration & Nomination Committee	Other (specify)

University Hospitals Bristol
NHS Foundation Trust

Minutes of the Public Trust Board Meeting

Held on Thursday 30th March 2017 11:00-13:00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

Present
Board Members

Member Name	Job Title/Position
John Savage	Chairman
Emma Woollett	Non-Executive Director / Vice- Chair
Julian Dennis	Non-Executive Director
Alison Ryan	Non-Executive Director
Lisa Gardner	Non-Executive Director
David Armstrong	Non-Executive Director
Guy Orpen	Non-Executive Director
John Moore	Non-Executive Director
Robert Woolley	Chief Executive
Sean O'Kelly	Medical Director
Carolyn Mills	Chief Nurse
Mark Smith	Chief Operating Officer/ Deputy Chief Executive
Alex Nestor	Acting Director of Workforce and Organisational Development
Paula Clarke	Director of Strategy and Transformation
Paul Mapson	Director of Finance and Information

In Attendance

Name	Job Title/Position
Pam Wenger	Trust Secretary
Tony Watkin	Patient and Public Involvement Lead (for Item 3)
David Crofton	Health Watch (for Item 3)
Steffie Denton	Health Watch (for Item 3)
Hestor Myaci	Member of the public
Jeanette Jones	JUC Governor Lead
Nikki Evans	Care Quality Commission
Fiona Reid	Head of Communication
Rashid Jooman	Patient Governor
Paul Maddon	Member of the Public (O2)
Neina English	UHBristol
Merlyn Ipinson-Fleming	Member of the Public (Mentee NHS/UWE Leadership Programme)
Florene Jordan	Staff Governor
Carole Dacombe	Public Governor
Clive Hamilton	Public Governor
Graham Briscoe	Public Governor

Minutes:

Zainab Gill	Corporate Governance & FOI Administrator

The Chair opened the Meeting at 11:00am

Minute Ref	Item Number	Action
41/03/17	**1. Welcome and Introductions**	
	The Chairman welcomed everyone to the meeting. Apologies were noted from Jill Youds.	
42/03/17	**2. Declarations of Interest**	
	There was one declaration of interest from John Savage (Chairman). He advised that he was standing as an independent candidate for Metro Mayor. John Savage confirmed that this was a part time role and would not have any impact on his role as Chair.	
43/03/17	**3. Patient Experience Story**	
	The meeting began with a patient story, introduced by Carolyn Mills Chief Nurse. In this story, the Board heard about an "enter and view" carried out at South Bristol Community Hospital by Healthwatch in October 2016. The visit had generated positive feedback about inpatient care at the hospital. Most of the recommendations, following the visit focussed on non-clinical aspects of care. In particular, it was highlighted that many inpatients at the hospital have relatively long stays for rehabilitation, so it was important to ensure that they have access to magazines, activities, and the hospital café. A response from South Bristol Community Hospital which details the actions to be taken against agreed timescales had been provided to Healthwatch and was approved at the Trust's Patient Experience Group in February 2017. The Board were pleased to note the positive feedback from the visit. Emma Woollett commented on the need to address the issue of delayed discharge, which was apparent from the patient story. The Board discussed other areas where further improvement was needed and agreed that it was important to ensure that the Hospital is providing more stimuli. In relation to this Steffie Denton agreed to forward on to Tony Watkins a list of bedside activities currently being used by care homes.	

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Receive** the patient story; • **Receive** details on bedside actives in care homes	Health watch/Chief Nurse
44/03/17	**4. Minutes of the last meeting**	
	The minutes of the meetings held on the 28th February 2017 were agreed as a true and accurate record. **Members RESOLVED to:** • **Approve** the minutes as a true and accurate record from the meeting held on 28th February 2017.	
45/03/17	**5. Matters arising and Action Log**	
	Members received and reviewed the action log. The progress against completed actions was noted, there were no outstanding actions to review in this meeting. **Members RESOLVED to:** • **Note** the update against the action log.	
46/03/17	**6. Chief Executive's Report**	
	Robert Woolley, Chief Executive, discussed the highlights from the Chief Executive's report and updated the Board on several further matters which were not covered in the report: <u>Care Quality Commission</u> Robert Woolley reported to the Board that following the publication of the CQC report the Board had received a rating of outstanding, he confirmed that this would be discussed in detail later on the agenda. He further confirmed that the Trust had received letters of congratulation from Jim Mackey, Chief Executive at NHS Improvement, David Behan, Chief Executive of CQC and Jeremy Hunt, Secretary of State. <u>Spring Budget</u> Robert Woolley reported to the Board that the Spring Budget had been published and highlights from the Budget included: - An allocation of two billion pounds into social services over the next three years. He advised the Board that there had been communication from NHS England and NHS Improvement to Chief Executives at all Trusts, asking that that they confirm they are in dialogue with social care services to ensure the best use	

Minute Ref	Item Number	Action
	of funds. Robert Woolley assured the Board that the Trust was fully engaged with social care services and that this item would be on the Sustainability and Transformation Plan agenda. The Board were pleased to hear about the additional funding to social care services however noted that in addition to this funding, it was important for social care services to ensure that bed occupancy is reduced especially around discharge to asses and the agreed process is applied uniformly. - Additional funding had been allocated to increase the use of GP's in A&E, Robert Woolley assured the Board that the Trust would work closely with Clinical Commissioning Groups to ensure appropriate use of funding. Robert Woolley advised the Board that the information from NHS Improvement suggested that the correct use of funds could help to decrease bed occupancy significantly. <u>Sustainability and Transformation</u> Robert Woolley reported to the Board that he had expected NHS England to publish a Five Year Forward View Delivery Plan on Tuesday 28 March, emphasising the continuation of the original national strategy and the central importance of Sustainability and Transformation Plans to its implementation. The publication of this plan had however been delayed. <u>Brexit</u> Robert Woolley reported to the Board that a coalition of 34 health organisations had written to the all the secretaries of state requesting a system that allowed the NHS to recruit European professionals in order to maintain their health care workforce numbers in a clear transparent way, as well as ensuring there was a clear transition for individuals who already worked for the NHS. Robert Woolley confirmed that the Trust had been commended as one of only 40 Trusts and 40 CCG's to be recognised for their excellence in sustainability reporting by the sustainability unit and NHS England. **Members RESOLVED to:** • **Receive** the Chief Executive report for information.	

Minute Ref	Item Number	Action
47/03/17	**7. Outcome of the Care Quality Commission Inspection**	
	Robert Woolley presented the report to the Board. He explained that an inspection from the Care Quality Commission of the Trust's Main Site had taken place between 22 and 24 November 2016. In CQC registration terms, the 'Main Site' is a collective term describing the hospitals located around the Bristol Royal Infirmary precinct. It does not include the Central Health Clinic and South Bristol Community Hospital, which are separately registered sites and were not included in this latest inspection. Robert Woolley explained that the CQC inspected four core services at the Main Site: - Urgent and emergency services - Medical care - Surgery - Outpatients and diagnostic imaging Following the inspection, the Trust's overall rating had moved to **Outstanding**. He confirmed that the Trust was the only outstanding provider to have improved by two levels of rating between two consecutive visits. The Board noted that the CQC reports contain four 'requirement notices' pertaining to: - Secure storage of patient records - Access to MRI rooms - Use of sluice rooms for storage - Essential training compliance Robert Woolley confirmed that a plan to address these issues would need to be submitted to the CQC this week and that this was underway. The Board noted that a celebration relating to the achievement of the Trust's rating was being considered for all staff. Sean O'Kelly confirmed that a number of events had already taken place with staff to feedback the results. Julian Dennis commented on the positive presentation of the application of "Happy App" received in the Quality and Outcomes Committee. He said that the correlation of improving staff engagement and the Happy app would be successful and encouraged the continued roll out. Robert Woolley advised that this was the intention of the Trust and advised the Board that Health Education England were impressed with the "App" and had begun to fund local Trusts to use the "App".	

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	Alison Ryan commented on the improvement needed around patient records which had been noted by the CQC, Robert Woolley advised that this was an area of constant diligence as records were being used all the time, the main solution for this was around moving to an electronic system which was in progress. **Members RESOLVED to:** • **Receive** the Care Quality Commission Inspection for assurance.	
48/03/17	**8. Quality and Performance Report**	
	Mark Smith, Chief Operating Officer and Deputy Chief Executive presented this report, It was noted that the Trust had made further progress in recovering performance against the national access standards in February 2017, in line with the Trust's recovery forecasts. Mark Smith explained that BRI bed occupancy has been particularly high this month. However despite the pressure on wards the Trust has continued to see strong performance against most of the core metrics of inpatient service quality. Additional noteworthy improvements in quality metrics included achievement of the recovery trajectory for the number of patients waiting over 6 weeks for a diagnostic test, a reduction in outlier bed-days, zero reported cases of *Clostridium difficile*, the achievement of the non-purposeful omitted doses of listed critical medicines 1% standard for the twelfth consecutive month and the SHMI mortality indicator being restored to a green rating for the most recently reported rolling 12-month period. Performance against the metrics related to the management of patients who had sustained a fractured neck of femur had shown an improvement this month. But the performance against these metrics continued to be disappointing, and the focus of significant attention. *Members noted:* • Performance against the 62-day GP cancer standard remained below the 85% national standard in January. However, the 85% standard was met for internally managed pathways and performance exceeded the national average performance by a significant margin. • Performance against the A&E 4-hour standard continued to be below the in-month performance trajectory, although there was a small improvement in performance between January and February. • The size of the elective waiting list remains significantly above that of the same period last year, which in the context of a rising RTT backlog, puts continued achievement of the 92% RTT standard at risk for the end of March. Mark Smith confirmed that next year they	

Minute Ref	Item Number	Action
	would be concentrating on specialty level. He further confirmed that PTL Management would be looked at by the national team to provide the Trust with assurance around management of patients on waiting lists. • The overall level of emergency admissions into the Bristol Children's Hospital (BCH) in February was below the same period last year, and significantly down on January's levels. This reduction in demand supported a further improvement in 4-hour performance at the BCH, although the 95% national standard was not met. • Although the number of emergency admissions via the Bristol Royal Infirmary (BRI) Emergency Department (ED) was down by 3.7% on the same period last year, the total number of emergency admissions into the hospital remained at similar levels to that seen in February 2016. Emergency pressures continue to provide context to the ongoing workforce challenges, especially bank and agency usage. Levels of staff sickness have, encouragingly, shown a decrease this month, which should lead to a reduction in bank and agency spend. Turn-over rates have been maintained at the recent improved levels, and vacancy rates remain Green rated and continue to fall, reflecting the continued strong internal focus on recruitment and retention of staff. Alex Nestor confirmed that although nursing vacancies had increased, there was a continued focus from divisions in this area and divisions were being encouraged to use Bank. Mark Smith informed the Board about the national focus on A&E performance and the improvement nationally against this standard. He explained that work was being taken forward to re-focus on the significance of the A&E pressures and the impact on elective performance. He confirmed that following the re-focus he would report back to the Quality and Outcomes Committee. The Board were provided with assurance in terms of the fractured neck of femur target which had been picked up in the Quality and Outcomes Committee and at the last Board meeting. Mark Smith advised that he and Sean O'Kelly had met with the Clinical Chair and Divisional Director to request a formal response to the British Orthopaedic Association report, review of job plans and theatre activity and to look for a plan of improvement with a trajectory. Sean O'Kelly confirmed that there had been some improvement in the target within the last month, however there was a continued focus on the target and a formal update would be provided to the Quality and Outcomes Committee. **Members RESOLVED to**:	

Minute Ref	Item Number	Action
	• **Receive** the Quality and Performance Report for assurance.	
49/03/17	**9. Quality and Outcomes Committee Chair's Report**	
	Members received a written report following the meeting of the Quality and Outcomes Committee held on the 28th March 2017. Members also received a verbal account of the meeting held on 28th March 2017 from Alison Ryan, Non-executive Director and Chair of the Quality and Outcomes Committee, covering the following key areas: - The Committee discussed the recent letter from NHS Improvement in relation to the supply of agency staff following the issue raised by the Governors on the 27 March 2017. It was noted that this was being discussed internally and an update would be brought in due course. - The Committee had received a detailed overview of the Happy App and were pleased to see the simple approach that had been used in the App. - Members received assurance on the governance escalation methods that were being built into service design where services and clinical responsibility lay with partner organisations using UHB support/premises. - The Committee had received assurance in relation to the performance report and were aware of the significant risk on the performance target due to the RTT and cohort of patients going through the system. Clive Hamilton asked for assurance in relation to safety on the Trust scorecard, where the target around the "WHO" checklist seemed to be deteriorating, Sean O'Kelly explained that recording against this target had slightly changed, due to an update in software. He assured the Board that the "WHO" checklist was still performing at a high level. John Moore asked for clarity around the intention to explore waiting list statistics and how they were measured. Mark Smith advised that Trust wanted to assure the Board and themselves that external due diligence has been sought in relation to this measure. The Board had a discussion in some detail in relation to the "Breaking the cycle" scheme, which helps to provide insight on weak processes and how these can be improved or replaced. The Board noted that this approach was mandatory and had not been successful in the past in helping to sustain improvement of performance. Mark Smith explained	

Minute Ref	Item Number	Action
	that, going forward the findings from the "Breaking the cycle" scheme would be investigated by a new "urgent care group" who would help ensure that any findings are implemented appropriately. In addition to this, Mark Smith advised the Board that he had requested to NHS Improvement, a visit from "ECIP" national experts to help the Trust to understand what could be done to improve their position and sustain it. **Members RESOLVED to**: • **Receive** the Quality and Outcomes Committee Chair's Report for assurance.	
50/03/17	**10. Independent Review of Children's Cardiac Services progress report**	
	The Board received a progress report relating to the recommendations from the Independent Review of Children's Cardiac Services and a CQC expert review of clinical outcomes of the children cardiac service published on 30 June 2016. The key highlights from the report included : • Three recommendations have been closed since the last report, five actions are rated amber and twelve recommendations have moved from amber to a red status. • The delivery group status reports and action plans showed where the variations to delivery within the original timescales were and detailed the reasons for the changes. Ten of the twelve red rated recommendations should be closed at the March meetings of the relevant delivery groups and by the steering group meeting on the 4th of April. The Board were pleased to note the progress on the report and looked forward to seeking assurance that all actions would be completed by June 2017. **Members RESOLVED to:** • **Receive** the Independent Review of Children's Cardiac Services progress report	
51/03/17	**11. A)Quarterly Complaints Report**	

Minute Ref	Item Number	Action
	B)Quarterly Patient Experience Report	
	Carolyn Mills, Chief Nurse, introduced this report, the purpose of which was to provide the Board with assurance. Carolyn Mills confirmed that the Quality Outcomes Committee had reviewed the reports in detail at their recent meeting. The Board noted identification of a data error relating to the numbers of complaints attributed to the Bristol Royal Infirmary and Bristol Heart Institute. The error had affected the Quarter 3 report and the previous Quarter 2 report: the volume of complaints attributed to the Bristol Royal Infirmary had been lower than first reported, whilst the volume of complaints for the Bristol Heart Institute was correspondingly larger. The data error had been limited to the hospital-level analysis within the reports; divisional analysis was unaffected. Reporting of this data will be automated for Quarter 4. Highlights from the report included: - A general reduction in the number of complaints in all divisions. - The formation of a new complaints review panel, which would be set up from May 2017, which would work closely the patient association. - The continued low scores relation to wards providing care to the elderly in South Bristol Hospital. Carolyn Mills assured the Board that Trust was engaging with elderly patients in this area to review and address this issue. The Board were pleased with the report but noted the continued improvement required in responsiveness and communication, The Board were assured that there were no specific themes or trends and that actions were in place to address and improve communication. The Board received the Patient Experience and Involvement Report for assurance. The Committee noted the following highlights from the report: - The “enter and view” carried out at South Bristol Community Hospital by Healthwatch in October 2016 generated positive feedback about inpatient care at the hospital. Most of the recommendations focussed on non-clinical aspects of care. In particular, it was highlighted that many inpatients at the hospital have relatively long stays for rehabilitation, so it is important to ensure that they have access to magazines, activities, and the hospital café. - Feedback obtained from patients via the Trust’s corporate survey	

Minute Ref	Item Number	Action
	programme remained positive about the quality of care at UH Bristol. For example, 98% of inpatients would recommend the care to their friends and family and praise for staff was by far the most frequent type of written feedback received. - The positive correlation in chart 1 and 2 of the report kindness and understanding/ inpatient experience tracker. - Members noted the response from wards to negative comment, in the report. - Feedback obtained from patients via the Trust's corporate survey programme remained positive about the quality of care at UH Bristol. The Board noted the continued efforts by the complaints team ensure that there were new initiatives to obtain information and work closely with partnerships in the community. **Members RESOLVED to:** • **Receive** the Quarterly Complaints Report and Quarterly Patient Experience Report for assurance.	
52/03/17	**12. Finance Report**	
	Members received the report on the Trust's current financial position from Paul Mapson, Director of Finance and Information. The Trust is reporting a surplus of £13.168m (before technical items) at the end of February. The Operational Plan to date is a surplus of £14.479m and therefore the Trust is £1.311m behind plan. This position includes £10.427m sustainability and transformation (S&T) funding but is £1.490m behind the planned receipt of £11.917m. Therefore the Trust is reporting a surplus of £0.179m excluding S&T funding. It was agreed to take Item 12, 13 and 14 together. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	
53/03/17	**13. 2017/18 Financial Resources Book and 2017/19 revised Operational Plan**	
	Members received 2017/18 Financial Resources Book and 2017/19 revised Operational Plan for approval. <u>Highlights from the report included:</u>	

Minute Ref	Item Number	Action
	- Acceptance of the revised 2017/18 Control Total advised by NHS Improvement of a £13.0m net surplus. The revised Control Total is non recurrent i.e. it applies to 2017/18 only. Therefore, the Control Total for 2018/19 of a £22.8m net surplus is rejected by the Trust. The "self-certification" schedule is attached as appendix 1 accordingly. The 2017/18 Resources Book has been produced and reflects the revised 2017/18 Operational Plan submission of a net surplus of £13.0m. - There is no presumption of going concern status for NHS foundation trusts. The Trust is required to consider each year whether it is appropriate to prepare its accounts on the going concern basis. The Trust is required to include a statement within the annual report on whether or not the financial statements have been prepared on a going concern basis and the reasons for this decision, with supporting assumptions or qualifications as necessary. The Board were assured that the operational plan and resources book provided evidence that the Trust would continue to provide its services in the future and therefore assurance was given that the financial statements for the 2016/17 annual report and accounts were prepared on the going concern basis. **Members RESOLVED to:** • **Approve** the 2017/18 Financial Resources Book and 2017/19 revised Operational Plan; • **Approve** the going concern status of the Trust. • .	
54/03/17	**14. Finance Committee Chair's Report**	
	Members received reports from the meetings of the Finance Committee held on 24th February 2017. Lisa Gardner, Non-executive Director and Chair of the Finance Committee, highlighted that the Committee had been begun to look at the year ahead and were assured in terms of divisional capacity in achieving their financial position for the year ahead. Other areas of assurance received by the Committee were: - Divisional Financial Reports - Savings Programme - Contract and Activity Income	

Minute Ref	Item Number	Action
	- Service Profitability and Efficiency. Lisa Gardner confirmed that the Finance Committee considered whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows. It was noted that the guidance given was that "t*he anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."* The Resources Book is presented to the Trust Board as this evidence and therefore the Board is asked to formally recognise that the 2016/17 annual accounts are prepared on a going concern basis. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's report for assurance; and • **Approve** the going concern status of the Trust.	
55/03/17	**15. Operating Plan**	
	Paula Clarke, presented this report. She reminded the Trust Board that the Board had approved the two year Operational Plan on 22nd December 2016 with onward submission to NHS Improvement on 23rd December 2016. She further explained that the Plan provided the supporting narrative setting out the Trust's approach and position on activity, quality, workforce and financial planning. The Board noted that since the end of December work had continued to underpin assurance regarding delivery of the Plan, including negotiation with NHSI re control total and signing of all Service Level Agreements with commissioners (achieved on 23/12/16). The Board noted that on 15th March 2017, NHSI confirmed the following requirements to be completed by noon on 30th March 2017: • Prior to population of in year 2017/18 forms and post the operational plan review process, Trusts are offered a limited rules-based opportunity to refresh plans to correct errors; ensure plans have the appropriate monthly profile for in year monitoring and align with plans sign off by Boards. • Mandatory refreshes are required for Acute Trusts only for activity and performance trajectories for A&E, RTT and 62 day cancer standards. Paula Clarke explained that the requirement did indicate that	

Minute Ref	Item Number	Action
	submission of a revised narrative planning summary is not required but references that Trusts may wish to update previous narrative prior to publication. The Board further noted that the paper provided a brief summary of the key changes proposed for inclusion in our final narrative plan. This refreshed narrative Plan would be presented to April Board for approval and would inform publication of the Trusts plan in summary form on the website thereafter. **Members RESOLVED to:** • **Approve** the 2017/18 revised Operational Plan financial narrative including the "self-certificate" for onward submission to NHS Improvement on 30th March 2017; • **Approve** the revised ED performance trajectory for submission to NHS Improvement by Noon on 30th March 2017; and • **Note** the intention to complete a refresh of the Operational Plan narrative by end April 2017 and publish in line with best practice guidance	
56/03/17	**16. Governors' Log of Communications**	
	The report provided the Board with an update on governors' questions and responses from Executive Directors. **Members RESOLVED to:** • **Note** the Governors' Log of Communications.	
57/03/17	**17. Quarterly Report from the West of England Academic Health Science Network Board**	
	The Board received the Quarterly Report from the West of England Academic Health Science Network Board for information. **Members RESOLVED to:** • **Note** the Quarterly Report from the West of England Academic Health Science Network Board.	
57/03/17	**18. Any Other Business**	
	Infection Control Survey Julian Dennis queried the infection control survey which is received annually, Carolyn Mills advised that this is received by the infection control Committee and advised that they meet monthly and that there were no particular concerns to report to the Board.	

Minute Ref	Item Number	Action
	New instructions on use of agency staff The Board noted concerns around the new instructions from NHS Improvement around agency cap, which related to members of staff with formal NHS contracts, working for an agency at another Trust. The main concerns around this were the expectations on the individuals who manage staff working for agency and how they should approach individuals who are currently working for another Trust via an agency. Robert Woolley confirmed the intention of NHS Improvement and explained that the Trust had not received any guidance or details in terms of monitoring or reinforcing this, he advised that discussions were still taking place to understand what this meant for the Trust and that no conclusion had yet been agreed.	
58/03/17	**19. Date of Next Meeting**	
	Friday 28th April 2017, 11:00am-1:00pm, Conference Room, Trust HQ, Marlborough Street, Bristol, BS1 3NU.	

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

University Hospitals Bristol
NHS Foundation Trust

Trust Board of Directors meeting held in Public 30th March 2017
Action tracker

Outstanding actions following meeting held 30th March 2017					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	**43/03/17**	**Patient Experience Story** Receive details on bedside activities in care homes	Chief Nurse	April 2017	**Work in progress**

Completed actions following meeting held 30th March 2017					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
2.	**11/01/17**	**Item 11 – Quarter 2 Patient Experience and Involvement Report** Receive a report on the Trust's response to the Healthwatch review of South Bristol Community Hospital inpatient areas (March Trust Board meeting)	Chief Nurse	March 2017	**Completed.** The update will be incorporated into the Quarter 3 Patient Experience Report for March 2017. Agenda Item 11b.
3.	**32/02/17**	**Independent Review of Children's Cardiac Services progress report** Receive clarity on action criteria in relation to the recommendations on the Independent Review of Children's Cardiac Services progress report	Chief Nurse	March 2017	**Completed.** Agenda Item 10.

Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	6
Meeting Title	Trust Board	**Meeting Date**	28 April 2017
Report Title	Chief Executive Report		
Author	Robert Woolley, Chief Executive		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

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

Key issues to note

The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in April 2017.

Recommendations
The Trust Board is recommended to note the key issues addressed by the Senior Leadership Team in the month and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda. Members are asked to: • **Note** the report.

Intended Audience
(please select any which are relevant to this paper)

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

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

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

Corporate Impact Assessment
(please tick any which are impacted on / relevant to this paper)

Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

N/A

Resource Implications
(please tick any which are impacted on / relevant to this paper)

Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees

Audit Committee	Finance Committee	Quality and Outcomes Committee	Remuneration & Nomination Committee	Other (specify)

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – APRIL 2017

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in April 2017.

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **received** updates on the financial position for 2016/2017 and forward look into 2017/2018.

3. STRATEGY AND BUSINESS PLANNING

The group **noted** an update on the progress of the Operational Planning process and **approved** sign-off of Divisional Operating Plans for the Divisions of Specialised Services, Diagnostics and Therapies and Facilities and Estates.

The group received an update on and **approved** the completion of the Quality Impact Assessments to support decisions made through the Operational Planning Process not to proceed with either internal or external investment proposals.

The group **approved** proposals to support the government initiative to implement and deliver apprenticeships at UH Bristol from May 2017.

The group **supported** options for extended scoping and business case development for increasing capacity and developing timely discharge models within UH Bristol.

The group **noted** the proposal submitted to commissioners to manage demand for restorative dentistry in 2017/2018.

The group **noted** an update on the junior doctor contract implementation and assessment of gaps.

The group **noted** the impact assessment on UH Bristol of potential overnight closure of the Weston Emergency Department.

4. RISK, FINANCE AND GOVERNANCE

The group received and **noted** the Quarter 4 2016/2017 Themed Serious Incident Report, prior to submission to the Quality and Outcomes Committee.

The group **received** the Board Assurance Framework 2016/2017 Quarter 4 update prior to onward submission to the Trust Board.

The group **received** the Corporate Risk Register prior to onward submission to the Trust Board.

The group **noted** the 'must do' action plans that had been submitted to the Care Quality Commission in response to the four regulatory concerns highlighted following the Commission's inspection in November 2016.

The group **approved** the Annual Report for Emergency Planning Resilience and Response 2016-17 for onward submission to the Trust Board.

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

The group **received** four medium impact Internal Audit Reports in relation to Use of Locum Doctors, Morbidity and Mortality Review, Reporting of Sub Groups to the Quality and Outcome Committee and Adult Enhanced Observation Policy Review, and four low impact Internal Audit Reports in relation to Equal Pay Review, Electronic Data Management Project Review, Information Governance Toolkit Review (part 2) and Main Accounting.

The group **received** an update on the IR35 Regulations and Legislation changes.

The group **received** an update report from the Congenital Heart Disease Network.

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

The group **received** an update on private patients and overseas visitor activity across the Trust.

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

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

5. RECOMMENDATIONS

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

Mark Smith
Deputy Chief Executive/Chief Operating Officer
April 2017

Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	7
Meeting Title	Trust Board	**Meeting Date**	28 April 2017
Report Title	Board Assurance Framework 2016/17 (Quarter 4)		
Author	Sarah Wright, Head of Risk Management		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

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

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

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

- Second line of assurance robust forms of assurance, some gaps in controls around business continuity arrangements.
- Action Plan to address the issues around business continuity is ongoing.
- Further development has been made to the Quality Impact Assessment process to cover and support changes to service provision and the stopping of services.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- 14 associated Corporate Risks -

Principal Risk 3 - Failure to act on feedback from patients, staff and our public.

- First Line level of assurance but gaps due to lack of real time patient feedback system.
- The 'Happy App' has been successfully rolled out across clinical areas.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- No associated Corporate Risks.

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

- Second line level of assurance in relation to Health and safety issues, third line in respect of Internal Audit work programme.
- Gaps in assurance around roof and drain maintenance being addressed via operational and capital work programme for 2016/17, the impact of roof and drain issues on bed capacity and flow have reduced in year.
- Previous Risk Rating 8, Current Risk Rating 8, static trajectory.
- No associated Corporate Risks.

STRATEGIC PRIORITY 3:
We will strive to employ the best staff and help all our staff fulfil their individual potential
Principal Risk 4 - Failure to recruit, train and sustain an engaged and effective workforce.

- First & second line assurance around reporting arrangements and agency action plan now in place.
- Metrics continue to highlight risk around staff retention, although improving (see corporate risk 674).
- Previous Risk Rating 12, Current Risk Rating 12, static trajectory.
- 3 associated Corporate Risks.

STRATEGIC PRIORITY 4:
We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.
Principal Risk 5 - Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.

- Second line assurance in place but gaps identified Trust wide around supporting innovation and improvement, to be addressed by implementation of Innovation Strategy.
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- No associated Corporate Risks.

STRATEGIC PRIORITY 5:
We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.

Principal Risk 6 - Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.

- Second line assurance currently in place with potential for feedback via STP from BNSSG.
- Bid for research funding from NIHR successful.
- Partnership meetings now in place with NBT, UoB, UWE and memorandum of understanding in place with UoB.
- Senior staff involvement in North Somerset sustainability board programme
- Previous Risk Rating 6, Current Risk Rating 6, static trajectory.
- No associated Corporate Risks.

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

Principal Risk 7 - Failure to sustain financial sustainability

- Second line assurance in place via internal reporting and divisional reporting arrangements, weak controls and gaps in assurance identified.
- Previous Risk Rating 9, Current Risk Rating 9 static trajectory.
- 4 associated Corporate Risks - Addition of *Risk 951 - Risk financial penalties in excess of planned position, due to greater under-performance against key indicators*

STRATEGIC PRIORITY 7:
We will ensure we are soundly governed and are compliant with the requirements of our regulators

Principal Risk 8 - Failure to comply with targets, statutory duties and functions

- Robust second level assurance in place and third level in respect of NHS Improvement returns and CQC inspections.
- No significant gaps identified in either controls or assurance,
- Previous Risk Rating 9, Current Risk Rating 9, static trajectory.
- 6 associated corporate risks.

Summary

The current scores for principal risks are summarised in the following heat map - there has been no movement in Q4.

	Likelihood				
Impact	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic					
4 Major					
3 Moderate			1, 3, 5, 7, 8	4	
2 Minor			6	2	
1 Negligible					

Recommendations
Members are asked to: • **Review** the information contained within the report.

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

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

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

Impact Upon Corporate Risk
N/A

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

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

University Hospitals Bristol NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

Q4 2016-17

1. Board Assurance Framework for the delivery of Objectives.

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process. The Board achieves this, primarily through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.

2. The Trust Strategy

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

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

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

- Children's services;
- Accident and Emergency (and urgent care);
- Older people's care;
- Cancer services;
- Cardiac services;
- Maternity services;
- Planned care and long term conditions;
- Diagnostics and therapies; and
- Critical Care.

2.1 Trust Strategic Priorities

Our 2014-19 five year Strategic Plan outlines seven strategic priorities, structured according to the characteristic of our Trust Vision outlined above. Our strategic priorities are:

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

3. 2016/17 Priorities

The following priorities are outlined in our 2016/17 annual NHS Improvement Operational Plan.

	1. Care and Quality
1.1	Delivery of 12 Quality Objectives as follows; • Reducing cancelled operations; • Ensuring patients are treated in the right ward for their clinical condition; • Improving management of sepsis; • Improving timeliness of patient discharge; • Reducing patient-reported in-clinic delays for outpatient appointments, and keeping patients informed about how long they can expect to wait; • Reducing the number of complaints received where poor communication is identified as a root cause; • Ensuring public-facing information displayed in our hospitals is relevant, up-to-date, standardised and accessible; • Ensuring inpatients are kept informed about what the next stage in their treatment and care will be, and when they can expect this to happen; • Fully implementing the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted; • Increasing the proportion of patients who tell us that, whilst they were in hospital, we asked them about the quality of care they were receiving; • Reducing avoidable harm to patients; and • Improving staff-reported ratings for engagement and satisfaction.
1.2	Achievement of our 'Sign up to Safety' priorities as follows; • Early recognition and escalation of deteriorating patients to include early recognition and management of sepsis and acute kidney injury; • Medicines safety at the point of transfer of care with cross system working with healthcare partners; • Developing our safety culture to help us work towards, for example, zero tolerance of falls; and • Reducing never events for invasive procedures.
1.3	Delivery of the two objectives identified in the Medical Royal Colleges 2014 "*Guidance for taking responsibility: Accountable clinicians and informed patients" as follows;* "*A patient's entire stay in hospital should be coordinated and caring, effective and efficient with an individual named clinician – the Responsible Consultant/Clinician – taking overall responsibility for their care whilst retaining the principles of multidisciplinary team working"; and* "*Ensuring that every patient knows who the Responsible Consultant/Clinician, with this overall responsibility for their care is and also who is directly available to provide information about their care – the Named Nurse".*
1.4	Participate in the annual publication of avoidable deaths.
1.5	Demonstrate affordable progress towards delivery of the four key seven day services

	standards by 2020.
1.6	Further embed hosted Operational Delivery Networks (ODN), including paediatric neurosciences, Congenital Heart Disease and Critical Care.
1.7	Delivery of agreed specialised and local CQUIN targets.
	2. Non-Financial Performance
2.1	Deliver the agreed performance trajectories for Referral To Treatment (RTT), 6 week diagnostic, Cancer and the Accident and Emergency (A&E) four hour waiting standard.
2.2	Effective cross sector and patient flow remains a challenge due to external system wide factors. Work actively with our partners and through the STP, Better Care Programme and Urgent Care Network to develop and implement plans to improve flow and materially reduce the number of patients with a delayed discharge.
2.3	Successful implementation of the Orla Healthcare community based 'virtual ward'.
	3. IM&T and Estates
3.1	Continue with the necessary upgrading of the Estate along with medical equipment replacement.
3.2	During the coming year we will continue to deploy new digital capability throughout the Trust, further embedding and extending existing functions with particular emphasis on: • Rolling out digital case notes across our other hospital sites together with the implementation of e-forms and workflow automation; • Commencing delivery of a new nursing e-observations and replacement e-rostering systems; • Going live across the Trust with electronic prescribing and medicines administration; • Providing more convenient access to our systems and services through the wider use of mobile technology and telehealth techniques; and • Delivering the objectives of the Clinical Utilisation Review (CUR) by using existing systems rather than purchasing duplicate systems which are not supported by Clinicians or the IT function.
3.3	Development of our innovation and technology strategy
	4. Financial Performance
4.1	Maintain sound financial control working to a surplus plan for the 14th year running, albeit caveated with significant remaining risks – both from Commissioner SLAs and internal pressures.
4.2	Delivery of 16/17 income plans and Cost Improvement Programme.
4.3	Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital.

5. Organisational and System Strategy and Transformation	
5.1	Complete a full refresh of our Trust strategy in Autumn 2016, along with the development of a new governance structure for strategic planning and implementation, to ensure that we are aligned to the system wide Sustainability and Transformation Plan (STP) and maintain the recommendations of the Well Led Governance Review.
5.2	Further evaluate opportunities to continue to develop our specialised services portfolio throughout 2016/17.
5.3	Development of the system Sustainability and Transformation Plan - take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.
6. Workforce and Engagement	
6.1	Further development and implementation of strategic workforce plans, linked to the evolving STP.
6.2	Achieve NHS Improvement's locum and agency expenditure requirements.
6.3	Successful implementation of workforce recruitment and retention plan.
6.4	Delivery of agreed workforce KPIs.
6.5	Development and delivery of staff engagement plan, linked to the learning from the results of the 2015 staff survey.

4. Principal Risks

- **Principal Risk 1:** Failure to maintain the quality of patient services.
- **Principal Risk 2**: Failure to develop and maintain the Trust estate.
- **Principal Risk 3:** Failure to act on feedback from patients, staff and our public.
- **Principal Risk 4:** Failure to recruit, train and sustain an engaged and effective workforce.
- **Principal Risk 5:** Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.
- **Principal Risk 6:** Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.
- **Principal Risk 7:** Failure to maintain financial sustainability.
- **Principal Risk 8:** Failure to comply with targets, statutory duties and functions.

Risk scoring = consequence x likelihood

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

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

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

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

	Likelihood				
Likelihood score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic					
4 Major					
3 Moderate			1, 3, 5, 7, 8	4	
2 Minor			6	2	
1 Negligible					

University Hospitals Bristol Control Framework

Vision, organisational priorities and outcomes, aims, values and behaviours, policies and procedures, budget and budget control, performance measures and trajectories and management of associated risks

Leadership → Staff → Systems and Processes → Finances → Technology

Controls and Assurance Mechanisms

High Quality Care

***Controls*: evidenced within**

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

***Assurance*: gained via**

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

Performance Management

***Controls*:**

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

***Assurance*: gained via**

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

Risk Management

***Controls*:**

- Risk management strategy and Policy
- Board Assurance Framework
- Corporate Risk Register
- Divisional Risk Register

Reports to the Board, Senior Leadership Team and sub committees

Policies and Procedures

Scheme of Delegation

***Assurance*: gained via**

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

Levels of Assurance

VISION AND CORPORATE PRIORITIES

REGULATORS

EXTERNAL AUDIT

First Line
Operational

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

Second Line
Risk and Compliance

Assurance and Oversight Committees

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

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

Third Line
Independent

- Internal Audit Plan 2016-17
- External Audits (eg. Annual Accounts and Annual Report)
- CQC Inspections/NHS Improvement
- Visits by Royal Colleges
- Independent Reviews – Verita Investigations
- Independent Review Paediatric Cardiac Surgery
- Well Led Governance Review

Key

The Assurance Framework has the following headings:

Principal Risk	What could prevent the objective from being achieved? Which area within organisation does this risk primarily impact on – clinical, organisational or financial?
Key Controls	What controls / systems do we have in place to assist secure delivery of the objective?
Form of Assurance	How are the controls monitored?
Level of Assurance	What does the evidence tell us in relation to the effectiveness of the controls / systems which are being relied on
Gaps in Controls	Gaps in control: Are there any gaps in the effectiveness of controls/ systems in place?
Gaps in assurance	Where can we improve evidence about the effectiveness of one or more of the key controls / systems which we are relying on?
Actions Agreed for any gaps in controls or assurance	Plans to address the gaps in control and / or assurance
Current Risk Rating	Assessment of the risk taking into account the strength of the controls currently in place to manage the risk
Direction of travel	Are the controls and assurances improving? ↑ ↓ ↔
Ref	This should include the reference to the Strategic Priorities and also align with the top corporate risk register

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

OPERATIONAL PLAN 2016/17 PRIORITIES	**Quality and Care** • Delivery of 12 Quality Objectives • Achievement of our 'Sign up to Safety' priorities • Delivery of the two objectives identified in the Medical Royal Colleges 2014 "*Guidance for taking responsibility: Accountable clinicians and informed patients* • Participate in the annual publication of avoidable deaths. • Demonstrate affordable progress towards delivery of the four key seven day services standards by 2020. • Further embed hosted Operational Delivery Networks (ODN), including paediatric neurosciences, Congenital Heart Disease and Critical Care. • Delivery of agreed specialised and local CQUIN targets.	**Non-Financial Performance** • Deliver the agreed performance trajectories for Referral To Treatment (RTT), 6 week diagnostic, Cancer and the Accident and Emergency (A&E) four hour waiting standard. • Effective cross sector and patient flow remains a challenge due to external system wide factors. Work actively with our partners and through the STP, Better Care Programme and Urgent Care Network to develop and implement plans to improve flow and materially reduce the number of patients with a delayed discharge. • Successful implementation of the Orla Healthcare community based 'virtual ward'.

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Principal Risk 1 - *Failure to maintain the quality of patient services.*	Serious Incident process Risk Management Strategy and Policy Professional Standards and Code of Practice/Clinical Supervision Whole system approach being delivered through the Urgent Care Network. QIA process for savings schemes meeting specific criteria Trust Values Quality Objectives Productive theatre initiative to reduce the number of cancelled Operations. Sign up to Safety Campaign Business Continuity and Emergency planning arrangements NICE guidelines self-assessments/ Clinical Audit Programme. Monitoring of RTT Performance Monitoring of Access Performance: • RTT Operations Group / RTT Steering Group • Cancer PTL Meetings / Cancer Performance Improvement Group / Cancer Steering Group • Emergency Access Performance Improvement Group/Urgent Care Steering Group • Divisional Access performance scorecards • Divisional Monthly Reviews with Executive Team	Reports to Quality and Outcomes Committee. Annual Governance Statement providing assurance on the strength of Internal Control regarding risk management processes, review and effectiveness Annual Report. Quality metrics demonstrate that despite operational pressures, our patients are receiving good quality care despite delays in their discharge. Quality Account. Quality Strategy External - EPRR assessment (NHSE) Internal - self assessment Clinical Quality Group/Clinical Audit Group reporting mechanisms. Reports to SDG, SLT Trust Board	Internal performance reports form first line assurance. Reports to: • Trust Board, • Service Delivery Group • Senior Leadership Team • Audit Committee • Quality & Outcomes Committee • Clinical Quality Group Form second line assurance External audit/review forms third line assurance. Formal confirmation received from NHSE of improved EPRR position (from non-compliant to partially compliant).		Emergency Preparedness, Resilience and Response (EPRR) externally assessed as partially compliant.	There is a work programme in place to achieve full EPRR compliance. This is reviewed quarterly by Civil Contingencies Steering Group and will next be assessed in September by the CCG and NHS England where we expect to reach full compliance. Further development of the Quality Impact Assessment process to cover /support changes to service provision/stopping of services	Chief Nurse & Chief Operating Officer **Quality and Outcomes Committee**	Possible x Moderate 9	↔

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Principal Risk 3 - *Failure to act on feedback from patients, staff and our public.*	**Stakeholder feedback:** Participation in the national patient surveys. Comments cards available on wards and in clinics. The Friends and Family Test administered at discharge in day case, inpatient and Emergency Department settings Teams of volunteers visit wards to interview patients whilst at UH Bristol A monthly post-discharge inpatient, outpatient, parent and maternity survey is undertaken and volunteers who undertake the 15 Step Challenge in wards. Patient Stories are a monthly item on the Trust Board agenda. **Staff feedback:** National Staff Survey Regular staff workshops are held to gather feedback and views from staff members in an informal setting. The Staff Friends and Family Test. Other, local or more specific surveys/focus groups also take place sickness and turnover). Monitoring of progress in the achievement of KPI's. Happy App in clinical areas initially.	Programme of regular quality reports and reporting to committees and Board including: patient safety, workforce; patient experience; serious incidents; complaints; and trust wide learning Quality meetings with commissioners and information shared as part of the annual quality schedule; including serious incident investigation outcomes. Regular attendance of Trust staff at local authority overview and scrutiny committee meetings. Appointed governors on the Council of Governors from partner organisations including the local authority and universities. Council of Governor meetings Governor focus groups Non-Executive Director Counsel meetings Governors log of queries and concerns Internal Audit of Staff Engagement	Regular reports and KPI's form first line assurance. Reports to: • Trust Board, • Quality & Outcomes Committee • Meeting with Commissioners • Local Authority Overview & Scrutiny Committee • Council of Governor Meetings • Governor Focus Groups • NED Counsel Form second line assurance Internal Audit forms third line assurance.	Happy App not in all areas.	Although some of the patient feedback collected corporately is made available directly to inpatient wards (e.g. via posters and circulation of spreadsheets), there is an opportunity to make this more rapidly available and more accessible to ward staff.	The Patient Experience & Involvement Team is continuing to explore a solution to this, with a focus on responsiveness to patients' needs. Funding has been identified to procure a new patient feedback system during 2016/17. Roll out Happy App across whole organisation.	Chief Nurse & Director of Human Resources and Organisational Development **Quality and Outcomes Committee**	Possible x Moderate 9	↔

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

OPERATIONAL PLAN 2016/17 PRIORITIES	**IM&T and Estates** • Continue with the necessary upgrading of the Estate along with medical equipment replacement • During the coming year we will continue to deploy new digital capability throughout the Trust, further embedding and extending existing functions with particular emphasis on: ○ Rolling out digital case notes across our other hospital sites together with the implementation of e-forms and workflow automation; ○ Commencing delivery of a new nursing e-observations and replacement e-rostering systems; ○ Going live across the Trust with electronic prescribing and medicines administration; ○ Providing more convenient access to our systems and services through the wider use of mobile technology and telehealth techniques; and ○ Delivering the objectives of the Clinical Utilisation Review (CUR) by using existing systems rather than purchasing duplicate systems which are not supported by Clinicians or the IT function.

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Principal Risk 2 - *Failure to develop and maintain the Trust estate*	Incident reporting and risk assessments at Divisional and Departmental level. Regular inspections Internal Audit work programme. Recent PLACE (Patient-led assessments of the care environment) inspection reports did not surface any key risks.	Reports to Audit Committee, Risk Management Group, Divisional Boards and Health and Safety Groups Findings from inspections are included in reports to assurance committees. External audit of the Trust's Annual Accounts and Annual Report. Findings from independent assessments are included in reports to assurance committees.	Regular inspections form first line assurance. Reports to: • Trust Board, • Audit Committee • Divisional Boards Form second line assurance External assessment and audit forms third line assurance.	No significant gaps in controls.	Incident reporting in relation to aspects of estate, reveal limited assurance in respect of drain blockages and roofs	Operational and capital works programme for 16/17 provides resources to address issues in relation to drains and roofs (both to improve controls and mitigate future risks).	Chief Operating Officer **Service Delivery Group**	Major x Unlikely 8	↔

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

OPERATIONAL PLAN 2016/17 PRIORITIES	**Workforce and Engagement** • Further development and implementation of strategic workforce plans, linked to the evolving STP. • Achieve NHS Improvement's locum and agency expenditure requirements. • Successful implementation of workforce recruitment and retention plan. • Delivery of agreed workforce KPIs. • Development and delivery of staff engagement plan, linked to the learning from the results of the 2015 staff survey.

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Principal Risk 4 - *Failure to recruit, train and sustain an engaged and effective workforce.*	HR Policies and Procedures Clear accountability at Divisional level for staff engagement Trust wide learning opportunities all advertised on Connect Monthly compliance reports on Essential Training are sent to Divisions and include trajectories to achieve compliance. Appraisal Process/Personal Development Plan moving towards E-Appraisal in May 2017 in order to measure quality in the future Corporate and Local Induction Quality objective on staff engagement Agency Controls Group. Divisional Reviews including performance against workforce plans and HR KPI's to improve staff experience commencing in April 2017 Health and Wellbeing Programme (to include delivery of the NHS Staff Health and Wellbeing CQUIN 2016/17). Comprehensive development plans at Divisional and trust wide level. Staff Recognition Awards and rewards framework being developed	Metrics in relation to key controls are reviewed by the Senior Leadership Team, QOC and Trust Board: Staff survey results/ Exit Interviews. Review of ET compliance. Annual learning and development report. Health and Safety Reports. Friends and Family Test. Weekly returns agency staffing. Agency action plan. Reports from New E-Appraisal system	Regular internal reports form first line assurance. Reports to: • Trust Board, • Senior Leadership Team • Quality Outcome Committee • Workforce and OD Form second line assurance .	Metrics indicate we have a risk around staff retention, although improving.	Limited assurance primarily around achieving compliance with essential training rates.	Refresh of the Workforce and OD Strategy. Mid-year review of workforce KPIs to understand forecast out turn.	Director of Workforce and Organisational Development **Trust Board**	Major x Possible 12	↔

STRATEGIC PRIORITY 4 : We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.									
OPERATIONAL PLAN 2016/17 PRIORITIES	• Development of our innovation and technology strategy								
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Principal Risk 5 - *Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.*	Memorandum of agreement with University of Bristol. Joint Posts. Clinical Networks. Research Standing Operating Procedures. Process in place for corrective and preventative actions where breaches of GCP/protocol are identified to support learning by PI/CI and research team. Regular review of research recruitment on a trust-wide level. Key Performance Indicators at divisional level (bed holding only) finalised for regular divisional review. Staff engagement embedded in planning service improvement and transformation work via direct involvement and variety of communication mechanisms. Transformation and other service improvement leads networked across the divisions – role includes identifying and supporting local innovation. Partnership with the Academic Health Science Network to train a cohort of improvement coaches to add capacity to this support network. Programmes such as Bright Ideas. During 16/17 review of approach to supporting innovation across the Trust completed and Innovation & Improvement strategy developed Research grants, Research Capability Funding, commercial and delivery income maintained. SPAs recognised in consultant job plans.	Trust Research Group. Divisional research committees/groups. Regular reports to the Board KPI reviews (trust wide & divisional) Board metrics. Audit/inspections. Education and Training Annual Report Project steering groups /reporting to Transformation Board & Senior Leadership Team. Regular reports to the Trust Board. Evidence of wide range of innovation and improvement programmes completed/underway. Good response to Bright Ideas/Trust Recognising Success awards. NIHR award £21m over 5 years for Biomedical Research Centre to Trust and UoB partnership	Regular reviews form first line assurance. Reports to: • Trust Board, • Quality & Outcomes Committee • Divisional Groups • Transformation Board Form second line assurance Internal/External Audit/inspections forms third line assurance.	Medicine divisional research meetings now in place; Surgery, Head and Neck divisional research committee/group under review, but due to change in Clinical Chair timelines to be revisited during Q4 Evidence that Improvement & Innovation approach promotes and encourages innovation and improvement, in order that staff with good ideas can bring them to life, so that patients, staff, the Trust and the wider NHS will benefit Within this, there are three aims: 1. To support and connect people with our structured programmes 2. To provide support to staff with good ideas outside these programmes 3. To build capability to support staff to lead improvement independently of these programmes	Clear mechanism for protecting time for non-medical PIs recruiting to National Institute of Health Research portfolio trials not in place. Implementation timeline into 2017/18 needed to provide assurance.	Work in progress to address the divisional research committee's gaps. Implementation of plan for supporting Innovation & Improvement in line with action plan agreed by Transformation Board and supported by SLT.	Medical Director **Trust Board**	Moderate x Possible 9	↔

STRATEGIC PRIORITY 5 : We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.

OPERATIONAL PLAN 2016/17 PRIORITIES

Organisational and System Strategy and Transformation

- Complete a full refresh of our Trust strategy in Autumn 2016, along with the development of a new governance structure for strategic planning and implementation, to ensure that we are aligned to the system wide Sustainability and Transformation Plan (STP) and maintain the recommendations of the Well Led Governance Review.
- Further evaluate opportunities to continue to develop our specialised services portfolio throughout 2016/17.
- Development of the system Sustainability and Transformation Plan - take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Principal Risk 6 - *Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.*	Executive to Executive meetings with NBT. Partnership Programme Board with NBT. Partnership meeting and MOU in place with UoB 4 way Partnership meeting with NBT, UoB, UWE Chief Executive agreed as local system leader for STP for BNSSG with other Executives playing lead roles within the STP processes. Range of senior staff involvement in NS Sustainability Board programme Staff involved in wide range of external activities e.g. Bristol Health Partners, Better Care Bristol, CLAHRC West, BNSSG System Leadership Group. Implementation of new Strategic Governance Process Development of new internal STP Leads meeting to improve visibility of staff engagement in external activities, reporting into Strategy Steering Group	Board Partnership Reports. Reports to Trust Board. Staff survey feedback. Appraisal process KPI. "Critical Friend" approach being considered within STP process. Tender Framework in place from April 2016 explicitly addressing partnership opportunities. Evidence in recent tenders that Trust is a sought after partner - Children's Community Services; Sexual Health National feedback on Sustainability and Transformation Plan processes and leadership. Bristol Research Centre successful bid for NIHR funding 2016 No indication in current self-assessment within STP of adverse perceptions.	Internal reviews and monitoring of KPI's form first line assurance. Reports to: • Trust Board, Form second line assurance	Complete visibility of scope of staff engagement in external activities challenging and not necessarily required.	No significant gaps. Ability to harness soft information.	None.	Director of Strategy and Transformation **Trust Board**	Moderate x Unlikely 6	↔

STRATEGIC PRIORITY 6 :
We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal

OPERATIONAL PLAN 2016/17 PRIORITIES

Financial Performance

- Maintain sound financial control working to a surplus plan for the 14th year running, albeit caveated with significant remaining risks – both from Commissioner SLAs and internal pressures.
- Delivery of 16/17 income plans and Cost Improvement Programme
- Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital.

Principal Risk description	Key Controls	Form of Assurance	Level of Assurance	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Principal Risk 7 - *Failure to sustain financial sustainability*	Budgetary control systems in place. Scheme of delegation and agreed budget holders. Financial Control Procedures. Standing Financial Instructions. Monthly Divisional CIP reviews. Monthly Finance & Operational Divisional Performance reviews. Divisional Board monthly scrutiny of operational and financial performance. Monthly review of financial performance with Divisional budget holders. Monthly Divisional contract income and activity reviews, savings reviews. Monthly savings work stream reviews. Monthly review by Savings Board Divisional control of vacancies and procurement monitored at monthly performance meetings. Income and Expenditure performance, capital expenditure, the statement of financial position and cash flow statement scrutiny at the Finance Committee.	Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital. Regular Reporting to the Finance Committee and Trust Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board. Monthly Pay Controls Group, Non Pay Controls Group and Nursing Controls Group scrutiny of Divisions performance. Detailed monthly submission of financial performance submitted to the Regulator, NHS Improvement. Strong statement of financial position. Liquidity metric of 1 (highest) and Use of Resources Rating of 1 (highest rating) for 2016/17 year to date.	Capital expenditure for year to date at 85% within the 85% to 115% tolerance specified by the Regulator. Regular divisional board scrutiny and reviews form first line assurance. Reports to: • Trust Board, • Finance Committee • NHSI Form second line assurance External review of financial position forms third line assurance.	Evidence that staffing controls are weak in some areas Evidence that income and activity performance controls are weak e.g. inpatient activity planning and delivery performance. Weak assurance in Divisions given adverse positions to Operating Plans largely due to income underperformance, shortfall in savings delivery and high levels of nursing and medical expenditure.	Lack of assurance that pay expenditure controls are fully effective. Lack of assurance that activity capacity planning and income performance controls are fully effective. Lack of assurance that new savings ideas will be developed. Lack of assurance that capital expenditure controls for operational capital and major medical equipment are fully effective Limited assurance that all controls are effective in light of continued spend above plan in some areas e.g. agency spend.	Prioritised Executive review at Divisional Reviews. Transformation Board and productivity review process via Savings Board to identify further savings. Trust Capital Group has been established to scrutinise delivery of capital plans and has met since November,	Chief Operating Officer Director of Finance **Savings Board** **Monthly & Quarterly Divisional Reviews** **Finance Committee**	Moderate x Possible 9	↔

STRATEGIC PRIORITY 7 : **We will ensure we are soundly governed and are compliant with the requirements of our regulators**									
OPERATIONAL PLAN 2016/17 PRIORITIES	• Implementation of the recommendations from the Well Led Governance Review								
Principal Risk description	**Key Controls**	**Form of Assurance**	**Level of Assurance**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Principal Risk 8 - *Failure to comply with targets, statutory duties and functions*	Trust Board and all committees have an annual forward plan aligned to their terms of reference, Trust's Standing Orders and Standing Financial Instructions to ensure appropriate annual reporting against plans is in place. Regular reporting to NHS Improvement following Board approval. Monitoring of CQC inspection action plans via Clinical Quality Group, Senior Leadership Team, QOC	Annual Report, Annual Governance Statement, and Annual Quality Report, Annual Account submitted to Trust Board. NHS Improvement returns signed off by the Trust Board. Internal Audit Reports on Governance, risk management and financial accounts reported to Audit Committee. Self-assessment. Monthly Board Reports. Performance and Finance Reports at each Board Meeting. Committee Reports at each Board Meeting. Independent reports from CQC on Inspection Visits.	Regular reviews form first line assurance. Reports to: • Trust Board, • Quality & Outcomes Committee • Audit Committee Form second line assurance CQC Inspection Report provides third level assurance into areas inspected.	No significant gaps in control.	Partial assurance of effectiveness of controls, in light of on-going failure of some standards.	None.	Chief Executive **Trust Board**	Moderate x Possible 9	↔

Appendix 2: Links to the Corporate Risk Register

Strategic Objective	Principal Risk	Corporate Risk Register	Current Risk Rating
STRATEGIC PRIORITY 1: We will consistently deliver high quality individual care, delivered with compassion.	**Principal Risk 1:** Failure to maintain the quality of patient services.	**423 -** Risk that length of stay does not reduce in line with planning assumptions resulting in an increase in bed occupancy. **588** - Risk of patients coming to harm or having sub-optimal outcomes due failure to recognise and respond to deterioration. **674 -** Risks of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff. **856 -** Risk that the emotional & Mental Health needs of children and young people are not being fully met. **888** - Risk of failure to deliver the agreed recovery trajectories for all RTT standards **910** - Risk to the provision of timely and efficient care and patient experience due to being held in the ambulance queue **919 -** Risk that the Trust does not meet the national standard for cancelled operations. **932 -** Risk of failure to deliver care that meets National Cancer Waiting Time Standards. **949 -** Risk that perinatal mental health services are not adequate to the needs of those requiring to access the service. **961 -** Risk of harm to patients awaiting discharge, once medically fit **1497 -** Risk of Delays in transfer of North Somerset patients due to temporary closure of Clevedon Hospital. **1595 -** Risk that patients detained under s136 may be brought to ED due to lack of capacity in community provision **1598 -** Risk of Patients Falls Resulting in Harm. **1640 -** Risk of poorer quality service for patients due to delays with reporting of histology samples following service transfer.	9 ↔
	Principal Risk 3: Failure to act on feedback from patients, staff and our public.	No corporate risk identified	9 ↔
STRATEGIC PRIORITY 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	**Principal Risk 2:** Failure to develop and maintain the Trust estate.	No corporate risk identified	8 ↔
STRATEGIC PRIORITY 3: We will strive to employ the best staff and help all our staff fulfil their individual potential**.**	**Principal Risk 4:** Failure to recruit, sustain an engaged and effective workforce.	**674 -** Risks of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff. **793 -** Risk of work related stress affecting staff across the organisation. **921 -** Risk of not achieving 90% compliance for Essential Training for all Trust staff.	12 ↔
STRATEGIC PRIORITY 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	**Principal Risk 5:** Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	No corporate risk identified	9 ↔
STRATEGIC PRIORITY 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	**Principal Risk 6:** Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	No corporate risk identified	6 ↔
STRATEGIC PRIORITY 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	**Principal Risk 7:** Failure to sustain financial sustainability.	**674 -** Risks of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff. **951** - Risk financial penalties in excess of planned position, due to greater under-performance against key indicators **959 -**Risk that Trust does not Deliver 2016/17 financial plan due to Divisions not achieving their current year savings target **1843** - Trust's 2016/17 Operational Plan Control Total surplus of £15.9m	9 ↔
STRATEGIC PRIORITY 7: We will ensure we are soundly governed and are compliant with the requirements of our regulators.	**Principal Risk 8:** Failure to comply with targets, statutory duties and functions.	**801 -** Risk that the Trust does not maintain a GREEN Monitor Governance Rating **869 -** Risk of Reputational Damage Arising From Adverse Media Coverage of Trust Activities **919 -** Risk that the Trust does not meet the national standard for cancelled operations **932 -** Risk of failure to deliver care that meets National Cancer Waiting Time Standards **970 -** Potential risk of non-compliance with some of Monitor's core 4-hour Wait Clinical Indicator **1530 -** Risk of adverse operational impact arising from unplanned closure of Weston Emergency Department due to staffing shortages	9 ↔

Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	8
Meeting Title	Trust Board	**Meeting Date**	28 April 2017
Report Title	Research and Innovation Report		
Author	David Wynick, Consultant		
Executive Lead	Sean O'Kelly, Medical Director		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

The purpose of this report is to provide an update on performance and governance for the Board.

Key issues to note

See executive summary in report.

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

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

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

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

Impact Upon Corporate Risk
N/A

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

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

Executive Summary

Performance:

We continue to maintain a good level of performance in achieving the 70 day benchmark set by the NIHR, currently standing in 8th position out of 20 providers in our league. In order to maintain performance, project work is underway within Research & Innovation with relevant research teams to review and streamline set up activities.

Following on our focussed efforts to increase performance of our trials recruiting patients to time and target we have seen a further improvement for our closed commercial trials achieving 47% (from 40% previous quarter). This places us at 17/22 in our league.

We have received our funding allocation from the West of England Clinical Research Network. We have received a 2% cut, but alongside this we received a small increase in research capability funding, which allows for stability in 2017/18.

Future CRN allocations will be made based on financial year performance (not mid-year cut). Full details of the mechanism for the allocation are not yet available, however a new financial principles paper will be developed by the LCRN during 2017/18, and this will determine how partner organisation allocations are made in 2018/19.

Partnerships and Governance:

The NIHR Biomedical Research Centre has now commenced (start date 1st April 2017). The contract has been signed and the partnership agreement is in preparation. Initial appointments are under way. Governance structures and reporting routes are under discussion and will be agreed with reference to UHBristol as contract holder, in order to ensure the appropriate mechanisms for assurance are in place.

Benchmarking:

Measure	***Value/number***	***Value/number (previous)***	***Place (current)***	***Place (previous)***	***Frequency of update***	***Source***
Research capability funding	***£1,691,941***	***£1,615,303***	***12***	***15***	***Annual***	***NIHR***
Infrastructure funding (BRC/U)	***£20,892,445***	***11,470,180***	***11/20***	***15/22***	***Every 5 years***	***NIHR***
Number of patients recruited	***5,357***	***4,429***	***N/A***	***N/A***	***Every year***	***Quality account***

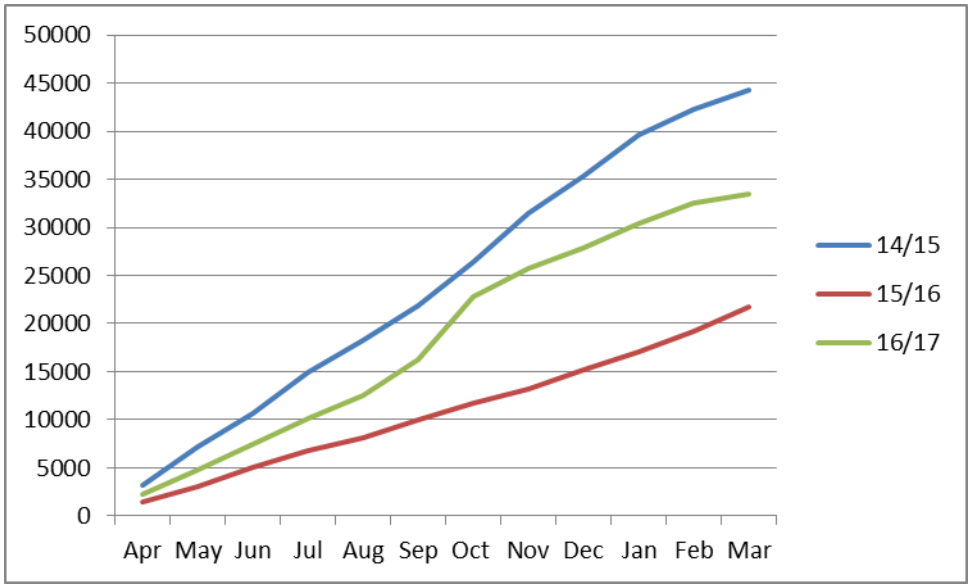
Overview

Successes	Priorities
• Performance in initiating and delivering research continues to be maintained at a good level for 6 successive quarters. Performance in delivering commercial research has improved with renewed focus on that indicator.	• Focus attention on optimising our performance in delivering research to time and target, for both commercial and non-commercial trials. • Support the new NIHR BRC COO in her role so that she can work effectively • Develop communications activities in order to raise the profile of research for both staff and patients. • Appoint to two vacancies in R&I core team in order to mitigate risk of fall in performance in initiating and delivering research
Opportunities	**Risks and Threats**
• Work with divisional staff to identify important clinical questions that might be developed to generate high quality grants for submission to NIHR and other funding bodies. Longer term this will help support our research infrastructure through research capability funding and delivery funding. • Undertake work with neighbouring trusts, in particular NBT, to identify areas of research/studies already being carried out that can be opened in UHBristol. Introduce systems to allow easy identification of such studies as we receive them, and flag to other partners. • Review our portfolio and aim to increase the proportion of band 2 research taking place (observational), compared to band 3 (complex, interventional). • Identify clinical areas where commercial research activities might be exploited in order to generate income.	• The CRN has adjusted the time period over which the activity cut is taken that determines financial allocations (from mid-year to end of financial year). This should not make a material difference going forwards, and we are working with the CRN to develop principles that support fair allocation of funding to partner organisations. • We have been unable to appoint to one of our vacancies in the R&I core team and a second member of staff has subsequently resigned. Lower levels of staffing have the potential to reduce our setup times for research and impact on performance initiating and delivering research.

Performance Overview

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

a) Cumulative weighted recruitment into NIHR portfolio studies in 16-17. [NB. There is a 6 week lag in recruitment data becoming visible on the system.]



Please note the reporting period in this graph is based on what the NIHR use to determine funding allocations. This has recently been updated to financial year.

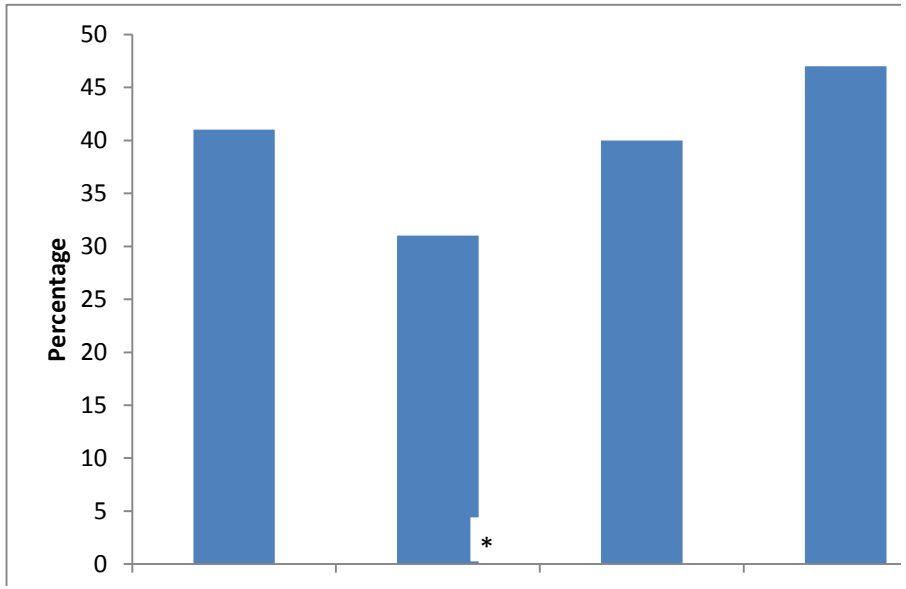
b) Performance in meeting the 70 day first patient first visit benchmark adjusted by NIHR in comparison to other Trusts

NIHR PID report- latest received Q3 16/17

91%	88%	84%	88%
Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17

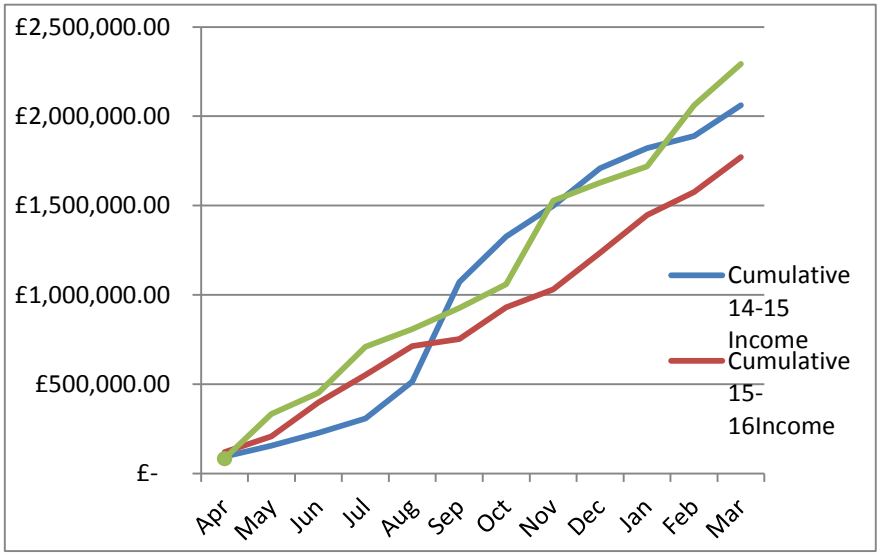
Green: >81.4% (Upper Quartile)
Red: <70.7% (Median)

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

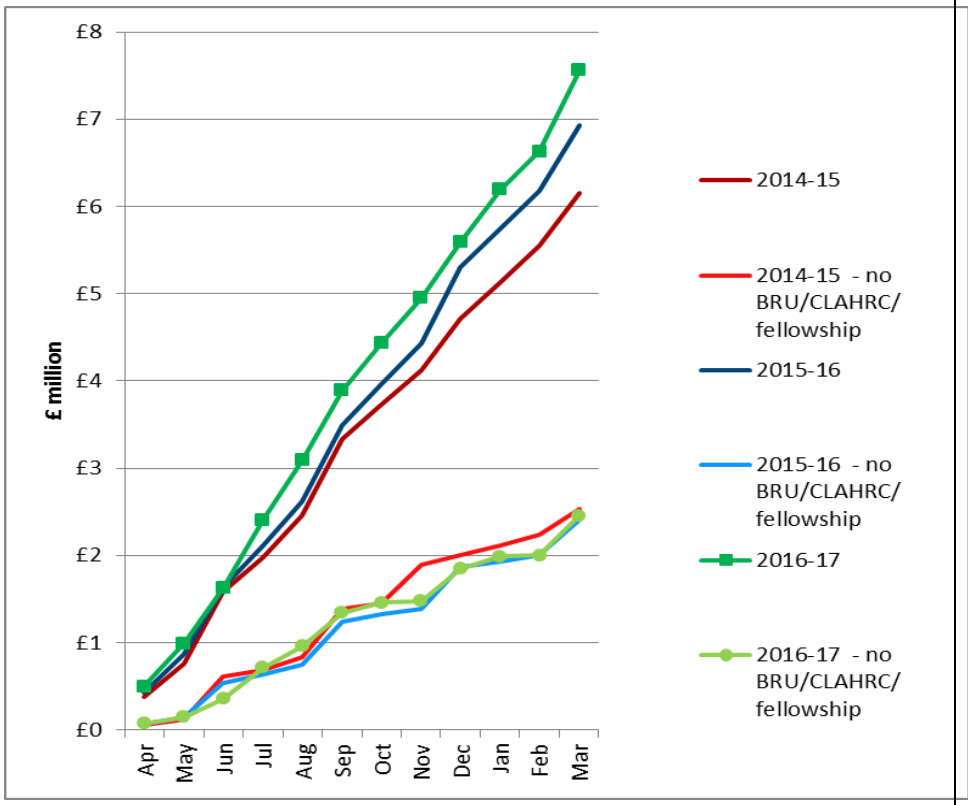


*DH changed the way the reporting metrics were analysed, effective Q1 16/17

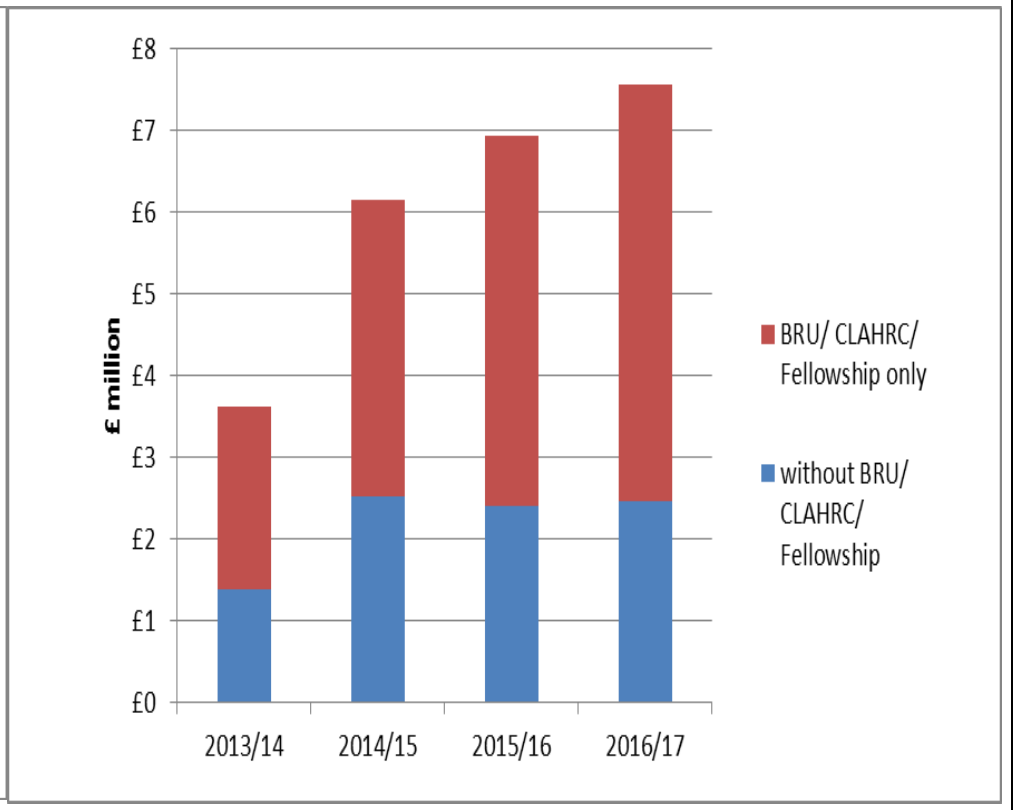
d) Monthly commercial income



NIHR monthly grant income – year on year comparison



NIHR grant income – drives research capability funding.



Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	9
Meeting Title	Trust Board	**Meeting Date**	28 April 2017
Report Title	Trust's Art Strategy		
Author	Robert Woolley, Chief Executive		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

The attached paper articulates the case for development of a Trust arts strategy. It is designed to inform discussions between the Board and the Charitable Trustees about the benefits of developing a Trust-wide programme of arts activities at this point in time and the approach to doing so.

Key issues to note

There is good evidence, accepted by the Department of Health and the British Medical Association, of a positive connection between the arts and health, and that patients and staff benefit from being in a conducive environment enhanced by good design and art.

There is a strong case for development of a formal arts strategy at this time in pursuit of the patient benefit, the evident contribution to staff health and well-being and the potential for supporting wider community well-being through public involvement.

Recommendations

Members are asked to:
 	
• **Express full support for the development of a Trust-wide arts strategy at this time, as a means of:**
  ○ **supporting the psychological and social needs of our patients and potentially improving their outcomes and relations with healthcare professionals**
  ○ **fostering an even stronger relationship with staff, with patients and with the civic community.**

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

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

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

Impact Upon Corporate Risk
N/A

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

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

University Hospitals Bristol
NHS Foundation Trust

THE CASE FOR A TRUST ARTS STRATEGY

this is the great error of our day in the treatment of the human body, that physicians first separate the soul from the body

(Plato, *Charmides*, ch. 154-160, 380 B.C., trans. Benjamin Jowett, 1892)

1. INTRODUCTION

This paper articulates the case for development of a Trust arts strategy. It is designed to inform discussions between the Board and the Charitable Trustees about the benefits of developing a Trust-wide programme of arts activities at this point in time and the approach to doing so.

2. THE CASE FOR THE ARTS IN HOSPITAL

The case that there is a connection between the arts and health, and that people benefit from being in a conducive environment enhanced by good design and art, as well as from active engagement in creative pursuits, has been long made. Florence Nightingale herself asserted that environmental factors can influence patient recovery (*Notes on Nursing*, 1859).

An evidence review published by the Arts Council in 2004 showed "a number of medical areas in which the research studies have shown clear and reliable evidence that clinical outcomes have been achieved through the intervention of the arts" (*Arts in health: a review of the medical literature*, Dr Rosalia Lelchuk Staricoff, Arts Council England, August 2004).

The Department of Health commissioned a Strategic Review of Arts and Health, and accepted its findings, publishing *A Prospectus for Arts in Health* in 2007, which contains guidance and examples of best practice. The Department's policy is that the arts have a major contribution to make to wellbeing, health, healthcare provision and healthcare environments, to the benefit of patients, service users, carers, visitors and staff, as well as to communities and the NHS as a whole.

In 2011, the British Medical Association stated (*Psychological and Social Needs of Patients*, 2011):

> *Creating a therapeutic healthcare environment extends beyond the elimination of boredom. Arts and humanities programmes have been shown to have a positive effect on inpatients. The measured improvements include:*
>
> - *inducing positive physiological and psychological changes in clinical outcomes*
> - *reducing drug consumption*

- *shortening length of hospital stay*
- *promoting better doctor-patient relationships*
- *improving mental healthcare*

The report goes on to identify the following range of activities which may contribute to meeting patients' psychological and social needs:

- recreational activities
- humour
- creative writing
- storytelling and poetry
- music
- visual art
- dancing and singing.

2.1 CONTEXT: UNIVERSITY HOSPITALS BRISTOL

2.1.1 Implicit arts strategy

The Trust has recognised the importance of incorporating art into its physical environment, most obviously in the internal design of the new Bristol Royal Hospital for Children in 2001 but also as an integral part of major capital schemes over the last 8 years, often supported by the Charitable Trustees, including:

- the Bristol Heart Institute development
- the Bristol Haematology and Oncology Centre refurbishment
- the Teenagers and Young Adults with Cancer unit
- the Bristol Royal Infirmary Terrell Street extension
- the BRI Queen's Building facade
- the BRI King Edward's Building new sanctuary, mortuary and bereavement suite.

A public arts strategy was prepared for the Trust in June 2011by arts consultancy, Willis Newson, but related solely to the planned redevelopments of the Bristol Royal Infirmary and the Bristol Royal Hospital for Children.

This implicit strategy of exploiting individual construction or refurbishment projects has resulted in a patchwork of arts interventions and a visible mismatch between old and new environments across the Trust.

It has not supported holistic management of the external appearance of the Trust's estate nor a consistent approach to public arts, such that special steps have had to be taken in the past to ensure corporate sign-off of proposed public artworks and, even then, major exterior design decisions have had limited corporate oversight.

The default strategy has encompassed the physical environment, to the exclusion of the other beneficial arts activities identified by the British Medical Association (although staff have adopted best practice interventions to good effect in limited clinical areas, such older people's health).

2.1.2 Relationship to other Board strategies

In recent years, the Trust has consciously pursued closer engagement with its own staff, with patients and the public, and with the wider health and civic community, which has arguably contributed both to the recent achievement of an outstanding rating from the Care Quality Commission and to its standing as a system leader.

The potential of a well managed and fully supported Trust arts programme to build on these successes and foster an even stronger relationship with staff, with patients and with the civic community is substantial and timely.

This is strong enough cause to propose development of an arts strategy at this time, quite apart from pursuit of the patient benefits outlined above, the evident contribution to staff health and well-being and the potential for supporting wider community well-being through public involvement.

3. IDEA GROUP

In 2016, a sub-group of the Senior Leadership Team was formed called the Image, Design, Environment and Arts Reference Group, with the following membership:

- Chief Executive
- Director of Strategy and Transformation
- Director of Facilities and Estates
- Chief Executive of Above and Beyond Charities
- Non-Executive Director representative
- Governor representative
- Head of Communications
- Clinical Division representatives
- Staffside representative
- Lay representative

Working with Above and Beyond, the group has researched the approach to the arts taken by other Trusts and has supported the proposition that a Trust arts strategy be formally commissioned by the Board, as set out in this paper, to guide the development of a wide-ranging programme of arts activities which will:

- Improve the environment of the hospitals for the benefit of staff, patients, visitors and the local community
- Promote patient well-being through art and design
- Create a stimulating atmosphere to support the recruitment and retention of staff.

4. PROPOSED APPROACH

The following proposals are drawn from published guidance, especially *Improving the patient experience: The art of good health* (Arts Council of Wales, July 2009) and are based on the principle that establishing a coherent arts programme will ensure projects are developed in the context of the Board's strategic objectives, will help projects grow in a sustainable rather than a piecemeal way, will be easier to raise funding for and will deliver wider benefits:

- Recruit an arts producer/director to establish, manage and fundraise for an ongoing programme of projects and events
- Mandate the arts producer/director to engage with stakeholders, research the needs of the Trust and develop a strategy for the arts programme
- Mandate the IDEA Group to manage the programme and widen the membership to include staff, artists, curators, community or patient representatives and partner agencies.
- Ensure that Trust staff feel ownership of the programme and commit to the principle of involvement of patients, service users and staff in the planning (and possible delivery) of projects.

4.1.1 Resources

There are opportunities to influence Trust spending priorities from some budgets (for instance, estates maintenance and refurbishment) to promote the holistic design approach described earlier in this paper but it would clearly be inappropriate to use designated income for clinical services, research or teaching to support the development and operation of an arts programme.

It follows that charitable fundraising is the primary means by which established arts programmes in other Trusts are resourced, although core funding for programme staff is sometimes provided internally.

Informal discussions with Above and Beyond have indicated a willingness in principle to support the development of an arts strategy and programme, provided there is full support from the Board and greater clarity about the proposed approach and the benefits that will be pursued. As a rule, the Trustees will not fund recurrent staffing costs.

In line with the approach outlined above, it is proposed that an application is made to the Trustees to support the creation of an arts producer/director post for one year, to produce the strategy and identify, as part of that exercise, how the programme will be sustained thereafter.

5. RECOMMENDATIONS

The Board is recommended to:

- Express its full support for the development of a Trust-wide arts strategy at this time, as a means of:

    1. supporting the psychological and social needs of our patients and potentially improving their outcomes and relations with healthcare professionals
    2. fostering an even stronger relationship with staff, with patients and with the civic community.

Robert Woolley
Chief Executive
20 April 2017

Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	10
Meeting Title	Trust Board	**Meeting Date**	28 April 2017
Report Title	Quality and Performance Report		
Author	• Xanthe Whittaker, Associate Director of Performance • Anne Reader, Head of Quality (Patient Safety) • Heather Toyne, Head of Workforce Strategy & Planning		
Executive Lead	Mark Smith, Chief Operating Officer/Deputy Chief Executive		
Freedom of Information Status		Open	

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

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

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

Recommendations
Members are asked to: • **Note** report for Assurance

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

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

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

Impact Upon Corporate Risk
N/A

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		26th April 2017		

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

April 2017

Executive Summary

There was a deterioration in performance against the national access standards this month, with performance falling below trajectory in several areas. The 92% Referral to Treatment (RTT) time standard was not achieved in the month, following four consecutive months of achievement. Whilst performance against the diagnostic 6-week waiting times standard was similar in percentage terms to that of February, the number of patients waiting over 6 weeks for a diagnostic test increased. Performance against the 62-day GP cancer standard was also below the 85% national standard in February. However, the 85% standard was met for internally managed pathways and performance was only marginally below the national average performance. Performance against the A&E 4-hour standard continued to be below the in-month performance trajectory, although there was an improvement in performance between February and March. The Overview page of this report provides further details of the priorities, risks and threats for the coming months, to access, quality and workforce standards, along with noteworthy successes in the period.

The number of patients on the new outpatient waiting list stayed similar to last month despite a sharp rise in referrals to outpatients. The rise in demand, which was across all sources of referrals, was offset by increased attendances in the period. The number of patients on the elective waiting list rose again in March, driven by the increase in outpatient attendances and resulting additions to the elective waiting list. This was a major contributory factor in the decline in RTT performance, with the number of patients on admitted RTT pathways rising by 160 in the month. The continued rise in the elective waiting list puts immediate recovery of the 92% RTT standard at risk. There are also ongoing risks to restoring achievement of the 6-week wait for a diagnostic test, due to a doubling of demand for Cardiac CT scans in February and March.

The overall level of emergency admissions into the Bristol Children's Hospital (BCH) in March was above the same period last year. This led to a decrease in in 4-hour performance at the BCH. Although the number of emergency admissions via the Bristol Royal Infirmary (BRI) Emergency Department (ED) was down by 3.4% on the same period last year, the total number of emergency admissions into the hospital was 7.9% up on the levels seen in March 2016. Although there continues to be a higher than average rate of discharge of long stay patients in the month, the number of current over 14 day stays in hospital at month-end has increased slightly. Encouragingly though, the percentage of emergency admissions for patients aged 75 years and over has fallen below last year's levels. This suggests we should see a reduction in the number of long stays and bed occupancy in a few weeks' time, once the existing cohort of long stay patients have completed their stays. There was a further decrease in the number of days patients spent outlying from their correct specialty ward in March. This may in part explain why flow out of the ED, and hence 4-hour performance, was worse than expected, with delays being introduced in accessing the 'right' bed for a patient. However, this focus on reducing the level of outlying improves patient experience, and will in time decrease length of stay. The number of operations cancelled at last minute for non clinical reasons fell in March, but remained above the 0.8% national standard.

There was only one change in performance against the headline measures of quality that sit within the Trust Summary Scorecard, which was the metric relating to the management of deteriorating patients moving to a Green rating. Performance against the other core measures of the quality of care provided by wards remains strong, despite the evident pressure from ongoing high levels of bed occupancy. In addition to the continued reduction in outlier bed-days, other noteworthy improvements in measures of quality in the period were a further month of no reported cases of *Clostridium difficile*, and the achievement of the non-purposeful omitted doses of listed critical medicines 1% standard in every month since February

2016. Performance against the metrics related to the management of patients who have sustained a fractured neck of continued at the same improved level seen last month. But the performance against these metrics continues to be disappointing, and the focus of significant attention.

Emergency pressures continue to provide context to the ongoing workforce challenges, especially bank and agency usage. Levels of staff sickness have, encouragingly, shown a further decrease this month, which should lead to a reduction in bank and agency spend. Turn-over rates have been maintained at the lower levels seen since October 2016, and vacancy rates remain Green rated and continue to fall, reflecting the continued strong internal focus on recruitment and retention of staff. 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
(March 2017)

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

NHS Choices

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

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

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

NHS Improvement Single Oversight Framework

For the latest month reported (i.e. March for A&E, RTT and 6-weeks and February for 62-day GP) the Trust failed to achieve the trajectory for the A&E 4-hours and 6-week diagnostic access standards in the Single Oversight Framework (SOF). The 92% Referral to Treatment (RTT) standard was also failed to be achieved, following four consecutive months of achievement. Although the 85% national standard for 62-day GP cancer was not met, performance was above 85% for internally managed pathways.

The Trust has been off trajectory for the A&E 4-hour and 6-week diagnostic waiting times standards for greater than two consecutive months. Under the rules of the SOF this means that NHS Improvement (NHSI) may consider providing additional support to the Trust to recover performance. NHSI recently undertook a Critical Friend visit to the Bristol Royal Infirmary and Bristol Children's Hospital Emergency Departments, for which the Trust received a written report. The recommendations made in this report are under review and will inform the next revision of the Trust's urgent care plan.

Access Key Performance Indicator		Quarter 2			Quarter 3			Quarter 4		
		Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
A&E 4-hours	Actual	89.3%	90.0%	87.3%	82.9%	78.5%	79.6%	80.4%	80.7%	83.3%
	STF trajectory	87.6%	88.4%	92.2%	93.3%	90.0%	89.3%	88.5%	87.4%	91.0%
62-day GP cancer	Actual	72.9%	84.5%	80.5%	79.5%	85.2%	81.5%	84.7%	79.0%	
	STF trajectory*	84.7%	81.7%	85.0%	85.0%	85.1%	86.9%	83.6%	85.7%	85.9%
Referral to Treatment Time (RTT)	Actual	92.0%	90.5%	90.4%	91.2%	92.0%	92.0%	92.2%	92.0%	91.1%
	STF trajectory*	93.2%	93.2%	93.4%	93.4%	93.4%	92.8%	92.8%	92.8%	93.0%
6-week wait diagnostic	Actual	96.1%	95.5%	96.9%	98.9%	99.0%	98.2%	98.4%	98.7%	98.7%
	STF trajectory*	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%

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

Summary Scorecard

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

Key changes in indicators in the period:

AMBER to RED:
- Cancer waiting times
- Diagnostic waiting times

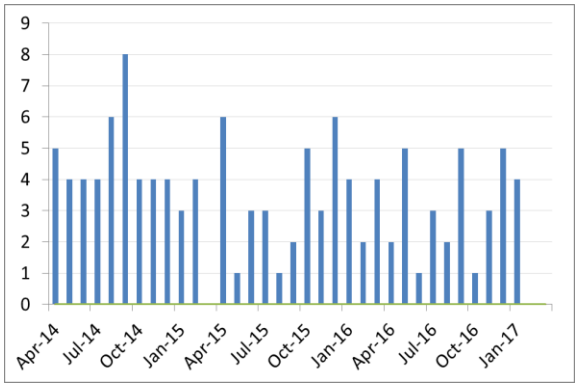
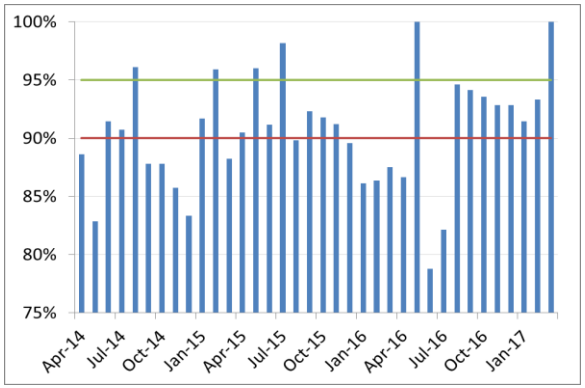
AMBER to GREEN:
- Deteriorating patient
- Sickness

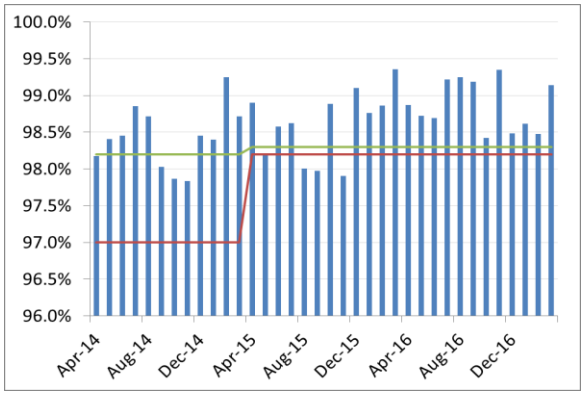
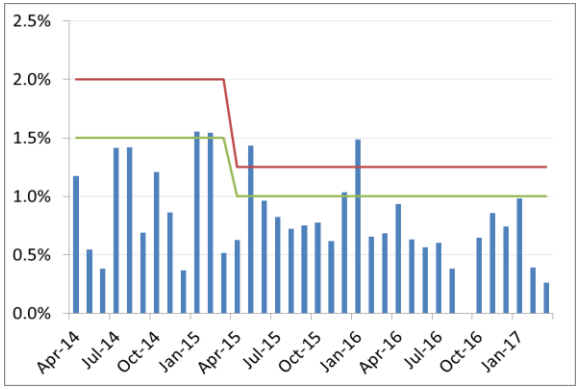
GREEN to RED
- Referral to Treatment Times (RTT)

Overview

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

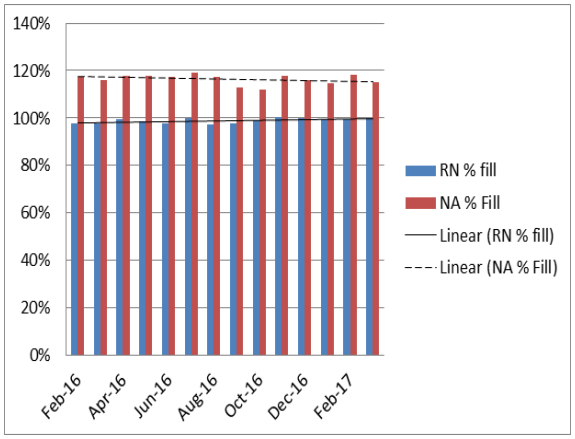
Successes	**Priorities**
• The outlier bed-day figure for March 2017 was 510, which was 225 bed-days fewer that the figure for February 2017 of 735; • In February 2017 the figure for non-purposeful omitted doses of listed critical medicines was 0.39%. This means that the improvement goal of fewer than 1% has been achieved every month since February 2016; • There were no reported cases of *Clostridium difficile* infections in either February or March 2017; • There was a 100% (27/27) compliance with NEWS acted upon in March 2017. This is first time that the 95% improvement goal has been achieved since May 2016; • Vacancies are at their lowest level for a year, and reduced across all staff groups. Nursing vacancies reduced in all Divisions.	• Sustained improvements in fractured neck of femur metrics; • There is a continued focus on the reduction of turnover, agency usage and sickness absence, and this has been highlighted as an ongoing priority in the operating plans for 2017/18; • Reduction in the number of patients waiting over 18 weeks Referral to Treatment (RTT), by delivering additional activity in April, May and June; • Sustained improvement in performance against the 62-day GP cancer waiting times standard during quarter 1, relative to the national average; • Recovery of performance against the 6-week diagnostic waiting times standard by the end of May.
Opportunities	**Risks & Threats**
• The e-Appraisal system will go live in May 2017; this is in response to staff feedback from the staff survey and our commitment to ensuring appraisals are of real value and quality; • The annual falls work plan contains a range of actions to mitigate falls risks as a result of learning from incident analysis e.g. the Division of Medicine is developing and testing a rapid falls response initiative to see if the number of repeat falls can be reduced.	• Five falls with moderate or higher levels of harm occurred in March 2017, the most in a single month during 2016/17; • The Trust's targets for 2016/17 in respect of sickness absence, agency and turnover were not achieved, and the targets agreed through the operating planning process for 2017/18 will again be challenging for the Trust; • Ongoing emergency pressures could make recovery of achievement of the 92% RTT national waiting times standard challenging, especially in the context of an elective waiting list that has increased in size; • Late referrals from other providers continue to impact on achievement of the 62-day GP cancer waiting times standard; • The number of over 6-week waiters for Cardiac CT scans is expected to remain high in April due to a doubling of demand and an inability to establish enough ad hoc capacity to meet this.

Description	Current Performance	Trend	Comments
Infection control The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16).	There were no cases of *Clostridium difficile* (C. diff) attributed to the Trust in March 2017.	**Total number of C. diff cases**  A total of 31 cases (unavoidable + avoidable) have been reported in the year against a limit of 45 for April 2016 to March 2017.	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 thirty one. Twenty one cases have been assessed as unavoidable, and ten cases assessed as avoidable.
Deteriorating patient National early warning scores (NEWS) acted upon in accordance with the escalation protocol (excluding paediatrics). This is an area of focus for our Sign up to Safety Patient Safety Improvement Programme. Our three year goal is sustained improvement above 95%.	Performance in March 2017 was 100% against a three-year improvement goal of 95%. This is an improvement from February's position of 93 % (two breaches).	**Deteriorating patient: percentage of early warning scores acted upon** 	This is measured by a monthly point prevalence audit. Work continues in the deteriorating patient work stream of our patient Safety Improvement Programme and is reported in detail to the Programme Board. Details of the actions being taken are described in the actions section (Actions 1A to 1G).

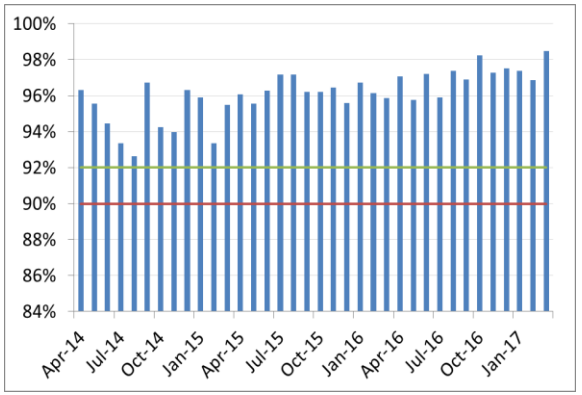
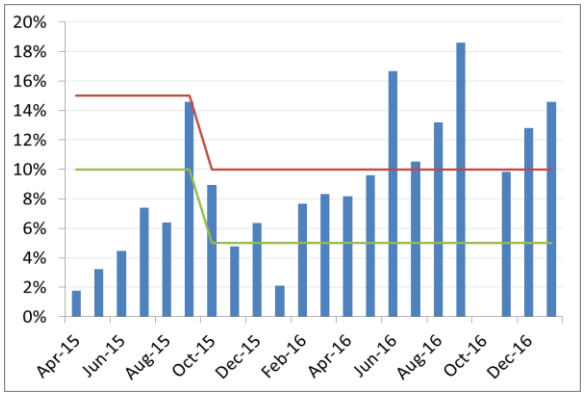
Description	Current Performance	Trend	Comments
Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.	In March 2017, the percentage of patients with no new harms was 99.1% (7 patients had new harms), 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 March 2017 Safety Thermometer point prevalence audit showed one new catheter associated urinary tract infection, three falls with harm, no new pressure ulcers and three new venous thrombo-emboli
Non-purposeful omitted doses of listed critical medicines Monthly audits by pharmacy incorporate a review of administration of critical medicines: insulin, anti-coagulants, Parkinson's medicines, injected anti—infectives, anti-convulsants, short acting bronchodilators and 'stat' doses.	In March 2017, 0.26% of patients reviewed (3 out of 1148) had one or more omitted critical medications in the past three days. The target for omitted doses is no more than 1.25%, the average for the year to date is 0.59%. The 0.26% for March 2017 is an improvement from the February 2016 figure of 0.39% (4 out of 1017).	**Percentage of omitted doses of listed critical medicines** 	Month-on-month performance has remained consistently below the target for omitted doses of no more than 1.25%. Actions being taken are described in the actions section (Actions 2A and 2B)

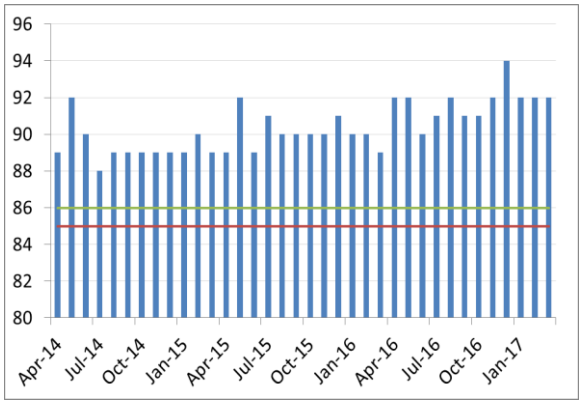
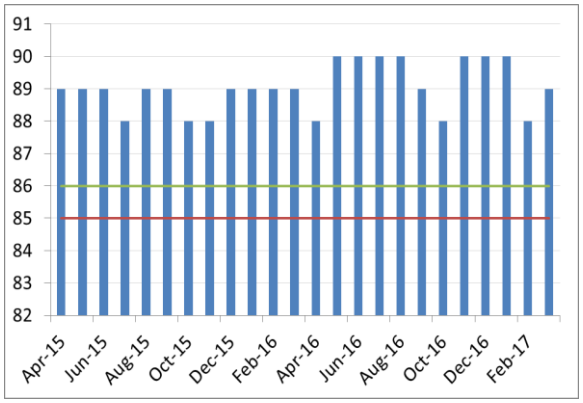
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Overall compliance is 87% (excluding Child Protection Level 3), which has reduced from 89% last month. Compliance with each of the reporting categories is provided below
<table>
<tr><th>March 2017</th><th>UH Bristol</th></tr>
<tr><td>Total</td><td>87%</td></tr>
<tr><td>Three Yearly (14 topics)</td><td>85%</td></tr>
<tr><td>Annual (Fire)</td><td>83%</td></tr>
<tr><td>Annual (IG)</td><td>76%</td></tr>
<tr><td>Induction</td><td>97%</td></tr>
<tr><td>Resuscitation</td><td>71%</td></tr>
<tr><td>Safeguarding</td><td>91%</td></tr>
</table>
</td>
<td>There are four graphs which are included in Appendix 2 which show performance against trajectory for Fire and Information Governance.</td>
<td>This month overall compliance has reduced as a result of changes in reporting, as follows:

Compliance information now includes Dementia Awareness (currently 39%). Trajectories have been developed and will be included in Divisional monthly performance and operational review meetings;
Resuscitation now includes compliance for three areas: Adult, Paediatric and Neo-natal resuscitation, and the target group now includes allied health professionals.

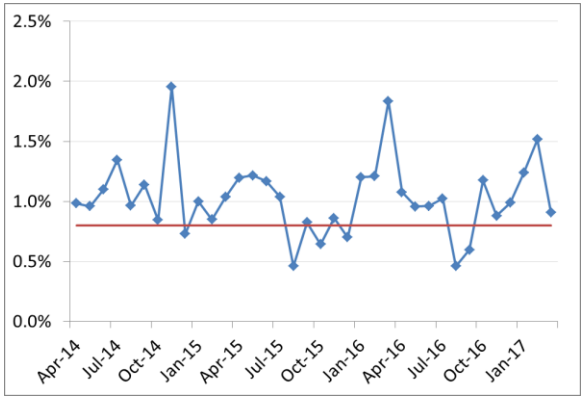
</td>
</tr>
<tr>
<td>Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.</td>
<td>The report shows that in March 2017 the Trust had rostered 224,380 expected nursing hours, with the number of actual hours worked of 233,493. This gave a fill rate of 104%.
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>64,909</td><td>58, 342</td><td>+6,576</td></tr>
<tr><td>Specialised Services</td><td>39,960</td><td>40,847</td><td>-887</td></tr>
<tr><td>Surgery Head & Neck</td><td>46,304</td><td>42,626</td><td>+3,678</td></tr>
<tr><td>Women’s & Children’s</td><td>82,320</td><td>82,565</td><td>-245</td></tr>
<tr><td>Trust</td><td>233,493</td><td>224, 380</td><td>+9,113*</td></tr>
</table>
*The difference of one hour between the mathematical sum of the column and this figure explained by rounding of part-hours at divisional level.
</td>
<td>The percentage overall staffing fill rate by month


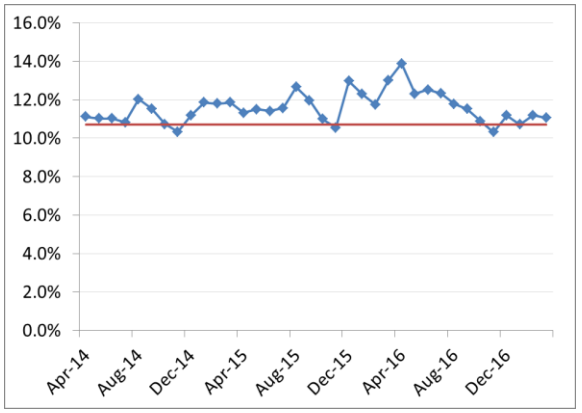
</td>
<td>Overall for the month of March 2017, the Trust had 99% cover for Registered Nurses (RN) on days and 101% RN cover for nights. The unregistered level of 111% for days and 121% for nights reflects the activity seen in March 2017. This was due primarily to Nurse Assistant specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night. Close monitoring continues (Action 4).</td>
</tr>
</table>

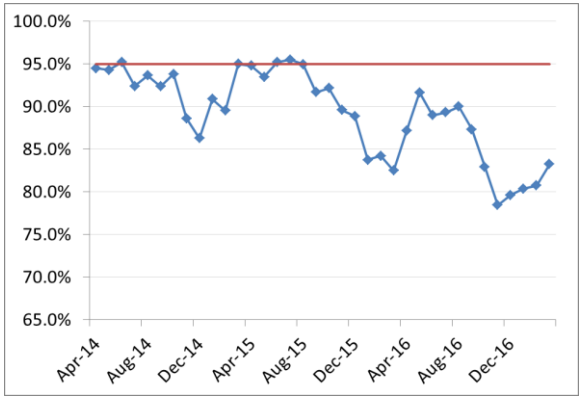
Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for March 2017 was 98.5%. This metric combines Friends & Family Test scores from inpatient and day-case areas of the Trust, for both adult and paediatric services. Division and hospital-level data is provided to the Trust Board on a quarterly basis in the quarterly Patient Experience and Involvement report	**Inpatient Friends & Family scores each month** 	The scores for the Trust are in line with national norms. A very high proportion of the Trust's patients would recommend the care that they receive to their friends and family. These results are shared with ward staff and are displayed publically on the wards. Division and hospital-level data is provided to the Trust Board and is explored within the Quarterly Patient Experience report.
Dissatisfied Complainants. By October 2015 we are aiming for less than 5% of complainants to report that they are dissatisfied with our response to their complaint by the end of the month following the month in which their complaint response was sent.	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 January 2017. Performance for January was 14.6% against a green target of 5%. As of 18th April; 2017, 7 of the 48 responses sent out in December had resulted in dissatisfied replies.	**Percentage of compliantaints dissatisfied with the complaint response each month** 	Our year to date performance for 2016/17 is 11.4%, compared with 6.1% for 2015/16 and 11.1% reported in the Trust's 2014/15 Quality Report. Informal Benchmarking with other NHS Trusts suggests that the rates of dissatisfied complainants are typically in the range of 8% to 12%. Actions continue as previously reported to the Board (Actions 5A to 5E).

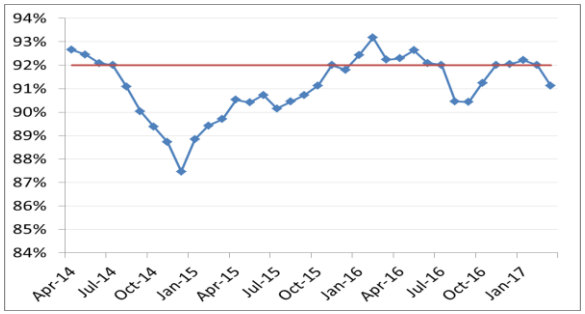
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as “key drivers” of patient satisfaction via analysis and focus groups.</td>
<td>For the month of March 2017, the score was 92 out of a possible score of 100, and 91 for Q4 as a whole. Divisional level scores are provided on a quarterly basis to ensure sample sizes are sufficiently reliable.
<table>
<tr><th></th><th>Q3 2016/2017</th><th>Q4 2016/2017</th></tr>
<tr><td>Trust</td><td>92</td><td>91</td></tr>
<tr><td>Medicine</td><td>90</td><td>90</td></tr>
<tr><td>Surgery, Head & Neck</td><td>92</td><td>91</td></tr>
<tr><td>Specialised Services</td><td>92</td><td>92</td></tr>
<tr><td>Women's & Children's (Bristol Royal Hospital for Children)</td><td>94</td><td>92</td></tr>
<tr><td>Women's & Children's Division (Postnatal wards)</td><td>92</td><td>91</td></tr>
</table>
</td>
<td>Inpatient patient experience scores (maximum score 100) each month
 
</td>
<td>UH Bristol performs in line with national norms in terms of patient-reported experience. This metric would turn red if patient experience at the Trust began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the score remains green. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report.</td>
</tr>
<tr>
<td>Outpatient experience tracker comprises four scores from the Trust’s monthly survey of outpatients (or parents of 0-11 year olds):
1) Cleanliness
2) Being seen within 15 minutes of appointment time
3) Being treated with respect and dignity
4) Receiving understandable answers to questions.</td>
<td>The score for the Trust as whole was 89 in March 2017 (out of score of 100). Divisional scores for quarter 4 are provided as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful.
<table>
<tr><th></th><th>Q3 2016/2017</th><th>Q4 2016/2017</th></tr>
<tr><td>Trust</td><td>90</td><td>89</td></tr>
<tr><td>Medicine</td><td>89</td><td>90</td></tr>
<tr><td>Specialised Services</td><td>89</td><td>86</td></tr>
<tr><td>Surgery, Head & Neck</td><td>88</td><td>89</td></tr>
<tr><td>Women's & Children's (Bristol Royal Hospital for Children)</td><td>85</td><td>87</td></tr>
<tr><td>Diagnostics & Therapies</td><td>96</td><td>93</td></tr>
</table>
</td>
<td>Outpatient Experience Scores (maximum score 100) each month
 
</td>
<td>The Trust’s performance is in line with national norms in terms of patient-reported experience.

This metric would turn red if outpatient experience at UH Bristol began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the Trust score remains green. Divisional scores are examined in detail in the Trust’s Quarterly Patient Experience Report.</td>
</tr>
</table>

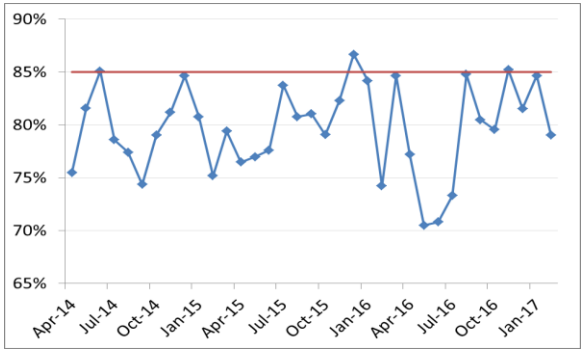
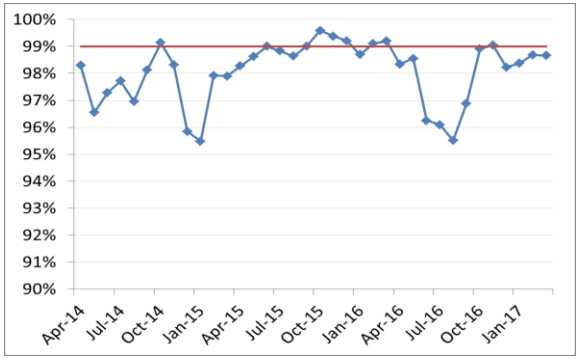
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In March the Trust cancelled 63 (0.91% of) operations at last-minute for non-clinical reasons. The reasons for the cancellations are shown below:
<table>
<tr><th>Cancellation reason</th><th>Number</th></tr>
<tr><td>No HDU/ITU/CICU bed available</td><td>17 (27%)</td></tr>
<tr><td>No ward bed available</td><td>14 (22%)</td></tr>
<tr><td>Emergency patient prioritised</td><td>7 (11%)</td></tr>
<tr><td>Surgeon ill/unavailable</td><td>6 (10%)</td></tr>
<tr><td>Non-emergency patient prioritised</td><td>4 (6%)</td></tr>
<tr><td>Clinically complicated patient in theatre</td><td>4 (6%)</td></tr>
<tr><td>Other causes (8 different breach reasons - no themes)</td><td>11 (17%)</td></tr>
</table>
Fifteen patients cancelled in February were readmitted outside of 28 days. This equates to 83.1% of cancellations being readmitted within 28 days, which is below the former national standard of 95%.</td>
<td>Percentage of operations cancelled at last-minute
 

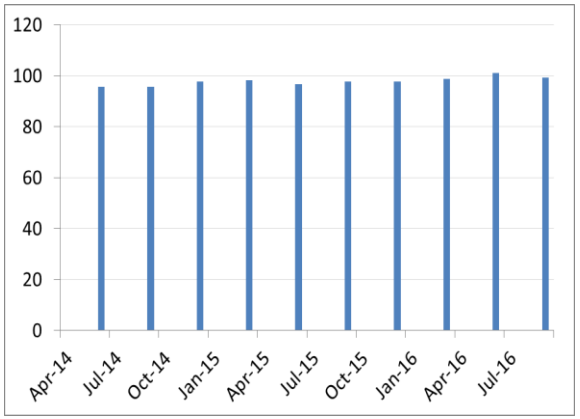
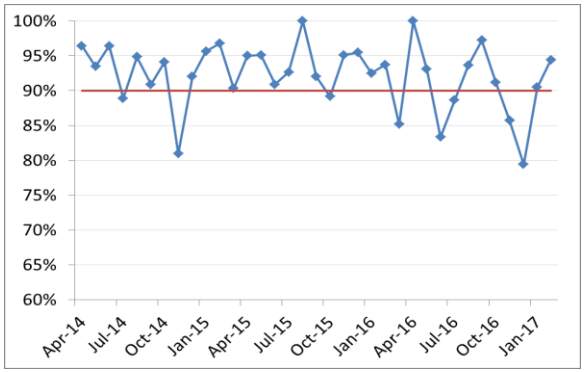
The national 0.8% standard is currently not forecast to be met in April due to continued high bed occupancy levels.</td>
<td>The level of last-minute cancellations dropped to the lowest level seen since November 2016. Emergency pressures continues to be the predominant cause of cancellations this month, with ward bed availability, critical care bed availability and emergency patients needing to be prioritised, making-up 60% 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 8J) and outlier bed-days (13).</td>
</tr>
<tr>
<td>Outpatient appointments cancelled is a measure of the percentage of outpatient appointments that were cancelled by the hospital. This includes appointments cancelled to be brought forward, to enable us to see the patient more quickly.</td>
<td>In March 11.1% of outpatient appointments were cancelled by the hospital, which is above the Red threshold of 10.7%. This is a 0.1% decrease on last month. The level of cancellation remains lower than earlier in the year.</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 is prioritising those actions that are likely to reduce the current underlying rate of cancellation by the hospital (Actions 7A to 7C).</td>
</tr>
</table>

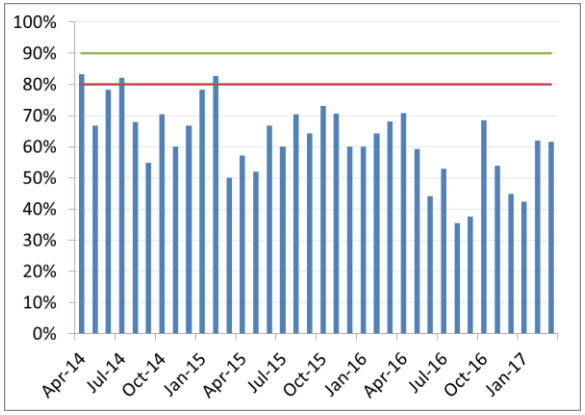
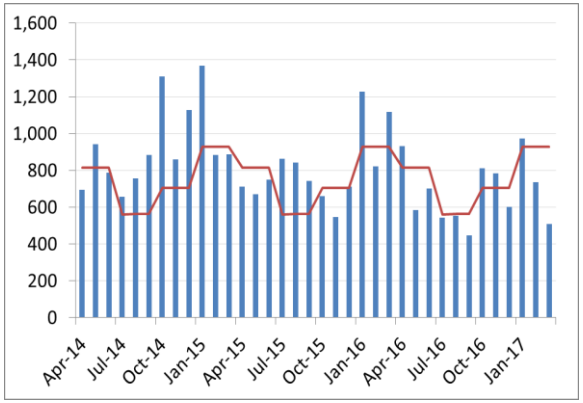
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% national standard was not achieved in March. Trust-level performance improved to 83.3%, but was below the in-month trajectory (91.0%). Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Mar 2016</th><th>Feb 2017</th><th>Mar 2017</th></tr>
<tr><td>Attendances</td><td>5,867</td><td>4,977</td><td>5,572</td></tr>
<tr><td>Emergency Admissions</td><td>1,977</td><td>1,739</td><td>1,910</td></tr>
<tr><td>Patients managed < 4 hours</td><td>4407
75.1%</td><td>3392
68.2%</td><td>4117
73.9%</td></tr>
<tr><th>BCH</th><th>Mar 2016</th><th>Feb 2017</th><th>Mar 2017</th></tr>
<tr><td>Attendances</td><td>3,936</td><td>2,927</td><td>3,735</td></tr>
<tr><td>Emergency Admissions</td><td>826</td><td>735</td><td>869</td></tr>
<tr><td>Patients managed < 4 hours</td><td>3936
85.6%</td><td>2927
92.1%</td><td>3735
88.9%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments
 

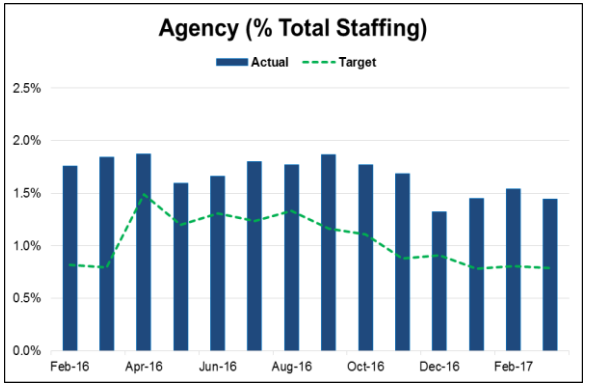
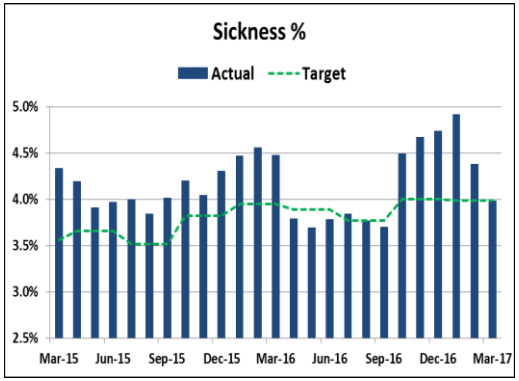
The trajectory of 82.5% is forecast to be met in April.</td>
<td>Whilst emergency admissions via the BRI ED were down in March, total emergency admissions into the BRI were 7.9% up on the same period last year. The number of 14 day stays has remained high, which together with the increased level of admissions has resulted in bed occupancy being un-seasonally high. The lower level of outlier bed-days will help to reduce length of stay. But the time taken to access the 'right' bed may have worsened 4-hour performance relative to last year. Actions continue to be taken to reduce length of stay (Actions 8A to 8J).</td>
</tr>
<tr>
<td>Referral to Treatment (RTT) is a measure of the length of wait from referral through to treatment. The target is for at least 92% of patients, who have not yet received treatment, and whose pathway is considered to be incomplete (or ongoing), to be waiting less than 18 weeks at month-end.</td>
<td>The 92% national standard was not met at the end of March, with reported performance of 91.1% against the recovery forecast of 92.0% (see Appendix 3). The number of patients waiting over 40 weeks RTT at month-end increased in March, mainly due to continued theatre capacity pressures in the Division of Women's & Children's. There were two over 52-week waiters, both within Surgery, Head & Neck, due to patient choice and errors made in recording pathways.
<table>
<tr><th></th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>86</td><td>106</td><td>133</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>3</td><td>3</td><td>2</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 

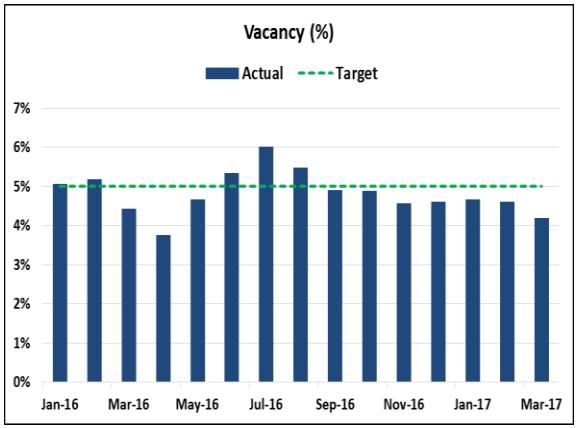
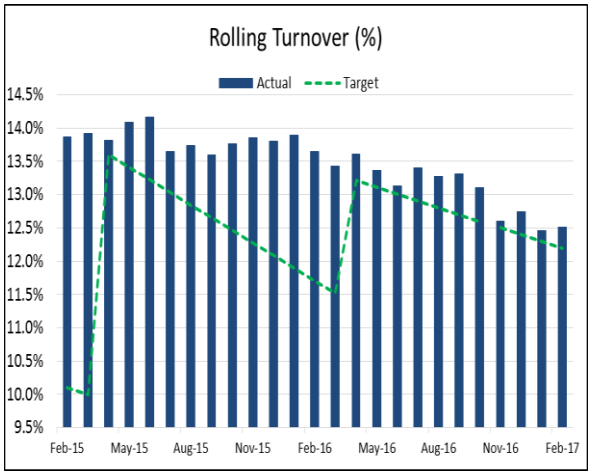
Recovery of the 92% standard in April is at risk, due to size of the current backlog and size of the elective waiitng list.</td>
<td>The total number of patients on an incomplete RTT pathway has increased, as has the number of patients waiting over 18 weeks. This is despite an increase in RTT activity (i.e. treatment stops) in the period. The current size of the elective waiting list poses risks to early recovery of the 92% standard. The RTT recovery plan is currently being refreshed and will continue to be monitored through fortnightly meetings with Divisions (Action 9A to 9C).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.	February's performance was 79.0% against the 85% 62-day GP standard, and a trajectory of 85.7%. The 85% standard was met for internally managed pathways with performance at 90.5%. The main reasons for failure to achieve the 85% 62-day GP standard for individual patients is shown below. **Breach reason** / **Feb 17** Late referral by/delays at other provider: 8.5 Medical deferral/clinical complexity: 2.0 Delayed outpatient appointment: 3.5 Delayed radiology or admitted diagnostic: 2.0 Administrative/tracking error: 1.0 Surgery cancelled: 1.5 Pathway management (clinical): 1.0 **TOTAL**: **19.5**	**Percentage of patients treated within 62 days of GP referral**  Performance against the 90% 62-day screening standard in February was 100%. The 31-day subsequent surgery standard failed to be met due to elective capacity constraints and cancellations.	Performance continues to be impacted by factors outside of the Trust's control, most notably late referrals. A CQUIN came into effect on the 1st October, along with a national policy for 'automatic' breach reallocation of late referrals. Adjusted performance based upon these rules was, however, only 80.0%. This reflects the internal issues highlighted by the breach analysis this month, in particular, thoracic outpatient delays for Lung pathways. An improvement plan continues to be implemented to minimise avoidable delays (Action 10).
Diagnostic waits – diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end.	Performance was 98.7% in March, which is below the 99% national standard, and marginally below the agreed recovery trajectory. The number and percentage of over 6-week waiters at month-end, is shown below: **Diagnostic test** / **Jan** / **Feb** / **Mar** MRI: 16 / 15 / 5 Ultrasound: 0 / 0 / 0 Sleep: 51 / 31 / 32 Endoscopies: 19 / 19 / 23 CT: 36 / 40 / 60 Echo: 0 / 0 / 0 Other: 4 / 3 / 1 **TOTAL**: **126** / **108** / **121** Percentage: **98.4%** / **98.7%** / **98.7%** Recovery trajectory: 99.0% / 98.2% / 98.7%	**Percentage of patients waiting under 6 weeks at month-end**  Achievement of the recovery trajectory at the end of April is at risk due to a steep rise in demand for Cardiac CT scans.	Despite high demand in February the number of patients waiting over 6 weeks for a Sleep Studies test did not materially increase at the end of March due to the additional capacity established. The backlog is forecast to halve by the end of April. There has been a doubling of demand for Cardiac CT scans, the reason for which is unclear but is under investigation These high levels of demand cannot be met in the short-term, with ad hoc sessions. A medium term capacity plan is being established (Actions 11A and 11B).

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 September 2016 was 99.4 This statistical approach estimates that there were 11 fewer actual deaths than expected deaths in the 12-month period up to September 2016.	**Summary Hospital Mortality Indicator (SHMI) for in hospital deaths each month** 	Our overall performance continues to indicate that fewer patients died in our hospitals than would have been expected given their specific risk factors. The Quality Intelligence Group continues to conduct assurance reviews of any specialties that have an adverse SHMI score in a given quarter. We will continue to track Hospital Standardised Mortality Indicator monthly to give earlier warning of a potential concern.
Door to balloon times measures the percentage of patients receiving cardiac reperfusion (inflation of a balloon in a blood vessel feeding the heart to clear a blockage) within 90 minutes of arriving at the Bristol Heart Institute.	In February (latest data), 34 out of 36 patients (94.4%) were treated within 90 minutes of arrival in the hospital. Performance for the year as a whole remains above the 90% standard at 90.8%.	**Percentage of patients with a Door to Balloon Time < 90 minutes by month** 	Routine monthly analysis of the causes of delays in patients being treated within 90 minutes continues. There were no emerging themes in February.

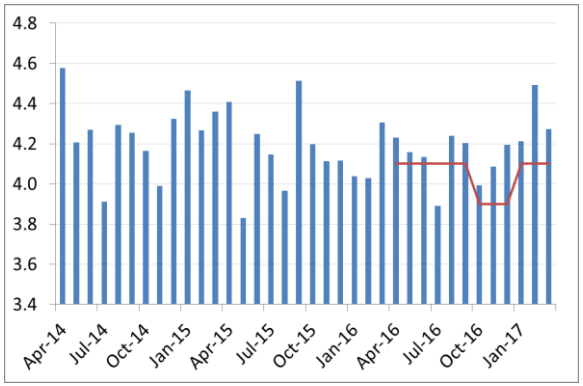
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In March 2017 we achieved 61.5% (16/26 patients) overall performance in Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 80.8% (21/26 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number of patients</th></tr>
<tr><td>Lack of theatre capacity.</td><td>2</td></tr>
<tr><td>Required surgical procedure for both hips. One procedure was performed within 36 hrs the other was not.</td><td>1</td></tr>
<tr><td>Awaiting medical optimisation</td><td>1</td></tr>
<tr><td>Died pre-operatively</td><td>1</td></tr>
</table>
Five patients did not receive any ortho-geriatrician review due to sickness and the clinician having to cover the Older Person Assessment Unit.</td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.
 
</td>
<td>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 March 2017 there were 510 outlier bed-days against a target of 928 outlier bed days.
<table>
<tr><th>Outlier bed-days</th><th>Mar 2017</th></tr>
<tr><td>Medicine</td><td>279</td></tr>
<tr><td>Surgery, Head & Neck</td><td>124</td></tr>
<tr><td>Specialised Services</td><td>91</td></tr>
<tr><td>Women's & Children's Division</td><td>13</td></tr>
<tr><td>Diagnostics and Therapies</td><td>3</td></tr>
<tr><td>Total</td><td>510</td></tr>
</table>
In the month there were significant reductions in outlier bed-days in the Division of Medicine and Division of Surgery, Head & Neck.</td>
<td>Number of days patients spent outlying from their specialty wards
 
</td>
<td>Performance showed a significant improvement in March with a decrease of 225 bed-days over February’s figure of 735.
This month’s figure of 510 is the lowest reported figure since April 2016.
Ongoing actions are shown in the action plan section of this report. (Action 13).</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 7.3 FTE, down from 1.5% to 1.4% of total staffing. Nursing agency usage increased by 2.3 FTE, associated with managing the Emergency Department queue. **March 2017** / **FTE** / **Actual %** / **KPI** **UH Bristol** 123.7 1.4% 0.8% Diagnostics & Therapies 3.6 0.4% 0.6% Medicine 39.8 3.1% 0.9% Specialised Services 8.7 0.9% 1.2% Surgery, Head & Neck 31.5 1.7% 0.4% Women's & Children's 17.4 0.9% 0.4% Trust Services 15.6 2.1% 2.2% Facilities & Estates 7.2 0.9% 1.0%	**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 reduced from 4.4% to 4.0%. There have been reductions across all Divisions with the exception of Trust Services. **March 2017** / **Actual** / **KPI** **UH Bristol** 4.0% 4.0% Diagnostics & Therapies 3.2% 2.9% Medicine 3.9% 4.5% Specialised Services 3.1% 3.6% Surgery, Head & Neck 4.5% 3.7% Women's & Children's 3.3% 4.2% Trust Services 4.1% 3.1% Facilities & Estates 6.5% 5.9%	**Sickness absence as a percentage of full time equivalents by month**  *Please note: Sickness data is refreshed retrospectively to capture late data entry, and to ensure the data is consistent with the Trust's final submission for national publication.*	The average monthly sickness for 2016/17 was 4.1% compared with a Green threshold of 3.9%. See Action 15 for further details of the plans that continue to be implemented to improve performance. It should be noted that there have been some technical issues with the sickness reporting process which may have impacted on data accuracy. Sickness absence data for March will be confirmed in May 2017.

Description	Current Performance	Trend	Comments
Vacancies - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.	Overall vacancies reduced from 4.6% to 4.2%. Registered nursing vacancies reduced from 4.9% (120.6 FTE) to 4.3% (106.3), with reductions in all Divisions. Ancillary vacancies also reduced from 7% (60 FTE) to 6.3% (54.6%).	**Vacancies rate by month** 	Appendix 2 shows that Heygroves Theatres and Coronary Intensive Care nursing vacancies have reduced due to new starters. See Action 16 for further details of the plans that continue to be implemented to improve performance.
Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.1% by the end of 2016/17. The red threshold is 10% above monthly trajectory**.**	Turnover increased from 12.6% to 12.7%. There were increases in all Divisions except Facilities & Estates, Trust Services and Medicine Division. Registered nurse turnover increased from 12.5% to 12.9%.	**Staff turnover rate by month** 	The turnover KPI threshold for 2016/17 of 12.1% was not achieved, with a rolling 12 month turnover figure of 12.7% at the end of the year. See Action 17 for further details of the plans that continue to be implemented to improve performance.

March 2017	Rate
UH Bristol	**4.2%**
Diagnostics & Therapies	6.8%
Medicine	5.7%
Specialised Services	3.8%
Surgery, Head & Neck	4.5%
Women's & Children's	1.3%
Trust Services	4.0%
Facilities & Estates	5.3%

March 2017	Actual	KPI
UH Bristol	**12.7%**	**12.1%**
Diagnostics & Therapies	11.6%	12.5%
Medicine	13.9%	13.2%
Specialised Services	12.7%	12.4%
Surgery, Head & Neck	12.3%	12.1%
Women's & Children's	12.0%	10.8%
Trust Services	12.4%	11.1%
Facilities & Estates	14.7%	13.5%

Description	Current Performance	Trend	Comments
Length of Stay (LOS) measures the number of days inpatients on average spent in hospital. This measure excludes day-cases. LOS is measured at the point at which patients are discharged from hospital.	In March the average length of stay for inpatients was 4.27 days, which is above the quarter 4 RED threshold of 4.1 days. This is a decrease from the previous month of 0.22 days. The percentage of patients discharged in the month who were long-stay stay patients (14 day plus stays) was high, but not as high as in February. But despite this there was still a small increase in the number of long stay patients in hospital at month-end, reflecting the sizeable cohort in higher acuity patients we are still managing through the system.	**Average length of stay (days)**  Length of stay is forecast to remain above the RED threshold in April, and remain high until the current cohort of long-stay patients are discharged.	The total number of Green to Go patients in hospital remains more than double the jointly agreed planning assumption of 30 patients. The number of 14-day plus stays remains at a high level. However, the percentage of emergency patients admitted aged 75 years and over has fallen, which suggests acuity is dropping and we should start to see a reduction in 14 day plus stays in the coming weeks. Work to reduce delayed discharges and over 14 days stays continues as part of the emergency access community-wide plan (Actions 8A to 8J and 13).

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.	On-going	Monthly progress reviewed in the deteriorating patient work stream and quarterly by the Patient Safety Improvement Programme Board, Clinical Quality Group and Quality and Outcomes Committee	Sustained improvement to 95% by 2018.
	1B	Accessing doctor education opportunities to assist with resetting triggers safely.	On-going	As above	Sustained improvement to 95% by 2018.
	1C	Conduct 1:1 debriefs to further understand the reasons why nurses and doctors are unable to escalate or respond to escalation and address these accordingly. Also please see 1E below.	Completed. Actions in response to thematic analysis now under consideration.	As above	Sustained improvement to 95% by 2018.
	1D	Spreading point of care simulation training in adult general ward areas to address human factors elements of escalating deteriorating patients and use of structured communication.	On-going	As above	Sustained improvement to 95% by 2018.
	1E	Additional time allocated for patient safety in doctors' induction to train new appointees on resetting triggers safely and	Ongoing	As above	Sustained improvement to 95% by 2018.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		human factors awareness of escalation conversations.			
	1F	Review and response to outputs of mapping exercise of coverage of responders to escalation calls out of hours actions.	May 2017	As above	Sustained improvement to 95% by 2018.
	1G	Procurement of e-observations system to enable automatic calculation of NEWS and notification of elevated NEWS to responder.	To be confirmed.	As above	Sustained improvement to 95% by 2018.
Non-purposeful omitted doses of critical medication	2A	Datix dashboard being developed to capture omitted doses, to allow detailed thematic analysis.	Commenced February 2017 and ongoing	Improvement under development	Maintain current improvement and sustain performance below 1%
	2B	Teaching session to be run for new Pharmacists on data collection and background	Commenced February 2017 and ongoing	Teaching session under development	Maintain current improvement and sustain performance below 1%
Essential Training	3	Continue to drive compliance including increasing e-learning functionality. Divisional action plans are in development to achieve 90% for Safeguarding, Resuscitation, and Fire Safety and 95% for Information Governance. Communication to staff to highlight the importance of essential training is ongoing.	Ongoing May 2017 May 2017	Oversight by the Education Group via the Essential Training Steering Group. Monthly and quarterly Divisional Performance Review meetings. Oversight by the Education Group via the Essential Training Steering Group.	Trajectories to achieve compliance for Safeguarding, Resuscitation, Information Governance and Fire Safety by March 2017 have not been achieved. Divisional action plans are in place to achieve compliance. Divisional Trajectories for Dementia Awareness training show compliance by the end of March 2018, and will be

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
					monitored through Divisional Review meetings.
Monthly Staffing levels	4	Continue to validate temporary staffing assignments against agreed criteria.	Ongoing	Monitored through agency controls and action plan.	Action plan available on request.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Caring					
Dissatisfied complainants	5A	Response writing training continues to be rolled-out to Divisions	Ongoing	Completion of training signed-off by Patient Support & Complaints Team and Divisions.	Achieve and maintain a green RAG rating for this indicator.
	5B	Upon receipt of written response letters from the Divisions, there is a thorough checking process, whereby all letters are firstly checked by the case-worker handling the complaint, then by the Patient Support & Complaints Manager. The Head of Quality for Patient Experience & Clinical Effectiveness also checks a selection of response letters each week. All responses are then sent to the Executives for final approval and sign-off.	Ongoing	Senior Managers responsible for drafting and signing off response letters before they leave the Division are named on a Response Letter Checklist that is sent to the Executives with the letter. Any concerns over the quality of these letters can then be discussed individually with the manager concerned and further training provided if necessary.	Achieve and maintain a green RAG rating for this indicator
	5C	Dissatisfied responses are now routinely checked by the Head of Quality (Patient Experience & Clinical Effectiveness) to identify learning where appropriate. All cases where a complaint is dissatisfied for a second time are escalated to and reviewed by the Chief Nurse.	Implemented September 2015 and ongoing		Achieve and maintain a green RAG rating for this indicator
	5D	In January 2017, the Head of Quality (Patient Experience and	Findings discussed by the Patient	Learning has been shared with Divisions via the Patient	Achieve and maintain a green RAG rating for this indicator

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Clinical Effectiveness) and Acting Patient Support and Complaints Manager undertook a detailed review of all dissatisfied cases from August and September 2016.	Experience Group on 23rd February 2017.	Experience Group. In five of the 12 cases, the opinion of the reviewers was that opportunities were missed which may have had a bearing on the dissatisfied outcome. Heads of Nursing have committed to review these cases for local learning. No common themes.	
	5E	The Trust will be establishing a new complaints review panel in 2017.	Terms of Reference established March 2017	Evidence that the panel is in place and learning identified and shared with Divisions	Achieve and maintain a green RAG rating for this indicator
Last minute cancelled operations	6A	Continued focus on recruitment and retention of staff to enable all adult BRI HDU/ITU beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited and in post. Development and implementation of a strategy for managing ITU/HDU beds across general adult and cardiac units, to improve ability to manage peaks in demand.	Ongoing To be confirmed – expected to be by quarter 4, when virtual ward up to full impact, relieving ward bed pressures	Monthly Divisional Review Meetings; Relevant Steering Group to be confirmed, but likely to be Clinical Strategy Group.	Sustained reduction in critical care related cancellations in 2017/18. 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.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Outpatient appointments cancelled by hospital	7A	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.	Ongoing	Outpatient Steering Group	Amber threshold expected to be achieved again by the end of June.
	7B	Confirm that no leave is being agreed within six weeks (or timescale locally agreed).	Ongoing	Outpatient Steering Group	
	7C	Weekly report circulated to Divisions, showing total backlog of patients on the eReferral System (eRS) 'no slots' list, split by specialty.	Ongoing	Outpatient Steering Group	
	7D	eRS Improvement Plan to be developed, following review by NHS Digital, to help improve eRS access for patients and reduce un-necessary re-arrangement of outpatient appointments.	End May	Outpatient Steering Group	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Responsive					
A&E 4-hours	8A	Extended escalation capacity (A518) likely to end of quarter 4, and continued use of ORLA	Ongoing	Monitoring of expected improvement in relevant KPI through the Emergency Access Improvement Group (EAPIG)	Achievement of recovery trajectory in each month of Q1 2017/18.
	8B	Flexible use of community beds via system partners	Ongoing	Progress monitored through daily ALAMAC calls. Actions expected to reduce and/or smooth demand. Monitoring of expected improvement in relevant KPI through the Emergency Access Improvement Group (AEPIG)	
	8C	Additional GP Support Unit and Urgent care capacity	Ongoing		
	8D	Alternative transport to smooth flow of medically expected patients	Ongoing		
	8E	Commissioning of Pulse to provide domiciliary care packages, to support early supported discharge	Complete	Contract monitoring	
	8F	Review of formal feedback from NHS Improvement Critical Friend Visit, to feed into refresh of the action plan	Mid April	Review and monitoring of agreed actions by EAPIG.	
	8G	Division of Medicine to embed new medical model of Acute Physicians and develop clear strategy of medical admissions flow from ED, learning from their first two weeks in post	Ongoing	Review and monitoring of agreed actions by EAPIG.	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	8H	ED to pilot escalation of delayed speciality review of patients in ED to Silver (operational meetings) for respective divisions (Surgery and Specialised Services) using ipods. This is Monday to Friday with the purpose of capturing in real-time what the issues are, and looking for innovative ways to improve access to speciality review. Contributes to implementation of refreshed professional standards	Ongoing		
	8I	Breaking the Cycle Together event – to be planned for end of March or pre-Easter. Focus on the transition from DTA to admission to ward bed, using metrics of total time in ED for patients.	Complete		
	8J	Consideration of strategic solutions to potential bed capacity shortfalls for 2017/18, including ways of increasing early supported discharge.	End April	Review of options to be considered at Senior Leadership Team	Achievement of STF trajectory in 2017/18
Referral to Treatment Time (RTT)	9A	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory. Continued weekly review of management of longest waiting patients through RTT Operations Group.	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review meetings.	Achievement of recovery trajectory (to be confirmed).

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	9B	RTT Plan to be for the first half of 2017/18, focusing on areas of recent growth and those specialties whose backlogs are still above sustainable levels	End April	RTT Steering Group	
	9C	Refresh of IMAS Capacity and Demand modelling for key specialties (including Clinical Genetics, Paediatric Cardiology and Sleep Studies	Mid-April	Modelling to be reviewed by Associate Director of Performance	
Cancer waiting times	10	Implementation of Cancer Performance Improvement Plan, including ideal timescale pathways, and reduced waits for 2-week wait appointments.	Ongoing	Oversight of implementation by Cancer Performance Improvement Group, with escalation to Cancer Steering Group.	Achieve 85% for internally managed pathways and 85% with application of CQUIN. Sustain performance above national average each quarter.
Diagnostic waits	11A	Additional Sleep Studies waiting list sessions being undertaken to help address the bulge in demand;	End April	Weekly monitoring by Associate Director of Performance, with escalation to monthly Divisional Review meetings as required.	Recovery of 99% standard by end of October - achieved for October and November, but not in December. Additional sessions now being booked in February, March and April, with achievement expected by end of April.
	11B	Additional cardiac CT sessions to be established to meet unmet demand.	End June	Weekly monitoring by Associate Director of Performance, with escalation to monthly Divisional Review meetings as required.	Achievement of 99% standard again for this diagnostic modality by the end of June (subject to confirmation).

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Effective					
Fracture neck of femur Best Practice Tariff (BPT)	12A	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 avoid breaches due to annual leave etc.	September 2016	Successful funding bid and subsequent recruitment to post.	Post on hold pending completion of business case of investment to service following British Orthopaedic Association (BOA) report and recommendations
	12B	Build and submit case for specialist acute fracture nurse support (Band 6 permanent).	April 2017	Successful funding bid and subsequent recruitment to post.	Post on hold pending completion of business case of investment to service following BOA report and recommendations
	12C	Review the ward structure to see whether separate wards with protected beds and capacity for fractured neck of femurs will allow additional focus to meet patients' needs	April 2017	Focussed care consolidated in each ward, suitable to meet the patients' needs. Improved recruitment and retention of ward staff.	Proposals have been submitted to split the wards into one elderly trauma and fractured neck of femur ward (A604), and one young trauma and elective ward (A602). Awaiting full feedback, but the initial reaction was positive.
	12D	Review and make the case to increase physiotherapy services to support fractured neck of femurs patients on the trauma and orthopaedic wards across seven days	April 2017	Earlier physiotherapy and nutritional support, earlier mobilisation and better chest management.	Post on hold pending completion of business case of investment to service following BOA report and recommendations.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Outlier bed-days	13	Ward processes to increase early utilisation of discharge lounge to facilitate patients from Acute Medical Unit getting into the correct speciality at point of first transfer. See also actions 8A to 8J.	Ongoing	Oversight in Ward Processes Project Group	Linked to increased and timely use of discharge lounge

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Efficient					
Agency Usage	14	**Effective rostering**: 'Healthroster' to provide improved rostering, booking and data.	Allocate system Go live April 2017	Nursing agency: oversight by Savings Board. Medical agency: oversight through the Medical Efficiencies Group.	The KPI for 2016/17 of 0.8% of total staffing was not achieved. A revised KPI has been agreed for 2017/18 of 1%. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings.
		Controls and efficiency: • Rigorous escalation process. • Nurse and AHP agency supplier contracts - awarded in April 2017. • Operating plan agency trajectories monitored by divisional reviews.	Ongoing End April 2017 Monthly/quarterly reviews		
		Enhancing bank provision: • Recruitment and marketing plan for all staff groups in place for 2017/18. • Bank shifts uploaded onto Allocate, allowing shifts to be viewed from home. • Pilot to extend opening hours of the Temporary Staffing Bureau.	Ongoing May 2017 May 2017		
Sickness Absence	15	**Supporting Attendance Policy:** Revised policy to Policy Group April 2017; implementation and training from June/July 2017.	Dec 2016 –June 2017	Oversight by Workforce and Organisational Development (OD) Group via the Staff Health and Well Being Sub	The KPI for 2016/17 of 3.9% was not achieved. A revised KPI has been agreed for 2017/18 of 3.8%.

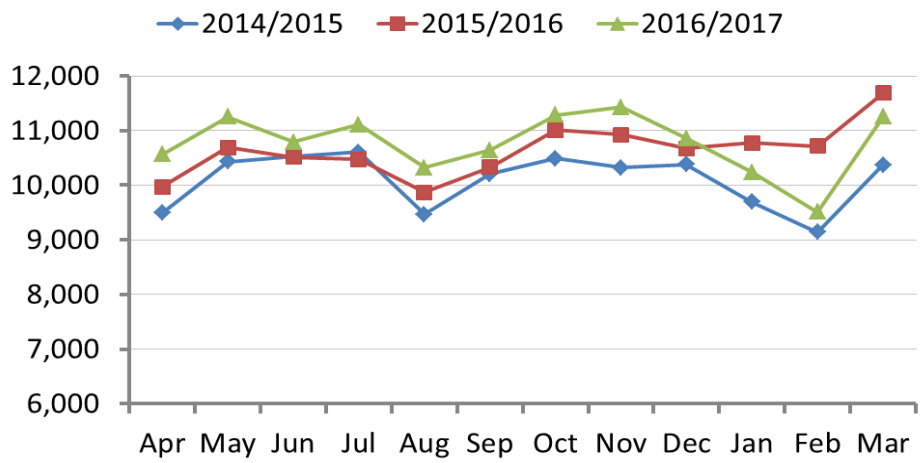
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Supporting Attendance Surgeries: To expedite cases where possible.	Ongoing	Group	Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings.
		Musculo-skeletal: Interventions by Occupational Health, Physio Direct, and Manual Handling Team.	Ongoing	Workplace Wellbeing Steering Group (quarterly) /CQUIN Delivery Group	
		Mental health: Draft Stress management strategy framework.	Senior Leadership May 2017		
		Staff Health and Well Being: Trust review of model for well-being including healthy food and beverages.	January 2016 to March 2019		
Vacancies	16	**Recruitment Performance:** • Divisional Performance and Operational Review Meetings monitor vacancies and performance against KPI of 45 days to recruit.	Reviewed quarterly	Workforce and OD Group /Recruitment Sub Group.	The target for vacancies continues to be 5% in 2017/18. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings.
		Marketing and advertising: • Recruitment and marketing plan for nursing in place for 2017/17. • Radiology recruitment website mirroring nurse recruitment. • Divisional Nurse Recruitment Leads - funding in bed-holding divisions for 12 months.	Ongoing May 2017 April 2017-18	Divisional Performance and Operational Reviews	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Support for recruitment and retention initiatives in specialist areas: • Heygroves Theatres and CICU Trajectories (see Appendix 2).	Reviewed monthly		
Turnover	17	**Complete review of appraisal**: Including: • Updated policy • E-Appraisal • Revised Training	May 2017	Transformation Board.	Turnover has reduced from 13.4% in March 2016 but missed KPI for 2016/17 of 12.1%. A revised KPI has been agreed for 2017/18 of 12%. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance reviews meetings.
		Transformational Engagement and Retention: Leadership Behaviours workshops complete, Senior Leadership Team updated March 2017. SLT Sub-group developing Framework.	Framework being developed for SLT in June 2017	Senior Leadership Team/Board.	
		Engagement (Staff Survey): Results and heat maps disseminated, detailed staff action plans being developed at divisional level. HR BPs developing Improving Staff Experience Plans for 2017/2018.	End of June 2017	Divisional Boards/ Senior Leadership Team/Workforce and OD Group.	

Operational context

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

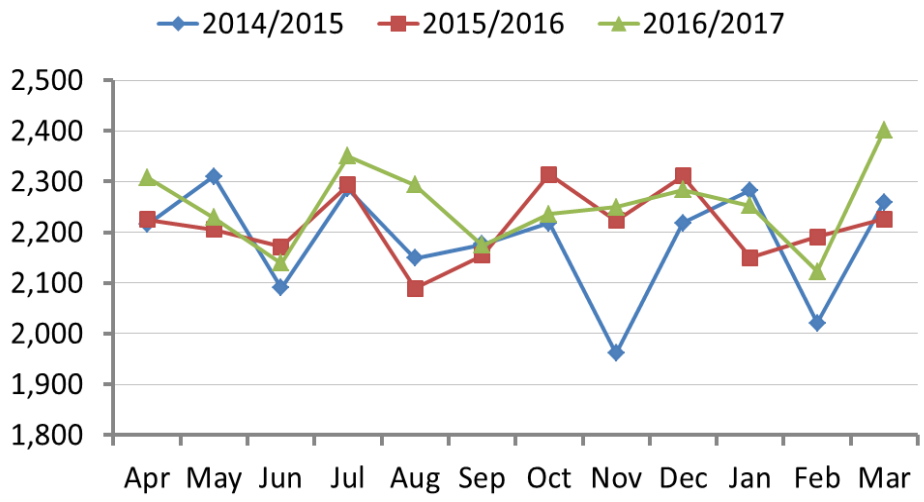
Emergency Department (ED) attendances



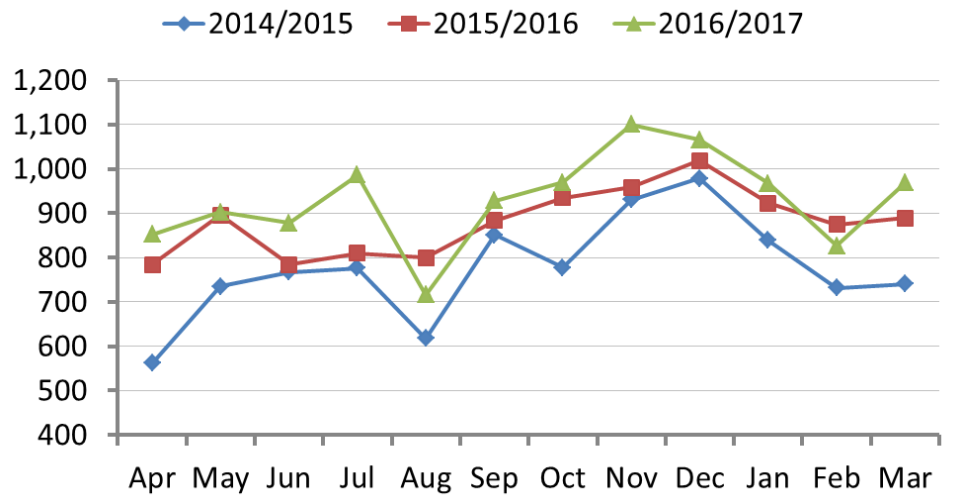
Summary points:

- Emergency attendances have remained below last year's levels;
- The total number of emergency admissions into the BRI and BCH are now significantly above the same period last year;
- The number of new outpatient attendances has increased above the same period last year;
- The number of elective admissions has also increased above last year's levels, despite higher level of cancellations due to emergency pressures;
- The number of patients waiting over 18 weeks for treatment has increased, as has the total number of pathways; the ongoing rise in the elective waiting list means there is a 'bulge' in the waiting list that will need to be met to prevent any further increases in over 18 week waiters in future months (see Assurance and Leading Indicators section).

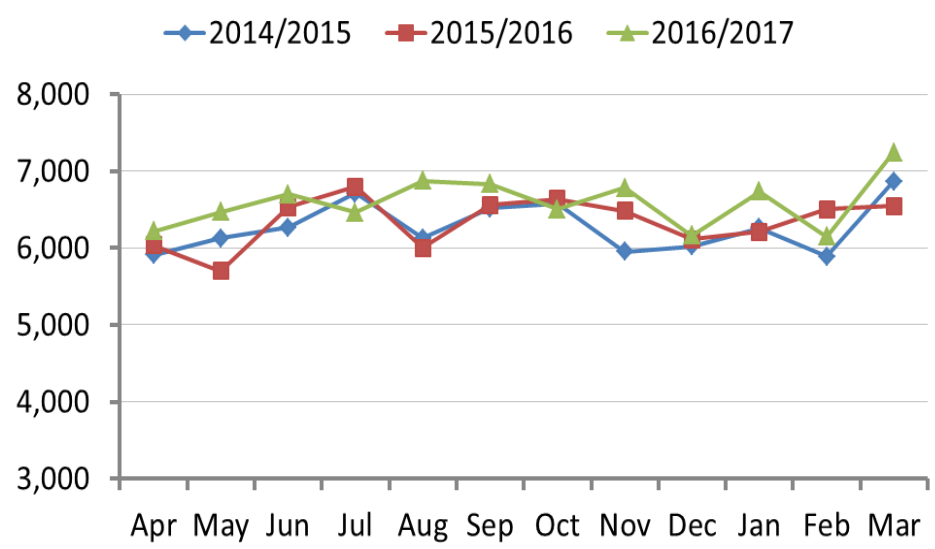
Emergency admissions (BRI)



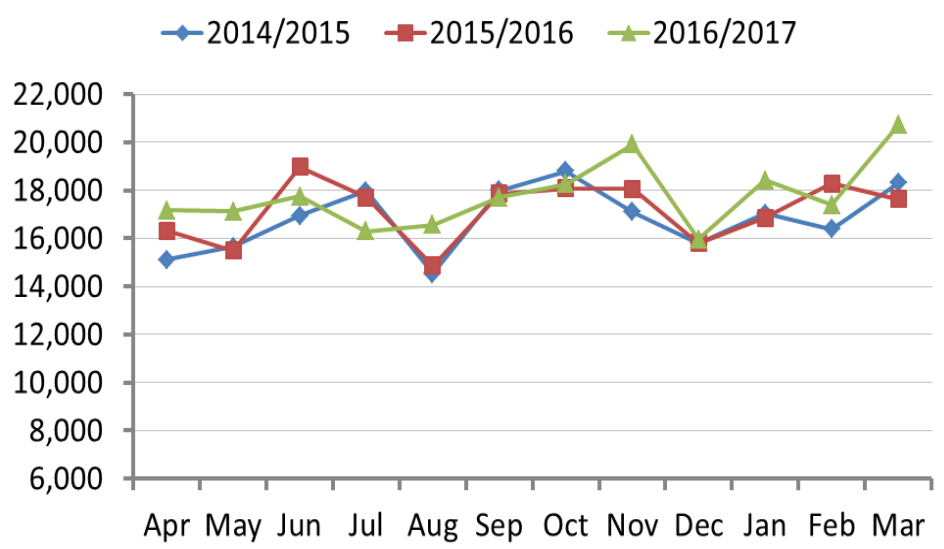
Emergency admissions (BCH)



Elective admissions



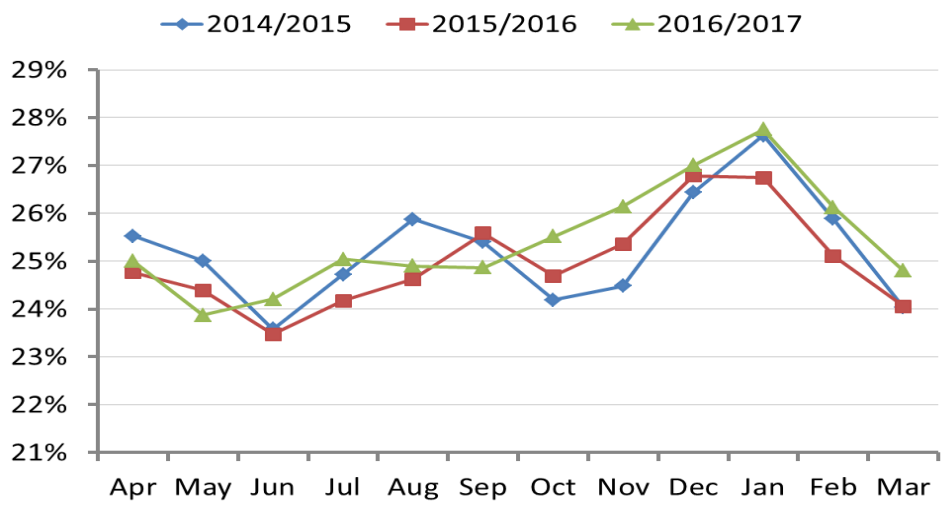
New outpatient attendances



Assurance and Leading Indicators

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

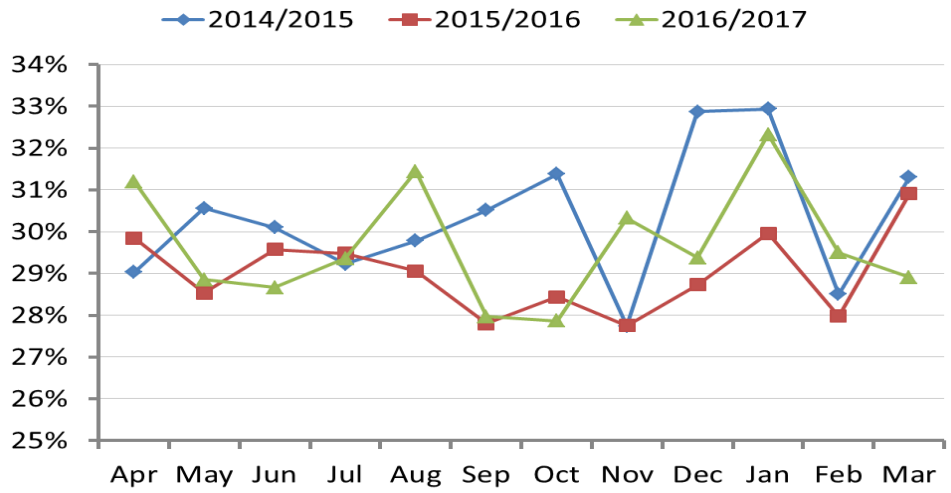
Percentage ED attendances resulting in admission



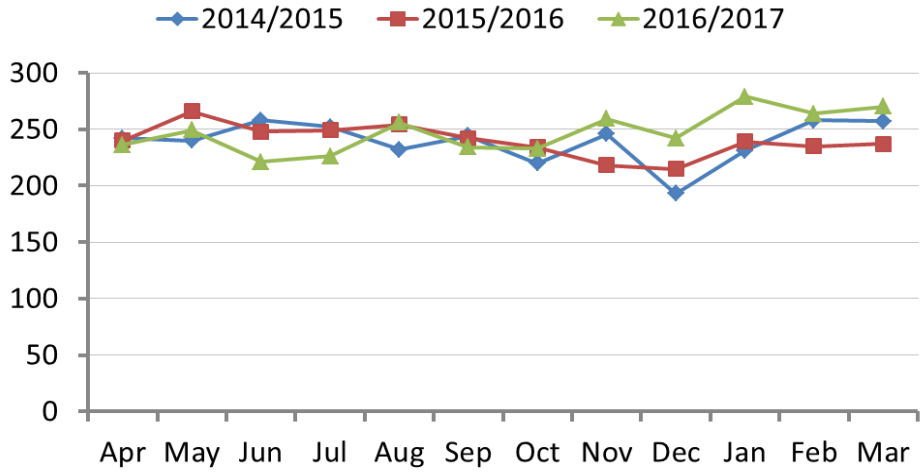
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission continues to show the usual seasonal pattern but is above last year's levels; the percentage of patients admitted aged 75 years and over has, however, fallen below the seasonal norm and is significantly lower than last year;
- The number of over 14 days stays is above the high levels seen in 2014/15; BRI bed occupancy levels remain high and above the seasonal norm;
- The number of patients on the outpatient waiting list has stayed similar to that of the previous two months; this is despite a significant increase in referrals, with the higher than normal levels of attendances having offset the heightened demand; the elective waiting list continues to rise even in the context of an increase in elective admissions;
- The number of patients referred by their GP with a suspected cancer (2-week waits) has fallen to 2015/16 levels.

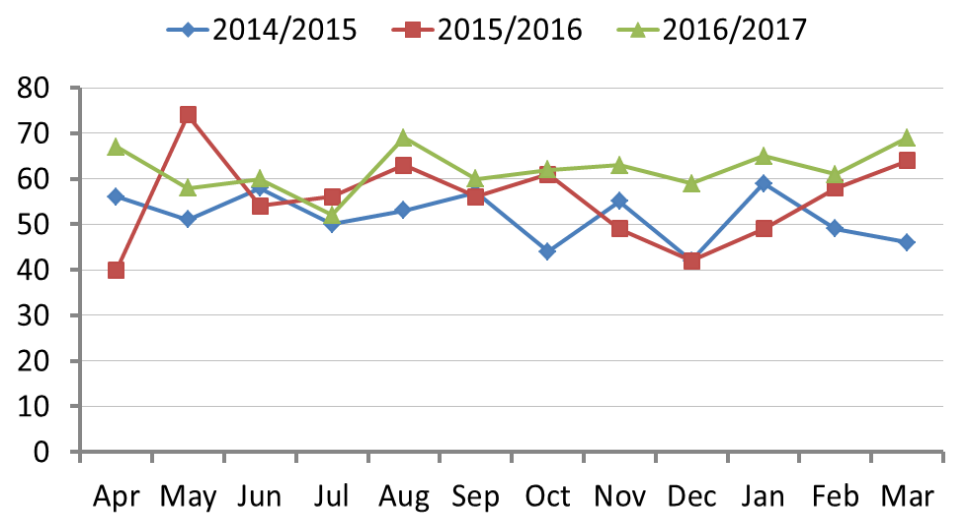
Percentage of Emergency BRI spells patients aged 75 years and over



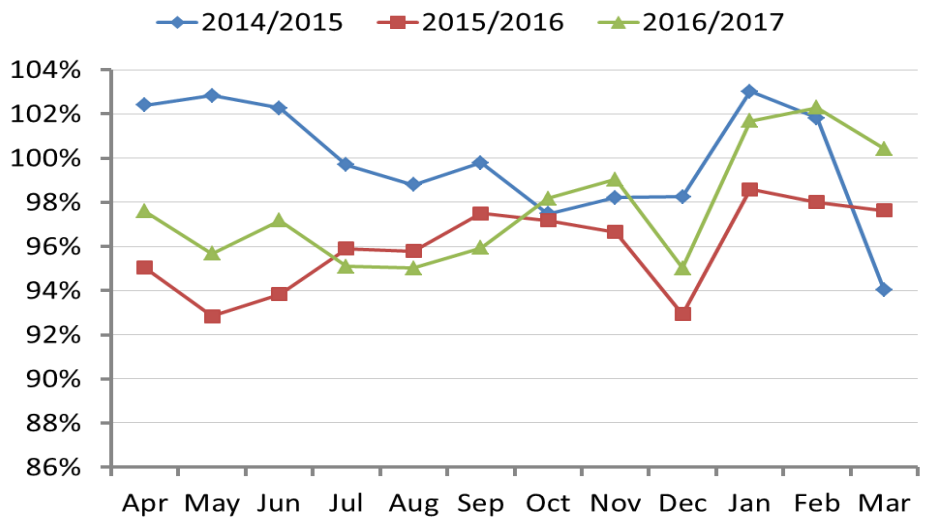
Over 14 day stays



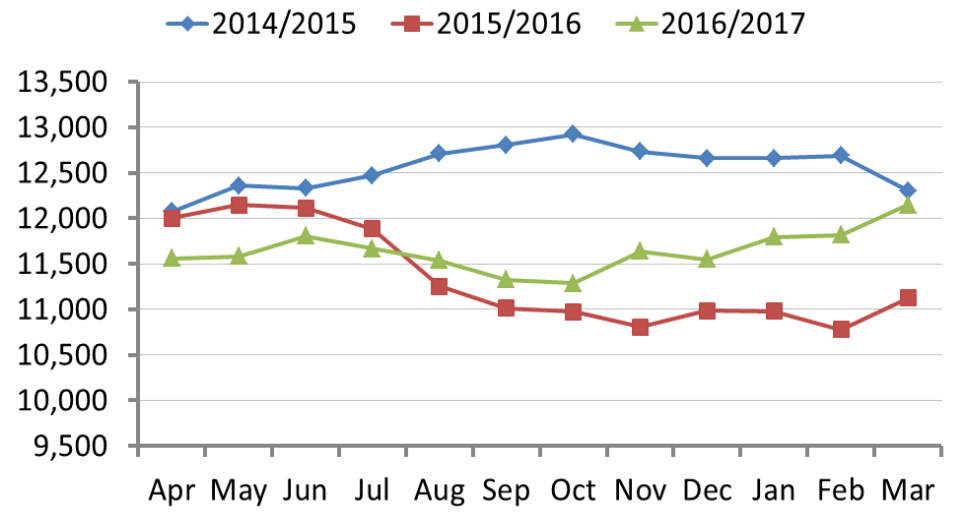
Delayed discharges (Green to Go)



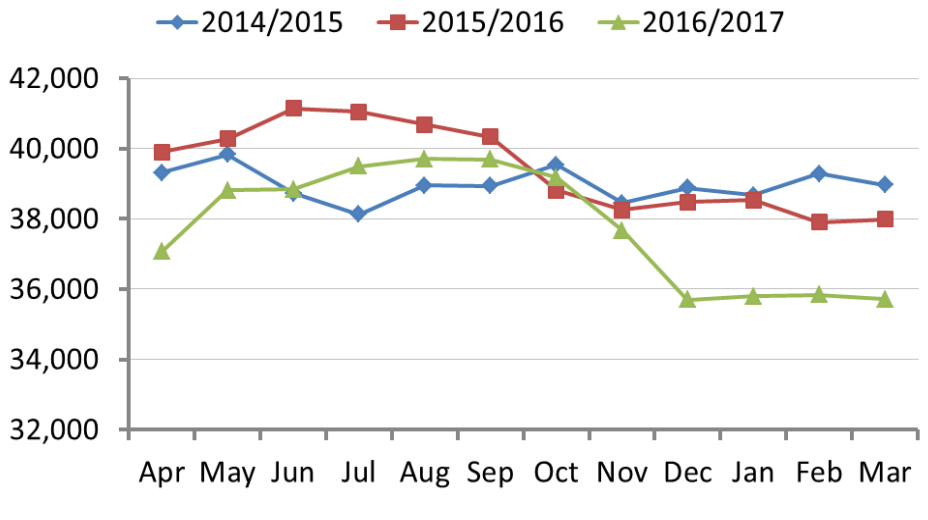
BRI Bed Occupancy



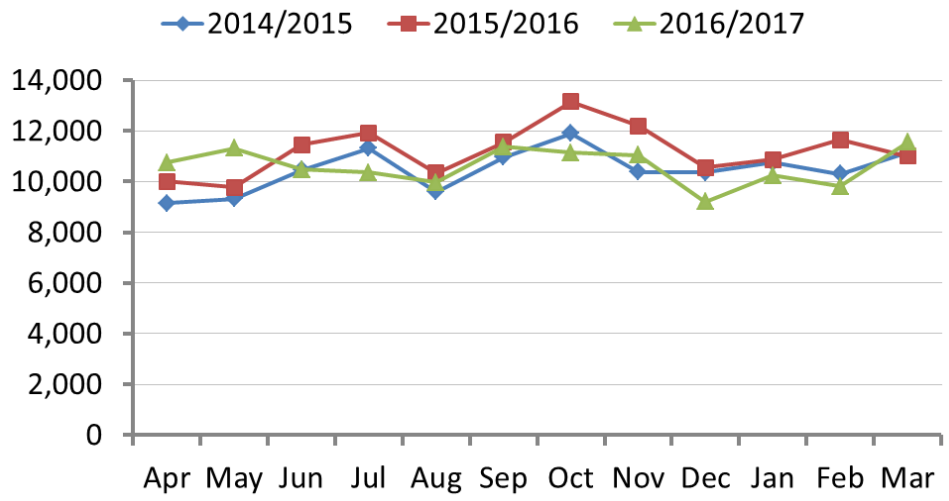
Elective waiting list size



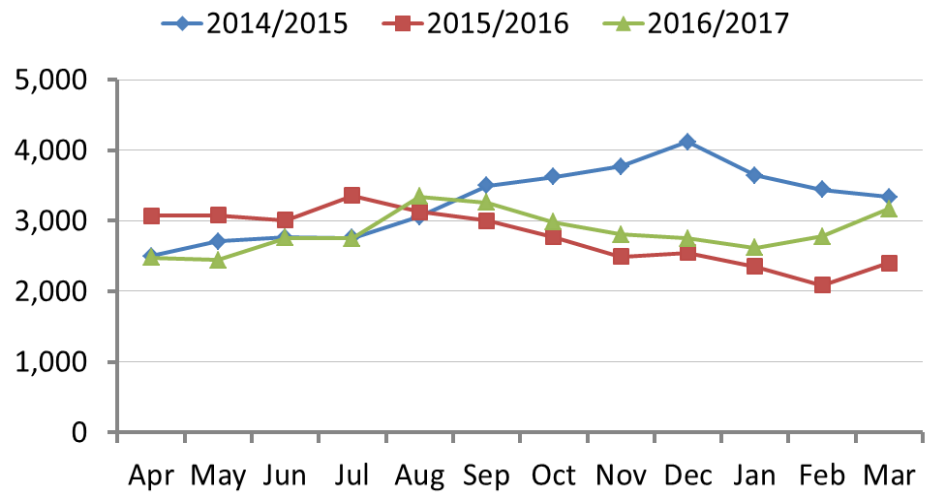
Outpatient waiting list size



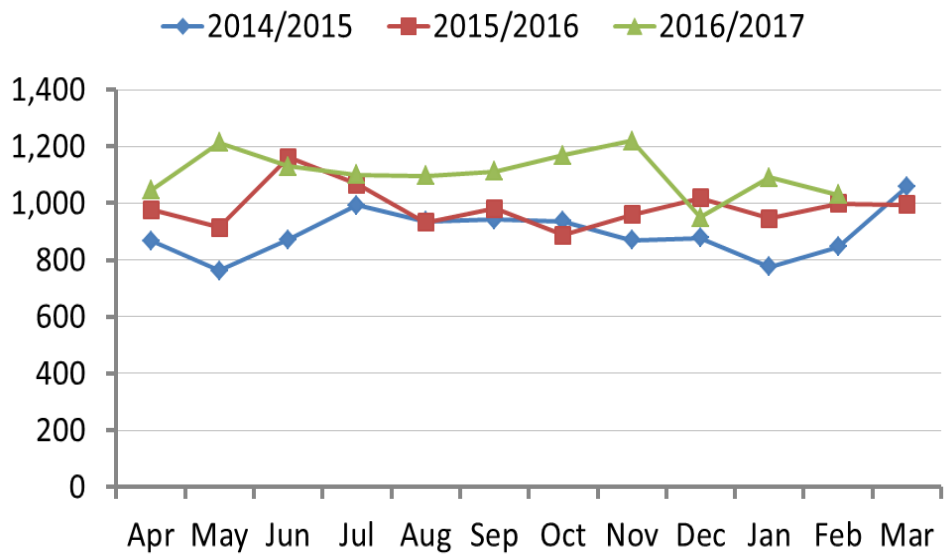
Number of RTT pathways stopped (i.e. treatments)



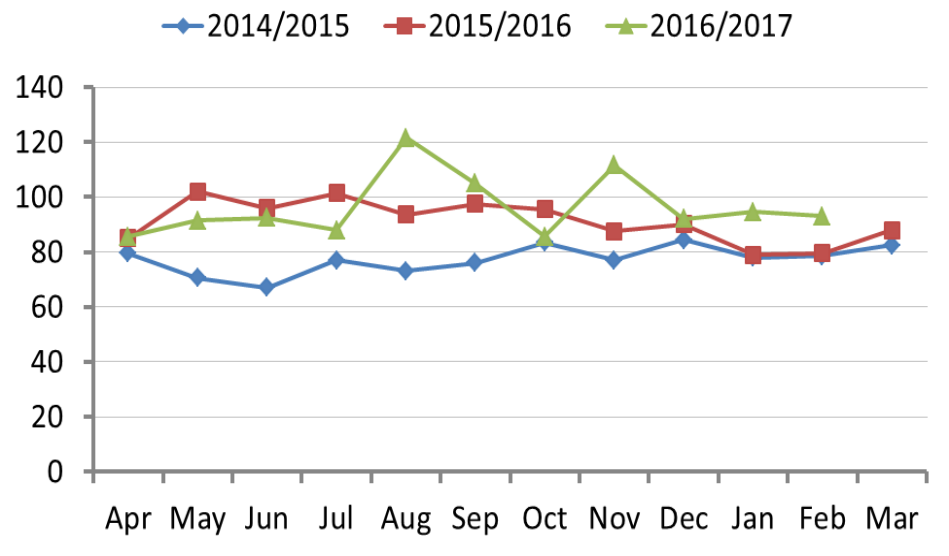
Number of RTT pathways over 18 weeks



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	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	0	0	0	0	0	0	0	1	1	1	1	1	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	3	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0
	DA03	C.Diff Cases - Monthly Totals	40	31	2	5	1	3	2	5	1	3	5	4	0	0	8	10	9	4
	DA02	MSSA Cases - Monthly Totals	26	37	2	3	3	7	4	2	0	6	2	3	3	2	8	13	8	8
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	0	1	2	3	4	5	5	8	9	10	10	10	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.3%	96.6%	96.6%	97.3%	98%	96.9%	98.4%	94.9%	97%	96.5%	95.7%	95.5%	95.4%	97%	97.3%	96.8%	96.4%	96%
	DB02	Antibiotic Compliance	87.6%	88.3%	84.4%	85.3%	83.9%	88.2%	86.5%	86.8%	90.9%	90.3%	91.2%	91.7%	92%	88.1%	84.5%	87.4%	90.8%	90.8%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	95%	95%	95%	96%	97%	95%	95%	96%	96%	96%	94%	95%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	98%	98%	98%	98%	98%	97%	97%	97%	98%	97%	97%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	96%	96%	96%	96%	97%	97%	96%	96%	97%	96%	96%	95%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	69	52	3	8	2	6	8	1	4	5	3	5	2	5	13	15	12	12
	S02a	Number of Confirmed Serious Incidents	55	38	3	7	2	5	7	1	4	5	3	1	-	-	12	13	12	1
	S02b	Number of Serious Incidents Still Open	5	12	0	1	0	0	0	0	0	0	0	4	2	5	1	0	0	11
	S03	Serious Incidents Reported Within 48 Hours	84.1%	94.2%	66.7%	100%	100%	83.3%	87.5%	100%	100%	100%	100%	100%	100%	100%	92.3%	86.7%	100%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	-	90.4%	66.7%	100%	100%	100%	87.5%	100%	75%	80%	66.7%	100%	100%	100%	92.3%	93.3%	75%	100%
	S04	Serious Incident Investigations Completed Within Timescale	74.1%	98%	100%	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%	100%	100%	100%	93.3%	100%
Never Events	S01	Total Never Events	3	2	0	0	0	1	0	0	1	0	0	0	0	0	0	1	1	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	13787	13534	1145	1216	1258	1173	1139	1263	1220	1389	1185	1335	1211	-	3619	3575	3794	2546
	S06b	Patient Safety Incidents Per 1000 Beddays	44.75	47.76	45.19	46.88	50.22	45.32	44.67	50.77	45.61	52.93	46.21	48.94	48.67	-	47.41	46.88	48.25	48.81
	S07	Number of Patient Safety Incidents - Severe Harm	97	90	2	8	9	10	10	2	10	12	10	10	7	-	19	22	32	17
Patient Falls	AB01	Falls Per 1,000 Beddays	3.95	4.23	4.26	3.93	4.59	4.6	3.84	4.42	4.86	4.04	3.74	3.74	4.9	3.89	4.26	4.29	4.22	4.16
	AB06a	Total Number of Patient Falls Resulting in Harm	30	36	1	4	3	3	3	3	2	2	4	3	3	5	8	9	8	11
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.221	0.148	0.276	0.154	0.04	0.077	0.196	0.161	0.075	0.114	0.195	0.11	0.201	0.182	0.157	0.144	0.127	0.163
	DE02	Pressure Ulcers - Grade 2	61	40	7	3	1	2	5	4	1	3	5	3	3	3	11	11	9	9
	DE03	Pressure Ulcers - Grade 3	7	6	0	1	0	0	0	0	1	0	0	0	2	2	1	0	1	4
	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%	99.3%	99.1%	99%	99.1%	99.1%	99%	99%	99.4%	99%	99.1%	98.9%	99.1%	99.2%	99.1%	99.1%	99%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.6%	96.4%	94.8%	96.3%	96.6%	97.3%	95.7%	94.1%	97%	96.5%	97%	97.8%	98%	96.6%	95.8%	95.8%	96.8%	97.4%
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	90.4%	89.6%	83.6%	94%	86.3%	89.4%	89.8%	89.7%	86.5%	87.1%	94.3%	92.7%	89.1%	90.2%	88.5%	89.6%	89.4%	90.6%
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	-	86.9%	-	-	80.8%	-	-	88%	-	-	91.2%	-	-	87.9%	80.8%	88%	91.2%	87.9%
Safety	Y01	WHO Surgical Checklist Compliance	99.9%	99.1%	99.8%	100%	98.9%	99.6%	99.9%	100%	99.6%	-	97.7%	98.4%	98%	97.8%	99.6%	99.9%	98.7%	98.1%

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual 15/16	Annual 16/17 YTD	Monthly Totals Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Quarterly Totals 16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4
Patient Safety																				
Medicines	WA01	Medication Incidents Resulting in Harm	0.8%	0.41%	0%	0.51%	0%	0.55%	0%	1.01%	0.55%	1.19%	0%	0%	0.53%	-	0.16%	0.51%	0.64%	0.25%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.87%	0.59%	0.93%	0.63%	0.56%	0.6%	0.38%	0%	0.65%	0.86%	0.74%	0.98%	0.39%	0.26%	0.73%	0.33%	0.75%	0.52%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.1%	97.9%	97.1%	97.7%	98.3%	98.4%	98.6%	98.6%	97.6%	97.5%	97.4%	98%	97.3%	98.3%	97.7%	98.6%	97.5%	97.9%
	AK04	Safety Thermometer - No New Harms	98.6%	98.9%	98.9%	98.7%	98.7%	99.2%	99.2%	99.2%	98.4%	99.3%	98.5%	98.6%	98.5%	99.1%	98.8%	99.2%	98.7%	98.7%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	90%	92%	87%	100%	79%	82%	95%	94%	94%	93%	93%	91%	93%	100%	89%	90%	93%	95%
Out of Hours	TD05	Out of Hours Departures	10.7%	7.7%	8.1%	7.5%	7.2%	7.8%	8.7%	7.3%	7.1%	7.6%	7.9%	8.3%	9%	6.4%	7.6%	7.9%	7.5%	7.8%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	20.3%	22.2%	23%	22.3%	23.4%	23.1%	21.1%	22.3%	21.9%	22.3%	22.3%	22.1%	21.8%	21.3%	22.9%	22.1%	22.2%	21.7%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	10444	11360	970	952	989	1004	909	939	978	971	943	928	833	944	2911	2852	2892	2705
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.1%	103.7%	104.7%	104%	103.1%	104.3%	102.7%	101.9%	102.6%	105.3%	104.2%	103.6%	104.5%	104.1%	103.9%	103%	104%	104%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	97.7	100.3	-	-	101.2	-	-	99.4	-	-	-	-	-	-	101.2	99.4	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	97.2	92.7	85.1	86.7	90	100	89.7	81.6	91.1	110.3	100	-	-	-	87.2	90.5	100.8	-
Readmissions	C01	Emergency Readmissions Percentage	2.74%	1.8%	1.74%	1.56%	1.7%	1.76%	2%	2.29%	1.48%	1.7%	1.93%	1.75%	1.84%	-	1.67%	2.01%	1.7%	1.79%
Maternity	G04	Percentage of Spontaneous Vaginal Deliveries	62.1%	60%	66.6%	60.9%	56.4%	62.1%	61.5%	59.4%	58.8%	62.8%	58.3%	60%	59.3%	54.6%	61.2%	61%	60%	57.9%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	75.9%	70.5%	87.5%	74.1%	72%	73.5%	61.3%	58.3%	73.7%	69.2%	51.7%	69.2%	81%	80.8%	77.6%	65.2%	63.5%	76.7%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	82.5%	74%	83.3%	81.5%	72%	79.4%	64.5%	58.3%	89.5%	69.2%	86.2%	61.5%	71.4%	73.1%	78.9%	68.5%	81.1%	68.5%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	63.5%	51.9%	70.8%	59.3%	44%	52.9%	35.5%	37.5%	68.4%	53.8%	44.8%	42.3%	61.9%	61.5%	57.9%	42.7%	54.1%	54.8%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	35.8	61.4	44.1	44.4	72.2	53.5	49.4	51.7	53.2	48.8	43.3	37.3	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	61.5%	58%	69.2%	67.6%	65.9%	59%	51.4%	63.4%	56.8%	61.8%	35.3%	52.4%	50%	-	67.7%	58.3%	51.4%	51.2%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	93.5%	90.4%	88.5%	88.2%	93.2%	92.3%	85.7%	92.7%	97.3%	88.2%	94.1%	90.5%	84.1%	-	90%	90.4%	93.3%	87.2%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.4%	66.8%	58.3%	68.8%	61.5%	76.5%	71.4%	80%	60%	65.2%	81.8%	51.7%	72.2%	61.5%	63.4%	76.5%	68.2%	60%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	91.6%	90.4%	94.5%	95.8%	94.1%	98%	96.3%	93.2%	93.1%	88.9%	89.1%	80.8%	80.1%	84%	94.8%	96%	90.2%	81.6%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	95.8%	97.2%	96.8%	97.8%	98.1%	98.1%	97.8%	100%	96.8%	94.1%	97.6%	97.6%	88.9%	100%	97.5%	98.6%	96.3%	96.2%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	92.3%	94.7%	95.2%	100%	100%	100%	100%	85.7%	100%	100%	71.4%	100%	100%	100%	97.2%	92.3%	88.2%	100%
	AC04	Percentage of Dementia Carers Feeling Supported	88.3%	75%	75%	-	-	-	-	-	-	-	-	-	-	-	75%	-	-	-
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	9666	8178	933	583	702	545	554	447	811	784	602	972	735	510	2218	1546	2197	2217

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	92	92	90	91	92	91	91	92	94	92	92	92	91	91	92	91
	P01g	Patient Survey - Kindness and Understanding	-	-	96	96	94	93	96	96	95	96	97	96	95	96	95	95	95	95
	P01h	Patient Survey - Outpatient Tracker Score	-	-	88	90	90	90	90	89	88	90	90	90	88	89	89	90	90	89
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	19.5%	35.5%	35.2%	42.4%	40.5%	36.5%	36.8%	30.7%	33.7%	35.9%	30.6%	31.7%	34.8%	36.8%	39.4%	34.6%	33.5%	34.5%
	P03b	Friends and Family Test ED Coverage	13%	16.4%	14.8%	13.5%	15.5%	12%	16.8%	15.5%	17.3%	18.9%	15.4%	21.2%	17.7%	18.4%	14.6%	14.7%	17.2%	19.1%
	P03c	Friends and Family Test MAT Coverage	22.7%	22.5%	16.2%	26.3%	19%	24.4%	20.4%	21.1%	22.6%	22.1%	19.8%	24.6%	29.7%	25.3%	20.5%	21.9%	21.6%	26.4%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	96.3%	97.2%	97.1%	95.8%	97.2%	95.9%	97.4%	96.9%	98.2%	97.3%	97.5%	97.4%	96.9%	98.5%	96.6%	96.7%	97.7%	97.6%
	P04b	Friends and Family Test Score - ED	75.4%	78.2%	80.2%	78.1%	74.4%	71.8%	79.6%	78.6%	79.3%	78.9%	74.1%	80.8%	79.6%	80.2%	77.5%	77.1%	77.6%	80.2%
	P04c	Friends and Family Test Score - Maternity	96.6%	96.8%	96.6%	98.9%	95.5%	96.2%	97.8%	97.3%	97.7%	94.3%	94.5%	98.2%	96.2%	97.4%	97.2%	97%	95.6%	97.3%
Patient Complaints	T01	Number of Patient Complaints	1941	1874	176	146	198	200	155	162	140	139	118	129	143	168	520	517	397	440
	T01a	Patient Complaints as a Proportion of Activity	0.252%	0.232%	0.272%	0.218%	0.296%	0.315%	0.246%	0.24%	0.204%	0.19%	0.19%	0.186%	0.222%	0.22%	0.262%	0.266%	0.195%	0.21%
	T03a	Complaints Responded To Within Trust Timeframe	75.2%	86.1%	81.6%	73.1%	73.8%	86.8%	90.6%	86%	92.3%	93.4%	97.4%	87.5%	87.5%	83.3%	76.2%	88.1%	94.2%	86%
	T03b	Complaints Responded To Within Divisional Timeframe	91.3%	86.6%	87.8%	92.3%	95.2%	89.5%	94.3%	81.4%	92.3%	85.2%	76.9%	85.4%	85%	72.9%	91.6%	88.8%	84.9%	80.9%
	T04c	Percentage of Responses where Complainant is Dissatisfied	6.15%	11.42%	8.16%	9.62%	16.67%	10.53%	13.21%	18.61%	0%	9.84%	12.82%	14.58%	-	-	11.19%	14.18%	7.91%	-
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.03%	0.98%	1.08%	0.96%	0.96%	1.03%	0.46%	0.6%	1.18%	0.88%	0.99%	1.24%	1.52%	0.91%	1%	0.69%	1.01%	1.2%
	F01a	Number of Last Minute Cancelled Operations	713	734	63	59	61	63	30	39	73	57	58	79	89	63	183	132	188	231

Please note: *The reduction in the WHO checklist compliance is a recording issue following the switch to the new BlueSpier theatre system in November. The new system allows staff to override a warning that a mandatory field has not been completed, and save the theatre episode even if the WHO checklist field remains incomplete. This is being addressed via the "Key Training Messages" for staff who use the BlueSpier system. A development for the system is already planned to flag an incomplete mandatory WHO checklist field at the end of the theatre list to the person reviewing. Clinical staff report they are confident that the previous high level of use of the WHO checklist in theatres continues in practice.*

RESPONSIVE

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	15/16	16/17 YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.3%	91.7%	92.3%	92.6%	92.1%	92%	90.5%	90.4%	91.2%	92%	92%	92.2%	92%	91.1%	92.3%	91%	91.8%	91.8%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	2480	2442	2753	2749	3344	3256	2978	2805	2751	2619	2777	3171	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	8	11	0	0	0	0	0	1	0	1	1	3	3	2	0	1	2	8
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	471	696	24	22	14	27	33	27	53	78	93	86	106	133	60	87	224	325
	A09	Referral To Treatment Ongoing Pathways 35+ Weeks	-	-	1738	2158	80	80	85	117	113	179	209	188	252	276	279	300	245	409	649	855
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	95.9%	94.6%	94.5%	94.6%	93.5%	95.4%	93.7%	91.6%	94.3%	96.2%	96%	95.8%	95.5%	-	94.2%	93.6%	95.5%	95.7%
	E01c	Cancer - Urgent Referrals Stretch Target	80%	80%	-	67.2%	64.8%	68%	65.3%	67.6%	68.4%	67%	55.1%	71%	60.8%	75.4%	76%	-	66.1%	67.6%	62.4%	75.7%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	97.5%	96.7%	91.5%	96.2%	96.7%	99.1%	96.5%	97.4%	97.8%	98.3%	96.1%	96.8%	96.8%	-	94.9%	97.6%	97.4%	96.8%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.9%	98.7%	97.7%	100%	97.3%	97.5%	97.7%	99.1%	97.5%	100%	99.1%	100%	100%	-	98.3%	98.1%	98.9%	100%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	96.8%	94.1%	80%	94%	97.7%	97.1%	92.6%	98.4%	96.4%	98%	95.9%	92.9%	92.2%	-	90.2%	96.1%	96.8%	92.5%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.1%	96.6%	97.9%	98.4%	96.8%	96.7%	95.2%	92%	95.4%	98.1%	98.2%	96.8%	97.6%	-	97.7%	94.5%	97.3%	97.2%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	80.6%	79.2%	77.2%	70.5%	70.8%	73.3%	84.8%	80.5%	79.5%	85.2%	81.5%	84.7%	79%	-	72.7%	80.1%	82.4%	81.9%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	68.6%	68%	41.7%	35.3%	85.7%	66.7%	55.6%	44.4%	100%	83.3%	100%	57.1%	100%	-	47.2%	55.6%	94.3%	75%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	91.1%	87.8%	75.9%	86.6%	96.9%	89.3%	91.1%	92.5%	88%	90.1%	82.1%	92.9%	77.8%	-	86.8%	90.8%	86.5%	85.2%
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	1.03%	0.98%	1.08%	0.96%	0.96%	1.03%	0.46%	0.6%	1.18%	0.88%	0.99%	1.24%	1.52%	0.91%	1%	0.69%	1.01%	1.2%
	F01a	Number of Last Minute Cancelled Operations	-	-	713	734	63	59	61	63	30	39	73	57	58	79	89	63	183	132	188	231
	F02c	Number of LMCs Not Re-admitted Within 28 Days	38	38	76	72	23	2	2	4	3	0	3	6	4	4	6	15	27	7	13	25
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.28%	1.36%	1.35%	1.82%	1.14%	1.5%	1.12%	1.33%	2.11%	1.61%	1.38%	0.67%	1.16%	1.13%	1.43%	1.31%	1.7%	0.99%
	F07a	Number of Admissions Cancelled Day Before	-	-	887	1020	79	112	72	92	73	87	131	104	81	43	68	78	263	252	316	189
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	75.4%	71.3%	83.8%	55.2%	66.7%	70.5%	76.6%	75%	73.5%	57.1%	64.7%	69%	86.1%	-	69.8%	74%	65%	76.9%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	93.3%	90.8%	100%	93.1%	83.3%	88.6%	93.6%	97.2%	91.2%	85.7%	79.4%	90.5%	94.4%	-	92.7%	92.9%	85.4%	92.3%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	98.97%	97.79%	98.34%	98.55%	96.25%	96.09%	95.51%	96.88%	98.91%	99.05%	98.23%	98.38%	98.69%	98.65%	97.68%	96.17%	98.74%	98.58%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	11.8%	11.6%	13.9%	12.3%	12.5%	12.3%	11.8%	11.5%	10.9%	10.3%	11.2%	10.7%	11.2%	11.1%	12.9%	11.9%	10.8%	11%
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	34	23	22	29	31	25	30	28	28	29	29	29	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	3	6	4	5	6	5	4	2	3	4	2	16	-	-	-	-
Green To Go List	AQ01	Numbers on the Green to Go List (Acute)	-	-	-	-	59	48	50	46	60	45	56	56	51	59	52	47	-	-	-	-
	AQ02	Numbers on the Green to Go List (Non-Acute)	-	-	-	-	8	10	10	6	9	15	6	7	8	6	9	22	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.16	4.17	4.23	4.16	4.13	3.89	4.24	4.2	3.99	4.09	4.19	4.21	4.49	4.27	4.17	4.11	4.09	4.32

RESPONSIVE (continued)

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 15/16	Annual 16/17 YTD	Monthly Totals Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Quarterly Totals 16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4
Emergency Department Indicators																						
ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	90.43%	85.01%	87.17%	91.66%	88.99%	89.33%	90.01%	87.33%	82.94%	78.45%	79.64%	80.37%	80.73%	83.25%	89.32%	88.89%	80.35%	81.53%
		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%	85.01%	87.17%	91.66%	88.99%	89.33%	90.01%	87.33%	82.94%	78.45%	79.64%	80.37%	80.73%	83.25%	89.32%	88.89%	80.35%	81.53%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	87.4%	77.42%	79.8%	87.73%	81.8%	83.73%	83.71%	80.78%	73.39%	71.69%	73.47%	68.86%	68.15%	73.89%	83.17%	82.77%	72.85%	70.4%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	90.56%	89.89%	93.02%	93.84%	95.11%	93.58%	97.29%	91.57%	90.65%	78.6%	79.38%	90.19%	92.11%	88.92%	94.01%	93.94%	82.63%	90.28%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	99.48%	98.97%	99.33%	99.54%	99.24%	98.65%	98.61%	99.26%	98.06%	99.06%	99.15%	98.56%	99%	99.18%	99.37%	98.84%	98.74%	98.93%
		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	40	0	1	0	0	0	1	2	1	11	19	5	0	1	1	14	24
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	99%	97.6%	96.2%	98.2%	94.7%	97%	97.9%	97.3%	98.3%	97.9%	97.9%	98%	98.5%	98.8%	96.4%	97.4%	98%	98.4%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	93%	92.8%	93.3%	94.2%	92.1%	91.7%	91.8%	91.2%	91.8%	92.7%	93.7%	93.6%	94.1%	93.9%	93.2%	91.6%	92.7%	93.8%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.8%	52.6%	55.2%	51.7%	51.7%	51.1%	56.5%	55.2%	52.8%	48.2%	50.5%	53.3%	54.3%	51%	52.8%	54.2%	50.5%	52.8%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.9%	98.5%	98.8%	98.9%	98.5%	98.3%	98.9%	98.5%	98%	98.5%	98.3%	98.7%	98.1%	98.1%	98.7%	98.6%	98.3%	98.3%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	3%	2.6%	3%	2.4%	2.3%	2.2%	2.2%	2.3%	2.4%	2.5%	3.3%	2.5%	3.1%	2.5%	2.6%	2.3%	2.7%	2.7%
	B05	ED Left Without Being Seen Rate	5%	5%	2.4%	2.2%	2.1%	2%	2.5%	2.9%	1.8%	2.2%	2.6%	2.2%	2.4%	1.4%	1.8%	2%	2.2%	2.3%	2.4%	1.8%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1102	1216	62	72	114	77	125	140	161	119	114	138	83	11	248	342	394	232
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	4.1%	2.1%	4.2%	3.1%	6.2%	5.1%	6.2%	4.8%	5.6%	2.8%	2.8%	2.2%	4.1%	3.1%	5.8%	4.4%	3.1%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	49.5%	39%	56.3%	29%	52.4%	29.2%	25%	37.2%	30.3%	52.6%	33.3%	55%	57.1%	44.1%	42.6%	30.5%	40.2%	50%

EFFICIENT

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4
Sickness	AF02	Sickness Rate	4.2%	4.1%	3.9%	3.7%	3.8%	3.8%	3.8%	3.7%	4.5%	4.7%	4.7%	5%	4.4%	4%	3.8%	3.7%	4.8%	4%
	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	8446.1	8241.7	8239	8304	8334.2	8364.5	8364.5	8393.1	8402.2	8407.6	8434.2	8436	8446.1	8304	8364.5	8407.6	8446.1
	AF09A	Actual Staff FTE (Including Bank & Agency)	8319.4	8566.5	8339.7	8277.5	8315.7	8322.1	8398.3	8436.4	8427.7	8468.8	8412.7	8458.1	8496.4	8566.5	8315.7	8436.4	8412.7	8566.5
	AF13	Percentage Over Funded Establishment	0.7%	1.4%	1.2%	0.5%	0.1%	-0.1%	0.4%	0.9%	0.4%	0.8%	0.1%	0.3%	0.7%	1.4%	0.1%	0.9%	0.1%	1.4%
	Green is below 0.5%. Amber is 0.5% to below 1% and Red is 1% or above																			
Bank Usage	AF04	Workforce Bank Usage	350.9	427.9	337.2	370	394.7	429.9	437.9	410.7	376.3	387	358.5	378.3	398.9	427.9	394.7	410.7	358.5	427.9
	AF11A	Percentage Bank Usage	4.2%	5%	4%	4.5%	4.7%	5.2%	5.2%	4.9%	4.5%	4.6%	4.3%	4.5%	4.7%	5%	4.7%	4.9%	4.3%	5%
	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	123.7	156.4	131.9	138.3	149.8	148.5	157.4	149.1	142.7	111.5	122.5	131	123.7	138.3	157.4	111.5	123.7
	AF11B	Percentage Agency Usage	1.8%	1.4%	1.9%	1.6%	1.7%	1.8%	1.8%	1.9%	1.8%	1.7%	1.3%	1.4%	1.5%	1.4%	1.7%	1.9%	1.3%	1.4%
	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	349.8	305.8	380	439.2	494.8	452.7	404.5	404.5	379.6	383.7	389.4	384	349.8	439.2	404.5	383.7	349.8
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.4%	4.2%	3.8%	4.7%	5.3%	6%	5.5%	4.9%	4.9%	4.6%	4.6%	4.7%	4.6%	4.2%	5.3%	4.9%	4.6%	4.2%
	For 2015/16, target is below 5% for Green, 5% or above for Red																			
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	148	137	229	191	137	169	367	205	128	109	133	165	111	137	137	205	133	137
	AF10	Workforce Turnover Rate	13.4%	12.7%	13.6%	13.3%	13.1%	13.4%	13.3%	13.3%	13.1%	12.6%	12.7%	12.5%	12.6%	12.7%	13.1%	13.3%	12.7%	12.7%
	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%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	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%	88%	88%	89%	89%	89%	85%	88%	88%	89%	85%
	AF21b	Essential Training Compliance - Annual Training (Fire & IG)	-	-	-	56%	63%	66%	67%	73%	75%	-	-	-	-	-	63%	73%	-	-
	AF21f	Essential Training Compliance - Fire Safety		83%	-	-	-	-	-	-	-	80%	81%	82%	82%	83%	-	-	81%	83%
	AF21g	Essential Training Compliance - Information Governance		76%	-	-	-	-	-	-	-	76%	76%	76%	77%	76%	-	-	76%	76%
	AF21c	Essential Training Compliance - Induction	-	97%	-	96%	95%	96%	94%	96%	96%	96%	96%	96%	97%	97%	95%	96%	96%	97%
	AF21d	Essential Training Compliance - Resuscitation Training	-	75%	-	78%	79%	79%	77%	81%	81%	81%	83%	85%	85%	75%	79%	81%	83%	75%
	AF21e	Essential Training Compliance - Safeguarding Training	-	91%	-	88%	88%	89%	86%	88%	89%	90%	90%	90%	90%	91%	88%	88%	90%	91%
	Green is above 90%, Red is below 85%, Amber is 85% to 90%																			

Appendix 1

Glossary of useful abbreviations, terms and standards

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

	7. Completion of a Joint Assessment 8. Abbreviated Mental Test done on admission and pre-discharge
GI	Gastrointestinal – often used as an abbreviation in the form of Upper GI or Lower GI as a specialty or tumour site relating to that part of the gastrointestinal tract
ICU / ITU	Intensive Care Unit / Intensive Therapy Unit
LMC	Last-Minute Cancellation of an operation for non-clinical reasons
NA	Nursing Assistant
NBT	North Bristol Trust
NICU	Neonatal Intensive Care Unit
NOF	Abbreviation used for Neck of Femur
NRLS	National Learning & Reporting System
PICU	Paediatric Intensive Care Unit
RAG	Red, Amber Green – the different ratings applied to categorise performance for a Key Performance Indicator
RCA	Root Cause Analysis
RN	Registered Nurse
RTT	Referral to Treatment Time – which measures the number of weeks from referral through to start of treatment. This is a national measure of waiting times.
STM	St Michael's Hospital

Appendix 2

Breakdown of Essential Training Compliance for March 2017:

All Essential Training

	UH Bristol	Diagnostic & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Three Yearly	85%	83%	76%	86%	87%	86%	80%	84%
Annual Fire	83%	82%	84%	80%	85%	84%	85%	82%
Annual IG	76%	76%	73%	74%	76%	80%	80%	76%
Induction & Orientation (I&O)	97%	98%	98%	97%	98%	97%	98%	97%
I&O (Medical & Dental)	71%	33%	N/A	58%	75%	71%	-	77%
Resuscitation	75%	67%	N/A	85%	79%	78%	60%	68%
Safeguarding	91%	93%	88%	92%	92%	90%	92%	88%

Timeline of Trust Essential Training Compliance:

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

Safeguarding Adults and Children

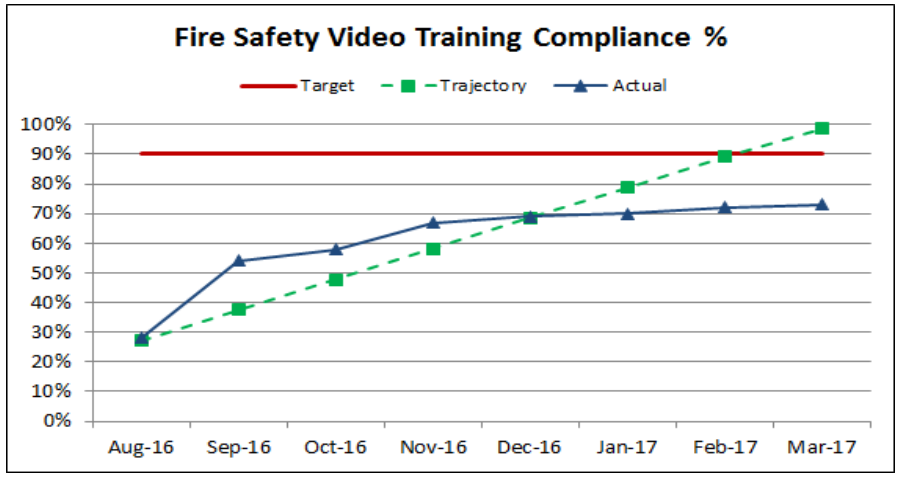
	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Safeguarding Adults L1	**91%**	95%	90%	91%	91%	85%	91%	91%
Safeguarding Adults L2	**91%**	92%	80%	93%	93%	92%	90%	87%
Safeguarding Adults L3	**78%**	75%	N/A	79%	100%	62%	88%	58%
Safeguarding Children L1	**92%**	95%	88%	93%	93%	89%	93%	N/A
Safeguarding Children L2	**91%**	92%	86%	92%	89%	90%	88%	95%

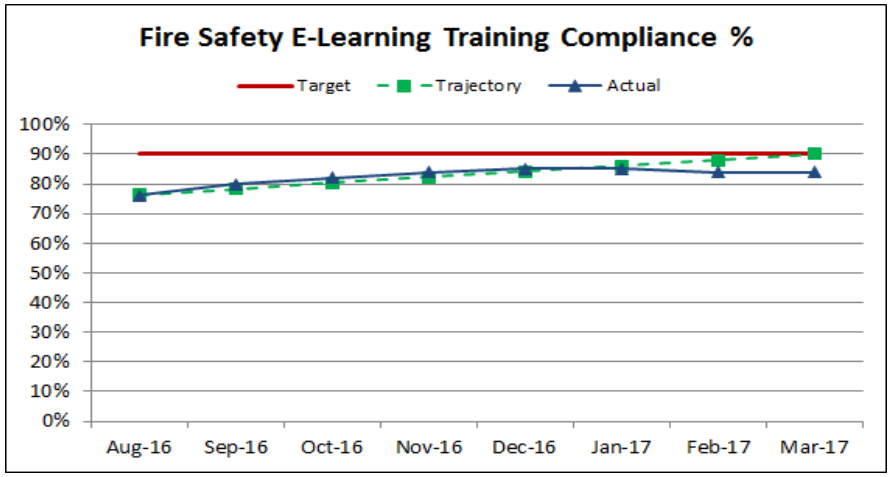
Child Protection Level 3

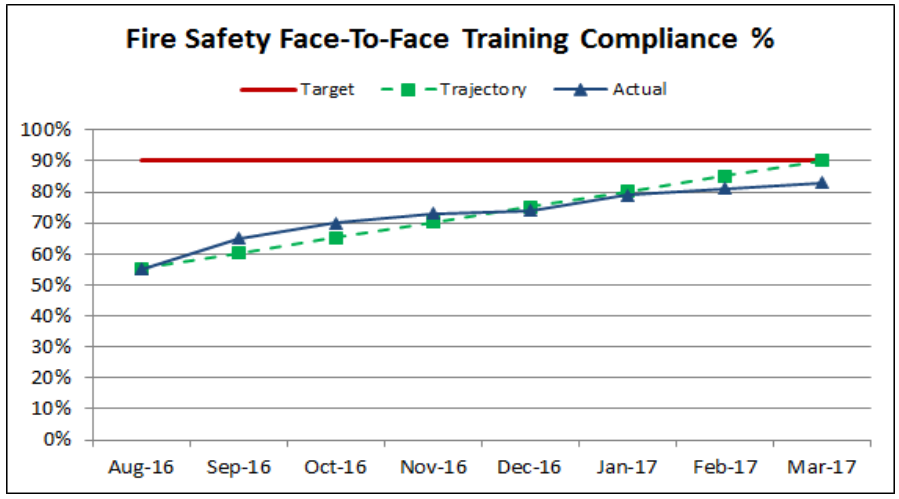
	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women`s & Children`s
Core	**78%**	76%	62%	80%	73%	66%	80%
Specialist	**73%**	-	-	-	-	100%	73%

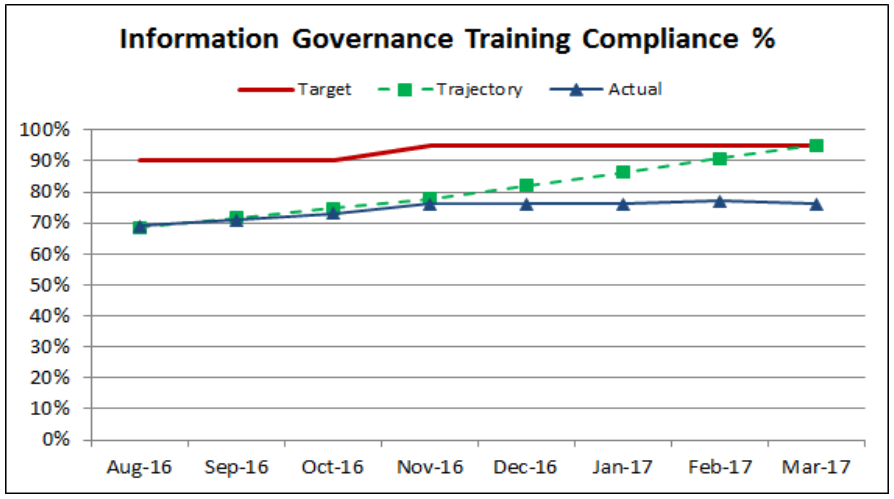
Appendix 2 (continued)

Performance against Trajectory for Fire and Information Governance









Please note: there are two types of fire training represented in these trajectories, two yearly and annual, with different target audiences. In addition, there are a number of staff who require an additional training video under the previous fire training requirements. This will not be a requirement in the future once all are trained. The agreed Trust target for all essential training continues to be 90%, except Information Governance, which has a national target of 95%.

Appendix 2 (continued)

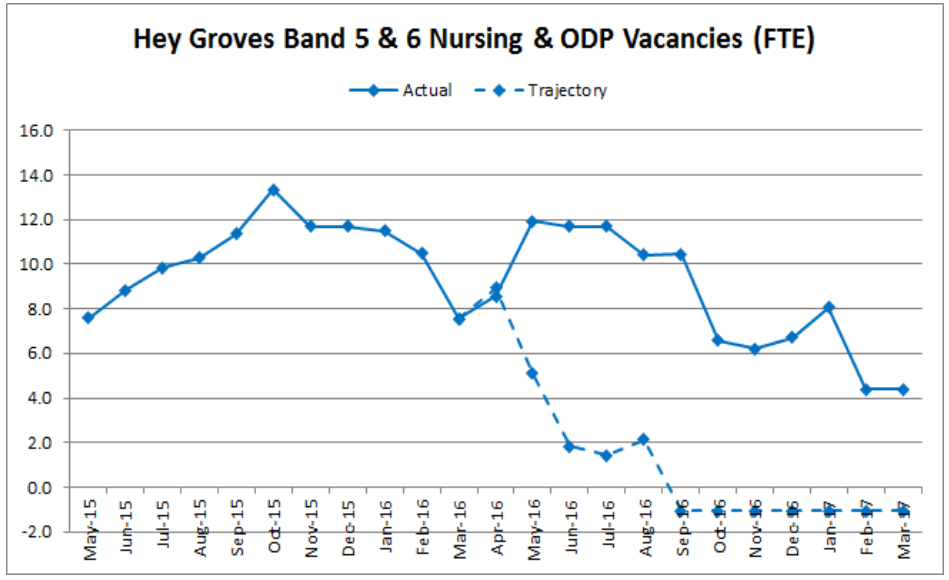
Agency shifts by staff group for 17th February 2017 to 12th March 2017

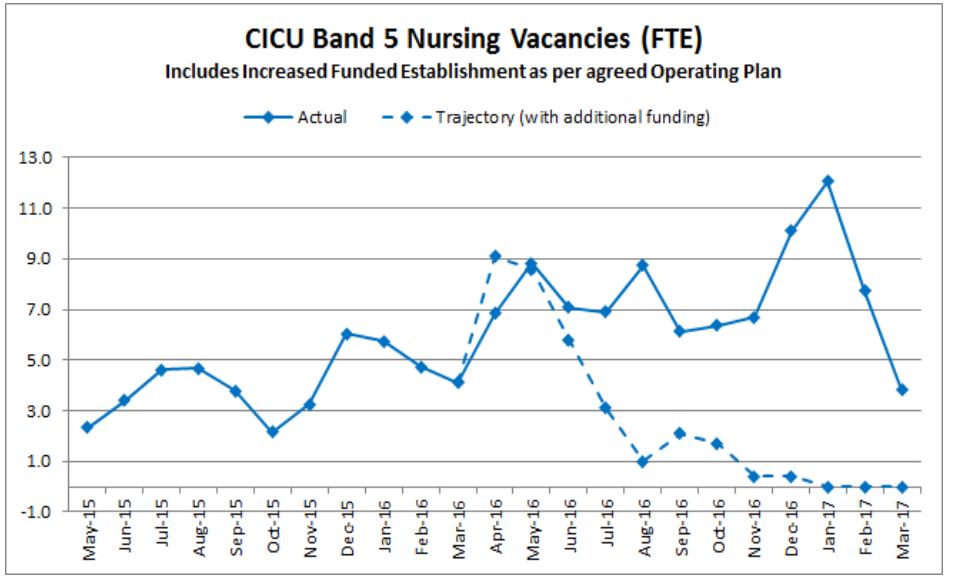
This report provides the Trust with an opportunity to do a retrospective submission to NHS Improvement of all our agency activity for the preceding four calendar week period, confirming over-rides with agency rates, worker wage rates and frameworks.

Staff Group	Within framework and price cap	Exceeds price cap	Exceeds wage cap	Non framework and above both price and wage cap	Exceeds price and wage cap	Total
Nursing and Midwifery	3	58	0	215	917	1193
Health Care Assistant & other Support	52	9	10	10	8	89
Medical & Dental	0	0	0	0	36	36
Scientific, therapeutic / technical Allied Health Professional (AHP) & Healthcare Science	0	0	0	0	0	0
Administrative & Clerical and Estates	958	0	0	0	0	958

Appendix 2 (continued)

Recruitment compared with trajectory for Heygroves Theatres and CICU





Heygroves and CICU have both had new starters, and no longer have exceptional numbers of vacancies. These graphs will not be included in future monthly performance reports.

Appendix 3

Access standards – further breakdown of figures

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

Tumour Site	UH Bristol	Internal operational target	National
Breast†	100%	-	95.9%
Gynaecology	95.7%	85%	74.4%
Haematology (excluding acute leukaemia)	100%	85%	81.3%
Head and Neck	78.9%	79%	59.1%
Lower Gastrointestinal	76.2%	79%	67.8%
Lung	48.3%	79%	71.3%
Sarcoma*	100%	-	74.0%
Skin	92.6%	96%	96.2%
Upper Gastrointestinal	68.4%	79%	71.9%
Urology*†	0.0%	-	71.5%
Total (all tumour sites)	**79.0%**	**85.0%**	**79.6%**
Improvement trajectory	**85.0%**		
Performance for internally managed pathways	**90.5%**		
Performance for shared care pathways	**55.0%**		
Performance with breach reallocation/CQUIN applied	**80.0%**		

*3 or fewer patients treated in accountability terms

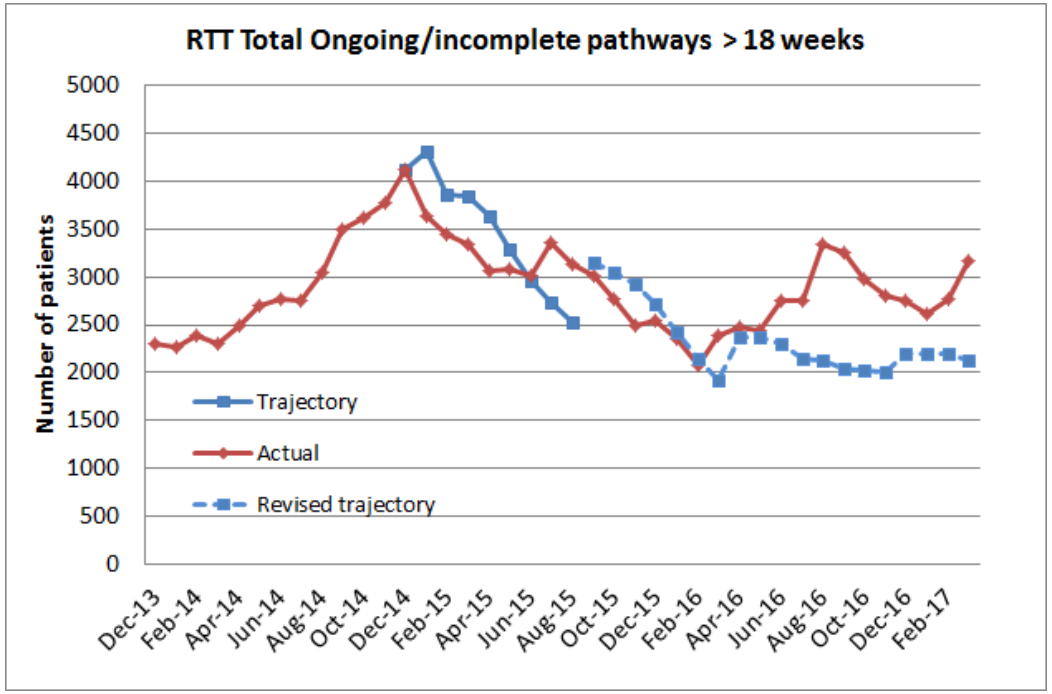
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

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 March 2017

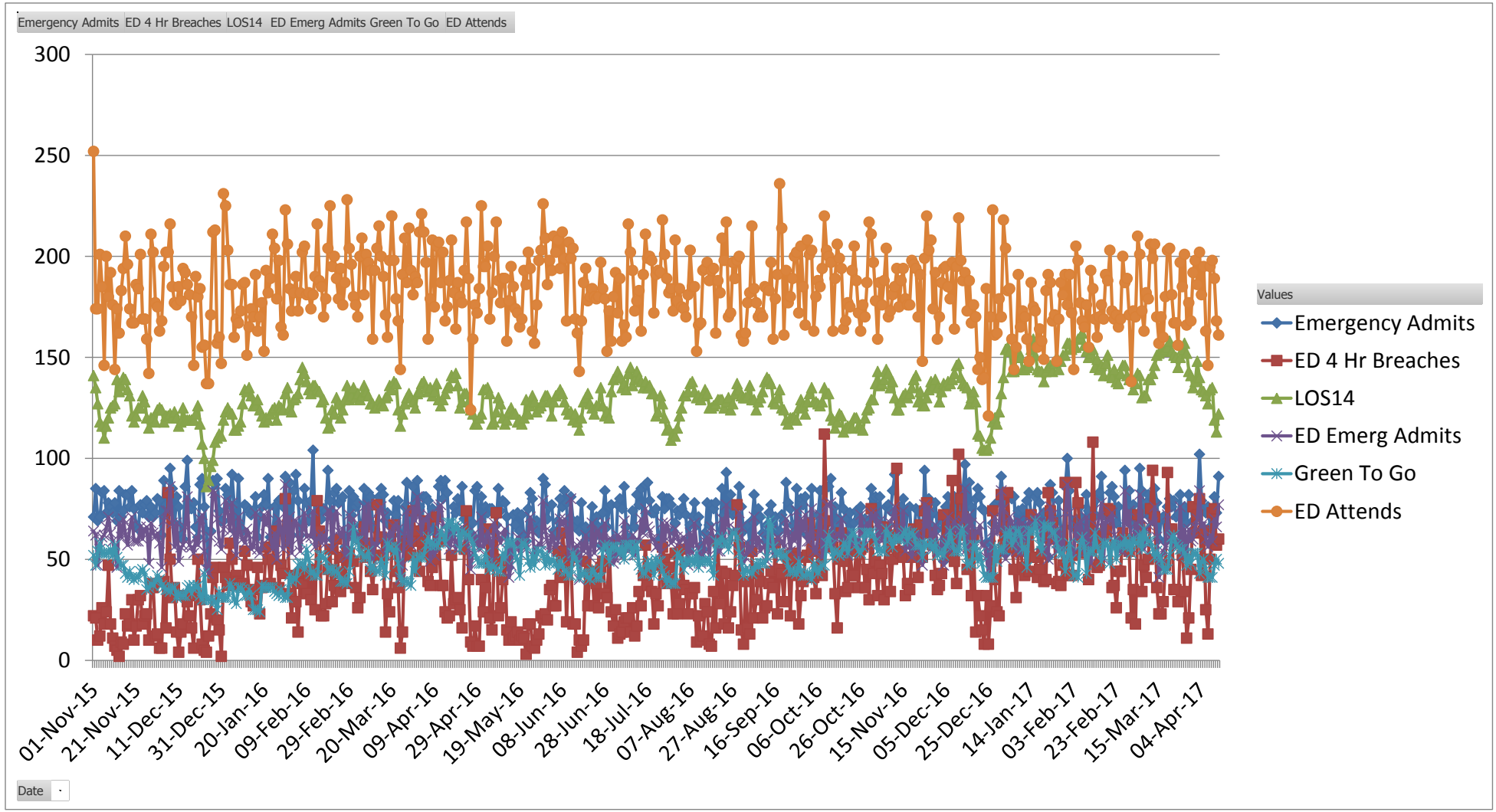
RTT Specialty	Ongoing Over 18 Weeks	Ongoing Pathways	Ongoing Performance
Cardiology	269	2,165	87.6%
Cardiothoracic Surgery	11	268	95.9%
Dermatology	74	2,392	96.9%
E.N.T.	43	2,367	98.2%
Gastroenterology	34	456	92.5%
General Medicine	0	49	100.0%
Geriatric Medicine	2	213	99.1%
Gynaecology	145	1,639	91.2%
Neurology	101	492	79.5%
Ophthalmology	313	5,358	94.2%
Oral Surgery	156	1,745	91.1%
Other	1,877	15,930	88.2%
Rheumatology	7	610	98.9%
Thoracic Medicine	7	931	99.2%
Trauma & Orthopaedics	132	1,095	87.9%
Urology	0	1	100.0%
Grand Total	**3,171**	**35,711**	**91.1%**



	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Non-admitted pathways (target/actual)	1185/2189	1106/2060	1140/1852	1123/1677	1306/1594	1306/1528	1306/1592	1245/1826
Admitted pathways (target/actual)	940/1155	940/1196	890/1126	890/1128	890/1157	890/1091	890/1185	890/1345
Total pathways (target/actual)	2125/3344	2046/3256	2030/2978	2013/2805	2196/2751	2196/2619	2196/2777	2135/3171
Target % incomplete < 18 weeks	93.2%	93.4%	93.4%	93.4%	92.8%	92.8%	92.8%	93.0%
Actual target % incomplete < 18 weeks	90.5%	90.4%	91.2%	92.0%	92.0%	92.2%	92.0%	91.1%
Recovery forecast	N/A	N/A	90.8%	91.4%	91.6%	92.0%	92.0%	92.0%

Appendix 3 (continued)

BRI Flow metrics



Cover report to the Public Trust Board meeting to be held on Thursday, 30 March 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	12
Meeting Title	Trust Board	**Meeting Date**	28 April 2017
Report Title	Independent Review of Children's Cardiac Services Progress Report		
Author	Carolyn Mills, Chief Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose This paper provides an update to Board members on the delivery of the programme plan to address the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network as set out in the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and a CQC expert review of clinical outcomes of the children cardiac service published on 30 June 2016. It also provides and update on work to ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the actions within the programme plan

Key issues to note

The April 2017 Steering Group approved the closure of twelve recommendations:

- recommendation 9
- recommendation 11
- recommendation 12
- recommendation 13
- recommendation 14
- recommendation 16
- recommendation 21
- recommendation 27

- recommendation 28
- CQC action 1
- CQC action 4
- CQC action 5

The aim remains to complete all the actions by June 2017.

Recommendations

Members are asked to:

- **Note** the report.

Intended Audience
(please select any which are relevant to this paper)

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

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

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

Corporate Impact Assessment
(please tick any which are impacted on / relevant to this paper)

Quality	☒	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

N/A

Resource Implications
(please tick any which are impacted on / relevant to this paper)

Finance	☒	Information Management & Technology	☐
Human Resources	☒	Buildings	☐

Date papers were previously submitted to other committees

Audit Committee	Finance Committee	Quality and Outcomes Committee	Remuneration & Nomination Committee	Other (specify)
				Nil

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

1.0 Introduction

This paper provides an update to Board members on development of the programme plan to address the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network as set out in the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and a CQC expert review of clinical outcomes of the children cardiac service published on 30 June 2016. It also provides and update on work to ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the actions within the programme plan.

2.0 Programme management

The tables below details a high level progress update of delivery against the agreed programme plan for the three delivery groups. The plan shows the progress of the work that is ongoing to deliver the actions to support the closure of the recommendations. It also shows where delivery of the actions is not within the initially set timescales.

Table one shows that no recommendations were closed since the last report, one further recommendation moved to red as it was not at a stage to support completion at the delivery group meeting; four actions remain amber rated with six still on target and 9 fully completed. The delivery group status reports and action plans show where the variations are. A more detailed explanation of the reasons for the change in status to a red rating is detailed later in the report. Of the thirteen red rated recommendations nine were closed at the March meetings of the relevant delivery groups and supported for closure by the steering group meeting on the 4th of April.

Table 1: Status all actions

	Actions in Progress						Recommendations Closed by Steering Group
MONTH	**Red**	**Amber**	**Blue- on target**	**Green- completed**	**TBC**	**Not started**	
Sept '16	0	0	16	1	11	4	**0 of 32**
Oct '16	0	0	26	5	1	0	**0 of 32**
Nov'16	0	5	19	8	0	0	**0 of 32**
Dec'16	0	5	19	8	0	0	**2 of 32**
Jan'17	0	18	6	8	0	0	**5 of 32**
Feb'17	12	5	6	9	0	0	**8 of 32**
Mar'17	13	4	6	9	0	0	**8 of 32**

Table 2: Status Women's & Children's Delivery Group (total= 18)

	Actions in Progress						Recommendations Closed by Steering Group
MONTH	**Red**	**Amber**	**Blue- on target**	**Green- completed**	**TBC**	**Not started**	
Sept '16	0	0	13	1	4	0	**0 of 32**

Oct '16	0	0	15	3	0	0	**0 of 32**
Nov'16	0	3	9	6	0	0	**0 of 32**
Dec'16	0	3	9	6	0	0	**2 of 32**
Jan'17	0	9	3	6	0	0	**5 of 32**
Feb'17	6	3	3	6	0	0	**5 of 32**
Mar'17	7	2	3	6	0	0	**5 of 32**

Table 3: Consent Delivery Group (total= 5)

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	**Red**	**Amber**	**Blue- on target**	**Green- completed**	**TBC**	**Not started**	
Sept '16	0	0	1	0	1	3	**0 of 32**
Oct '16	0	0	5	0	0	0	**0 of 32**
Nov'16	0	0	5	0	0	0	**0 of 32**
Dec'16	0	0	5	0	0	0	**0 of 32**
Jan'17	0	4	1	0	0	0	**0 of 32**
Feb'17	4	0	1	0	0	0	**0 of 32**
Mar'17	4	0	1	0	0	0	**0 of 32**

Table 4: Status Incident and Complaints Delivery Group (total= 5)

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	**Red**	**Amber**	**Blue- on target**	**Green- completed**	**TBC**	**Not started**	
Sept '16	0	0	1	0	4	0	**0 of 32**
Oct '16	0	0	5	0	0	0	**0 of 32**
Nov'16	0	2	3	0	0	0	**0 of 32**
Dec'16	0	2	3	0	0	0	**0 of 32**
Jan'17	0	3	2	0	0	0	**0 of 32**
Feb'17	1	2	2	0	0	0	**0 of 32**
Mar'17	1	2	2	0	0	0	**0 of 32**

Table 5: Status Other Actions governed by Steering Group (total=4)

	Actions in Progress	RECOMMENDATIONS CLOSED BY

MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	STEERING GROUP
Sept '16	0	0	1	0	2	1	**0 of 32**
Oct '16	0	0	1	2	1	0	**0 of 32**
Nov'16	0	0	2	2	0	0	**0 of 32**
Dec'16	0	0	2	2	0	0	**0 of 32**
Jan'17	0	2	0	2	0	0	**0 of 32**
Feb'17	1	0	0	3	0	0	**3 of 32**
Mar'17	1	0	0	3	0	0	**3 of 32**

Exception report- Red actions

Recommendation 7 – (Management of follow up appointments) All actions to deliver the recommendation have been completed as has the validation of the outpatient backlog; next steps will be to provide a recovery trajectory for the backlog at the next delivery meeting with a view to signing off the recommendation by May 2017. The risk relating to the potential impact on delivery of the recommendation remains on the risk register.

Recommendation 18 – (risk assessment of cancellations) a request to close was submitted to the March '17 delivery group with associated supporting documentation to support the cancellation process in place in the hospital; the group were unable to establish from the evidence presented whether the process was embedded in practice within cardiac services and therefore did not approve the request to close. Further communication with the cardiac team and scrutiny of the process in place is planned prior to the next delivery group; the timescale for delivery has been extended to May '17 in order to ensure that any actions required to deliver the recommendation can be implemented and reviewed for efficacy.

CQC 2 – (provision of a formal echocardiogram report following surgery) the initial audit, completed in December 2016, of compliance demonstrated 73% of patients had the formal report in their records on admission to PICU; the audit was repeated in February 2017 and demonstrated an improvement to 83% with evidence in the other 27% of a record of echocardiogram being undertaken. The delivery group felt that 100% compliance with the use of the formal report template was required prior to sign off. A further audit will be undertaken and presented to the April delivery group with a view to proceeding to closure of the recommendation by May '17

Recommendation 24 – a request to close was submitted to the April steering group however the CCG representative was unable to attend and there were outstanding queries the meant the recommendation could not be closed and therefore this has been rolled to the May steering meeting.

All other red rated recommendations were supported for closure by the delivery groups and April steering group.

3.0 Risks to Delivery

One new risk to delivery was added to the project risk register:

- Risk to the completion of recommendation 2 with agreed timescales due to the requirement to review the roles and responsibilities of the existing NCHDA data team in order to establish how the additional requirements can be met from within existing resources. The score of this risk was agreed at the steering group to be 6.

4.0 Parent and young person's reference group and family involvement activities

- A listening event took place in conjunction with the Heart Children Gloucester group on 22nd March 2017 with over 50 families in attendance and 19 new families signing up to receive the LIAISE welcome pack and ongoing information. Next steps are to use the successful format from Gloucester to inform development of the Exeter listening event planned for May 2017.

- The foetal pathway questionnaire has been reviewed by the virtual reference group and sent to families for completion; feedback will be collated by the Network group and used to inform next steps for foetal service development and also to support the completion of recommendation 4.
- The network website is currently out to tender with a view to going live in July 2017, the website will signpost families to the hospital website and the information held there.
- Letters are being sent to patients who responded to the young person's survey advising them of the services that we will be offering to them following their feedback. In addition a letter has been devised to give to any new patients who show an interest in helping to develop services advising how to become part of the young persons reference group.

5.0 Wider Communications

The progress review document has been drafted to provide an overview of progress to date for staff, families and members of the public and will shortly be added to the Trust website.

7.0 Recommendations closed

The April 2017 Steering Group approved the closure of twelve recommendations:

- recommendation 9
- recommendation 11
- recommendation 12
- recommendation 13
- recommendation 14
- recommendation 16
- recommendation 21
- recommendation 27
- recommendation 28
- CQC action 1
- CQC action 4
- CQC action 5

Appendix 1

PROGRESS REPORT AGAINST UH BRISTOL RECOMMENDATIONS FROM THE INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SERVICES – March 2017

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

W&C Recommendation's delivery timeframe

MONTH	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '17	Jun '17
Recommendations	**8-** Outpatients experience **Approved as closed by Steering Group (09/01/17)**	**18-** Cancelled Operations risk assessment **-** timescale change request to Feb'17 **Change req to Mar'17 Final SOP and new Next steps SOP with transformation team** March'17 delivery group felt unable to sign off recommendation; all documentation has been produced to support the process however we have been unable to evidence that the process is being followed robustly; request for a further delay to May 17 to enable the demonstration of embedding in practice.	**16-** communication with families about team working/ involvement of other operators timescale change request to Feb'17 **Change request to Mar'17 Intervention leaflet amendment & printing as a trial pending additions** Mar'17 information booklets complete and approved through the divisional assurance process; some FI comments to include and then print, trial and evaluate; RTC supported by delivery group. Subject to steering group sign off an official launch date will be established and communicated to all staff.	**7-** periodic audit of follow up care timescale change request to Feb'17 **Change request to May'17 in view of numbers of outpatients and inpatients requiring validation to establish risk – added to RR** Mar'17 initial validation of data completed; next steps to return to April mtg to consider alternative accommodation for additional clinics and associated costs and equipment requirements		**21-** (Commissioner) - provision of a comprehensive service of Psychological support, Trust-Expression of Interest submission **(green-provider actions)** Mar'17 RTC supported by the delivery group in view of successful recruitment	**2-** NCHDA data team staffing Mar'17 recommendation added to IR risk register (is also on divisional risk register) as no current solution in place to provide additional resource to the data collection team.		
		20- End of life care and bereavement support **(approved as closed by Steering group 07/02/17)**	**23-** reporting and grading of patient safety issues **(approved as closed by Steering group 07/02/17)**	**9 &11-** Benchmarking exercise (gaps/actions/implement plan) timescale change request to Feb'17 **Change request Mar'17 – benchmarking almost complete – action plan to be devised** Mar'17 feedback provided to support the RTC of recommendations with the caveat that, as the action plan is a work in progress it would be held and progressed by the cardiac business meeting.			**3 & CQC 5-** review access to information – diagnosis and pathway of care Mar'17 rec. 3 progressing to plan CQC 5 supported for closure in view of the production of information sheets to support over 33 different operations; FI comments to be incorporated and then print, trial and evaluate		

		CQC 3- Pain and comfort scores **Approved as closed by Steering Group (06/12/16)**	**CQC 4** CNS recording of discussions with families in notes timescale change request to Feb'17 **Change request to Apr 17 to allow for additional training** *Mar17 delivery group supported RTC in view of provision of medway communications page in use and accessible to all appropriate staff, plan to audit quality of records and return to delivery group.*	**CQC 6-** Discharge planning to include AHP advice **(approved as closed by Steering group 07/02/17)**			**4-** Support for women accessing fetal services between Wales and Bristol – *timescale change request to Jun '17* *Mar'17 update, FI review of questionnaire complete, letter produced to*		
		CQC 2 Formal ECHO report during surgery *change request to Mar'17 to allow re-audit Mar'17 re-audit shows an improvement in the use of the echo forms however they are still not in use 100% of times. Request to amend delivery date to May'17 to allow for reaudit*					**5-** Improved pathways of care paed. cardiology services between Wales and Bristol – *timescale change request to May '17*		

	Progress overview						**Detailed actions**				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
2	That the Trust should review the adequacy of staffing to support NCHDA's audit and collection of data.	Deputy Divisional Director	Apr '17	**Blue- on target**	None		Review of staffing	Assistant General Manager for Paediatric Cardiac Services	Sept '17	**Green- complete**	Staffing review report
							Results and recommendations reported at Women's and Children's Delivery Group in Sept. '16.	Assistant General Manager for Paediatric Cardiac Services	Sept '17	**Green- complete**	Women's and Children's Delivery Group Agenda and minutes 20.09.16

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							Requirement for additional staff will feed into business round 2016-17	Assistant General Manager for Paediatric Cardiac Services	Apr' 17	**Blue- on target**	Expression of interest form and Women's and Children's Operating Plan Feb Meeting – review of current resources (FU/VM) Mar'17 added to IR RR in view of concerns over ability to meet recommendation requirements due to lack of support for additional resource
3	That the Trust should review the information given to families at the point of diagnosis (whether antenatal or post-natal), to ensure that it covers not only diagnosis but also the proposed pathway of care. Attention should be paid to the means by which such information is conveyed, and the use of internet and electronic resources to supplement leaflets and letters.	Specialist Clinical Psychologist	Apr '17	**Blue- on target**			Information given to families at the point of diagnosis reviewed by the clinical team and the cardiac families – remaining information for Catheter Procedures and Discharge leaflet. Website and leaflets updated to reflect improvements	Clinical Team & Cardiac Families	Jan' 16	**Green- complete**	Revised patient information leaflets
							Links to access relevant information to be added to the bottom of clinic letters for patients.	Specialist Clinical Psychologist	Dec '16	**Green - Complete**	Clinic letter with links (examples Feb mtg docs)
							Review and amendment of Catheter and Discharge leaflet	Cardiac CNS team	Feb' 17	**Green - Complete**	Revised Catheter and Discharge leaflet Feb mtg – this may replicate work in recomm 16 CNS team to check (JH/ST)
							Enhance existing information with a visual diagram displaying pathways of care (FI).	Specialist Clinical Psychologist	Apr' 17	**Blue- on target**	Pathways of Care devised – update to come to Mar'17 mtg re opportunities to link with Network website to enable interactive

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											functionality VG/LS to discuss timescales to share with Virtual group Mar'17 visual pathways shared at listening event – supportive of structure and content; charitable funding secured; designer commissioned with a timescale of draft drawings by April 17 mtg for RTC
							Website proposal to be written for new Children's website including cardiac information similar to Evelina to improve accessibility of our information. *This will be additional and not essential for delivery of the recommendation* (FI).	LIAISE Team Manager and Specialist Clinical Psychologist	tbc	**Started**	
							Smart phone App proposal to be written for Cardiac Services to enable patient/families to access information electronically (FI). *This will be additional and not essential for delivery of the recommendation*	LIAISE Team Manager and Specialist Clinical Psychologist	tbc	**Not started**	
4	That the Commissioners and providers of fetal cardiology services in Wales should review the availability of support for women, including for any transition to	CHD Network Clinical Director	Apr '17	**Amber – behind plan**	Risk that we are unable to get commitment / agreement on the changes that are required across the	Jun 17 due to delay in engagement with UHW and the operational challenges in their fetal cardiology service	Meeting arranged for 18th November with English and Welsh commissioners as well as Bristol and Cardiff trusts to establish: 1. Commissioner oversight of network 2. Commissioner support for IR actions (4,5 &11) 3. Establishment of working group(s) to address the specific changes in practices required	CHD Network Clinical Director and Network Manager	Nov '16	**Green - complete**	Agreed pathway of care in line with new CHD standards and in line with patient feedback

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	Bristol or other specialist tertiary centres. For example, women whose fetus is diagnosed with a cardiac anomaly and are delivering their baby in Wales should be offered the opportunity, and be supported to visit the centre in Bristol, if there is an expectation that their baby will be transferred to Bristol at some point following the birth				two hospitals / commissioning bodies Risk that operational challenges in delivery of the fetal cardiology service in UHW prevent focus on the achievement of this recommendation business plan						
							Ahead of the meeting: define specifics of recommendation (e.g. approaches to diagnosis and counselling); options for patient involvement (survey then focus group); CHD standards that relate to this recommendation; examples of practice from other centres	CHD Network Clinical Director and Network Manager	Nov '16	**Green-complete**	
							University Hospital Wales to define how additional foetal sessions will be delivered and who from foetal cardiology will lead the recommendation implementation and collaborate with Bristol to set up working group in January	Clinical Director for Acute Child Health, university hospital wales	~~Dec '16~~ Revised to Mar '17. UHW have appointed lead, but have not yet resolved operational issues	**Green - Complete**	Feb mtg – outline plan for foetal sessions, process to manage referral through acceptance criteria in short term
							Foetal working group to define changes / new pathways, taking account of patient feedback	Working group	~~Jan '17~~ Revised to Feb '17. Working group established, but struggling to coordinate diaries for meeting	**Amber – behind plan**	Feb mtg - Changes defined; joint review of approach to counselling; establishment of joint service review meeting Outstanding – patient feedback; survey complete ready to go to QIS group before circulation Mar'17 foetal survey being sent

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											out having been for FI feedback which has been incorporated.
							Undertake patient survey and focus groups (FI).	CHD Network Manager	~~Jan '17~~ Revised to Jun 17due to delay in engagement with UHW and the operational challenges in their fetal service	**Amber – behind plan**	As above
							Co-design the offer with patient representatives for women whose fetus has been diagnosed with cardiac anomaly and deliver agreed model.	CHD Network Manager	Apr 17	**Blue- on target**	Feb mtg -Focus group to come from survey results Mar'17 as above
							New pathways in place	CHD Network Clinical Director and Network Manager	~~Apr '17~~ Revised to Jun 17	**Amber – behind plan**	Feb mtg - Summary paper showing previous and new ways of working, detailing an assessment of the benefits; Pathways to follow completion of actions above
5	The South West and Wales Network should regard it as a	CHD Network Clinical	Apr '17	**Amber – behind plan**	Risk that we are unable to get	Final completion delayed to May 17 due to initial	Network Manager and Network Clinical Director to contact Welsh Commissioners and University of Hospital of Wales to meet to	CHD Network Manager	Nov 16	**Green- complete**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	priority in its development to achieve better co-ordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol.	Director			commitment / agreement on the changes that are required across the two hospitals / commissioning bodies Risk that lack of paediatric cardiology lead in UHW delays the ability to undertake actions	delay getting engagement from UHW	discuss and agree process including method of monitoring its implementation				
							Set up joint working group set up with Network Team facilitating. UHB, UHW and commissioners to deliver the relevant actions and improvements required for service.	CHD Network Manager	Dec 16	**Green-complete**	Minutes of meeting and action plan
							To define the opportunities for improvement in coordination and the actions to achieve this	CHD Network Manager	Dec 16	**Green-complete**	Action plan
							To undertake a patient engagement exercise (e.g. focus group, survey, online reference group) to test the proposed options for improvement	CHD Network Manager	Jan 17	**Green - complete**	Feb mtg - Proposal sent to virtual ref group, 1 response to date which will be incorporated into plans; any further feedback received will be incorporated
							Deliver actions to improve coordination	CHD Network Manager	May 17	**Blue- on target**	Feb mtg - improved in-pt transfer process; joint audit and training; improved IT for sharing images; standardised patient information; further changes required to meet recommendation
7	The paediatric cardiac service in Bristol should carry out periodic audit of follow-up care to ensure that the care is in line with the intended treatment plan, including with regards to the timing of follow-up	Deputy Divisional Director	Jan '17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	None	Timescale change request to Feb'17 to provide assurance about backlog validation Timescale change request to May 17 in	Audit proposal submitted to the audit facilitator for inclusion on the Children's annual audit plan	Patient Safety Manager	Aug '16	**Green-complete**	Audit proposal
							Conduct 1st annual audit into follow up care for cardiac patients as per recommendation	Patient Safety Manager	Nov '16	**Green-complete**	Audit report
							Report findings of the audit	Patient Safety Manager	Jan '17	**Green-complete**	Audit presentation and W&C delivery group Agenda and

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	appointments.					view of requirement to validate backlog to establish risk – item added to risk register					minutes November meeting
							System developed for the regular reporting and review of follow up waiting lists at monthly Cardiac Business meeting.	Assistant General Manager for Paediatric Cardiac Services	Aug '16	**Green-complete**	Follow up backlog report, Cardiac Monthly Business meeting standard agenda Feb mtg – validation work ongoing; added to RR (VM/FU) action can be RTC once complete and any risks established Mar'17 validation complete; options for delivering additional activity being scoped as described above.
8	The Trust should monitor the experience of children and families to ensure that improvements in the organisation of outpatient clinics have been effective.	Nurse Project Lead	Oct '16	**Approved as closed by Steering Group (09/01/17)** **22/11/16- approved for closure by W&C delivery group**			Baseline assessment (monthly outpatient survey) of current experience of children and families in outpatients reviewed)	Outpatients Experience working group	Aug '16	**Green-complete**	1.Outpatients and Clinical Investigations Unit Service Delivery Terms of Reference
							Gap analysis of current monitoring vs monitoring required to understand patients experience of the organisation of outpatient's completed	Outpatients Experience working group	Sept '16	**Green-complete**	2. Outpatients and Clinical Investigations Unit Service Delivery Group

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							Systems in place for regular and specific monitoring, and reviewing and acting on results (FI)	Outpatients & CIU Service Delivery Group	Oct '16	**Green-complete**	Agenda(3.10.16) 3. Outpatients and Clinical Investigations Unit Service Delivery minutes of meeting (3.10.16) 4. OPD Patient Experience Report (October 2016) 5. Paediatric Cardiology – Non-Admitted RTT Recovery (Appendix 1) 6. Cardiology Follow-Up backlog update (Appendix 7. Project on a Page: Outpatient Productivity at BRHC (Appendix 7)
9	In the light of concerns about the continuing pressure on cardiologists and the facilities and resources available, the Children's Hospital should benchmark itself against comparable centres and make	Divisional Director	Jan'17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Risk that other sites are unable to share data required to complete a comprehensive benchmarking exercise	Request to delay to Feb '17 due to late return of benchmarking Request to delay to Mar'17 as some benchmarking data received	Undertake benchmarking exercise with other CHD Networks, reviewing a defined list of criteria including aspects such as: job planning, IT and imaging links, information governance. To include site visits as appropriate	CHD Network Manager	Jan '17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Feb mtg - Benchmarking data collection analysis ongoing Site visits dates to be agreed for Mar mtg (JD) Mar'17 RTC supported by delivery group with the caveat

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	the necessary changes which such an exercise demonstrates as being necessary.				Dependent on the action required to address the gaps it may not be possible to have implemented all the changes in the timescale.	late; analysis ongoing with visits to be planned by Mar'17					that the action plan is held by the cardiac business meeting for completion
							Identification of actions required to address the gaps	CHD Network Manager	Jan '17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Gaps to be identified from completion of analysis; action held by Cardiac business group (JD)
							Progress to implementing any changes in practice that are deemed necessary	CHD Network Manager and Divisional Director	Jan '17 Revised to Feb '17. Delayed responses from other centres	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	As above, change implementation plan to be devised following gap analysis (JD)
11	That the paediatric cardiac service benchmarks its current arrangements against other comparable centres, to ensure that its ability, as a tertiary 'Level 1' centre under the NCHD Standards, to	CHD Network Clinical Director	Jan'17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Linked to recommendation no.9. Actions detailed under recommendation no. 9 will also achieve recommendation no. 11. Risks to delivery, timescales, progress against delivery and evidence will be the same as per recommendation no. 9 Mar'17 benchmarking complete; RTC supported by delivery group						

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	communicate with a 'Level 2' centre, are adequate and sufficiently resourced. Benchmarking would require a study both of the technical resources underpinning good communication, and the physical capacity of clinicians to attend planning meetings such as the JCC (Links to recommendation no. 5)										
16	As an interim measure pending any national guidance, that the paediatric cardiac service in the Trust reviews its practice to ensure that there is consistency of approach in the information provided to parents about the involvement of other operators or team members.	Clinical Lead for Cardiac Services and Consultant Paediatric Cardiac Surgeon	Dec '16	**Red – second revision of timescales**		Request delay to Feb'17 to allow update of catheter leaflets in line with surgery ones Request delay to Mar'17 to allow completion of intervention leaflet and consideration for any others requiring this information to be included.	Enhance existing guidance to describe team working and in particular the involvement of other operators and team members in patient care. Review by the Trust wide consent group and Cardiac Clinical Governance for approval and then implement.	Consultant Paediatric Surgeon and Specialist Clinical Psychologist	Dec '16	**Green-complete**	Revised 'Preparing for Surgery' leaflet and email to surgeons about new guidance VG/LS to add updated leaflets to website Consider revision of ward 32's leaflet to replicate changes made (ST) Complete changes to interventional leaflet (AP) and produce in draft as a trial for use with patients (ST). Mar'17 Booklets produced and formatted; shared widely for family

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											input; signed off by business meeting with all comments incorporated prior to printing, trial and evaluation – RTC supported by delivery group
18	That steps be taken by the Trust to review the adequacy of the procedures for assessing risk in in relation to reviewing cancellations and the timing of re-scheduled procedures within paediatric cardiac services.	Deputy Divisional Director	Nov '16	**Red – second revision of timescales**		Request delay to Feb'17 to allow implementation of new cancellation policy Request delay to Mar'17 to allow development of next steps SOP to support process Request to delay to May '17 to enable the demonstration of the implementation of the process to risk assess patients adequately	Assessment of current process of risk assessing patients who have been cancelled and the timing of their rescheduled procedure	Cardiac Review Programme Manager	Aug '16	**Green-complete**	Current process review report
							Develop new and improved process for risk assessing cancelled patients ensuring outcomes of this are documented	Consultant Paediatric Surgeon and Cardiac Review Programme Manager	Nov '16	**Green-complete**	JCC performance review meeting agenda and cancelled operations report Sops for cancellation and next steps being reviewed/devised for presentation at Mar'17 mtg (ST) March'17 delivery group felt unable to sign off recommendation; all documentation has been produced to support the process however we have been unable to evidence that the process is being followed robustly

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
20	That the Trust should set out a timetable for the establishment of appropriate services for end-of-life care and bereavement support.	Deputy Divisional Director	Nov '16	**Green-complete**	None		End-of-life care and bereavement support pathway developed (FI)	Deputy Divisional Director	Sept '16	**Green-complete**	End-of-life and bereavement support pathway
							Implementation and roll out of new pathway	Deputy Divisional Director	Nov '16	**Green-complete**	Communication and presentations to roll out
21	Commissioners should give priority to the need to provide adequate funds for the provision of a comprehensive service of psychological support	Commissioners		**Green-complete (provider actions)**			Previous submission to commissioners for psychological support updated	Head of Psychology Services	Sept '16	**Green-complete**	Submission to Commissions
							Expression of Interest for increased resource to be submitted as part of business planning	Head of Psychology Services / Deputy Divisional Director	Mar'17	**Green-complete**	Expression of interest and W&C Business plan Mar 17 update Recruitment completed RTC supported by delivery group
23	That the BRHC confirm, by audit or other suitable means of review, that effective action has been taken to ensure that staff possess a shared understanding of the nature of patient safety incidents and how they should be ranked.	Deputy Divisional Director	Dec '16	**Green-complete**	None		Review results of Trust wide Manchester Patient Safety (MAPSAF) to understand current baseline for both team level and divisional staff views on patient safety incident reporting and management	Deputy Divisional Director	Sept '16	**Green-complete**	
							Annual programme- Targeted approach to all staff groups to be developed with implementation of bespoke training and regular updates to clinical staff	Deputy Divisional Director	Dec '16	**Green-complete**	Training plan and log of attendance
CQ C.2	Provision of a formal report of transoesophageal or epicardial echocardiography performed during surgery	Clinical Lead for Cardiac Services	Nov '16	**Amber-behind target**		Mar '17 Delayed to allow audit to demonstrate improvement	ECHO form for reporting in theatres implemented	Consultant Paediatric Cardiologist	Aug '16	**Green-complete**	
							Audit to assess implementation (Nov'16) and request to Steering Group to close	Patient Safety Manager	~~Nov '16~~ Revised to Mar 17	**Amber-behind target**	Repeat audit results expected at Mar'17 delivery group with a view to proposing closure of

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											recommendation (JM/BS) Mar'17 audit shows improvement however not 100% compliance at present therefore further communication to clinicians and reaudit prior to closure
CQ C. 3	Recording pain and comfort scores in line with planned care and when pain relief is changed to evaluate practice	Ward 32 Manager	Aug '16	**Green-complete** **22/11/16-approved for closure by W&C delivery group**			Documentation developed to record pain scores more easily	Ward 32 Manager	Jan'16	**Green-complete**	Nursing documentation
							Complete an audit on existing practise and report findings	Ward 32 Manager	Aug '16	**Green-complete**	Audit of nursing documentation
CQ C. 4	Ensuring all discussions with parents are recorded to avoid inconsistency in communication. This includes communications with the Cardiac Liaison Nurses, who should record contacts with families in the patient records (links with review recommendation 12)	Head of Nursing	Dec '16	**Amber-behind target**		Request delay to Feb'17 to ensure process is robust Request delay to Apr'17 in view of potential training needs for staff	Work with Cardiac Nurse Specialists to improve recording communication in the patients' medical records and review option of Medway proforma's to support recording in notes	Head of Nursing	~~Dec '16~~ Feb 17 revised timescale for wider issue	**Green-complete**	Examples of stickers in notes and Heartsuite entries Audit of compliance to be undertaken by MG/VG pre Mar mtg Process to provide consistent recording in accessible patient records to be established (ST) Mar'17 Medway record in place and in use; RTC supported by delivery group subject to audit of quality of records

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											to return to delivery group April 17 (MG/VG)
CQC. 5	Providing written material to families relating to diagnosis and recording this in the records. (links to review recommendation 3)	Clinical Lead for Cardiac Services	Apr '17	**Blue- on target**	Linked to recommendation no. 3. Actions detailed under recommendation no. 3 will also achieve CQC recommendation no. 5 Mar'17 Information sheets produced and formatted; shared widely for family input; signed off by governance meeting with all comments incorporated prior to printing, trial and evaluation; RTC supported by delivery group.						
CQC.6	Ensuring that advice from all professionals involved with individual children is included in discharge planning to ensure that all needs are addressed.	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Jan '17	**Green-complete**		Agreed mechanism for including AHP advice into discharge planning for children within Cardiac Services	Assessment of current Allied Health Professionals input into discharge planning for Cardiac Services Audit completed and results to be formulated 27th October 2016.	Head of Allied Health Professionals	Oct '16	**Green-complete**	Assessment documentation
							Agree with Cardiac Services Team an effective mechanism for including Allied Health Professionals into discharge planning for Cardiac Services. Meeting setup for 4th November.	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Nov'16	**Green-complete**	Agreed mechanism for including AHP advice into discharge planning for children within Cardiac Services
							Implement agreed mechanism for including Allied Health Professionals into discharging planning for Cardiac Services	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Jan 17	**Blue – on target**	Implementation plan delivery report

Appendix 2 - Trust wide Consent Delivery Group Action Plan – Senior Responsible Officer: Jane Luker, Deputy Medical Director

TW Consent delivery timeframe – March 2017

MONTH	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '17	Jun '17
Recommendations			**12-** That clinicians encourage an open and transparent dialogue with patients and families upon the option of recording conversations when a diagnosis, course of treatment, or prognosis is being discussed. Request to delay completion to Mar 17 due to ongoing discussion about inclusion of details in patient information Mar 17 update – request to close submitted to April steering group	**13-** Review of Consent Policy and the training of staff, to ensure that any questions regarding the capacity of parents or carers to give consent to treatment on behalf of their children are identified and appropriate advice sought Mar 17 update - Request to close submitted to April steering group				**17-**That the Trust carry out a review or audit of (I) its policy concerning obtaining consent to anaesthesia, and its implementation; and (ii) the implementation of the changes to its processes and procedures relating to consent	
				14- Review of Consent Policy to take account of recent developments in the law in this area, emphasising the rights of patients to be treated as partners by doctors, and to be properly informed about material risks Mar 17 update - Request to close submitted to April steering group					
				CQC1- Recording the percentage risk of mortality or other major complications discussed with parent/carers on consent forms Mar 17 update - Request to close submitted to April steering group					

	Progress overview	Detailed actions

No.	Recommendation	Lead Officer	Completion date of recommendation	Status	Delivery Risks	Revised timescale & reason	Actions to deliver recommendations	By	When	Status	Evidence
12	That clinicians encourage an open and transparent dialogue with patients and families upon the option of recording conversations when a diagnosis, course of treatment, or prognosis is being discussed.	Medical Director	Dec '16	Red		Request to delay to Feb '17 to enable new guidance to be incorporated into cardiac surgery leaflet Feb 17 – Req to delay to Mar 17 Details not currently in cardiac surgery or intervention leaflet	**12.1** Guidance developed to medical staff to ensure patients and families are given the option to record conversations when a diagnosis, course of treatment, or prognosis is being discussed	Medical Director	Aug '16	**Green-completed**	Medical Staff Guidance
							12.2 Review of new existing guidance to reflect the recommendation and include recommendation in updated consent policy , guidance notes and e-learning	Deputy Medical Director	Nov '16	**Green-Completed**	Consent policy Guidance on consent policy e-learning for consent
							12.3 Incorporate new guidance into existing Children's Consent pathway (existing letter that goes to families before their surgical appointment) (FI)	Consultant Paediatric Cardiac Surgeon	Dec '16	**Green**	Parent/Patient information booklet to be sent with letter to families Feb 17 Not currently added to patient letter or information
13	That the Trust review its Consent Policy and the training of staff, to ensure that any questions regarding the capacity of parents or carers to give consent to treatment on behalf of their children are identified and appropriate advice sought	Deputy Medical Director	Jan '17	Red	E-learning lead is currently on long term sick which has led to a delay in updating e-learning material	Request to delay to Feb '17. Actions are complete, but need to be reviewed and signed off by Delivery Group. Request to delay to Mar 17 steering as consent group have not met; plan to agree evidence virtually in order to progress	**13.1** Trust wide Consent delivery group set up	Deputy Medical Director	Sept '17	**Green-Completed**	Terms of reference for Trust Wide Consent Group Minutes and actions from meetings
							13.2 Review the consent policy and agree a re-write policy or amend existing policy to ensure patients and clinicians are supported to make decisions together	Consent Group	Nov'16	**Green Completed**	Revised consent policy ratified by CQC December 2016
							13.3 Develop training and communication plan	Deputy Medical Director	Dec '16	**Green Completed**	Training and communications plan Multi professional Consent workshop 6th April 2017
							13.4 Advice from legal team and safeguarding on revised consent policy and e-learning	Deputy Medical Director	Nov '16	**Green Completed**	Legal and safeguarding agreement and comments on consent policy and

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											e-learning
							13.5 Update e-learning for any changes to consent policy and process	Deputy Medical Director	Jan '17	**Green Completed**	Updated E-learning package for consent
14	That the Trust reviews its Consent Policy to take account of recent developments in the law in this area, emphasising the rights of patients to be treated as partners by doctors, and to be properly informed about material risks	Deputy Medical Director	**Linked to recommendation no. 13, actions, timescales and status as detailed under this recommendation – Red – delayed, date completion now anticipated to be Mar 17**								
17	That the Trust carry out a review or audit of (I) its policy concerning obtaining consent to anaesthesia, and its implementation; and (ii) the implementation of the changes to its processes and procedures relating to consent	Deputy Medical Director	May'17	**Blue- on target**			**17.1** Anaesthetic group to be set up to review current practise in pre-op assessment in relation to consent for anaesthesia and how they can implement a consent for anaesthesia process trust wide (FI)	Consultant Paediatric Cardiac Anaesthetist	Dec '16	**Green Completed**	Minutes and actions from meeting
							17.2 Liaise with Royal College of Anaesthesia and other appropriate professional bodies with regarding national policy	Paediatric Anaesthesia consent group	Jan' 17	**Green Completed**	Correspondence with Royal College of Anaesthetists and Associations AAGBNI Guidance on Consent January 2017
							17.3 Implementation plan for trust wide consent process	Paediatric Anaesthesia consent group	May '17	**Green Completed**	Business case for paediatric pre-op assessment – planned for April 2017 therefore rtc to be submitted for May 17 meeting

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
CQC. 1	Recording the percentage risk of mortality or other major complications discussed with parents or carers on consent forms	Deputy Medical Director	Jan' 17	**Red**		Request to delay to Feb '17. Actions have been completed, but there was insufficient time to get new consent forms printed in time for January sign off. Request to delay to Mar'17 mtg to allow for all consent forms to be amended This Recommendation will go to next consent group meeting for approval to sign off	**1.1** Review trust wide consent form in use to agree whether they should be amended to improve recording of risk	Consent Group	Dec '17	**Green**	Updated / amended trust consent forms
							1.2 Paediatric Cardiac Services to agree whether service would benefit from a bespoke cardiac consent form that includes percentage risk	Consultant Paediatric Cardiac Surgeon	Nov '16	**Green**	Agreement of Paediatric Consent Group to utilise bespoke consent forms where appropriate
							1.3 Cardiac Services- agree and implement process for discussing percentage risk with families (FI)	Consultant Paediatric Cardiac Surgeon	Nov '16	**Red**	Information and consent forms available to parents Which outline the procedure and include percentage risks. Thses will supplement consent forms

Appendix 3 Trust wide Incidents and Complaints Delivery Group Action Plan – Senior Responsible Officer; Helen Morgan, Deputy Chief Nurse

TW Incidents and complaints delivery timeframe – March 2017

MONTH	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '17	Jun '17
			28-That guidance be drawn up which identifies when, and if so, how, an 'independent element' can be introduced into the handling of those complaints or investigations which require it. *Request to delay to Feb ' 17* *Feb mtg – sufficient evidence to complete recommendation to close for March meeting but now red as did not meet revised date;* *Evidence complete, RTC to Apr steering*	**26-** Development of an integrated process for the management of complaints and all related investigations- *timescale changed from Jan '17 to Jun '17* Mar mtg progress noted; work still to do re integrating adult information and further FI following inclusion of their comments to date			**29 -** Options for more effective handling of complaints, including the introduction of an independent element, serious consideration be given to offering as early as possible, alternative forms of dispute resolution, such as medical mediation. Mar mtg – evidence complete; awaiting outcome of QAC to recommend next steps before RTC		**27-** Design of the processes (26) should take account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue Mar mtg – evidence complete; action plans for ongoing monitoring in place therefore RTC to be submitted to the Apr steering group
			30 - Review its procedures to ensure that patients or families are offered not only information about any changes in practice, seek feedback on its effectiveness, but also the opportunity to be involved in designing those changes and overseeing their implementation- *timescale changed from Dec '16 to Apr'16* *Mar mtg progress noted; work still to do*						

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
26.	That the Trust should explore urgently the development of an integrated process for the management of complaints and all related investigations following either a death of a child or a serious incident, taking account of the work of the NHS England's Medical Directorate on this matter. Clear guidance should be given to patients or parents about the function and purpose of each element of an investigation, how they may contribute if they so choose, and how their contributions will be reflected in reports. Such guidance should also draw attention to any sources of support which they may draw upon.	Chief Nurse	Jan '17	**Amber-behind target**		Jun'17 additional and amended actions to fulfil recommendation	**26.1** Develop an appendix to the Serious Incident (SI) policy defining "link" between Child Death Review (CDR), complaints and SI investigations / reporting, includes adults and children.	Women and Children's Head of Governance	July '16	**Green-Complete** ***Approved by delivery group 15.11.16***	Link between serious incidents and other investigatory procedures (e.g. Complaints and Child Death Review) July 2016
							26.2 Develop and implement guidance for staff in **children's services** on standards procedures / practices that need to be followed to provide a high quality and equitable service for all patients / families in the event of bereavement.	Women and Children's Head of Governance	Dec '16	**Green – complete. 10.01.17 5/8 members approved, remainder virtually.**	Document approved within the Division via Quality Assurance Group. Monitored weekly at the Bereavement Group. Audit Apr 17 Audit of compliance complete; action plan sits with bereavement group
							26.3 Develop and implement guidance for staff in **adult services** on standards procedures / practices that need to be followed to provide a high quality and equitable service for all patients / families in the event of bereavement.	Head of Quality (Patient Safety)	Jul '16	**Green-Complete**	Guidance for Supporting and Working with patients/families after unexpected death of an adult or a serious incident involving an adult, July 2016 (latest version)
							26.4 Develop 'guidance' / information for **families** in **children's services** how the x3 processes of Child Death Review (CDR) / Serious Investigation (SI) / Root Cause Analysis (RCA) investigation inquests and complaints are initiated / managed and integrate ***(FI)***	Women and Children's Head of Governance	April '17	**Green action complete** **Mar mtg action complete**	Unformatted version sent to VRG group for comment on content with an associated leaflet

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											to demonstrate format; comments incorporated to add in adult version and resend to VRG
							26.5 Develop 'guidance' / information for **staff** in **children's services** on how the x3 processes of CDR / SI / RCA investigation inquests and complaints are initiated / managed and integrate.	Women and Children's Head of Governance	Dec '16	**Green action complete Due for presentation at February 17 meeting Now rated red as not approved at meeting Mar mtg – action complete**	Draft guidance presented; comments from group members to be incorporated and represented at March 2017 meeting SOP completed; to go to Mar QAC and implement; audit initially at 6/12 but then annually
							26.6 Develop the above **staff** guidance for **adult** patients and families (minus CDR)	Head of Quality (Patient Safety)	Dec '16	**Green – action complete**	As above Complete, signed off by CQG
							26.7 Develop the above **family** guidance for **adult** patients and families (minus CDR) **(FI).**	Head of Quality (Patient Safety)	Apr '17	**Blue- on target**	Leaflet produced but ongoing discussion around the process of sharing a draft RCA with family Links to rec 30
							26.8 Review options for how patients / families can participate (if they want to) with the SI RCA process implement preferred options **(FI).**	Head of Quality (Patient Safety)	Jun '17	**Blue- on target**	As above
							26.9 Implement a process for gaining regular feedback from patients / families involved in a SI RCAs process to understand what it felt like for them and how we can improve the process for them **(FI)**	Head of Quality (Patient Safety)	Jun '17	**Blue- on target**	Ongoing work on how to achieve this

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
27	That the design of the processes we refer to should take account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue.	Chief Nurse	Jun '17	**Blue- on target**			**27.1** Guidance developed for staff for the preparation and conduct of meetings with parents/families to discuss concerns and/or adverse event feedback	Medical Director	Jun '16	**Green- complete Action approved 10.01.17 pending any further comments within 1 week.**	Guidance for the Preparation and Conduct of Meetings with Parents/Families to discuss concerns and/or adverse event feedback, June 2016
							As per actions 26.4 and 26.5, included in recommendation no. 26 to develop guidance for staff				
							27.2 Develop a framework for training staff to support them to effectively and sensitively manage processes relating to CDR/SI's and complaints. Develop and pilot session. Existing complaints training materials to be reviewed and updated to include guidance on supporting families in circumstances where a complaint is being investigated alongside a CDR or SI. January 2017. Other bespoke training opportunities to be considered in light of development of staff guidance by Children's Services (see 26.5), due April 2017.	Head of Quality (Patient Experience and Clinical Effectiveness) And Head of Quality (Patient Safety)	Jun '17	**Blue- on target**	Training updated for pt safety, RCA, induction and complaints – add link to new documents developed as part of this action plan and then complete. BRHC training programme complete Plans for next steps to combine training for pt safety for BRHC and adults. Evidence to be provided for where & to whom training is being delivered then RTC
28	That guidance be drawn up which identifies when, and if so, how, an 'independent	Chief Nurse	Dec '16	**Red – behind target.**		Request to delay to Feb ' 17	**28.1** To review UHBristol's previous use of independent review / benchmarking from other trusts to inform above. - Complaints - RCA's	Patient Support and Complaints Manager and Patient	Nov '16	**Green- complete Action approved 10.01.17**	Reports of the Reviews undertaken and available in evidence folder

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	element' can be introduced into the handling of those complaints or investigations which require it.							Safety Manager	Nov '16		
							28.2 Develop guidance for when to access 'independent advise / review' for - Complaints - SI RCAs	Head of Quality (Patient Experience and Clinical Effectiveness) And Head of Quality (Patient Safety)	Oct '16 Dec '16	**Green – Complete Action approved 14.2.17**	Complaints policy Serious Incident Policy (appendix 9, pg. 33) Email from CS to all divisions on 6th February 2017
							28.3 The Trust has entered into exploratory discussions with the Patients Association about developing a model for exceptional independent investigation/review. This work will commence with a focus group of previous dissatisfied complainants in February 2017.	Head of Quality (Patient Experience and Clinical Effectiveness)	Mar '17	**Green – complete**	Focus meeting planned but not until May 17 due to pt assoc availability; letter of invitation to be added to evidence; ongoing assurance to be held by PEG RTC to be completed
							28.4 Consider how an independent review can be introduced for 2nd time dissatisfied complainants / involve users in developing a solution.	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green-complete**	This action has been completed
29	That as part of the process of exploring	Chief Nurse	Apr '17	**Blue-on**			29.0 Visit the Evelina to understand their model for mediation and possible replication at UHBristol. A	SRO for I&C	Feb 17	**Green - Complete**	Medical Mediation

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	the options for more effective handling of complaints, including the introduction of an independent element, serious consideration be given to offering as early as possible, alternative forms of dispute resolution, such as medical mediation.			**target**			report will be presented following the visit to consider next steps and possible resource implications. - Action reviewed and agreed to receive a presentation from the Medical Mediation Foundation who provide the Evelina service.				Foundation meeting completed on 9/3/17. Feedback written up and sent to BRHC Quality Assurance Committee 17/3/17 for recommendation re next steps; RTC completed
30	That the Trust should review its procedures to ensure that patients or families are offered not only information about any changes in practice introduced as a result of a complaint or incident involving them or their families and seek feedback on its effectiveness, but also the opportunity to be involved in designing those changes and overseeing their implementation.	Chief Nurse	Dec '16	**Amber- behind target**		Apr '17 Revised to allow for family involvement	**30.1** Develop a clear process with timescales trust-wide for feedback to families / patients outcomes involved in SI panels / review and actions ongoing from this and staff **(FI).**	Head of Quality (Patient Safety)	Apr '17	**Blue- on target**	Links to other engagement work; likely to be completed in conjunction Mar mtg discussed all actions link to Rec 26 (points 4,7,8 & 9) Process exists within Being open policy/Duty of Candour policy. Adult sheet to be added to options available for April 17 Del group RTC
							30.2 Ensure complainants are routinely asked whether and how they would like to be involved in designing changes in practice in response to the concerns they have raised **(FI)**	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green- complete**	Evidence pro forma of questions used. Agreed additional action 30.3 before closing. Mar mtg - Audit data to date shows process in

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											place and in use – more detailed audit to sit with the complaints work plan & feed into PEG
							30.3 Use of process for asking patients how they would like to be involved in designing changes in practice in response to the concerns they have raised to be audited at the end of February 2017, including review of survey replies.	Head of Quality (Patient Experience and Clinical Effectiveness)	Feb '17	**Green-complete**	Audit results due to be presented at March 2017 delivery group Mar mtg - Audit data to date shows process in place and in use – more detailed audit to sit with the complaints work plan
							30.4 Regular complainant focus groups to be held from April 2017 onwards as part of routine follow-up of people's experience of the complaints system. Ambition is for these focus groups to eventually be facilitated by previous complainants.	Head of Quality (Patient Experience and Clinical Effectiveness)	April '17	**Green-complete**	Mar mtg – action outwith original scope of Rec and will enhance effectiveness but not fundamental to completion. Process in place to ensure that complainants are asked to attend focus group. First focus group scheduled for May 17 and ongoing will sit within the complaints work plan for ongoing work and scrutiny through PEG

Appendix 4 Other Actions Plan – governed by the Independent Review of Childrens Cardiac Services Steering Group

Other Recommendation's delivery timeframe March 2017

MONTH	Sept'16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17
Recommendations	**22 -** That the Trust review the implementation of the recommendation of the Kennedy Report that a member of the Trust's Executive, sitting on the Board, has responsibility to ensure that the interests of children are preserved and protected, and should routinely report on this matter to the Board. – **complete Sept 16 signed off by steering group Mar 17**	31 That the Trust should review the history of recent events and the contents of this report, with a view to acknowledging publically the role which parents have played in bringing about significant changes in practice and in improving the provision of care. **Completed Oct 16; signed off by steering group Mar 17**		32 That the Trust re designate its activities regarding the safety of patients so as to replace the notion of "patient safety" with the reference to the safety of patients, thereby placing patients at the centre of its concern for safe care. **Completed Feb 17, signed off by Steering group Mar 17**	24 -That urgent attention be given to developing more effective mechanisms for maintaining dialogue in the future in situations such as these, at the level of both the provider and commissioning organisations. Mar 17 Added to the IP risk register in view of delayed completion of action by CCG, CM in communication with CCG leads			

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
22	That the Trust review the implementation of the recommendation of the Kennedy Report that a member of the Trust's Executive, sitting on the Board, has responsibility to ensure that the interests of children are preserved and protected, and should	Trust Secretary	Sept '16	**Green-complete**			Review of current arrangements and processes (Sept '16)	Trust Secretary	Sept '16	**Green-complete**	Executive Lead Role description April 2015 Board annual report BRCH 2015/2016 Steering group Mar 7th agreed closure of action

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	routinely report on this matter to the Board.										
24	That urgent attention be given to developing more effective mechanisms for maintaining dialogue in the future in situations such as these, at the level of both the provider and commissioning organisations.	Commissioners and Trust	Jan '16	**Red**		Proposal for addressing developed./in the process of being approved via NHSE governance framework.	Discussion with commissioners about the issues and agreement to mitigate a similar occurrence	Commissioners and Trust	Jan '16	**Red**	Added to the IR risk register in view of delayed completion of action by CCG; CM in communication with CCG leads RTC submitted with supporting documentation, unable to be presented at April steering therefore returning to May steering group for discussion
31	That the Trust should review the history of recent events and the contents of this report, with a view to acknowledging publically the role which parents have played in bringing about significant changes in practice and in improving the provision of care.	Chief Nurse	Oct '16	**Green-complete**			Trust board paper presented in July acknowledging the role which parents have played in bring about significant changes in practice and in improving the provision of care	Chief Executive	July '16	**Green-complete**	Trust Board Paper and Trust Board Agenda, July '16 Steering group Mar 7th agreed closure of action
							Presentation to Health and Overview Scrutiny Committee	Chief Executive, Medical Director, Chief Nurse and Women's and Children's Divisional Director	Aug '16	**Green-complete**	Meeting minutes - August 2016 & February 2017 Two visits – February 2016 Steering group Mar 7th agreed closure of action

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							Presentation to the Bristol Safeguarding Children's Board	Chief Nurse	Oct '16	**Green-complete**	Minutes of BSCB Sept 2016 Steering group Mar 7th agreed closure of action
32	That the Trust redesignate its activities regarding the safety of patients so as to replace the notion of "patient safety" with the reference to the safety of patients, thereby placing patients at the centre of its concern for safe care.	Medical Director	Dec '16	**Amber**		To be signed off as complete at March 7th meeting	Adoption of the term "Safety of Patients" in place of "Patient Safety" going forward and communication of preferred term Trust wide . Terms of Reference of Patient Safety Group Revised and approved by CCG Feb 2, 2017 Role descriptions for Patient safety staff revised and to be approved by end Feb 2017	Medical Director	Feb '17	**Green-complete**	Steering group Mar 7th agreed closure of action

Key	
R	Milestone behind plan, requirement to revise delivery date on more than one occasion; impact on recommendation delivery date and/or benefits delivery
A	Milestone behind plan, delivery date revised on one occasion
B	Blue - Activities on plan to achieve milestone
TBC	To be confirmed
G	Complete / Closed
FI	Indicates family involvement in the action(s)

Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	13
Meeting Title	Trust Board	**Meeting Date**	28 April 2017
Report Title	Finance Report		
Author	Paul Mapson, Director of Finance and Information		
Executive Lead	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

To inform the Finance Committee of the financial position of the Trust at the end of March 2017 and the performance against the financial drivers key to achieving the 2016/17 plan.

Key issues to note

The summary income and expenditure statement shows a surplus (before technical items) of £15.042m. After technical items (including impairments of £8.565m) the surplus becomes £5.918m. The Operational Plan required a surplus of £15.900m and therefore the Trust finished the year £0.858m behind plan. The adverse position is due to the loss of £0.894m Sustainability and Transformation (S&T) performance funding, therefore the Trust was £0.036m above the plan excluding S&T funding.

Recommendations
Members are asked to: •

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

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

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

Impact Upon Corporate Risk
N/A

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

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

University Hospitals Bristol
NHS Foundation Trust

REPORT OF THE FINANCE DIRECTOR

1. Year End Position

The summary income and expenditure statement shows a surplus (before technical items) of £15.042m. After technical items (including impairments of £8.565m) the surplus becomes £5.918m. The Operational Plan required a surplus of £15.900m and therefore the Trust finished the year £0.858m behind plan. The adverse position is due to the loss of £0.894m Sustainability and Transformation (S&T) performance funding, therefore the Trust was £0.036m above the plan excluding S&T funding.

The financial values in this report are draft and subject to audit. The draft accounts will be submitted on the 26th April. Any changes, either from the external audit or from the NHS Improvement bonus review process (NHS Improvement are considering issuing further sustainability funding as a 'bonus' for organisations who have met or exceeded their control totals) will be reported to the next Finance Committee on the 22nd May.

The financial position described above represents the 14th year of break-even or financial surplus for the Trust.

Whereas the net surplus is in line with plan (excluding performance sustainability funding) there were a number of items at year end which are worthy of note:

1) The Trust is now expecting to achieve 93% of its CQUIN income target – this therefore contributed an additional £1m income to the bottom line compared to forecast, which has been incorporated into the final divisional positions

2) Performance sustainability funding was paid in full for quarter 4 despite A&E performance not being delivered. This contributed £0.8m income to the financial position

3) There were a number of increases in non-pay spending at year end – notably in Specialised Services where a £0.5m control issue was uncovered including a combination of late receipting and stock pricing. Steps will be taken to ensure this does not happen again;

4) A review of capital asset valuations resulted in lower depreciation and Public Dividend Capital charges than forecast in year to the value of £0.8m; and

5) The residual clinical Division overspend was c.£1.5m which was broadly in line with run rate albeit with high non-pay spending which requires further analysis.

On the 28th March 2017, NHS Improvement notified Trusts that 100% of the S&T funding for quarter four would be based on the delivery of the Control Total. This means that S&T performance funding applies to the delivery of the access performance trajectories in quarter two and three only. Further details are given in appendix 8.

The overspend in Clinical Divisions and Corporate Services increased in March by £1.271m. The year end position was an overspend of £13.325m, compared with the operating plan of £3.363m and the Divisional control totals based on their month 6 forecast out-turn which was £9.740m for the year end.

The following table summarises the financial performance in March for each of the Trust's management divisions against their budget, Operating Plan trajectory and control total. This includes the expected £1.024m additional CQUIN performance for March.

	Budget Variance favourable/(adverse)			Operating Plan Trajectory favourable/(adverse)		Control Total
	To 28 Feb £m	March £m	To 31 March £m	Trajectory To March £m	Variance £m	£m
Diagnostic & Therapies	0.652	0.058	0.710	-	0.608	-
Medicine	(4.042)	(0.431)	(4.473)	(0.943)	(3.681)	(2.480)
Specialised Services	(1.594)	(0.369)	(1.963)	(0.197)	(1.969)	(1.060)
Surgery, Head & Neck	(3.613)	(0.397)	(4.010)	(1.084)	(3.135)	(3.700)
Women's & Children's	(3.893)	(0.232)	(4.125)	(1.139)	(3.222)	(2.500)
Estates & Facilities	0.043	0.133	0.176	(0.001)	0.054	-
Trust Services	(0.029)	0.002	(0.027)	0.004	(0.031)	-
Other corporate services	0.422	(0.035)	0.387	-	0.387	-
Totals	**(12.054)**	**(1.271)**	**(13.325)**	**(3.360)**	**(10.989)**	**(9.740)**

The adverse variance of £1.271m in March represented a further deterioration and compares with £1.160m in February, £0.861m in January and £1.544m in December. Analysis of the variances by subjective heading is shown below:

(Adverse)/Favourable	March £m	Feb £m	Jan £m	Quarter 3 £m	Quarter 2 £m	Quarter 1 £m	2016/17 Outturn £m
Nursing & midwifery pay	(0.505)	(0.290)	(0.541)	(1.151)	(0.963)	(1.154)	(4.604)
Medical & dental staff pay	(0.078)	(0.041)	(0.104)	(0.347)	(0.453)	(0.419)	(1.442)
Other pay	0.069	0.133	0.135	0.629	0.506	0.630	(2.102)
Non-pay	(2.129)	(1.415)	(0.829)	(3.222)	(0.938)	(0.926)	(9.459)
Income	1.372	0.453	0.478	0.783	(2.179)	(0.832)	(0.949)
Totals	**(1.271)**	**(1.160)**	**(0.861)**	**(3.308)**	**(4.027)**	**(2.701)**	**(14.349)**

The major deterioration in the March position related to non-pay. Whilst £0.364m in Corporate Services was offset by a movement in operating income, there were significant overspends in Specialised Services due to the late receipting of consignment stock and opening stock valuations and Surgery, Head and Neck due to outsourcing costs and clinical supplies in theatres.

The nursing pay adverse variance increased this month across all of the clinical divisions. The year end overspend of £4.604m compares with the 2015/16 outturn overspend of £2.8m (after £1.4m of 1:1 costs were funded).

The other pay underspend was largely unchanged this month.

The improvement in income included £1.024m relating to expected CQUIN performance, excluding this there was a favourable variance in month of £0.348m. £0.560m of this related to income from operations. This related to increased research income offsetting increased non pay costs and income from Welsh commissioners in respect of TPP patient costs in Specialised Services. Income from activities reduced by £0.212m. The outturn income under-performance on activity based SLA lines is £2.023m.

2. Key Financial Drivers

The five financial drivers key to achieving the financial plan are as follows:

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

The year end outturn for these is described in the following sections.

a) Sustainability Funding

The Trust's financial position to date includes £12.106m of S&T funding, £0.894m behind the plan for the year of £13.000m. The position is summarised in the following table. Further detail is provided in Appendix 8.

	Q1	July	Aug	Sept	Oct	Nov	Dec	Q4	Total YTD
Control Total achieved	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
STF earned £m	3.250	0.758	0.758	0.759	0.758	0.759	0.758	3.250	11.050
A&E trajectory achieved	N/A	Yes	Yes	Yes	No	No	No	N/A	
STF earned £m	N/A	0.135	0.135	0.135	0.000	0.000	0.000	N/A	0.405
Cancer trajectory achieved	N/A	No**	Yes	No**	No	Yes	No	N/A	
STF earned £m	N/A	0.000	0.055	0.000	0.000	0.055	0.000	N/A	0.110
RTT National target achieved	N/A	Yes	No**	No**	Yes	Yes	Yes	N/A	
STF earned £m	N/A	0.135	0.000	0.000	0.135	0.135	0.136	N/A	0.541
Total STF £m	3.250	1.028	0.948	0.894	0.893	0.949	0.894	3.250	12.106

** appeal rejected by NHS Improvement

b) Nursing & Midwifery Pay

The nursing and midwifery pay variance for the month is £0.505m adverse. The table below shows the analysis between substantive, bank and agency for the last three months, previous quarters and year to date. The 2015/16 position is shown for comparison.

	March £m	Feb £m	Jan £m	Quarter 3 £m	Quarter 2 £m	Quarter 1 £m	2016/17 Outturn £m	2015/16 Outturn exc. 1:1 funding £m
Substantive	0.806	0.813	0.581	2.236	2.466	2.23	9.132	10.099
Bank	(0.654)	(0.543)	(0.553)	(1.551)	(1.599)	(1.440)	(6.340)	(5.684)
Agency	(0.657)	(0.56)	(0.569)	(1.836)	(1.830)	(1.945)	(7.397)	(7.268)
Total	**(0.505)**	**(0.290)**	**(0.541)**	**(1.151)**	**(0.963)**	**(1.154)**	**(4.604)**	**(2.853)**
Restated for agency accrual					(0.387)		(0.387)	
Reversal of 15/16 accrual					0.387		0.387	
Total	**(0.505)**	**(0.290)**	**(0.541)**	**(1.151)**	**(0.963)**	**(1.154)**	**(4.605)**	**(2.853)**

The adverse variance on nursing continues to be driven by high bank and agency usage, offset by a favourable variance on substantive posts due to vacancies. The adverse variance of £0.505m in March has deteriorated compared with February, caused by an increased overspend on bank and agency.

The improvements in permanent staffing from recruitment and retention initiatives are not yet being matched by the expected equivalent reduction in bank and agency spend. This is almost certainly due to significantly higher sickness levels.

The Nursing and ODP price and volume variance for March is shown at appendix 3. Nursing and ODPs were £0.546m adverse with a £0.440m adverse variance due to volume above the funded establishment and a £0.105m adverse variance due to price.

The nursing control dashboard is attached at appendix 4. Surgery Head & Neck's sickness rate fell to 5.3% in March but remains on an upwards trend since November when it was 4.5%. The Division's vacancy rate fell by 0.1% to 6.8% but also remains higher than earlier in the year. Despite these increases the Division's nursing variance has generally been improving, although additional beds and patient acuity in ITU caused very high agency expenditure in March of £0.212m.

Medicine's sickness rate continues to fluctuate and showed a 0.4% month on month increase. Its vacancy rate has steadily increased from a low point of 5.3% in November to 7.7% in March. Whilst the increased vacancy rate is likely to be a contributing factor to Medicine's deteriorating variance against nursing expenditure, the use of escalation capacity remains the primary cause. Medicine's agency expenditure remains high, although it did fall from £0.277m to £0.261m from February to March despite temporary RMN expenditure increasing to £0.060m from £0.034m.

The Women's and Children's Division has reduced its sickness rate from a high of 5.8% in November to 4.3% in March, and its vacancy rate remains low at 1.7%. The Division's monthly agency expenditure has generally been reducing however it increased from £0.116m to £0.142m between February and March. The Division's overall nursing variance fluctuates with no particular trends.

Specialised Services' nursing variance also follows no particular trend over recent months. Its sickness rate has varied between 3.7% and 4.5%, however its vacancy rate reached a twelve month low of 3.6% in March. Agency nursing expenditure was £0.054m.

c) Non Pay

The non-pay variance in the month was £2.129m adverse, and compares with an adverse variance of £1.415m in February, £0.829m in January, and £1.091m in December. This is analysed between categories of non-pay expenditure in the following table.

(Adverse)/Favourable	March £m	Feb £m	Jan £m	Dec £m	2016/17 Outturn £m
Blood	(0.106)	(0.191)	(0.138)	0.070	(0.446)
Clinical supplies & services	(0.633)	(0.154)	0.258	(0.565)	(1.101)
Drugs	0.108	(0.100)	0.032	(0.165)	(0.470)
Establishment	(0.118)	0.003	(0.021)	(0.001)	0.040
General supplies & services	(0.039)	(0.002)	(0.004)	(0.059)	(0.098)
Premises	(0.170)	(0.002)	0.047	0.019	0.254
Services from other bodies					
- Excluding research	(0.569)	(0.369)	(0.167)	(0.314)	(2.220)
- Research	0.032	(0.079)	(0.082)	0.104	(0.375)
Other non-pay expenditure	(0.546)	(0.264)	(0.433)	0.089	0.414
Unidentified non-pay savings	(0.088)	(0.257)	(0.321)	(0.269)	(3.337)
Totals	**(2.129)**	**(1.415)**	**(0.829)**	**(1.091)**	**(7.337)**

The adverse variance on blood expenditure in February was high due to the continued treatment of a high cost patient in Specialised Services, but returned to normal in March.

In January a review of activity and clinical supplies budgets led to an allocation of contract transfer funding. The overspend in March increased compared to February due to the late receipting of consignment stock in Cardiology, issues relating to the value of stock in the previous year and increased costs in theatres.

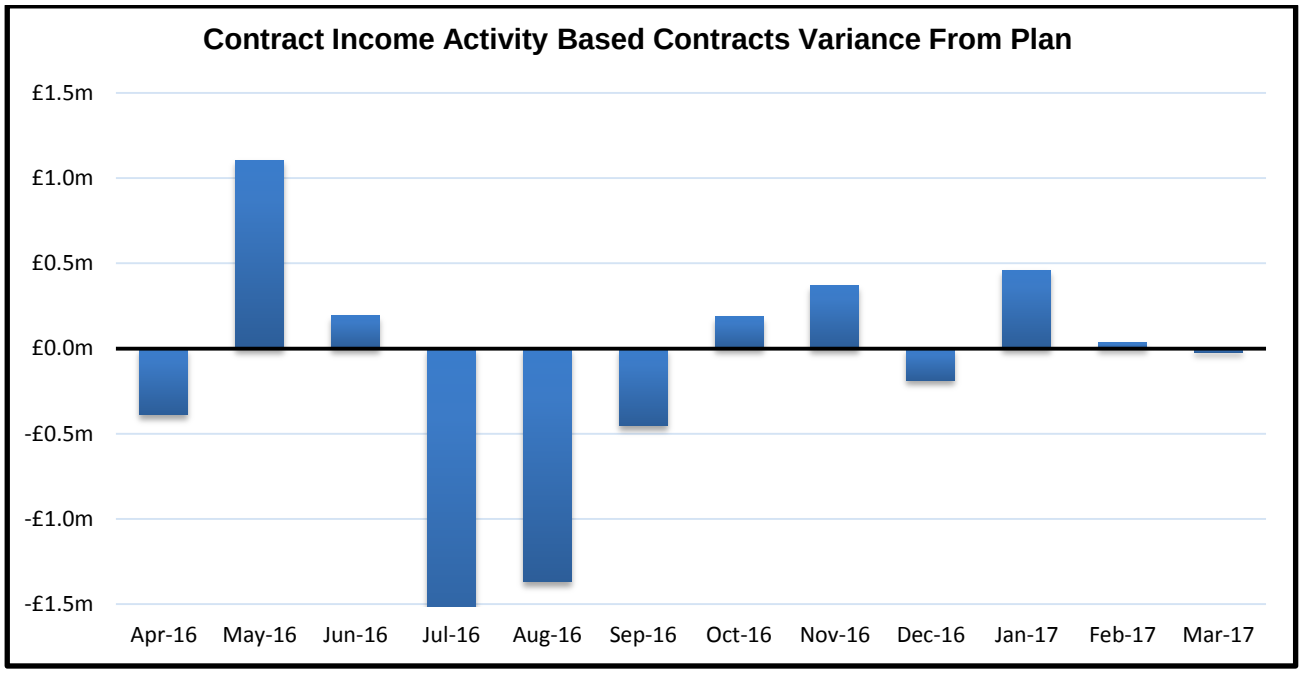
Premises and fixed plant expenses increased due to computer network and maintenance costs in Diagnostics and Therapies and printing and postage costs across the Trust.

The overspend on services from other bodies excluding research relates to BMT donor charges, maternity pathway costs from North Bristol NHS Trust (NBT), outsourcing of Dermatology services and costs relating to community premises. The adverse variance in March increased due to backdated invoices received relating to maternity pathway costs and additional capacity.

The other expenditure variance continued from outsourcing of surgical activity to Glanso and CESP as well as repair and maintenance costs of a Linear Accelerator. Research and Innovation also overspent on external hosting costs, however this was offset by an underspend against pay budgets.

d) Clinical Activity

March activity is not available to inform the year end position so a forecast is used. Activity based contract performance is forecast to decrease by £0.022m in March to give a cumulative under performance of £2.023m. Within this, Specialised Services worsened in the month by £0.112m, and Women's and Children's by £0.193m. Performance at Clinical Divisional level is shown in appendix 5a. The graph below shows the monthly performance for all activity based contracts.



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

	In Month Variance Fav/(Adv) £m	Plan £m	Outturn £m	Outturn Variance Fav/(Adv) £m
Activity Based				
Accident & Emergency	(0.006)	15.764	15.943	0.178
Bone Marrow Transplants	(0.135)	8.272	7.371	(0.902)
Critical Care Bed days	0.027	44.184	44.016	(0.168)
Day Cases	0.184	38.695	39.526	0.832
Elective Inpatients	(0.389)	51.033	48.621	(2.412)
Emergency Inpatients	0.334	77.776	81.621	3.845
Excess Bed days	0.037	6.942	7.101	0.158
Non – Elective Inpatients	(0.309)	27.303	23.955	(3.348)
Other	(0.160)	81.270	80.503	(0.767)
Outpatients	0.394	82.759	83.321	0.562
Sub Totals	**(0.022)**	**433.999**	**431.976**	**(2.023)**
Contract Penalties	(0.039)	(0.985)	(1.735)	(0.750)
Contract Rewards	1.141	8.088	10.001	1.913
Pass through payments	(0.030)	86.580	83.851	(2.729)
Sustainability and Transformation Funding	0.596	13.000	12.106	(0.894)
2016/17 Totals	**0.646**	**540.682**	**536.199**	**(4.483)**
Prior year income	0.299	-	3.986	3.986
Overall Totals	**1.945**	**540.682**	**540.185**	**(0.497)**

Outpatient activity improved in the month by £0.394m and reflects ongoing increased activity notably cardiology, clinical genetics and ophthalmology. The outturn position is ahead of plan by £0.562m.

Elective inpatients and day cases together were £0.205m below plan in month. The outturn position is £1.580m below plan. The Women's and Children's Division is forecast to be £3.065m behind plan mainly in spinal surgery (£1.037m below plan) and cardiac surgery (£0.662m below plan). Specialised Services is £0.914m above plan mainly in clinical/medical oncology and haematology (£0.880m above plan).

Bone Marrow Transplants are forecast to be £0.902m below plan, of which £0.482m relates to adults and £0.419m to paediatrics.

Emergency inpatients, offset by non-electives, were £0.497m above plan reflecting the high volume of emergency activity mainly within gastrointestinal surgery (£0.920m above plan), trauma & orthopaedics (£0.600m above plan) offset by cardiac surgery £1.160m below plan).

An assessment of forecast year-end delivery of CQUINs is 93.3% (90.4% on CCG CQUIN schemes, 96.19% on NHSE specialised CQUIN schemes and 100% on NHSE non-specialised CQUIN schemes), which equates to £10.000m. This is against an overall planning assumption of 75% achievement required to cover baseline commitments of £8.090m.

Performance against penalties was forecast as £0.390m below plan this month, reducing the year end outturn performance to £0.750m below plan. Of this £0.650m relates to the emergency marginal tariff adjustment and £0.330m to cancelled operations.

Pass through payments are forecast to be £0.030m lower than plan in March, increasing the adverse outturn position to £2.729m. The outturn adverse variance relates to excluded drugs (£1.440m), excluded devices (£0.930m) and blood products (£0.830m).

e) Savings Programme

The savings requirement for 2016/17 was £17.420m. Savings of £13.189m have been realised to date, a shortfall of £4.231m against plan. The shortfall is a combination of unidentified schemes of £3.175m and a further £1.056m for scheme slippage. The outturn is in line with that forecast last month and represents delivery of 76%.

A summary of progress against the Savings Programme for 2016/17 is summarised in the following table. A more detailed report is given under item 2.4 on this month's agenda.

	Outturn position		
	Plan £m	Actual £m	Variance fav / (adv) £m
Diagnostics & Therapies	1.642	1.597	(0.045)
Medicine	1.684	1.514	(0.170)
Specialised Services	1.510	1.283	(0.227)
Surgery, Head and Neck	4.956	2.979	(1.977)
Women's and Children's	4.638	2.542	(2.096)
Estates and Facilities	0.785	0.855	0.070
Trust Services	0.717	0.653	(0.064)
Corporate Services	1.488	1.766	0.278
Totals	**17.420**	**13.189**	**(4.231)**

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

	Outturn position		
	Plan £m	Actual £m	Variance fav / (adv) £m
Pay	2.597	2.203	(0.394)
Drugs	1.044	1.281	0.237
Clinical Supplies	3.073	3.471	0.398
Non Clinical Supplies	0.057	0.057	-
Other Non-Pay	4.241	3.629	(0.612)
Income	2.543	1.858	(0.685)
Capital Charges	0.690	0.690	-
Unidentified	3.175	-	(3.175)
Totals	**17.420**	**11.830**	**(4.231)**

3. Divisional Financial Position

Clinical Divisions and Corporate Services overspend against budget increased by £1.271m in March to an outturn position of £14.349m adverse to plan. This included allocation of expected CQUIN performance funding of £1.024m. The following table shows the Clinical Divisions and Corporate Services budget variances against the four main income and expenditure headings, with the CQUIN allocation identified separately.

	Budget Variance favourable/(adverse)		
	To 28 Feb £m	March £m	To 31 March £m
Pay	(3.054)	(0.493)	(3.547)
Non Pay	(4.272)	(2.061)	(6.333)
Operating Income	0.179	0.564	0.743
Income from Activities	(0.769)	(0.212)	(0.981)
Savings programme	(4.138)	(0.093)	(4.231)
CQUIN allocation		1.024	1.024
Totals	**(12.054)**	**(1.271)**	**(13.325)**

Analysis of the subjective movements by Division is summarised in the following table, with further detail given under agenda item 2.3 in the Finance Committee papers. Note that these Divisional reports were written before the allocation of the £1.024m CQUINs funding which is therefore excluded.

Variance favourable/(adverse)	Pay £m	Non Pay £m	Operating Income £m	Income from activities £m	Savings £m	Total £m
Diagnostic & Therapies						
– To 28 February	1.481	(1.209)	0.079	0.345	(0.044)	0.652
– March	0.134	(0.243)	(0.005)	0.071	(0.001)	(0.044)
– To 31 March	1.615	(1.452)	0.0074	0.416	(0.045)	0.608
Medicine						
– To 28 February	(2.219)	(0.840)	0.044	(0.770)	(0.257)	(4.042)
– March	(0.446)	(0.221)	0.001	(0.003)	0.087	(0.582)
– To 31 March	(2.665)	(1.061)	0.045	(0.773)	(0.170)	(4.624)
Specialised Services						
– To 28 February	(0.681)	(0.956)	0.155	0.150	(0.263)	(1.595)
– March	0.018	(0.674)	0.174	(0.126)	0.036	(0.572)
– To 31 March	(0.663)	(1.629)	0.329	0.024	(2.227)	(2.166)
Surgery, Head & Neck						
– To 28 February	0.003	(1.963)	(0.007)	0.264	(1.910)	(3.613)
– March	(0.021)	(0.644)	(0.033)	0.159	(0.067)	(0.606)
– To 31 March	(0.018)	(2.607)	(0.040)	0.423	(1.977)	(4.219)
Women's & Children's						
– To 28 February	(2.303)	1.214	0.049	(0.918)	(1.935)	(3.893)
– March	(0.099)	0.085	0.003	(0.296)	(0.161)	(0.468)
– To 31 March	(2.402)	1.299	0.052	(1.214)	(2.096)	(4.361)
Corporate Services						
– To 28 February	0.665	(0.520)	(0.141)	0.160	0.271	0.435
– March	(0.079)	(0.364)	0.424	(0.017)	0.013	(0.023)
– To 31 March	0.586	(0.883)	0.283	0.143	0.284	0.413

Medicine continued to incur additional pay costs associated with 1:1 nursing and staffing the ED queue and other escalation capacity. Women's and Children's pay overspend

continued but at a lower rate than previously reflecting reduced demand and supernumerary posts.

The £2.041m adverse variance in month on non-pay expenditure represents a further significant deterioration, of which £1.318m was in Specialised Services and Surgery, Head and Neck. The movement of £0.364m in Corporate Services was offset by the movement in operating income. Surgery Head and Neck incurred higher than planned costs relating to outsourcing costs as well as clinical supplies in theatres. Specialised Services incurred significantly higher costs in month for clinical supplies resulting from issues with the receipting of consignment stock (£0.245m) and prices used in the valuation of last year's closing stock (£0.107m) as well as (£0.057m) for repairs and replacement parts for a linear accelerator.

The £0.212m adverse variance on income from activities was within Women's and Children's and Specialised Services Divisions, offset by Surgery, Head and Neck.

The £0.564m favourable variance on income from operations was primarily within research and offset by non-pay. Specialised Services received income from Welsh commissioners for the cost of Octoplas used in the treatment of TTP patients.

The £0.093m adverse savings variance in month was predominantly in Women's and Children's as described in section 3e.

4. Use of Resources Rating

The Use of Resources Rating (URR) for the Trust for the year is 1, the highest rating and in line with the plan of 1.The following table summarises the position.

		31 March 2017	
	Weighting	Plan	Outturn
Liquidity			
Metric Result – days		11.96	14.25
Metric Rating	20%	1	1
Capital Servicing Capacity			
Metric Result – times		2.77	2.73
Metric Rating	20%	1	1
Income & expenditure margin			
Metric Result		2.53%	2.37%
Metric Rating	20%	1	1
Variance in I&E margin			
Metric Result		0.00%	(0.16)%
Metric Rating	20%	1	2
Variance from agency ceiling			
Metric Result		0.00%	18.24%
Metric Rating	20%	1	2
Overall URR		**1.0**	**1.4**
Overall URR (rounded)		**1**	**1**

The agency ceiling set by NHSI of £12.793m is based on data submitted in 2015/16 which included medical locums. Following the change in NHSI definition the Trust has split out the locum costs and whilst NHSI support this approach they have yet to confirm whether

this requires an adjustment to the ceiling. The recently communicated target for 2017/18 remains unchanged.

At the end of March the Trust is £2.367m adverse against the NHSI ceiling, deterioration in the month of £0.224m. The following table summarises this position:

	Current month position (March)			Outturn 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	-	(0.090)	-	-	1.100	-
Medical Locum – Zero Hours		0.129			1.107	
Medical Locum – Fixed Term		0.257			2.582	
Nursing Agency (RNs and NAs)	-	0.584	-	-	7.486	-
Other Agency	-	0.216	-	-	1.789	-
Totals	**0.872**	**1.096**	**(0.224)**	**12.793**	**15.160**	**(2.367)**

5. Capital Programme

A summary of income and expenditure for the year is provided in the following table. Capital expenditure was £29.894m against the revised internal plan of £32.006m. An assessment of the under and over spends to establish the slippage going forward into next year's programme will be reviewed by the Capital Programme Steering Group at its May meeting. Further information is provided under agenda item 3.1.

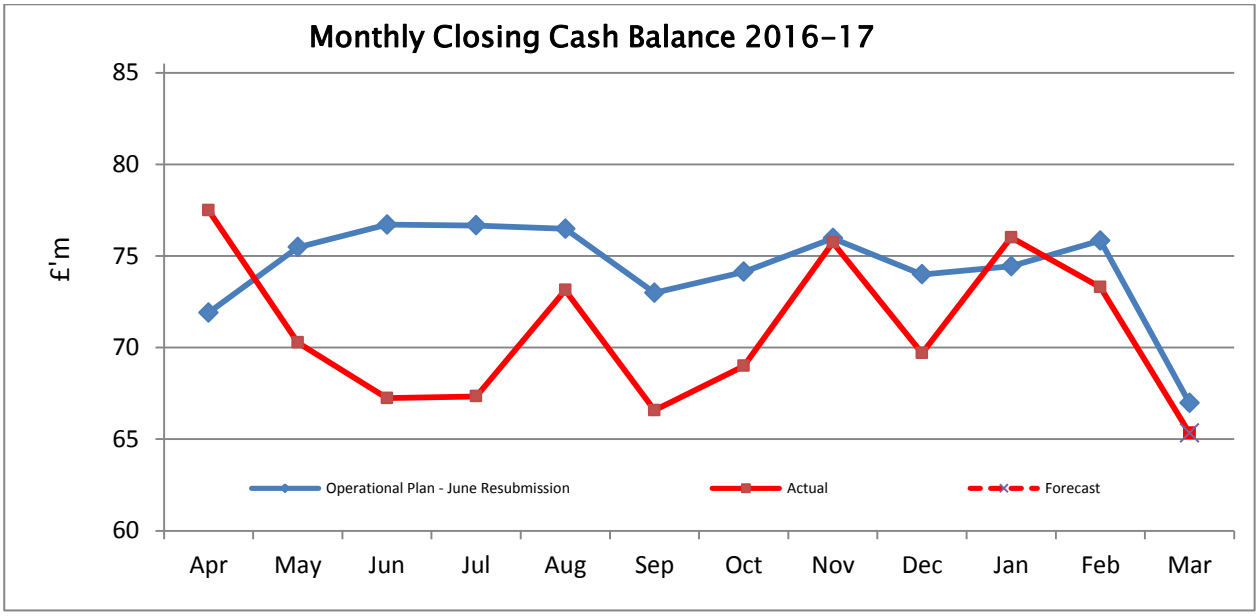
Last month, forecast expenditure for March was £6.919m and included a number of high cost major medical equipment items. Actual expenditure in March was £4.807m. Whilst the majority of major medical items were delivered, £1.243m related to the procurement of four key items which have been delayed and slipped into 2018/19.

Original Operational Plan £m	Subjective Heading	Year ended 31 March 2017		
		Revised Internal Plan £m	Actual £m	Variance £m
	Sources of Funding			
0.273	PDC	0.273	2.066	1.793
2.732	Donations	2.732	2.920	0.188
	Cash:			
22.054	Depreciation	21.273	20.997	(0.276)
9.941	Cash balances	7.728	3.911	(3.817)
35.000	**Total Funding**	**32.006**	**29.894**	**(2.112)**
	Expenditure			
(14.244)	Strategic Schemes	(11.417)	(12.240)	(0.823)
(11.142)	Medical Equipment	(8.428)	(6.525)	1.903
(4.659)	Information Technology	(3.276)	(3.069)	0.207
(2.815)	Estates Replacement	(2.528)	(2.493)	0.035
(13.191)	Operational Capital	(7.383)	(5.567)	1.816
(46.051)	**Gross Expenditure**	**(33.032)**	**(29.894)**	**3.138**
2.706	Slippage	1.026	-	(1.026)
8.345	I&E Variation from Plan	-	-	-
(35.000)	**Net Expenditure**	**(32.006)**	**(29.894)**	**2.112**

6. Statement of Financial Position and Cashflow

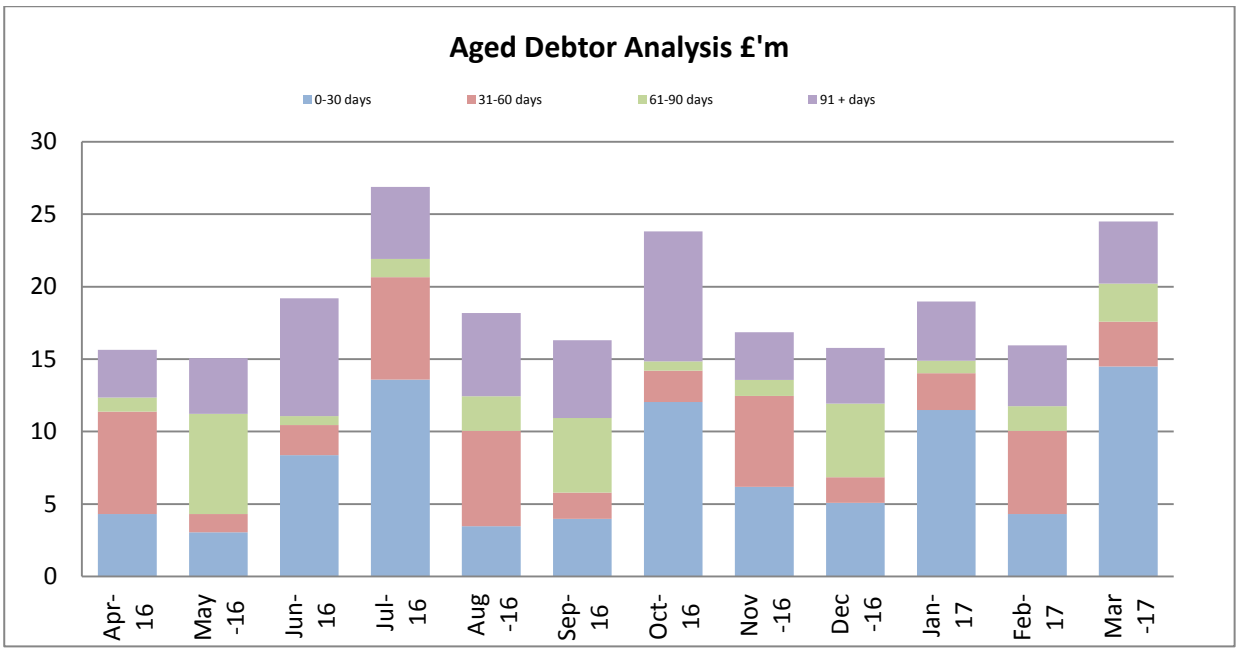
Overall, the Trust had a strong statement of financial position as at 31 March 2017 with net current assets of £35.429m, £5.404m higher than the Operational Plan.

The Trust held cash and cash equivalents of £65.441m at the end of March, £1.538m lower than plan mainly due to outstanding S&T funding offset by slippage in the capital programme. The graph below shows the month end cash balance trajectory for the financial year.

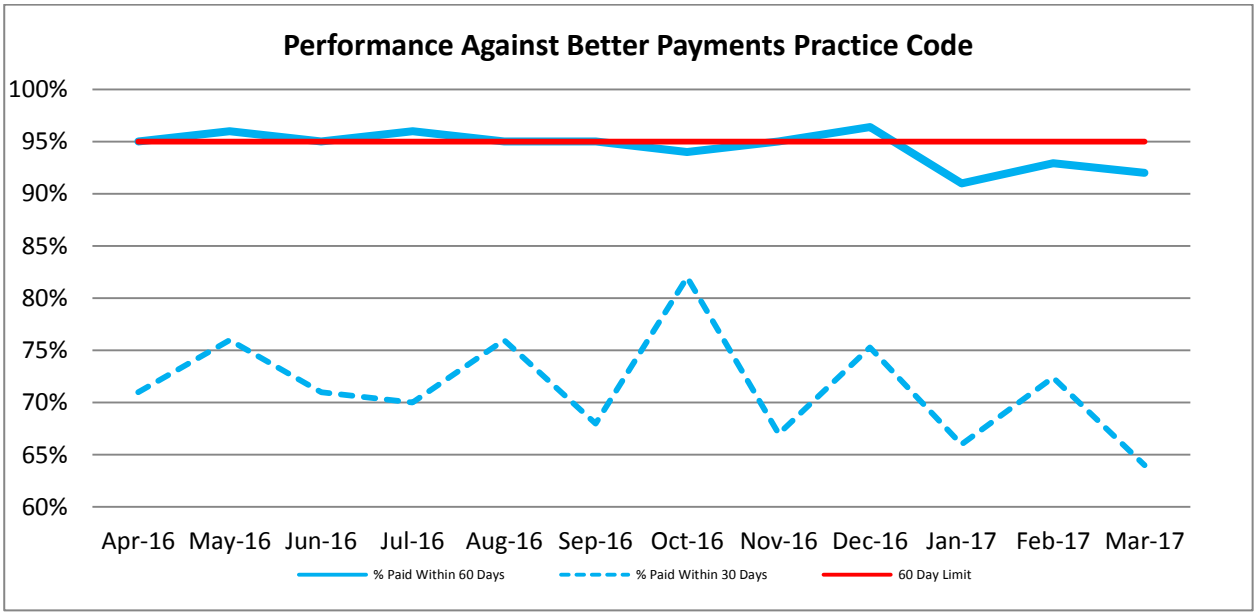


The total value of debtors was £24.505m (£11.285m SLA and £13.220m non-SLA). This represents an increase in the month of £8.560m (£2.730m SLA and £5.830m non-SLA).

Debts over 60 days old have increased by £1.031m (£0.951m SLA and £0.080m non-SLA) to £6.915m (£3.420m SLA and £3.495m non-SLA) and represents 28% of total debtors. The increase in SLA debtors is largely due to the increase in aged debt for North Bristol NHS Trust of £0.521m and NHS England - South West of £0.677m. The total debt relating to NBT (SLA and non SLA) over 60 days is £2.448m. The NHS England – South West payment was expected in March, however it was not received until April. The position is summarised in the following chart. Further details are provided in agenda item 4.1.



In March the Trust's performance against the 60 day target was 92% reflecting the continued focus on clearing older invoices and resolving supplier queries.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Nursing & ODP variances
Appendix 4 – Nursing KPIs
Appendix 5 – Key Financial Metrics
Appendix 6 – Monthly Analysis of Pay Expenditure
Appendix 7 - Release of Reserves
Appendix 8 – Sustainability funding and access performance trajectories

Appendix 1

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report March 2017- Summary Income & Expenditure Statement

Approved Budget / Plan 2016/17	Heading	Position as at 31st March Plan	Actual	Variance Fav / (Adv)	Actual to 28th February
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
540,174	From Activities	540,174	541,649	1,475	492,354
92,426	Other Operating Income	92,426	92,894	468	84,237
632,600	**Sub totals income**	**632,600**	**634,543**	**1,943**	**576,591**
	Expenditure				
(364,424)	Staffing	(364,424)	(368,365)	(3,941)	(337,993)
(209,831)	Supplies and Services	(209,831)	(219,050)	(9,219)	(195,408)
(574,255)	**Sub totals expenditure**	**(574,255)**	**(587,415)**	**(13,160)**	**(533,401)**
(8,294)	Reserves	(8,294)	-	8,294	-
	NHS Improvement Plan Profile			0	
50,051	**EBITDA**	**50,051**	**47,128**	**(2,923)**	**43,190**
7.91	**EBITDA Margin - %**		**7.43**		**7.49**
	Financing				
(22,472)	Depreciation & Amortisation - Owned	(22,472)	(20,997)	1,475	(19,488)
244	Interest Receivable	244	189	(55)	177
(290)	Interest Payable on Leases	(290)	(294)	(4)	(270)
(3,124)	Interest Payable on Loans	(3,124)	(2,884)	240	(2,646)
(8,509)	PDC Dividend	(8,509)	(8,100)	409	(7,795)
(34,151)	**Sub totals financing**	**(34,151)**	**(32,086)**	**2,065**	**(30,022)**
15,900	**NET SURPLUS / (DEFICIT) before Technical Items**	**15,900**	**15,042**	**(858)**	**13,168**
	Technical Items				
-	Profit/(Loss) on Sale of Asset	-	(76)	(76)	(30)
2,732	Donations & Grants (PPE/Intangible Assets)	2,732	2,920	188	2,224
(6,436)	Impairments	(6,436)	(8,565)	(2,129)	(1,362)
385	Reversal of Impairments	385	(1,848)	(2,233)	-
(1,610)	Depreciation & Amortisation - Donated	(1,610)	(1,555)	55	(1,452)
10,971	**SURPLUS / (DEFICIT) after Technical Items**	**10,971**	**5,918**	**(5,053)**	**12,548**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report March 2017- 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 28th February	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											
540,682	Contract Income	540,682	540,682	-	-	(36)	36	-	-	0		
-	Sustainability and Transformation Funding Variance	-	-	-	-	-	(894)	-	(894)	(1,490)		
159	Contract Penalties	159	-	-	-	-	(469)	-	(469)	(469)		
-	Contract Rewards	-	-	-	-	-	0	-	0	-		
-	Overheads	-	3,291	-	264	-	3,207	-	3,471	3,100		
37,185	NHSE Income	37,185	37,185	-	-	-	-	-	-	-		
578,026	**Sub Total Corporate Income**	**578,026**	**581,158**	**0**	**264**	**(36)**	**1,880**	**-**	**2,108**	**1,141**		
	Clinical Divisions											
(51,836)	Diagnostic & Therapies	(51,836)	(51,228)	1,615	(1,452)	74	518	(45)	710	652	0	608
(76,893)	Medicine	(76,893)	(81,517)	(2,665)	(1,061)	45	(622)	(170)	(4,473)	(4,042)	(943)	(3,694)
(103,639)	Specialised Services	(103,639)	(105,805)	(663)	(1,629)	329	227	(227)	(1,963)	(1,595)	(197)	(1,928)
(106,079)	Surgery Head & Neck	(106,079)	(110,297)	(18)	(2,607)	(40)	632	(1,977)	(4,010)	(3,613)	(1,084)	(3,195)
(120,950)	Women's & Children's	(120,950)	(125,311)	(2,402)	1,299	52	(978)	(2,096)	(4,125)	(3,893)	(1,139)	(3,330)
(459,397)	**Sub Total - Clinical Divisions**	**(459,397)**	**(474,158)**	**(4,133)**	**(5,450)**	**460**	**(223)**	**(4,515)**	**(13,861)**	**(12,491)**	**(3,363)**	**(11,539)**
	Corporate Services											
(36,160)	Facilities And Estates	(36,160)	(36,107)	50	(63)	(36)	155	70	176	44	(1)	63
(26,429)	Trust Services	(26,429)	(26,456)	598	(434)	(174)	47	(64)	(27)	(30)	4	(43)
2,305	Other	2,305	2,691	(62)	(386)	493	64	278	387	421	-	2,269
(60,284)	**Sub Totals - Corporate Services**	**(60,284)**	**(59,872)**	**586**	**(883)**	**283**	**266**	**284**	**536**	**435**	**3**	**2,289**
(519,681)	**Sub Total (Clinical Divisions & Corporate Services)**	**(519,681)**	**(534,030)**	**(3,547)**	**(6,333)**	**743**	**43**	**(4,231)**	**(13,325)**	**(12,056)**	**(3,360)**	**(9,250)**
(8,294)	Reserves	(8,294)	-	-	8,294	-	-	-	8,294	7,333		
-	NHS Improvement Plan Profile									1,005		
(8,294)	**Sub Total Reserves**	**(8,294)**	**-**	**-**	**8,294**	**-**	**-**	**-**	**8,294**	**8,338**		
50,051	**Trust Totals Unprofiled**	**50,051**	**47,128**	**(3,547)**	**2,225**	**707**	**1,923**	**(4,231)**	**(2,923)**	**(2,577)**		
	Financing											
(22,472)	Depreciation & Amortisation - Owned	(22,472)	(20,997)	-	1,475	-	-	-	1,475	1,095		
244	Interest Receivable	244	189	-	(55)	-	-	-	(55)	(47)		
(290)	Interest Payable on Leases	(290)	(294)	-	(4)	-	-	-	(4)	(4)		
(3,124)	Interest Payable on Loans	(3,124)	(2,884)	-	240	-	-	-	240	218		
(8,509)	PDC Dividend	(8,509)	(8,100)	-	409	-	-	-	409	4		
(34,151)	**Sub Total Financing**	**(34,151)**	**(32,086)**	**-**	**2,065**	**-**	**-**	**-**	**2,065**	**1,266**		
15,900	**NET SURPLUS / (DEFICIT) before Technical Items**	**15,900**	**15,042**	**(3,547)**	**4,290**	**707**	**1,923**	**(4,231)**	**(858)**	**(1,311)**		
	Technical Items											
-	Profit/(Loss) on Sale of Asset	-	(76)	-	(76)	-	-	-	(76)	(30)		
2,732	Donations & Grants (PPE/Intangible Assets)	2,732	2,920	-	-	188	-	-	188	(46)		
(6,436)	Impairments	(6,436)	(8,565)	-	(2,129)	-	-	-	(2,129)	5,074		
385	Reversal of Impairments	385	(1,848)	-	(2,233)	-	-	-	(2,233)	-		
(1,610)	Depreciation & Amortisation - Donated	(1,610)	(1,555)	-	55	-	-	-	55	21		
(4,929)	**Sub Total Technical Items**	**(4,929)**	**(9,124)**	**-**	**(4,383)**	**188**	**-**	**-**	**(4,195)**	**5,019**		
10,971	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**10,971**	**5,918**	**(3,547)**	**(93)**	**895**	**1,923**	**(4,231)**	**(5,053)**	**3,708**		

Nursing & ODP Variance – March 2017

Division	Nursing Category	Price Variance fav/ (adv) £'000	Volume Variance fav/ (adv) £'000	Total Variance fav/ (adv) £'000	Lost Time % (Wards/ED/Theatres)
Medicine	Ward	4	(135)	(132)	
	Other	(53)	(98)	(151)	
	ED	(25)	(8)	(33)	
Medicine Total		**(74)**	**(242)**	**(315)**	**133%**
Surgery, Head & Neck	Ward	(9)	(130)	(140)	
	Theatres	(14)	17	3	
	Other	(82)	38	(44)	
	ED	2	(1)	0	
Surgery, Head & Neck Total		**(104)**	**(76)**	**(180)**	**130%**
Specialised Services	Ward	30	(32)	(2)	
	Other	39	(14)	25	
Specialised Services Total		**69**	**(45)**	**23**	**121%**
Women's & Children's Services	Ward	(13)	(73)	(86)	
	Theatres	(45)	(10)	(55)	
	Other	54	20	74	
	ED	7	(9)	(3)	
Women's & Children's Services Total		**3**	**(72)**	**(70)**	**128%**
Clinical Division Total	Ward	15	(374)	(360)	
	Theatres	(60)	8	(52)	
	Other	(43)	(54)	(97)	
	ED	(16)	(19)	(35)	
CLINICAL DIVISIONS TOTAL		**(105)**	**(439)**	**(544)**	**129%**
NON CLINICAL DIVISIONS	Other	(0)	(1)	(2)	
NON CLINICAL DIVISIONS TOTAL		**(0)**	**(1)**	**(2)**	
TRUST TOTAL		**(105)**	**(440)**	**(546)**	**129%**

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%	4.2%	5.4%	4.0%	3.6%	4.8%	3.8%	4.2%
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%	3.2%	2.5%	4.1%	3.7%	3.9%	4.4%	4.3%	3.8%
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%	4.1%	4.2%	4.7%	4.5%	5.1%	5.6%	5.7%	5.3%
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	3.8%	3.9%	3.4%	3.7%	4.0%	4.0%	4.9%	5.8%	5.8%	5.2%	4.4%	3.9%

Source: HR info available after a weekend

Graph 2 **Vacancies**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Medicine	Actual	7.5%	8.7%	8.3%	9.4%	10.6%	7.3%	6.1%	5.3%	5.8%	7.4%	7.8%	7.7%
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%	5.4%	5.6%	5.2%	5.9%	6.9%	5.6%	3.6%
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%	6.6%	5.4%	4.8%	4.9%	5.6%	6.9%	6.8%
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%	2.0%	0.5%	0.3%	1.4%	2.0%	2.0%	1.7%

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%	15.2%	15.2%	15.5%	16.7%	16.1%	15.7%	14.3%
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%	13.2%	12.9%	13.2%	12.5%	12.9%	13.0%	13.4%	13.6%	13.8%
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%	11.8%	11.0%	10.2%	10.2%	9.2%	9.8%	11.5%
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%	11.6%	11.2%	10.9%	10.7%	11.3%	11.3%	11.9%	12.4%

Source: HR - Registered
Note: M4 figs restated

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*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	203.8	265.4	179.6	245.8	197.9	166.2	271.4	276.6	260.7
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	85.2	135.7	129.2	119.5	99.5	64.3	53.2	75.3	54.2
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	182.8	245.2	247.3	187.9	179.3	109.2	117.2	111.1	212.6
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	219.1	179.2	173.3	176.3	186.7	141.0	124.0	116.3	141.5

Source: Finance GL (excludes NA 1:1)

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*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	27.2	31.1	27.9	24.6	36.4	38.6	31.6
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	14.4	14.1	12.7	8.0	5.9	8.6	6.0
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	28.8	26.0	23.8	17.6	15.7	17.3	28.5
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	19.1	16.8	18.9	11.7	11.1	16.0	16.4

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%	11.4%	14.6%	9.3%	13.0%	10.7%	9.3%	13.8%	14.7%	13.5%
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%	6.4%	9.8%	8.9%	8.2%	7.2%	3.9%	4.7%	5.5%	4.0%
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%	10.2%	13.2%	12.3%	9.9%	9.9%	6.3%	6.4%	6.2%	11.1%
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%	6.4%	5.1%	4.9%	4.9%	5.2%	4.0%	3.4%	3.4%	4.0%

Source: Finance GL (RNs only)

Graph 7 **Occupied bed days**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	Actual	9,235	9,359	9,250	9,543	9,238	8,621	9,394	8,944	8,983	9,581	8,732	9,368
Specialised Services	Actual	4,507	4,639	4,523	4,729	4,829	4,499	4,665	4,556	4,476	4,685	4,488	4,696
Surgery, Head & Neck	Actual	4,657	4,556	4,452	4,431	4,537	4,392	4,643	4,442	4,394	4,744	4,242	4,777
Women's & Children's	Actual	7,087	7,399	6,957	6,548	6,070	6,470	7,243	6,891	6,435	6,738	5,927	7,081

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	83	113	91	90	89	85	34	60
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	23	27	14	24	30	15	24	32	24	28	9	8
Surgery, Head & Neck	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery, Head & Neck	Actual	25	20	31	34	30	26	21	33	21	26	26	38
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	28	10	20	19	18	18	20	8	15

Source: Finance temp staffing graphs (history changes)

Key Financial Metrics -March 2017

Appendix 5

	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	3,506	4,521	3,608	7,295	9,077	360		7,881	36,248
Actual	3,545	4,605	3,445	7,385	8,884	356		7,954	36,174
Variance Fav / (Adv)	39	84	(163)	90	(193)	(4)	-	73	(74)
Year to date									
Budget	39,886	52,246	60,079	82,749	104,627	4,148		90,264	433,999
Actual	40,253	51,958	60,263	82,637	103,012	4,104		89,750	431,977
Variance Fav / (Adv)	367	(288)	184	(112)	(1,615)	(44)	-	(514)	(2,022)
Contract Income - Penalties									
Current Month									
Plan	-	(17)	(2)	(15)	(10)			(61)	(105)
Actual	-	(20)	(2)	(36)	(27)			(61)	(146)
Variance Fav / (Adv)	-	(3)	0	(21)	(17)	-	-	0	(41)
Year to date									
Plan	(1)	(196)	(28)	(96)	(46)			(618)	(985)
Actual	(1)	(208)	(24)	(245)	(171)			(1,088)	(1,737)
Variance Fav / (Adv)	0	(12)	4	(149)	(125)	-	-	(470)	(752)
Information shows the financial performance against the planned penalties as per agenda item 5.2									
Contract Income - Rewards									
Current Month									
Plan	68	101	136	140	159	82	-	0	686
Actual	80	118	159	164	186	96	-	1,024	1,827
Variance Fav / (Adv)	12	17	23	24	27	14	-	1,024	1,141
Year to date									
Plan	806	1,192	1,605	1,649	1,868	969	-	0	8,089
Actual	894	1,322	1,781	1,831	2,074	1,075	-	1,024	10,001
Variance Fav / (Adv)	88	130	176	182	206	106	-	1,024	1,912
Information shows the financial performance against the planned rewards as per agenda item 5.2									
Cost Improvement Programme									
Current Month									
Plan	137	140	126	413	386	65	60	124	1,451
Actual	136	227	162	346	226	82	26	154	1,359
Variance Fav / (Adv)	(1)	87	36	(67)	(160)	17	(34)	30	(92)
Year to date									
Plan	1,642	1,684	1,510	4,956	4,638	785	717	1,488	17,420
Actual	1,597	1,514	1,283	2,979	2,542	855	653	1,766	13,189
Variance Fav / (Adv)	(45)	(170)	(227)	(1,977)	(2,096)	70	(64)	278	(4,231)

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17															
		Q1	Q2	Q3	Q4	Total	Mthly Average	Mthly Average	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Total	Mthly Average	Mthly Average
		£'000	£'000	£'000	£'000	£'000	£'000	%	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	%
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	3,449	10,305	3,476	3,473	3,497	10,446	3,526	3,415	3,538	10,479	41,529	3,461	
	Bank	82	109	93	88	371	31	0.9%	20	21	25	66	29	32	31	92	23	21	27	72	12	22	25	59	289	24	0.7%
	Agency	377	242	186	168	972	81	2.4%	36	(11)	18	42	39	32	35	106	24	24	40	88	61	53	41	155	391	33	1.0%
	Waiting List initiative	98	54	95	95	342	29	0.8%	62	35	53	150	72	35	27	134	30	27	6	63	23	23	0	46	393	33	1.0%
	Overtime	147	94	100	110	450	38	1.1%	47	37	36	120	30	33	41	104	40	46	31	117	30	29	52	111	453	38	1.1%
	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	3,200	9,526	3,247	3,202	3,236	9,685	3,270	3,104	3,288	9,662	38,351	3,196	96.2%
	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	3,334	9,963	3,364	3,320	3,341	10,025	3,396	3,231	3,405	10,033	39,877	3,323	100.0%
	Variance Fav / (Adverse)	82	337	172	31	623	52		105	149	189	443	112	115	115	342	112	152	156	421	130	184	133	446	1,651	138	
Medicine	Pay budget	12,841	12,458	12,400	12,606	50,305	4,192		4,306	4,290	4,258	12,853	4,244	4,388	4,191	12,824	4,185	4,176	4,198	12,559	4,066	4,172	4,222	12,689	50,924	4,244	
	Bank	897	935	905	1,039	3,775	315	7.2%	243	319	318	880	338	358	290	986	277	293	292	861	312	298	337	946	3,673	306	6.8%
	Agency	826	875	814	1,119	3,634	303	7.0%	333	239	290	861	274	320	265	858	250	291	212	752	328	342	312	982	3,454	288	6.4%
	Waiting List initiative	51	45	56	42	194	16	0.4%	30	30	17	77	3	16	13	32	4	6	6	16	3	5	0	8	133	11	0.2%
	Overtime	16	21	35	32	105	9	0.2%	8	9	7	23	8	5	5	18	6	5	3	15	6	9	19	34	90	7	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	3,701	3,784	4,001	11,486	3,919	3,895	3,926	11,741	4,034	3,912	4,016	11,962	46,624	3,885	86.4%
	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	4,574	13,380	4,456	4,490	4,439	13,385	4,683	4,565	4,684	13,932	53,974	4,498	100.0%
	Variance Fav / (Adverse)	(161)	(359)	(391)	(933)	(1,846)	(154)		(97)	(157)	(170)	(424)	(80)	(95)	(383)	(557)	(272)	(314)	(240)	(827)	(616)	(393)	(462)	(1,243)	(3,050)	(254)	
Specialised Services	Pay budget	10,135	10,245	10,342	10,557	41,279	3,440		3,657	3,968	3,834	11,459	3,829	3,886	3,812	11,526	3,901	3,885	3,886	11,672	3,828	3,955	3,951	11,831	46,488	3,874	
	Bank	402	404	352	423	1,581	132	3.7%	94	159	172	425	151	176	122	449	139	155	131	425	104	131	131	366	1,665	139	3.5%
	Agency	671	710	582	689	2,651	221	6.3%	182	196	177	555	166	206	219	591	173	125	95	393	84	87	73	244	1,783	149	3.8%
	Waiting List initiative	125	144	156	103	528	44	1.2%	42	58	36	136	21	45	20	86	42	40	71	153	31	67	0	98	473	39	1.0%
	Overtime	29	29	30	25	114	9	0.3%	8	11	13	32	16	11	9	36	10	12	13	36	12	10	12	34	138	11	0.3%
	Other pay	9,189	9,222	9,395	9,674	37,480	3,123	88.5%	3,329	3,644	3,515	10,487	3,522	3,587	3,619	10,728	3,593	3,642	3,596	10,831	3,732	3,623	3,706	11,061	43,108	3,592	91.4%
	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	3,989	11,889	3,958	3,974	3,906	11,838	3,962	3,918	3,922	11,803	47,165	3,930	100.0%
	Variance Fav / (Adverse)	(280)	(265)	(174)	(356)	(1,075)	(90)		3	(100)	(79)	(176)	(47)	(139)	(177)	(363)	(57)	(89)	(20)	(167)	(134)	37	29	28	(678)	(56)	
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	6,739	6,846	6,785	20,371	6,804	6,743	6,817	20,364	6,830	6,795	6,977	20,682	81,307	6,776	
	Bank	559	683	488	624	2,355	196	3.0%	172	176	194	542	229	261	216	706	209	214	184	607	212	207	268	688	2,542	212	3.1%
	Agency	603	908	738	752	3,000	250	3.8%	262	251	193	707	238	242	256	736	217	205	123	545	133	131	251	515	2,503	209	3.1%
	Waiting List initiative	407	387	371	249	1,414	118	1.8%	98	154	130	382	90	71	45	206	12	58	97	167	84	46	0	130	885	74	1.1%
	Overtime	38	47	45	41	171	14	0.2%	11	12	9	33	8	11	7	26	10	10	7	27	10	8	9	27	112	9	0.1%
	Other pay	17,853	17,860	18,200	18,209	72,122	6,010	91.2%	6,144	6,165	6,159	18,467	6,040	6,202	6,389	18,631	6,381	6,271	6,283	18,935	6,466	6,324	6,487	19,277	75,309	6,276	92.6%
	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	6,913	20,304	6,829	6,758	6,693	20,280	6,905	6,715	7,015	20,636	81,352	6,779	100.0%
	Variance Fav / (Adverse)	(95)	(215)	(136)	(20)	(466)	(39)		(99)	(129)	(12)	(240)	134	60	(128)	66	(25)	(15)	124	84	(76)	80	(39)	45	(45)	(4)	

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17															
		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	Sep £'000	Q2 £'000	Oct £'000	Nov £'000	Dec £'000	Q3 £'000	Jan £'000	Feb £'000	Mar £'000	Q4 £'000	Total £'000	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	7,899	7,950	7,870	23,718	7,954	7,981	7,958	23,892	7,423	8,033	8,075	24,238	95,314	7,943	
	Bank	533	582	487	611	2,213	184	2.3%	141	185	172	498	181	194	173	549	119	176	131	426	169	167	168	504	1,977	165	2.0%
	Agency	703	840	866	719	3,128	261	3.3%	255	162	131	548	269	204	238	711	194	191	120	505	133	102	162	397	2,162	180	2.2%
	Waiting List initiative	205	169	203	206	783	65	0.8%	33	73	40	146	48	30	62	140	29	38	49	116	26	38	0	64	466	39	0.5%
	Overtime	23	19	26	35	102	9	0.1%	9	15	17	42	13	11	11	35	17	14	9	40	10	30	10	26	143	12	0.1%
	Other pay	21,492	21,695	22,409	22,958	88,554	7,379	93.4%	7,749	7,623	7,575	22,947	7,530	7,698	7,735	22,963	7,776	7,808	7,812	23,395	7,991	7,814	7,838	23,668	92,974	7,748	95.1%
	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	8,219	24,398	8,135	8,227	8,121	24,483	8,329	8,151	8,178	24,659	97,722	8,143	100.0%
	Variance Fav / (Adverse)	(393)	(477)	(701)	(750)	(2,320)	(193)		(244)	(456)	(16)	(716)	(142)	(187)	(349)	(679)	(181)	(246)	(163)	(591)	(907)	(118)	(104)	(421)	(2,407)	(201)	
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	1,780	5,291	1,739	1,705	1,732	5,175	1,735	1,747	1,715	5,209	20,914	1,743	
	Bank	296	320	278	246	1,140	95	5.6%	45	78	72	195	82	107	80	269	80	80	99	260	59	92	78	229	952	79	4.6%
	Agency	145	189	249	154	738	62	3.6%	32	27	37	96	26	29	28	84	33	27	33	93	36	16	28	80	353	29	1.7%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0.0%
	Overtime	225	244	207	200	876	73	4.3%	68	68	65	201	66	82	66	213	80	64	62	206	66	69	61	196	816	68	3.9%
	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	1,580	4,693	1,532	1,537	1,527	4,596	1,574	1,567	1,538	4,678	18,741	1,562	89.8%
	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	1,754	5,259	1,726	1,708	1,721	5,155	1,735	1,744	1,705	5,184	20,863	1,739	100.0%
	Variance Fav / (Adverse)	(16)	(12)	36	(30)	(21)	(2)		(9)	6	(22)	(26)	20	(16)	26	31	13	(3)	10	20	(0)	3	10	25	51	4	
(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	2,431	7,030	2,420	2,523	2,519	7,462	2,531	2,389	1,379	6,200	27,949	2,329	
	Bank	179	211	232	223	846	70	3.2%	60	61	92	213	70	71	43	184	84	63	39	185	79	64	96	239	822	68	3.0%
	Agency	69	177	390	367	1,002	83	3.7%	26	98	116	239	35	44	23	102	37	43	34	114	48	56	(155)	(51)	405	34	1.5%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
	Overtime	22	23	20	16	81	7	0.3%	4	5	3	13	5	9	7	21	5	5	9	19	2	3	5	10	63	5	0.2%
	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	2,283	6,474	2,288	2,360	2,305	6,953	2,333	2,255	1,515	6,103	26,123	2,177	95.3%
	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	2,356	6,781	2,414	2,470	2,387	7,271	2,462	2,378	1,461	6,301	27,413	2,284	100.0%
	Variance Fav / (Adverse)	188	118	134	169	610	51		47	155	(5)	197	77	97	75	249	6	53	132	190	69	11	(82)	(101)	536	45	
Trust Total	Pay budget	86,805	87,293	88,292	89,718	352,109	29,342		30,109	30,158	30,194	90,462	30,198	30,548	30,319	91,065	30,478	30,485	30,607	91,570	29,938	30,507	29,857	91,328	364,424	30,369	
	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	955	3,235	931	1,002	903	2,836	946	981	1,103	3,030	11,920	993	3.2%
	Agency	3,393	3,941	3,824	3,967	15,126	1,260	4.2%	1,127	961	961	3,049	1,047	1,078	1,064	3,188	929	904	657	2,491	823	787	712	2,321	11,050	921	3.0%
	Waiting List initiative	886	799	881	695	3,261	272	0.9%	265	350	276	891	234	197	167	598	117	169	229	515	167	179	1	347	2,351	196	0.6%
	Overtime	499	478	463	460	1,899	158	0.5%	156	157	150	463	146	160	148	454	168	157	134	459	136	159	167	438	1,814	151	0.5%
	Other pay	79,752	79,705	81,348	83,230	324,035	27,003	90.9%	28,083	28,223	27,876	84,183	27,616	28,078	28,805	84,500	28,737	28,715	28,685	86,136	29,400	28,598	28,388	86,411	341,229	28,436	92.6%
	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	31,139	91,975	30,882	30,947	30,608	92,438	31,472	30,703	30,372	92,548	368,365	30,697	100.0%
	Variance Fav / (Adverse)	(674)	(873)	(1,058)	(1,889)	(4,493)	(374)		(296)	(532)	(115)	(942)	74	(164)	(821)	(911)	(404)	(463)	(1)	(868)	(1,535)	(196)	(515)	(1,220)	(3,940)	(328)	

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 Movements		(6)	234		(80)	(118)	30	58	31	42	42	59	37	122	(421)	(30)
September movements	(17)	(9)	(120)		(165)	(105)	(416)	8	24	57	43	131	24	160	(31)	416
October movements	(53)	(529)	(1,532)		(143)	(98)	(2,355)	46	79	110	192	477	40	139	1,272	2,355
November movements	(34)	(22)	(294)		(122)	(171)	(643)	55	219	43	80	81	57	207	(99)	643
December movements	(31)	(31)	(104)		(122)	(145)	(433)	9	98	27	21	46	37	195	-	433
January movements	(2)	(39)	(139)		(210)	(130)	(520)	8	131	22	23	49	80	126	81	520
February movements	164	(53)	(99)		(100)	(131)	(219)	7	108	16	16	40	25	96	(89)	219
March																
Strategic Scheme Costs						(41)	(41)						25	16		41
Outsourcing	(68)						(68)		68							68
Spend to Save						(56)	(56)			3				53		56
Sexual Health						(79)	(79)		54					25		79
Service developments			(886)				(886)	97	(231)	683	55	266		16		886
Clinical Excellence Awards					27		27		7						(34)	(27)
CSIP						(39)	(39)							39		39
MADEL					13		13	25	10						(48)	(13)
CQUINs			(11)				(11)							11		11
SBCH	240						240						(240)			(240)
Rates refund		317					317						(317)			(317)
EWTD					(122)		(122)	8	26	17	21	46	2	1	1	122
Other	(29)	(11)			(50)	(12)	(102)			13			6	83		102
Month 12 balances	799	2,273	1,194	(683)	651	1,071	5,305	3,915	9,960	9,863	9,862	11,018	1,237	3,591	1,043	50,489

2016/17 Sustainability & Transformation Funding – March trajectory performance

In order for the Trust to be eligible for Sustainability & Transformation (S&T) funding, first it must deliver the monthly net surplus Control Total excluding S&T funding. Delivery of the Control Total entitles the Trust to 70% of the STF from July onwards.

On the 28th March 2017, NHS Improvement notified Trusts that 100% of the S&T funding for quarter four would be based on the delivery of the Control Total. This means that S&T funding applies to the delivery of the access performance trajectories in quarter two and three only as follows:

- S&T core funding – this represents £11.050m (previously £10.075m) of the total of £13.000m and is dependent on meeting the plan excluding S&T funding. The surplus excluding S&T funding has been achieved for the year, the surplus being £0.036m above plan. This metric is often referred to by NHS Improvement as the 'underlying position'.

- S&T performance funding – this represents £1.950m (previously £2.925m) of the total £13.000m and is dependent on meeting the control total and then delivery of performance trajectories for RTT, Cancer and A&E targets in quarters two and three only. For the year, the Trust earnt S&T performance funding of £1.056m, a loss of £0.894m due to the failure to achieve:

    - Cancer in July, September, October and December £0.220m
    - A&E in October, November and December £0.404m
    - RTT in August and September £0.270m

      £0.894m

The position to date is summarised in the table below:

Excluding technical items: Surplus/(deficit)	Operational Plan £m	Actual to date £m	Variance Fav/(adv) £m
Net surplus including S&T core funding only	13.950	13.986	0.036
S&T performance funding	1.950	1.056	(0.894)
Net surplus including all S&T funding	15.900	15.042	(0.858)

Net surplus Control Total

The cumulative net surplus Control Total (excluding S&T funding) was achieved for the period to March with an actual cumulative net surplus of £2.936m against a plan of £2.900m. This result means the Trust receives S&T funding of £3.250m for quarter 4 and brings the total S&T funding received for the year to £12.106m. Please see table one below.

Table one: 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	10.853	12.088	13.387	14.479	15.900
Less planned STF	(3.250)	(4.333)	(5.416)	(6.500)	(7.583)	(8.667)	(9.750)	(10.833)	(11.917)	(13.000)
Planned net surplus exc STF	**0.608**	**0.925**	**1.303**	**1.635**	**1.903**	**2.186**	**2.338**	**2.554**	**2.562**	**2.900**
Actual reported net surplus	3.871	5.275	6.722	8.170	9.086	10.062	10.929	12.272	13.168	15.042
Less STF	(3.250)	(4.279)	(5.308)	(6.337)	(7.014)	(7.773)	(8.585)	(9.615)	(10.427)	(12.106)
Actual net surplus exc STF	**0.621**	**0.996**	**1.414**	**1.833**	**2.072**	**2.289**	**2.344**	**2.657**	**2.741**	**2.936**
Control Total delivered / Eligible for STF?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

A&E waiting times

The Trust did not achieve the A&E waiting times standard trajectory in March with performance of 83.3% against the in-month trajectory of 91.0%. The cumulative performance was 85.0% behind the agreed trajectory of 88.1%. Table two summarises the position to date below.

Table two: 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%	86.6%	88.4%	92.2%	93.3%	90.0%	89.3%	88.5%	87.4%	91.0%
Actual performance	87.2%	91.7%	89.0%	89.3%	90.0%	87.3%	82.9%	78.5%	79.6%	80.4%	80.7%	83.3%
Agreed cumulative trajectory	81.9%	83.2%	84.1%	84.7%	85.2%	86.2%	87.2%	87.5%	87.7%	87.8%	87.7%	88.1%
Actual - cumulative performance	87.2%	89.5%	89.3%	89.3%	89.5%	89.1%	88.2%	86.9%	86.1%	85.6%	85.2%	85.0%
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory agreed/delivered	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
STF due	*£135k*	*£135k*	*£135k*	£135k	£135k	£135k	£0k	£0k	£0k	*£135k*	*£135k*	*£135k*

Italics represent notional values relating to the agreement of trajectories only for quarter 1 and the delivery of the Control Total in quarter 4 only.

Cancer waiting times

The draft performance for March is 81.4% which is below the trajectory of 85.9% and also the 85% national standard. With adjustments to performance taking into account breach reallocations that apply under the new national and local CQUIN rules which came into effect on the 1 October 2016, performance for the month may be above 85%. However, in quarter 4 STF monies are payable on the basis of achievement of control totals alone. For this reason the table below is showing notional STF monies due, despite the 85% national standard having not been achieved in February or March. Table three summarises the position to date below.

Table three: 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%	73.3%	84.8%	80.5%	79.5%	85.2%	81.5%	84.7%	79.0%	81.4%
Agreed cumulative trajectory	72.7%	73.0%	76.0%	83.7%	82.3%	82.8%	84.7%	84.6%	85.0%	83.6%	84.7%	85.0%
Actual - cumulative performance	77.2%	73.7%	72.7%	73.3%	80.0%	80.1%	79.5%	82.7%	82.4%	84.7%	81.9%	81.7%
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory agreed/ delivered	Yes	Yes	Yes	No*	Yes	No*	No*	Yes	No*	Yes	No	No
STF due	*£55k*	*£55k*	*£55k*	£0k	£55k	£0k	£0k	£55k	£0k	£55k	*£55k*	*£55k*

Italics represent notional values relating to the agreement of trajectories only for quarter 1 and the delivery of the Control Total in quarter 4 only.

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** Subject to appeal – subsequently rejected by NHS Improvement.*
Please note: March figures are still subject to final reporting

Referral to Treatment Time (RTT)

Final reporting of February's RTT performance confirmed achievement of the 92% national standard for the month. This had not been assumed in the financial forecast. Although the forecast for March is for the 92% standard to be failed, notional STF funding has been shown.

An appeal was made to attempt to secure the RTT funding for quarter two. The appeal was rejected by NHS Improvement. On this basis, the Trust has forfeited RTT STF of £0.270m for August and September. A further appeal was made for quarter three (i.e. for the month of October). The Trust has received notification that this appeal has been supported at a regional level and by NHS England and HM Treasury. Table four summarises the position to date below.

Table four: 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%	90.5%	90.4%	91.2%	92.0%	92.0%	92.2%	92.0%	TBC
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%	91.6%	91.6%	91.6%	91.7%	91.7%	91.7%	TBC
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 agreed/ delivered	Yes	Yes	Yes	Yes	No*	No*	Yes	Yes	Yes	Yes	No**	
STF due	*£135k*	*£135k*	*£135k*	£135k	£0k	£0k	£135k	£135k	£135k	£135k	*£135k*	*£135k*

Italics represent notional values relating to the agreement of trajectories only for quarter 1 and the delivery of the Control Total in quarter 4 only.
**Subject to appeal – rejected by NHS Improvement*
*** At financial close, failure is assumed. Figures for February are still subject to final reporting.*

Diagnostics

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

Summary

The Trust's Operational Plan Control Total surplus of £15.9m assumed full receipt of the S&T funding at £13.0m of which £2.925m originally related to the delivery of the Trust's access performance trajectories. The recent notification from NHS Improvement meant that only £1.950m of the S&T funding related to the delivery of the access performance trajectories in quarters two and three. Against the £1.950m, the Trust earnt S&T performance funding of £1.056m, a loss of S&T performance funding of £0.894m.

Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	15
Meeting Title	Trust Board	**Meeting Date**	28 April 2017
Report Title	Transforming Care Programme Board		
Author	Simon Chamberlain, Director of Transformation		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

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

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

Executive Summary
Purpose The purpose of this report is to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme. Key issues to note The report sets out the highlights of progress over the last quarter and the next steps
Recommendations

Members are asked to: • Receive the report for assurance.

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

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

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

Impact Upon Corporate Risk
N/A

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

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

Transforming Care

Transforming Care Update to Trust Board

April 2017

The purpose of this report is to update the Trust Board on progress over the last quarter with the Trust wide programmes of work within the Transforming Care programme.

1. In our Operating Model programme the work to roll out and embed our standard Ward Processes approach across inpatient areas has delivered a sustained improvement in timely discharge across our hospitals. A key part of consolidating the progress made has been to ensure that we use reporting tools to share information in real time and to make the information about patient and ward status visible both locally and to others. To support this in December we implemented our pilot electronic whiteboard in the Surgical and Trauma Assessment Unit (STAU). This replaces the traditional dry-wipe whiteboard, but crucially ensures the information displayed can be shared across teams for operational decision making. The pilot in STAU has proved successful and the roll out of this tool will begin shortly with wards in Medicine and the Children's hospital selected for the next installations. Making patient and ward status visible is an important element in further embedding the Ward Processes disciplines into routine practice.

2. One of these disciplines is ensuring each patent has an accurate and up to date Expected Date of Discharge (EDD). During the last quarter the project team has renewed our operational definition of EDD and updated related training and communications materials to support our work to embed this important discipline. This work has been supported by a multi-disciplinary team, including a group of junior doctors who undertook a survey into current practices to inform how to increase effective use of EDD. Good use of EDD is obviously important to our patients – to inform them when we expect them to leave – but critical for internal operational planning as it allows us to predict available beds.

3. The Ward Processes & Real Time work will build on this on the next quarter with trials of new operational reporting sourced directly from data in Medway. This is to be implemented on a number of pilot wards, with the aim of taking the phone calls and paper out of our daily reporting routines. The pilot wards will use electronic information to share patient and ward status. The new reporting will also improve the accuracy of the Patient Flow Trackers which are now live across Surgery, Head & Neck areas of the BRI.

4. In December, two teams from our Trust were accepted to take part in a Flow Improvement Coaching programme, organised by the West of England Academic Health Science Network, the Royal United Hospitals Bath, and Sheffield Teaching Hospitals. The programme uses the Microsystems Academy methodology for improvement which has been employed by Sheffield for some years, and aims to transform pathways of care from both a flow and team capability standpoint. The two pathway teams accepted onto the programme were the Paediatric Nero-Rehab team

and the Integrated Discharge Service. Both teams have now participated in three workshops and are mobilising their improvement programmes. The method combines flow improvement and focus building capability of the multi-disciplinary team involved in pathway delivery.

5. Our Outpatient Transformation programme has developed and made available on line the renewed standards for clinic preparation and delivery. A range of activities is underway to share and embed these, including the development of eLearning, use of quality assurance tools to assess compliance, and development and roll out of a reporting and tracking tools. These include improved operational reports allowing better analysis of clinic utilisation and Did Not Attend (DNA) performance, which supports improved clinic productivity. During the next quarter we also plan to learn from and apply the “Perfect Clinic” approach used in City Hospitals Sunderland, which will give us not only greater assurance that the standards are becoming embedded but also allow us to identify and fix other sources of delays in clinics.

6. In our Children’s Hospital, our Flow Improvement programme is delivering a wide agenda of changes to improve flow for both emergency and elective patents. The Children’s teams have been part of the Trust-wide Ward Processes & Real Time programme and the Flow programme builds on this work to address other barriers to flow. Work with the Clinical Investigations Unit is implementing changes to increase the utilisation of this unit by taking activity from ward areas. As part of this the SAFER bundle, which captures standards for managing patients and flow across hospital areas has been refreshed with clinical input from across the hospital for relaunch later his summer and as part of preparations for next winter.

7. In January our Admin Teams Transformation programme launched a values based assessment centre process to improve the recruitment of staff to our core clinical admin roles. This has now run for three months and has proved successful to date in ensuring that the candidates we hire pass a common set of competency tests and are interviewed in settings which allow us to better assess their suitability for the job. The assessment centre process relieves a significant burden of work from recruitment managers and has also identified a pool of talent to join our admin bank team. Our admin programme was mobilised to address vacancies and turnover in this key group of staff, and has contributed to a significant reduction in the costs and use of bank and agency staff to cover gaps in staffing in 2016/17.

8. In support of our Quality Strategy, we have been developing methods to drive innovation and improvement across the Trust, in order to promote innovation and to make improvement a part of everyone’s work. In support of this we have launched our Quality Improvement Academy to make training in improvement skills available to all our staff. The Academy will offer a range of training opportunities, beginning with the “Bronze” level which will provide awareness and basic training in fundamentals of Quality Improvement. The first Bronze session takes place in late April and will be run regularly with sessions open to all staff. Additional sessions are being planned to provide training to Core Medical Trainees, and we are planning other additional sessions to target specific staff groups. Alongside this we are launching the Quality Improvement Hub on our intranet to provide help and support to staff with good ideas to take forward.

9. During the last quarter the Transformation Board has led work to renew our transformation priorities for 2017/18. This has been informed by priorities for improvement identified at both Trust and Division level, and has been aligned with development of Operational plans. To support this, existing programmes within the Transforming Care portfolio have undertaken an assessment of progress and priorities. This is resulting in a revised set of priorities and plans to continue our transformational change programmes into the new financial year. The revised priorities largely build upon the progress we have made across the Transforming Care pillars in 2016/17, but two new programmes of work are of particular note: Principles of Customer Service, and the Global Digital Exemplar programme (GDE).

10. A programme to define and embed principles of customer service supports our quality strategy and quality improvement priorities for 2017/18 and aims to help us build on our “Outstanding" CQC rating. Through this work we aim to better define the things we must get right in our interactions with patients, including how we communicate with them, so that we can further improve our patients’ experience. A major strand of this work will be around communications, building on our work on letters and email and accelerating our work on voice and telephone communications, but the work also aims to understand the things we need to get better at in other interactions and seek how we systematically improve. We already have a wealth of information around this and are arranging a scoping workshop in late April to agree the priority areas of work for this programme.

11. Making better use of IT is increasingly embedded into all of our programmes of work as a key enabler of embedding changes in ways of working. The Global Digital Exemplar (GDE) programme gives us an opportunity to accelerate this work. Through GDE we will be introducing new IT tools and devices into many of our clinical areas, and the opportunity is to use this to accelerate and embed the transformational changes in ways of working we are already working on. Key to this will be engagement and involvement of staff in designing the new ways of working, and we are working now to ensure strong partnership working between Transformation and IT programmes to ensure we maximise the benefits of this opportunity for our patients and for our staff.

12. Finally, in resetting our priorities for 2017/18 we are working of the linkages between Transforming Care and other programmes of work – in particular the BNSSG wide Sustainability and Transformation Programme which will drive change and improvement in many of our services. All of our programmes of transformational change have cross-organisation linkages and through these we will ensure change aligned with STP programmes, to lead change in partnership with others as appropriate.

13. The latest version of the Transforming Care programme status report as prepared for the Transformation Board is attached at appendix 1.

Simon Chamberlain

Director of Transformation

19th April 2017

Transforming Care Programme report - April 2017

Pillar	Details	Purpose	Key deliverables	Planned		Forecast	Current status	Risks	Benefits / Measures
Delivering best care	**Project:** Patient Communications **Exec lead:** Carolyn Mills **Project lead:** Alison Grooms **Project phase:** implementation	**Patient Letters** To improve and standardise the quality of all appointment letters that are sent by UHBristol to patients, guardians and carer (both electronically and non-electronically generated) in line with the Trust's Objective 5 - 'To improve how the Trust communicates with patients'.	• Phased roll out of letter upgrades underway in SHN, BHI, D&T • Elective patient leaflet signed off • SH&N Letter Pilot commenced • Letter upgrades rolled out to Medicine and BHOC	Feb-Apr Dec Dec Jun	G A G G	Apr Apr Mar	• BHI Outpatients and majority of SHN inpatients letters have been signed off. D&T, Dental and some W&C letters ready to be signed off on 11th April. Others to be signed off on a staggered basis. • Sign off on 11th April • Currently being tested with Synertec and new printers	• Ability to resource the rewriting of letters Trust wide against the letter quality standards. • Costs associated with sending of new Outpatient and Inpatient leaflets. Costs will be established during pilot phase. Divisions to agree to spend for further roll out.	• To improve patient experience and reduce patient communication related complaints and DNA's
	Telecomms This project will improve the quality of verbal telephone communication with the Trust, and also ease of accessibility for patients to speak to the correct individual to deal with their query.	• Project relaunched • Outcomes of data analysis of case study area reviewed • Project governance set up and milestones agreed	Feb Mar Apr	A G G		• To be progressed under the Principles of Customer Service work		• Less complaints • More patient satisfaction
	Medway based email correspondence To provide our patients with the option of receiving their appointment letter via email instead of post, as preferred by many of our patients, especially those with visual impairment.	• Creation of inboxes and Medway functionality for administrators actioned by IM&T • Go-live coms in place prior to project launch • SOPs finalised • Training session arrangements in place for Appointment Centre Staff, Receptionists and Booking Coordinators. • Volunteers briefed • Email collection commenced	Jan Jan Mar Feb May Feb	A A G A G A	Apr May May Apr	• Will attend IRMG end of April to get sign off of improved process which reduces risk of patients being wrongly sent their letters via email • Will finalise based on IRMG sign off • Development of eLearning underway, to be rolled out by May • Volunteers to support patients with Q&As	• Low up-take of email option • High drop off • Staff training in SOP • Recruiting of Email Validators	• To provide our patients with the choice of receiving their appointment letter via email. • To reduce printing and postage costs
	Project: Sign up to Safety Patient Safety Programme **Exec lead:** Carolyn Mills **Project lead:** Caroline Beale **Project phase:** implementation	To reduce avoidable harm by 50% and to reduce mortality by a further 10% by 2018.	• Developing, testing and implementing WHO checklists and LocSSIPs for other invasive procedures continued • Medicines safety work stream milestone: the 'PharmOutcomes' referral pilot completed and U500 insulin prescription chart and guidelines produced • OPP funding bid for IT link to improve speed of PharmOutcomes referrals made (currently 20 mins per patient to complete for all, but those with simple dosette box, referrals). • Deteriorating patient work stream: Sepsis screening tool and pathway implemented and audits recommenced. Automated sepsis screening in CED in place. Joint education in place for deteriorating patient, sepsis and AKI. • AKI workstream refresh. Deliver Q3 sepsis CQUIN targets. NEWS credit cards produced. Focus doctor education on resetting triggers. Human factors thematic assessment of NEWS related incidents completed. • Safety culture feedback to clinical teams completed • 2017 walk rounds by all Executive Directors planned. Tests of change for ward round checklist in Oncology and Haemtology completed.	Q4 Q4 Q4 Q4 Apr-17 Q4	G A A G G A G		• Plan for Q1 - Contiue dissemination of the LocSSIPs to all procedural areas and raising awareness of their implementation particular focus on junior doctors • Plan for Q1 - Guidance for compatabilty of insulin pens and needles for insulin pens to be produced • Milestone has changed and rather than purchasing the IT link, the system is being developed locally and this is in D & T's OPP • Plan for Q1 -Continue testing sepsis screening tools in paediatrics and implement in maternity. Communication of escalation under review and actions to address cover of responders to be agreed with divisions . • Plan for Q1 -response to thematic analysis of human factors. Test new AKI care bundle in adult services. • Plan for Q1- Safety culture feedback to clincal teams to be completed and safety culture toolkit completed • Tests of change for ward round checklist in Oncology and Haemtology completed in Q4. Plan for Q1- explore adaptations and test sites in other specialties	• Risk front line staff cannot release sufficient time to enagage and particpate in quality and safety improvement Risk of delay in insulin safety improvement due to clincal commitments of staff leading the work • Risk to 2017/19 sepsis CQUIN in ED due to lack of success in recruiting an ED practitioner to the funded ED sepsis nurse role • Risk of slippage of programme due to long term absence of Programme Manager • Risk of inabilty to effectively measure improvements for some workstreams due to availabilty of valid and reliable data sources or need for signifcant manual audit	• Reduction in mortality and avoidable harm • Earlier recognition and management of deteriorating patients • Prevention of peri-procedure never events Reduction in insulin medication errors and readmissions due to poor medicines compliance • Increased sustained compliance with patient safety risk assessments and controls
	Project: CSIP **Exec lead:** Paul Mapson **Project lead:** Steve Gray **Project phase:** implementation	Implementation of a cohesive set of clinically-focused applications and technologies that will transform business processes and provide users with tools and opportunities to improve patient care and achieve efficiencies.	• Nursing Electronic Observations Project Initiation • GDE Programme Agreed • Submission of Clinical Utilisation Review (CUR) evaluation report • EDM go-live in BRI, BHI and SBCH • BigHand Go Live	Apr Feb Apr May TBC	G A G G	Apr	• The project is in early preparation stage and will need formal kick off once the Global Digital Excellence initiative is agreed • CSIP are currently finalising the arrangement for the Global Digital Exemplar Programme, which will provide extra investment to enable UHBristol to roll out more and better software, sooner than expected • CUR went live with the pilot wards on 1st Dec following a three day training roll out • Pre-scanning of records in readiness for go-live will begin in April • The Digital Dictation and Speech Recognition Project has had approval to implement the use of BigHand go allowing clinicians to manage their dictations on a mobile device.		• Improved patient safety and experience through ready access to timely, accurate information • Improved efficiency for all staff involved in handling/viewing/creating patient information • Increased security of patient information (e.g. patient images)
	Project: Outpatients **Exec lead:** Mark Smith **Project lead:** Alison Grooms **Transformation lead:** Marjolein Vries **Project phase:** implementation	To deliver a high quality service through a friendly, accessible, consistent and timely service.	• eLearning developed for Outpatients Standards • Remaining specialties and volumes to transfer to Appointment Centre identified • Stock take of Outpatients Programme carried out and themes identified • Implementation plan for piloting and roll out of EVOLVE electronic triaging module developed	Mar Dec Mar TBC	A A G TBC	Apr Apr	• eLearning slides to be produced via Operational Managers Outpatients group. Guidance to be developed for Managers on monitoring compliance (April) • Remaining Specialties identified (108 out of 158 Specialties remaining). Work with informatics underway to produce report on number of clinics and appointment slots per Specialty. • Will be discussed at Outpatients Steering Group 6th April and priorities of work agreed • Workshop with IM&T and supplier taken place 13th March. Supplier to review some questions and come back with proposed timescales	• Delays in Outpatients Programme due to gap in Outpatient Manager post and Appointment Centre Manager post.	• Improved patient experience due to services working according to the standards, improved training of outpatients staff and one single place to call for appointments • Income generation via 1% DNA reduction/activity increase in 6 specialties who pilot reworded text reminder • Utilisation targets to be agreed
Improving patient flow	**Project:** Operating Model **Exec lead:** Mark Smith Transformation Lead: Kirstie Corns **Project phase:** implementing **Project leads:** IDS lead: Andy Burgess Phase 1 Ward processes: Dr Rachel Bradley and Sarah Chalkley Phase 2 EDD and ?Home within 24 hours: Miss Meg Finch-Jones and Jennifer Pollock Phase 2 Discharge Lounge: Trevor Brooks Phase 3 Operational Reporting and Bed Management: Dr Rachel Bradley and Jan Sutton Phase 3 e-Whiteboards and effective board rounds: TBC Phase 4 Flow trackers and e-dashboards: Mr Andrew Hollowood ORLA: Dr Peter Collins >7 day LOS senior review: Julia Wynn Joint Front Door: Dr Peter Collins	**Integrated Discharge Service** To establish a fully Integrated Discharge Service which reduces occupied bed days whilst improving patient outcomes and experience	• Active Patient Flow Coaching Programme delivering Quality & Efficiency Improvement • Discharge to assess pathways 2 review • Pathway 3 Pilot (NBT and UHB) • Revised Managing Expectations for Discharge Policy launched • Pilot Single Referral Form	Feb Mar Mar May	G G A A		• Condition based programme of work to support quality improvement. Frail Elderly condition identified. NB: This work will work in conjunction with the Frailty Network programme • Pathway 2 - review in line with bed modelling for SBCH (JW/AB) • Pathway 3 - Pilot on C808 starts March 2017. • Documentation revised, in collaboration with NBT. Further clarity meeting arranged 24th Feb '17 with Helen Mee. • Initial re-engagement commenced.	• Insufficient capacity in the community • Insufficient resilience in community • Risk that without appointment of an IDS lead, the IDS project won't deliver	• Achievement of A518 (17 beds) closure • Achievement of occupancy at 92% in Medicine Division • Reduction in Medicine Green to Go to 38, to support reduction in bed base by 17 beds • Increase in before 12 noon discharges to 1100 pts per month • Increase nos. to the discharge lounge • Reduction in last minute cancellations to 0.8%
		Ward Processes and Real Time Roll out an integrated Ward Processes and Real Time programme	**Phase 1 Ward Processes work stream** • Ward Processes roll out in SHN completed • Ward processes roll out in W&C completed • Ward processes roll out in SPS completed **Phase 2 EDD and ?Home within 24 hours** • Updated definition launched and communicated • Reviews and audits undertaken • EDD and ?Home within 24 hours project plan complete **Phase 2 Discharge Lounge** • Project plan completed • Business case for band 6 nurse to manage Discharge Lounge signed off • Transport and pharmacy process review **Phase 3 Operational Reporting and Bed Management** • New operational report developed and ready to pilot • Pilot commenced **Phase 3 e-Whiteboards and effective board rounds** • Electronic ward whiteboard roll out plan developed **Phase 4 Flow trackers and e-dashboards** • Surgical flow tracker implemented and roll out across SHN (including escalation SOP) • BHI flow tracker implemented and roll out across BHI (including escalation SOP)	Mar Mar Mar Dec Mar Nov Nov Mar Ongoing Dec Apr Aug Q3 TBC	G A A G G A R A G A G A G	Mar Apr TBC Apr TBC Mar	• Weekly and monthly data sent to the wards. Fortnightly meetings on hold due to changes in the Transformation Team. • One workshop scheduled for March, one workshop still outstanding • SpS waiting for Transformation Team support to be in place • Trust definition approved and communicated via Newsbeat, Connect, email and laminated copies for every ward. • Audit, survey and literature review presented by junior doctors and next steps agreed. • Consultant engagement underway (clinical poster, online survey) • No Clinical or Operational Lead in place and resource constraints from Transformation Team • Project plan and project on a page to be re-drafted and shared with steering group for feedback following recent review. • 3 weekly meetings taking place to work through reasons for delays and solutions to remove barriers to discharge. • Work has started on developing a Discharge Lounge report to identify patients suitable for Discharge Lounge • Baseline data collection initiated • Pilot will take place on A900, commencing 3rd April for three weeks. • STAU board had updated version • A515 whiteboard functionality is ready, date for installing to be agreed with ward • Meeting scheduled with BHI to scope requirements for their whiteboard • IM&T put in a technical fix to improve performance and reliability • Walk about and demo on A700 and A800 with Above & Beyond taken place • Operational embedding handed over to Division • Requirements agreed and submitted to IM&T. Division proceeding independently whilst waiting for Transformation resource.	• Capacity within Divisions to lead and support programmes cross divisionally given operational demands and winter pressures • Short term capacity constraints within the Transformation Team • Divisions do not enact commitment to prioritise governance of ward processes at Divisional level	
		>7 day LOS senior review All patients with a >LoS of 7 days with have a senior review – business as usual.	• Review of meetings (linked with IDS meetings review) • KPIs developed	Feb Oct	G A	Apr	• Meetings underway • Work started but not complete	• Operational pressures with external partners leads to inconsistent meeting attendance	
	Project: Theatre Transformation Programme **Exec Lead:** **Project Lead:** **Project phase:** implementation	To provide individualised safe quality patient care with maximum efficiency in responsive operating theatres Trust wide. Which in turn will support the capacity demands for surgical intervention.	• Bluespier phase 1 hardware roll out completed • Bluespier phase 2 programme agreed	Dec-16 Dec-16	G R	Jan TBC	• Project scope for phase 2 is to be developed	• Theatre Management team recruitment and retention will impact capacity	• Start on time 90% achievement • Turnaround Time 85% achievement • Theatre utilisation 85% achievement
	Project: BRHC Flow **Exec Lead:** TBC **Project Lead:** Lisa Davies **Transformation lead:** Mel Jeffries **Project phase:** Implementation	To improve patient flow at Bristol Children's Hospital so that children and young people receive quality healthcare at the right time, in the right place with no delays.	• Analysis of CIU bed and room scheduling processes, including IM&T systems completed • One week EDD accuracy snapshot • 'Regional hospital and network' work stream milestones agreed • 7 day working information collecting survey distributed • Admissions to BRHC Connect hub go live • Revised BRHC SAFER bundle launched	May Mar Feb Mar Feb Sep	G G A G A G	May May	• Analysis being completed, for all Specialties (27) using CIU, to inform standardised robust scheduling processes for the unit • Comparison of EDD recorded on Medway with ward whiteboards and actual discharge dates. • Survey sent to all Service Leads to complete by 7th April • Elective booking standards for all 27 Specialties in BRHC currently being finalised and exceptions identified before go live • Being written at present and will then go for feedback to all Specialties and other key stakeholders for feedback	• Increase in winter demand and acuity of patients requiring more admissions impacting flow and capacity to deliver programme	• Improvement in 4 hour target in • Reduction in last minute cancellations
Building capability	**Project:** Real Time Staff Engagement (The Happy App) **Exec Lead:** Alex Nestor **Project Lead:** Anne Frampton, Andrew Hollowood **Transformation Lead:** Caitlin Bateman **Project phase:** implementation	To provide a method for staff to leave real-time feedback regarding how they are feeling and the related causes. By doing so we will improve engagement with staff, and in turn we believe this will help us to provide a better quality of care to our patients.	• IPad rolled out to 22 new areas and c.25 more iPads ordered • UHB governance to be agreed • Happy App usage now business as usual	Jan Apr Apr	G G G	Mar		• Availability of IT support/resource • Willingness of staff to engage • Administrator resource to respond to comments	• Use of app (number of hits a day per area) • No of areas using website • No of resolved & closed actions per area • Improved staff Friends and Family
	Project: Appraisal improvement project **Exec Lead:** Alex Nestor **Project Lead:** Sam Chapman **Project phase:** Implementation	• Staff appraisals are considered valuable and worthwhile • Staff receive an annual appraisal and regular reviews which integrate objectives, development, performance and career discussions • Staff appraisals link to the overall strategic direction of the organisation	• Trust wide comms plan in place (Meeting with Fiona Reid on Nov) • Communication and cut off plan commenced • Drop in sessions taken place • Electronic appraisal system implementation trust wide	Jan - Feb Apr Feb-Mar May	G G G G		• Divisional boards have been updated with additional HOS also being briefed. One board meeting will take place on 5th April • Ensure all HR web training is ready for go live and transition arrangements are in place • Are well attended by all staff groups • Go live date agreed: 15th May	• Challenges IT could delay project roll out - mitigated through the HRIS subgroup and weekly AIP meeting	• Improved Staff Experience • Reduction in staff turn over • Able to monitor the quality of appraisals • Support a culture of Collective Leadership
	Project: Leadership behaviours **Exec Lead:** Alex Nestor **Project Lead:** Sam Chapman **Project phase:** Implementation	To improve staff experience and consistency of leadership behaviours across the Trust this programme is designed to introduce UHBristol Leadership Behaviours in 2017.	• Findings shared with attendees of workshops • Findings shared and leadership behaviours agreed at SLT • UHBristol leadership behaviours to be developed by SLT subgroup	Feb Mar Apr	A G A	May May	• Findings shared at SLT. Further sub group discussion requested by SLT which will take place in April. Revised approach to SLT end of April. • Further milestones to be agreed	• Not realising the benefits of the leadership behaviour work in the 2017 staff survey due to timing of roll-out and staff survey • Not measuring the behaviour work through 360 feedback in 2017 due to system implementation post the roll-out of phase one of the appraisal improvement programme	Staff survey & implement leadership behaviours from appraisal process Specific targets to be agreed.
	Project: Admin Teams Transformation Trust Wide **Exec Lead:** Alex Nestor **Project Lead:** **Transformation Lead:** Caitlin Bateman **Project phase:** implementation	To join up the work going on across the Trust in relation to our admin teams and realise the benefits that we could be recognising in our savings programme.	• Training programmes per role designed • Engagement with staff • Third month of recruitment pilot • Admin and recruitment stock take workshops carried out to inform direction of travel for 17/18 • SOPs for each role created • Bank and agency recruitment process rolled out	Jan Jun Mar Mar Mar Mar	R G G G A A	Apr Apr	• TNA reviewed and GAP analysis performed. • Engagement with staff planned to roll out the 10 standardised job descriptions • Consultation possibly required if engagement alone isn't enough • 13 roles filled at assessment centre (not incl March), 15 candidates put into talent pool and 8 roles filled from talent pool • Capacity issues in the divisions is delaying the drafting of SOPs • New process to request bank and agency staff to be rolled out in first few weeks of April	• Divisional ability to resource project • Possibility for consultation required for changes to job descriptions	• Reduction in bank and agency spend • Reduction in manager time spent recruiting admin roles • Reduction in staff turnover • Improved staff retention • Improved friends and family score/trust survey from A&C staff • Reduction in stress related sick days

Milestone complete / Activities on track to achieve milestone
Milestone behind plan, with action to remedy
Milestone behind plan, project/programme risk

Updated: 31.03.2017

Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	16
Meeting Title	Trust Board	**Meeting Date**	28 April 2017
Report Title	Emergency Preparedness, Resilience and Response Annual Report		
Author	Simon Steele, Resilience Manager		
Executive Lead	Mark Smith, Deputy Chief Executive and Chief Operating Officer		
Freedom of Information Status	Open		

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

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

Executive Summary

Purpose: To highlight the trust position in relation to emergency preparedness, resilience and response over the past 12 months.

Key Changes

Between April 2016 and March 2017 the Trust has moved to being partially compliant with the NHS England Core Standards for Emergency Preparedness, Resilience and Response from a position of non-compliance previously. This report provides an overview of this position and the work programme to move to full compliance over the forthcoming year.

Recommendations

Members are asked to:

- **Accept** the report.

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

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

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

Impact Upon Corporate Risk
N/A

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
				Civil Contingencies Steering Group – 18th April 2017 Senior Leadership Team – 19th April 2017

Title:	Emergency Preparedness Resilience And Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	1.1

Emergency Preparedness, Resilience and Response

Annual Report 2016 – 2017

Prepared by: **Simon Steele,** Resilience Manager

Presented by: **Mark Smith,** Chief Operating Officer and Accountable Emergency Officer

Executive Summary

The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect the safe and effective operation of the Trust's services. These could be anything from severe weather to an infectious disease outbreak or a major transport accident.

Under the Civil Contingencies Act (2004), NHS organisations must show that they can effectively respond to emergencies and business continuity incidents while maintaining critical services to patients. This work is referred to in the health service as Emergency Preparedness, Resilience and Response (EPRR).

The Civil Contingencies Act 2004 (CCA) places a number of statutory duties on NHS organisations which are classed as either Category 1 or Category 2 responders.

Category 1 responders are those organisations at the core of an emergency response. As a Category 1 responder, University Hospitals Bristol NHS Foundation Trust (the Trust) is required to prepare for emergencies in line with its responsibilities under;

- The Civil Contingencies Act 2004,
- The Health and Social Care Act, 2012, and
- NHS England Core Standards for Emergency Preparedness Resilience and Response 2016.

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The Trust is positioned centrally in what is known as a 'Core' city. This position places an even greater emphasis on there being robust up to date emergency plans in place. This report outlines the position of the Trust in relation to Emergency Preparedness, Resilience and Response and how the trust will meet the duties set out in legislation and associated guidance, as well as any other issues identified by way of risk assessments and identified capabilities. The report also includes information relating to the Trust's position in the NHS England annual EPRR assurance audit.

Title:	Emergency Preparedness Resilience And Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	1.1

Acronym's and Definitions

Acronym	Definition
AEO	Accountable Emergency Officer – at UH Bristol this is the Chief Operating Officer & Deputy Chief Executive
BCWG	Business Continuity Working Group *(Internal Group)*
CBRN	Chemical, Biological, Radiological and Nuclear
CCSG	Civil Contingencies Steering Group *(Internal Group)*
EPRR	Emergency Preparedness, Resilience and Response
IRPG	Incident Response Planning Group *(Internal Group)*
ISO 22301	International Standardisation Organisation Business Continuity Management *(the International Standard for Business Continuity Management)*
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
OCMF	On Call Managers Forum *(Internal Group)*
SWASFT	South Western Ambulance Service NHS Foundation Trust

Title:	Emergency Preparedness Resilience And Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	1.1

Contents

Title:	Emergency Preparedness Resilience And Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	1.1

1. Introduction

1.1 Purpose

This report outlines the Trust's EPRR activities during the period April 2016 to March 2017 that relate to the requirements of the Civil Contingencies Act 2004, its associated regulations, statutory and non-statutory guidance.

The report is presented to the University Hospitals Bristol NHS Foundation Trust Board in line with the requirements of the NHS Core Standards for Emergency Preparedness, Resilience and Response 2016.

1.2 Background

The Civil Contingencies Act 2004 (CCA) sets out a single framework for civil protection in the United Kingdom. The Civil Contingencies Act provides a statutory framework for civil protection at a local level and divides local responders into two categories depending on the extent of their involvement in civil protection work, and places a set of duties on each.

Category 1 responders are those organisations at the core of emergency response. Acute Trusts are identified as Category 1 responders and are subject to the full set of civil protection duties.

The Trust is therefore required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning,
- Put in place emergency plans,
- Put in place business continuity plans,
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency,
- Share information with other local responders to enhance co-ordination,
- Co-operate with other local responders to enhance co-ordination and efficiency.

1.3 Context

Nationally across EPRR in 2016 there has been a continued and increased focus on ensuring incident response plans are fit for purpose, particularly for major incidents categorised as mass casualty events. The national threat level remains at severe. This focus gives an added importance to ensuring the Trust meets its statutory obligations and is able to provide high levels of patient care when responding to incidents

Given the importance of ensuring that the Trust is well positioned to meet all the requirements of the statutory obligations placed upon it, to continuously revise and exercise plans and provide relevant training. In a large inner city NHS Trust, the position of Resilience Manager is crucial. This is a post that has seen a large period of transition with the appointment of the third post holder in two years in September 2016.

EPRR within the Trust is overseen by the Deputy Chief Executive and Chief Operating Officer who acts as the Emergency Accountable Officer, supported by the Associate Director of Operations and Deputy Chief Operating Officer. They chair the Civil Contingencies Steering Group which drives the EPRR agenda. Under this group are two substantive working groups chaired by the Resilience Manager; the Incident Response Planning Group and the Business Continuity Working Group.

In the 2016 NHS England EPRR Core Standards review the Trust was deemed to be partially compliant with the standards having been non-compliant in 2015. This audit process required the Trust to complete a self-assessment against each of the core standards for EPRR. This self-assessment was subsequently reviewed by NHS England and Bristol Clinical Commissioning Group in discussion with the Trust and a final rating assigned. The work

programme has been updated to reflect partial compliance and is appended to this report. As the Trust is partially compliant with the EPRR Core Standards the risk published last year on the EPRR risk register has been updated to reflect the increased levels of compliance. The aim for the coming year is to achieve full compliance and a work programme appended to this report details steps to take to progress this.

2 Risk Assessment

This section details how the Trust is complying with the duty to undertake risk assessments for the purpose of informing contingency planning activities.

2.1 Community Risk Register (CRR)

University Hospitals Bristol NHS Foundation Trust contributes to the development and maintenance of the Avon and Somerset Community Risk Register (CRR) by the Resilience Manager attending the NHS England Avon & Somerset Local Health Resilience Partnership (Tactical Group), where amongst other areas, health related risks to the community are reviewed and updated.

2.2 Local Authority Risk Register

Bristol City Council has reviewed and applied the Community Risk Register to the Local Authority area.

2.3 Trust Risk Register

The Civil Contingencies Steering Group maintains an EPRR Risk Register for risks identified relating to EPRR. Risks assessed as scoring 12 or above are reviewed by the Trust Risk Management Group and Trust Board.

Risk Number	Category	Description	Current Risk Rating
199	Mass Gatherings	There are a number of large public events which attract a large crowd. An incident at one of these events could result in a major incident declaration impacting on the trusts ability to operate normally.	4
210	Snow and Ice	This is a seasonal risk which could result in an increased number of potential slips and falls or impact on ability of staff and patients to travel to site.	6
212	River Avon tidal surge	Adverse weather conditions could cause a tidal surge up the River Avon. If this resulted in flooding, parts of Bristol could be affected leading to increased pressure on health services.	4
800	Pandemic Influenza Outbreak	This is one of the highest risks the UK currently faces. Pandemic Influenza could put the health system under severe pressure due to a number of reasons. Impacts on the trust workforce and its ability to effectively manage an influx of patients with influenza type illness, the ability of the	4

		trust to manage an increase in pandemic influenza related deaths.	
802	Heatwave	Demand on Trust services could increase significantly due to heat related illness especially in the elderly. Internal hospital building temperatures could impact on patient wellbeing and staff working environment.	6
1426	Compliance with statutory emergency preparedness requirements	Risk that the Trust is unable to effectively respond in the event of an incident, due to not being fully compliant with the NHS England Core Standards for Emergency Preparedness, Resilience and Response	4
1607	Leaking CBRN container	ED CBRN equipment including PPE and decontamination showers are stored in a leaking container. There is risk of damage to equipment, reducing effectiveness and exposing staff and patients to risk.	9
1812	Business Continuity	Risk to delivering an effective and coordinated response to business continuity incidents due to large number of out of date business continuity plans.	8
1909	Incident response whilst in extreme escalation	If during periods of extreme escalation a major incident or business continuity incident were to occur there is the risk of the response being hampered due to pressures faced by the Trust.	12
2031	Risk of self-presenting contaminated patients to ED	There is a risk of contamination to patients, staff and the physical environment if the contaminated patient is not identified promptly, isolated and decontaminated by trained staff. Addition of this risk was a recommendation of SWASFT when auditing the Trusts CBRN capability.	3

3 Emergency Planning

This section details the activities undertaken to develop and maintain arrangements for responding to a major incident. The Trust has a number of EPRR related internal planning groups identified in the governance section. Since last year the only change in these has been the Resilience Manager taking over the chair of the Incident Response Planning Group from the ED Clinical Lead. Both Trust ED departments are still active members however it was agreed the Resilience Manager was best placed to drive the work programme of the group.

3.1 Incident Response Plan

The Incident Response Plan (formerly major incident plan) was rewritten to comply with national guidance through the incident response planning group. This plan was signed off by Senior Leadership Team (SLT) in November 2016. Since this date an ongoing programme of training has begun, initially focusing on key areas such as Adult and Children's ED. A major incident

exercise took place on 7th April 2017 to highlight areas of improvement in major incident planning. The plan will be reviewed in light of lessons identified at the exercise prior to further training for key areas across the Trust.

3.2 Chemical, Biological, Radiological and Nuclear (CBRN) Response Plan

The CBRN plan has been updated by the Adult ED CBRN leads supported by the Resilience Manager. Over the past year the Children's ED also have two CBRN trainers and a lead for the department. Quarterly training days have been instigated ensuring nursing staff in both EDs are trained in the elements of the plan including wearing the PPE suits and procedures for decontaminating patients. The Powered Respiratory Protective Suits (PRPS) which are the required PPE for any caustic substance are being replaced in 2018. New suits will be funded centrally and last for a period of 10 years.

The ambulance service has recently completed an annual audit of the Trust's CBRN response, commissioned by NHS England. This found the Trust is compliant with 48 of 51 requirements. To achieve full compliance the Trust has written a risk assessment for potential CBRN response, will ensure a robust maintenance schedule for all equipment is followed and continue to deliver the quarterly training for ED staff.

3.3 Pandemic Influenza Plan

The Pandemic Influenza Plan has recently been signed off by SLT having been developed by the Infection Prevention and Control (IPC) team alongside the Resilience Manager. Fit-test training on the FFP3 face masks is also being led by the IPC team to key clinical staff to then be further cascaded within the organisation.

3.4 Evacuation Planning

The Trust is currently without an up to date evacuation plan with the former plan not aligning to new shelter and evacuation guidance published by NHS England in 2015. An initial scoping meeting has taken place between the Resilience Manager and the Fire Officer who was previously responsible for planning. It was agreed that evacuation planning should fall under the remit of the Resilience Manager and align to ward evacuation plans in the event of a fire working closely with the Fire Officer. Progressing this work on a hospital by hospital basis is a priority for the coming months and is detailed in the work plan.

3.5 Severe Weather and Heatwave Plans

The Severe Weather Plan was reviewed prior to winter. The Resilience Manager is working with the finance department and divisions on ensuring value for money if the Trust was required to book hotel rooms to ensure staffing levels could be maintained particularly if Bristol and the surrounding area were affected by heavy snowfall. The Heatwave plan will be reviewed prior to the summer months.

4 Business and Service Continuity Planning

This section details the Trust's activities to develop, maintain and embed arrangements to ensure the continuity of service provision during an emergency or other disruption.

In previous years the NHS recognised that the British Standard BS25999 was the definitive standard for business continuity management and the Trust aligned all Business Continuity Plans to this standard. This standard has since been updated and has been adopted worldwide. The standard is now known as ISO22301. There are a number of changes with this standard and therefore the NHS England EPRR audit identified that Trust Business Continuity Plans did not fully reflect this standard.

The Trusts Overarching Business Continuity plan and strategy documents have been aligned to the new standards with the large number of division and service level plans being updated onto a template developed by the Resilience Manager to ensure compliance. These plans are being led by divisional leads supported by the Resilience Manager and should be completed by July 2017.

The Business Continuity Planning Group, which reports into the Civil Contingencies Steering Group, is driving this work forward and has full engagement form all Divisions and Departments. This group currently meets every six weeks, to monitor progress and to ensure all Divisions are supported. Between the meetings, the Resilience Manager is working closely with Divisions, to support them with planning.

Incidents and ongoing actions from debriefs are regularly reviewed by the group alongside other business continuity related agenda items.

5 Critical Equipment Task and Finish Group

The Critical Equipment Task and Finish Group was established to identify all critical equipment within the organisation, to ensure that equipment was appropriately protected against the risk of power failure and to ensure that personnel knew which equipment would continue to function in the unlikely event of a complete power failure.

The group met on a monthly basis attended by the Critical Equipment Lead from each division alongside representatives from Estates, Medical Equipment Management Organisation (MEMO), Information Management and Technology (IM&T) and the Trust Senior Electrical Engineer. This group was chaired by the Associate Director of Operations & Deputy Chief Operating Officer.

Having developed a workspace to identify and track all critical equipment and UPS provision provided the task and finish group was stood down in October 2016. A SOP was also developed to ensure new critical equipment brought into the Trust is accounted for. In line with this the risk on the EPRR risk register was closed. Moving forward MEMO are now responsible for the maintenance and oversight of critical equipment.

6 Cooperation

This section details how the Trust engages with regional EPRR groups.

6.1 Local Health Resilience Partnerships (LHRP)

The Local Health Resilience Partnership, chaired by NHS England, brings together all NHS organisations to ensure coordinated and joined up planning across Avon and Somerset.

There is a strategic group which meets quarterly and is attended by the Accountable Emergency Officers (AEO) from all organisations in the Avon and Somerset area. The Chief Operating Officer & Deputy Chief Executive is the UH Bristol Accountable Emergency Officer (AEO) and the Associate Director of Operations & Deputy Chief Operating Officer is the Deputy AEO. This group defines the strategic direction, the priorities and actively monitors the progress of the Tactical planning group.

The Tactical Planning Group also meets quarterly and is attended by the Resilience Manager. It is this group that develops the Avon and Somerset local health community overarching emergency plans and delivers against the Strategic Group work programme.

6.2 Local Health Resilience Partnership Sub-groups

There are a number of LHRP subgroups and task and finish groups; membership of these groups is dependent on the area of focus of the group. For example there is an Acute Provider Sub-group, which focusses on planning and issues which solely affect acute hospitals and the Ambulance Trust. The Resilience Manager attends a number of these groups as required.

6.3 Local Resilience Forum (LRF)

The LRF is a statutory planning group attended by Category 1, 2 and uncategorised responders in Avon and Somerset, as defined by the Civil Contingencies Act 2004. Health is represented by NHS England, who acts in the interests of all providers. This group also informs some of the planning activity undertaken by the LHRP.

7 Warning and Informing

As a Category One responder under the Civil Contingencies Act 2004 the Trust has a “duty, in partnership with others to warn and inform the public”.

The Trust Communications Team continue to work in partnership with NHS England and the CCG to inform and warn the public when circumstances warrant it. The Communications Team issue messages either directly or in collaboration with the CCG and Public Health England and are part of a local network of NHS Communications teams. In the event of a major incident NHS England would ensure communications are coordinated and link into the Trust communications department.

8 Training and Exercising

Below is a summary of EPRR training and exercising which has taken place over the past year:

- The Trust CBRN leads supported by the Resilience Manager facilitate regular training for Adult and Children's ED personnel on CBRN Response and decontamination of members of the public. This training also includes training about safely donning and doffing the Powered Respirator Protective Suit (PRPS) which is a one piece, gas tight, chemical protective suit for use by emergency response personnel after a CBRN incident.
- The Trust supported a Police and Ambulance Service live exercise in the centre of Bristol simulating the response to a Marauding Terrorist Firearms Attack (MTFA). Information collected from this exercise was used to run a major incident exercise for the Trust on 7th April. This involves key areas across the Trust who would be part of the response to a mass casualty incident.
- The Major Incident lead and Trauma network clinical lead for Children's ED attending a national mass casualty workshop in Birmingham alongside the Resilience Manager.
- As part of the EPRR work programme, a Training Needs Analysis has been finalised for On-call Managers based on updated local guidance for training requirements across the EPRR agenda. Much of this training will be delivered at the monthly On Call Manager Forum by the Resilience Manager.
- A number of personnel on the Senior Manager On-Call role have signed up to attend an upcoming Surviving Public Inquiries course.
- The Trust will continue to attend multi-agency exercises as they become available and on call managers have taken part in two NHS England exercises simulating the initial response to a major incident.
- All Adult ED reception staff and other ED admin staff have attended major incident training. This looks at their role in a major incident as well as if they suspect self-presenting patients of being contaminated. Major Incident training and an exercise have also been delivered to the ED Registrars.
- A Hospital Major Incident Management (H-MIMMs) course delivered by the Advanced Life Support Group (ALSG) was run for staff across the BRHC including representation from management, clinical site and CED. This day long course explored the theory of major incident management before exercising a response to an incident.
- Several members of clinical staff and the Resilience Manager attending the Trauma Risk Management course led by March on Stress. Practitioners are trained to perform peer to peer risk assessments for staff involved in traumatic incidents. The intention is to have a Trust wide coordinated approach to this to reduce risk of post-traumatic stress and staff absence either due to major incidents or other traumatic clinical events.

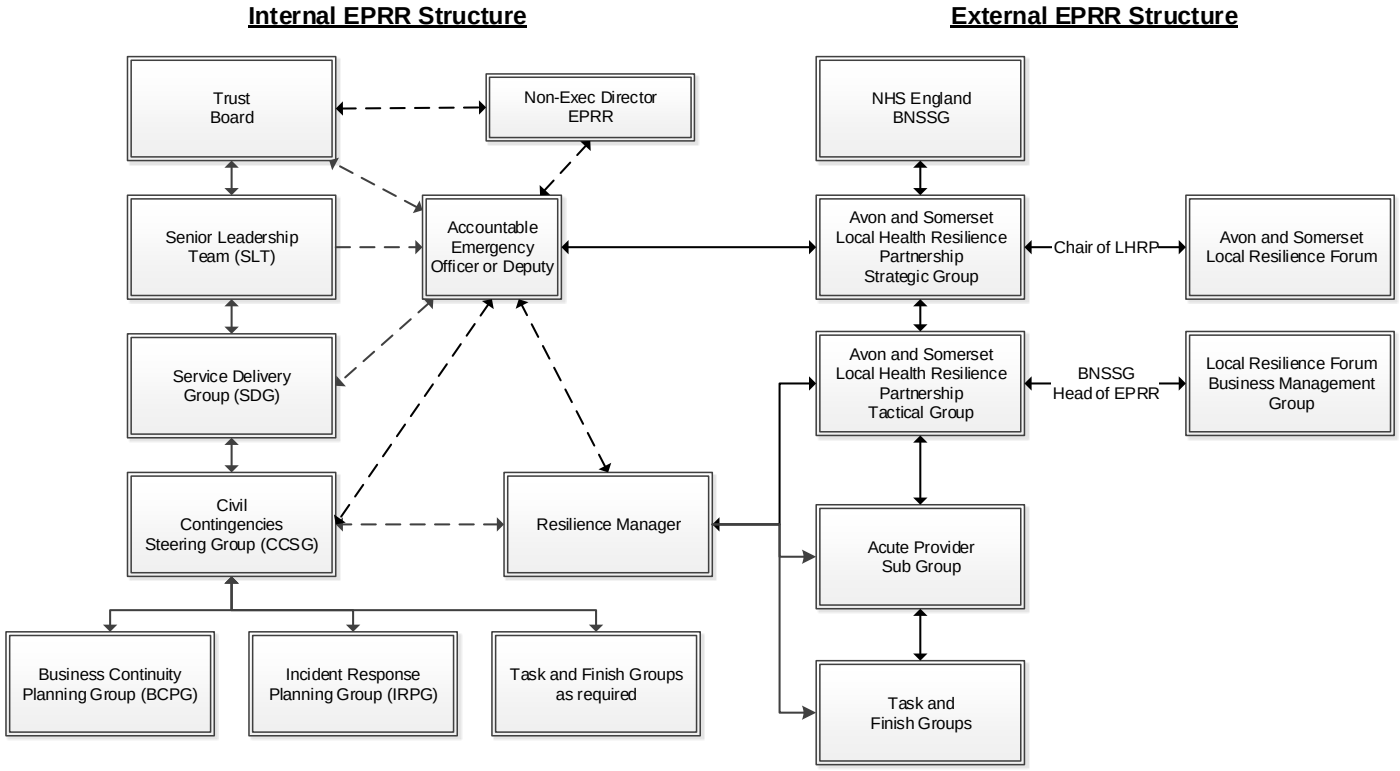
9 Communication Cascade Tests

The major incident communications cascade has been reviewed by Switchboard and the Resilience Manager to streamline the process and ensure those who need activating are done so in a timely manner. This will be tested in 2017 with the plan to move to regular 6 monthly tests.

South West Ambulance Service NHS Foundation Trust (SWAST) conduct weekly communications exercises with the Trust to ensure they are able to initiate contact to notify of a major incident. Notification is via an automated message to switchboard and both Adult and Children's EDs. To date, this process has proved to be robust and no issues or difficulties have been identified.

10 Governance

The diagram below represents the internal and external Emergency Planning, Resilience and Response (EPRR) governance structure.



11 Audit and Assurance

The Resilience Manager provides regular updates, assurance and work progress briefings to the Civil Contingencies Steering Group.

As mentioned above, NHS England and Bristol CCG conduct an annual EPRR audit and assurance process. This was conducted in October 2016. Their findings have informed the work programme below.

12 Work Programme

The current work programme, with progress and NHS England priorities is shown in appendix 1.

13 Recent Significant Events

The Trust has experienced the following untoward events during the April 2015 to March 2016 period. Where indicated the incidents are closed from an EPRR perspective with actions identified and undertaken by relevant individuals and monitored by the Business Continuity Working Group.

Title	Date	Debrief / RCA Held?	Action Plan produced?
Sewage Leak in Adult ED Resus	1/6/16	No	Yes
Medical Gas Outage	5/7/16	Yes	Yes
BRHC power cut	3/10/16	Yes	Yes

Power Outage and loss of bleeps	24/11/16	Yes	Yes
BRHC heating and water loss	27/12/16	Yes	Yes

14 Conclusions

2016/17 has been a year where the focus has been on finalising plans and training key areas. Several critical plans have signed off including the Incident Response, Plan, CBRN Response Plan, Overarching Business Continuity Plan and Pandemic Influenza Response Plan. Training against these plans has been started to ensure procedures are embedded within the organisation and can be utilised effectively if required. Progress has been recognised by achieving partial compliance with the NHS England Core Standards for 2016 but this also highlights the work to be done for the forthcoming year.

Priorities for the upcoming year to achieve full compliance and ensure the Trust is more prepared for the range of major incidents and business continuity incidents which may occur include:

- Ensuring a robust approach to Evacuation Planning on a hospital footprint
- Exercising and embedding the Incident Response Plan across the organisation
- Continuing to deliver training to identified staff and services
- Finalising outstanding service level business continuity plans to comply with the new international standard.

Appendix 1 EPRR Work Programme

Please see attachment.

Domain	Core Standard Section	Core Standard	2015 Assurance RAG Rating	2016 Updated Assurance RAG Rating	Current Position	Work Required	Progress *(Green - Complete, Amber - In progress, Red - Not started)*	Accountable	Responsible	Target Date for Delivery	Progress Against Target Date
Duty to maintain plans – emergency plans and business continuity plans	8	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	**AMBER**	**AMBER**	Part 1 approved with part 2 (action cards) requiring minor amendments having collated into one document. Will be included in TNA for training and exercising of plan.	Remove non-essential information.	Complete	M Smith	S Steele & Divisions	Nov-16	Actions cards completed with minor ammendments and cross-check required prior to SLT sign off
						Divisions to update divisional information and action cards,					
						Action Cards to go to CCSG					
						Incorporate latest guidance & best practice	Complete				
						Progress reports to the Incident Response Planning Group.	On going				
						Approve IRP @ Service Delivery Group (9 May 16)	Complete 09/05/16				
						Ratify IRP @ Senior Leadership Team (19 May 16)	Complete 19/05/16				
						Train staff to IRP	Ongoing- current focus on EDs and on call session in May			May-17	Training plan under development with exercise planned for April 2017
						Exercise IRP.	Exercise planned 7th April				
	8	Corporate and service level Business Continuity Plans (aligned to current nationally recognised BC standards)	**RED**	**AMBER**	Business Continuity Plans are currently aligned to BS25999. Internal guidance, templates and plans developed and with identified BC leads with progress varying. Work ongoing to identify priorities and gaps alongside review of overarching BC plan for Trust.	Identify Divisional BC Champions	Complete 16/02/16	M Smith	S Steele & Divisions	Jan-17	Divisional and departmental plans progressing against new templates. Jan Sutton is providing extra resource to help drive updating plans
						Create updated BCP guidance and Business Impact Analysis templates which reflect the requirements of ISO22301 and disseminate to divisions.	Complete 08/03/16				
						Commence Trustwide Business Continuity Planning.	Complete17/03/16				
						Divisional BC Champions to report progress into the Business Continuity Planning Group,	On-going at every meeting				
						Divisions to conduct BIA to inform planning	Gap analysis/prioritisation being undertaken				
						Divisions to update existing plans and fill gaps in planning		M Smith	S Steele		
						Review BC plan at Business Continuity Planning Group					
						Approve BC plan at Business Continuity Planning Group	Signed off- CCSG/SDG				
						Ratify BC Plans at Divisional Board (assurance via Div Dirs)	On going				
						Train Divisional staff to relevant BC Plan,					
						Conduct Divisional Business Continuity exercise.					
Duty to maintain plans – emergency plans and business continuity plans	8	HAZMAT/ CBRN Plan	**RED**	**GREEN**	The current version of the plan was published in August 2012 with a review cycle of two years. The plan will be updated to take into account the requirements of JESIP IOR and current best practice.	Assign ownership of CBRN / HazMat Plan to ED CBRN Lead.	Complete	M Smith	S Steele, ED/CED CBRN leads	Jul-16	Quarterly study days ensuring good coverage of staff across ED
						Review latest guidance,	Complete				
						Incorporate latest guidance into plan,	Complete				
						Involve BRHC in planning, training and response	Complete				
						Attend SWAST CBRN Course (6 places)	(Aug 16)				
						Ratify at Incident Response Planning Group,	Sep-10			Mar-17	
						Train all ED (BRI & BRHC) staff to the updated plan,	ED study days quarterly				
						Conduct ED (BRI & BRHC) CBRN Exercise.					
	8	Pandemic Influenza Plan	**RED**	**AMBER**	Published in Sept 2013, two year review cycle, so needs updating. This plan does not reflect current requirements or guidance	Delegated to Infection Control & Prevention Team	Complete	M Smith	Jo Davies	Nov-16	Plan approved by SLT
						Review current guidance.	Complete				
						Update Pandemic Influenza plan	Complete				
						Review Plan - CDSG	12-Jul-16				
						Approve Plan - CCSG	24-Jan-17				
						Ratify Plan - Service Delivery Group	15-Feb-17				
						Train staff to plan	Fit-testing on going				
						Exercise plan.					
	8	Mass Countermeasures Plan (e.g. mass prophylaxis, or mass vaccination)	**RED**	**RED**	No Mass Countermeasures Plan or arrangements in place	**Advised to put on hold awaiting national guidance. (23/03/16)**					

Domain	Core Standard Section	Core Standard	2015 Assurance RAG Rating	2016 Updated Assurance RAG Rating	Current Position	Work Required	Progress *(Green - Complete, Amber - In progress, Red - Not started)*	Accountable	Responsible	Target Date for Delivery	Progress Against Target Date
Duty to	8	Mass Casualties Plan	RED	AMBER	Captured as part of incident response planning awaiting IRP part 2 sign off	**Linked to Incident Response Plan** To be included in Incident Response Plan					
Duty to maintain plans – emergency plans and business continuity plans	8	Fuel Disruption Plan	AMBER	AMBER	Existing Fuel Disruption Plan out of date, needs reviewing and updating	**Linked to Corporate & Service Business Continuity** Team / Function / Service / Divisional Business Continuity Plans, to include Fuel Disruption, therefore negating the need to have standalone Emergency Plan.					
	8	Surge and Escalation Management Plan (Inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	RED	AMBER	Not currently described in any detail. Needs to be considerably more granularity. This is not routine escalation.	**Linked to Incident Response Plan**					
	8	Infectious Disease Outbreak Plan	AMBER	AMBER	Not a dedicated plan, but currently a number of standalone plans (MERS, Ebola etc). To be captured in communicable disease plan	**Linked to Pandemic Flu Plan**					
	8	Evacuation Plan	RED	RED	Draft April 2010, two year review cycle. Plan never completed or ratified. Needs to be reviewed, updated & ratified. Currently, there is a Trust Fire Policy and all wards have their evacuation plans, which predominantly consider horizontal or vertical evacuation. In the event of complete building evacuation, the plans say that the Trust Education Centre could be utilised to provide shelter. in the short term. Long term provision has not been developed.	Review, update and incorporate latest guidance.		M Smith	S Steele, D Pearce	Mar-17	Not started - delayed due to planning of Major Incident exercise. To be priority for planning over summer months.
						Review plan at Incident Response Planning Group					
						Approve plan at CCSG					
						Ratify plan at Service Delivery Group					
						Train staff to plan,		M Smith	S Steele		
						Disseminate plan,					
						Exercise Plan.					
	8	Lockdown Plan	AMBER	AMBER	A basic Lockdown 'strategy' is in place.	Currently being updated by LSMS with the aim of making the document more proceduralised including roles and responsibilities and how lockdown can be achieved.	In progress with Ian Britton - 28/06 - first draft provided and feedback given	M Smith	Ian Britton as LSMS	Dec-16	SOP in place for the Trust and key areas (ED, St Michael's) have specific plans in place. SOP requires more detail on specific arrangements, roles and responsibilities.
						Review Plan Incident Response Planning Group					
						Approve Plan at Service Delivery Group					
						Ratify Plan Senior Leadership Team					
						Train Staff to plan,				Mar-17	
						Disseminate Plan,					
						Exercise Plan.					
	8	Utilities, IT and Telecommunications Failure Plan	RED	AMBER	Detailed in IT and EFM plans, however, not currently considered in any depth within Divisional / departmental BC Plans.	**Linked to 4 above (Coprorate & Service Business Continuity).** EFM & IT to document scenarios, impacts and solutions. Divisional BC champions to include within Business Continuity Plans					
	8	Excess Deaths/ Mass Fatalities Plan	RED	AMBER	Not currently included in MIP or as standalone plan	**Linked to 3 above (Incident Response Plan).** Review guidance and current best practice.					
	9	Ensure that plans are prepared in line with current guidance and good practice which includes:	AMBER	AMBER	**See entries in Section 8**						
trol	12	Arrangements explain how VIP and/or high profile patients will be managed.	GREEN	AMBER	Detailed in IRP/Op Consort however work required to ensure these are linked and only high level information held in IRP		Complete	M Smith	S Steele	Nov-16	IRP to be reviewed

Domain	Core Standard Section	Core Standard	2015 Assurance RAG Rating	2016 Updated Assurance RAG Rating	Current Position	Work Required	Progress *(Green - Complete, Amber - In progress, Red - Not started)*	Accountable	Responsible	Target Date for Delivery	Progress Against Target Date
Command and Con	13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content	RED	AMBER	Currently undertaken with relevant stakeholders, however stakeholders are not recorded in plans and consultation dates also not included.	To be detailed in all plans with generic stakeholders to Trust populated by BC planning group. IRP to be consulted by key partners. Ensure lockdown and evacuation planning consults with key local partners. Key partners attending Major Incident exercise in April.		M Smith	S. Steele		Ongoing but not green as key external consultations for evacuation plan required due to impact on partners.
	16	Those on-call must meet identified competencies and key knowledge and skills for staff.	AMBER	AMBER	Training needs analysis finalised with training now ongoing	Key skills, knowledge and competancies identified and documented. TNA to be conducted, Training to be developed, Training to be delivered.	Complete Complete Some developed Ongoing delivery	M Smith	S Steele	Dec-16	TNA developed as part of Senior On-call Manager guidance
Training and Exercising	34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	AMBER	AMBER	Training programme incoporated into TNA	As emergency and business continuity plans are developed, training plan will be developed, TNA conducted and training delivered.	TNA Plan Training Ratify Training Programme Deliver Training	M Smith	S Steele	01/12/2016 for TNA then ongoing	TNA completed with training begun focusing currently on Eds and on call
	37	Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.	RED	AMBER	New on call guidance developed with competencies now to be delivered in accordance with TNA.	Record system to be developed to record participation in multi-agency exercises including attendance at internal or external in training and exercises		M Smith	S Steele	Dec-16	Centralised record system for essential to role training held by Resilience manager. Exploring centralised storage within Trust essential training records

Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	17
Meeting Title	Trust Board	**Meeting Date**	Friday, 28 April 2017
Report Title	Operational Plan 2017/18 to 2018/19		
Author	Paula Clarke, Director of Strategy and Transformation	Paul Mapson, Director of Finance and IM&T	
Executive Lead	Paula Clarke, Director of Strategy and Transformation	Paul Mapson, Director of Finance and IM&T	
Freedom of Information Status		Open	

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

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

Executive Summary

<u>Purpose</u>

Trust Board approved the two year Operational Plan on 22nd December 2016 with onward submission to NHS Improvement on 23rd December 2016. The Plan provides the supporting narrative setting out the Trust's approach and position on activity, quality, workforce and financial planning.

Since the end of December work has continued to underpin assurance regarding delivery of the Plan, including negotiation with NHSI regarding the control total and signing of all SLAs with commissioners (achieved on 23/12/16).

On 30th March and 13th April 2017, Trust Board approved a revised financial plan and performance trajectories based on the outcome of these negotiations. These changes and other less material updates have been incorporated into the full version of the Operational Plan, ensuring that we have a full and final version reflecting the latest submitted position for 2017/18-2018/19.

Trust Board are now asked to approve the revised version of the full Operational Plan, noting that this will support us to publish our Plan in line with best practice.

Key issues to note

Our final refreshed narrative plan includes the following material updates:

- Financial Plan - Acceptance of the revised 2017/18 Control Total advised by NHS Improvement of a £13.0m net surplus. The revised Control Total is non-recurrent i.e. it applies to 2017/18 only. Therefore, the Control Total for 2018/19 of a £22.8m net surplus is rejected by the Trust (as approved on the 30th March 2017).

- Performance Trajectories.
  - Revised ED trajectory: in line with NHSI guidance and prerequisites for securing STF funds, the ED trajectory has been further revised from that approved by Board on 30th March 2017 (page 7 of Plan) ;
  - No change to position with respect to Referral To Treatment or 62 day cancer standards.

- No impact on workforce from these changes and hence no requirement to update triangulation

- Reflect our commitment to a continued focus on delivering our quality strategy, through our quality improvement plan and particularly focussing on areas highlighted in our recent CQC inspection as requiring improvement. We will also be focussing in 2017/18-2018/19 on ensuring we continue to develop the outstanding practice recognised by the CQC and on maintaining our overall rating of Outstanding as a Trust.

Recommendations

Members are asked to:

- **Approve**
  - the 2017/18 revised Operational Plan Narrative, reflecting the revised financial and performance trajectories approved by Trust Board and submitted to NHS Improvement on the 30th March and 13th April 2017.

Intended Audience
(please select any which are relevant to this paper)

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

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient	☒	Failure to develop and maintain the Trust	☐

services.		estate.	
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☒
Failure to maintain financial sustainability.	☒	Failure to comply with targets, statutory duties and functions.	☒

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

Impact Upon Corporate Risk
N/A

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

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
	22nd December 2016 27th March 2017			

University Hospitals Bristol
NHS Foundation Trust

Operational Plan 2017/2018 to 2018/2019 – supporting narrative

1. Context for Operational Plan

Following approval by Trust Board on 22nd December 2016, the Trust two year Operational Plan was submitted to NHS Improvement (NHSI) on 23rd December 2016 as supporting narrative setting out the Trust's approach and position on activity, quality, workforce and financial planning. Following comments and further discussions with NHSI, revised financial and performance trajectories were submitted on the 30th March and 13th April 2017. The final position is based on a robust and integrated approach to operational planning within the Trust and alignment with the aspirations and relevant specific actions of the developing Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan (BNSSG STP). The Trust fully appreciates the financial challenges in the NHS overall and our track record evidences our commitment and ability to deliver affordable, quality care sustainably. Our leadership role within the STP footprint seeks to extend this experience into the system and we have supported the adoption of an open book approach through joint contract meetings with our commissioners, resulting in the full signing of contracts by the 23rd December 2016.

Our plan reflects the following position;

- The updated plan (as at 29th April 2017) reflects the Trust's acceptance of the revised 2017/18 Control Total advised by NHSI of a £12.957m net surplus. The revised Control Total is non recurrent, meaning it applies to 2017/18 only. The Control Total for 2018/19 of a £22.8m net surplus therefore remains as rejected by the Trust.
- Service Level Agreement (SLA) proposals have been negotiated with Commissioners and financial agreement has been reached. SLAs were signed by the 23rd December 2016. This includes Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCGs) and associates and NHS England (Specialised and Non-Specialised).
- Clarity and ownership of stretching quality priorities is in place, to be delivered through enabling quality improvement frameworks
- Workforce plans align to finance, activity and quality and include robust accountability processes for managing agency and locum expenditure
- Commitment to deliver improvements in core access and NHS Constitution standards aligned to proposed performance trajectories.

2. Strategic Backdrop

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

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

We are committed to addressing the aspects of care that matter most to our patients and during 2016/17, we have continued to ensure our strategy remains dynamic to the changing needs of our patients and significant changes within both the national and local planning environment. We have undertaken a review to prioritise and stratify our clinical strategy and established a clear governance framework within which to drive strategic decision-making, support implementation plans and ensure a proactive approach to influencing and assessing strategic reviews. A key aim in developing our own internal strategic programme is to align with the new processes, pathways and structures developing as part of the local STP and the changing national context. These new approaches provide us with a significant opportunity to progress our strategic priorities at pace and to work together with our partners to resolve some of the system-wide challenges we face.

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

3. Link to the local Sustainability and Transformation Plan

We remain clear that system leadership and collaborative working are essential for system sustainability and our two year Operational Plan is set firmly within the context of our local BNSSG STP. The BNSSG STP has developed five key principles that will enable the footprint to develop and implement a sustainable health and care system for our local population:

• Standardise and operate at scale.	• Develop a new relationship between organisations and staff.
• Develop system wide pathways.	• Build on existing digital work as a driver and enabler of cultural change.
• Develop a new relationship with our population to simplify access to the health and care system.	

Our two year Operational Plan has been developed in the context of these principles and there is clear alignment with our operational priorities. A transformational programme of change is being established through the STP, structured via three key system-wide work streams designed to deliver these principles. These are:

- Integrated primary and community care;
- Prevention early intervention and self-care; and
- Acute Care Collaboration (ACC)

Through our Operational Plan, we are clear that we play a key role in both leading and contributing to STP programmes of work. Delivery of our quality, performance and financial operating plan intent is predicated on both organisational and system actions. The BNSSG STP clearly identifies its ambitious but equally pragmatic vision, wherein the impact of a new model of care and specific transformational service delivery changes are agreed by all partners, but which remain to be developed to the stage that we can confidently reflect the impact in our contracts and our operational

delivery projections. As the STP plans mature, we will incorporate material changes in our 2017-19 contracts via variations and in the dynamic approach we adopt to our two year Operating Plan projections.

Specific areas of STP based action that we will support and lead include delivery against the principles within the ACC workstream:
- A collaborative provider model, supported by a single commissioning approach;
- Improving utilisation of acute hospital bed base; and
- Using our acute hospital resources to support the wider health and care system.

Improved productivity and effectiveness is a key focus of the developing projects within the STP and within our organisation, with specific emphasis placed on the need to maximise the use of acute facilities and resources, reducing costs, duplication and variation where possible and potentially reconfiguring or redistributing services between the three acute providers if this provides greater opportunity for services to develop and thrive. The Trust has already worked with other providers to deliver major change to the benefit of patients on a wide range of services and we are committed to develop the next phase of ACC based on shared leadership models accepting that this could lead to more standardisation across three or more sites on a differentiated or graduated basis as circumstances require. We will pursue these opportunities within the context of the STP.

During 2017-19, we will continue to lead and enable translation of the ACC principles into delivery through a smaller number of high impact projects to both realise 'quick wins' in closing the gaps and establish and build confidence in new ways of working and collaborating as a system. The phase one priority projects identified are;

• Stroke pathways	• Trauma and Orthopaedic and Musculoskeletal services
• Pathology consolidation	• Medicines optimisation
• Corporate overheads reduction	• Weston sustainability

In parallel, we will scope and implement projects in Cardiology; Neonatal Intensive Care; Interventional Radiology and Optimising outpatients and we will also ensure that the existing energy focussed on improving services in the following areas is harnessed through a single BNSSG approach to maximise the benefits afforded by a whole system view:

• Mental Health – Personality Disorders	• Urgent and Emergency Care – Including Urgent Care Network
• Acute mental health beds and out of area placements	• Cancer – Development of Cancer Alliances
• Developing Specialised Services and Networks	

This STP aligned work is reflected in the Trust's refreshed clinical strategy which will continue to be dynamically reviewed to both influence and respond to system opportunities and commissioner reviews that enable us to progress our strategic intent to provide excellent local, regional and tertiary services and maximise the benefit to our patients that comes from providing this range of services.

4. Organisational Strategy 2017-19 Focus

Our 2016/17 Monitor Operational Plan outlined our organisational commitment to the development of the BNSSG STP and how, as year one of the five year plan, our 2016/17 priority was to contribute to developing and implementing plans to address the identified system gaps in Care and Quality, Health and Wellbeing and Finance and Efficiency. Our 2017-19 plan now forms the basis of years two and three of our organisational contribution to the delivery of system plans, building on the themes of our previous year's plan. Within this context, the focus of our strategic and operational plans over the next two year period will be the following:

Care and Quality and Health and Wellbeing
- **Delivery of our quality objectives as agreed in our new quality strategy**, including delivery against requirements outlined in the nine 'must dos' and NHS mandate to close our identified gaps in care and quality. For our organisation; this will include a specific focus on;
  - Ensuring timely access to services
  - Delivering safe and reliable care
  - Improving patient and staff experience
  - Improving outcomes and reducing mortality
- Full delivery of the recommendations from the **Independent Children's Cardiac Review**.
- **Staff strategic engagement and retention strategy**, with a focus on staff engagement and wellbeing, supported by real-time feedback, using innovative approaches such as the 'Happy App' (2016 HSJ winner) and the ongoing development of leadership capacity and capability.
- **Improving performance against access standards** and delivery of our performance trajectories in the four core standards.

Finance and Efficiency
- **Operational and financial sustainability** with a specific focus on internal specialty level productivity and the efficient delivery of activity aligned to our capacity modelling, along with the implementation of Carter recommendations, including a system view of corporate overheads, estates and pathology.
- **Maximising the impact from STP system working** and service redesign and ACC, with development of shared leadership and associated opportunities to improve system and service level productivity.
- **Estates and capital strategy** for 2017-19 to continue to align the modernisation and development of our estate to our evolving clinical strategy and support delivery of the emerging STP new model of care.
- **Maximising workforce productivity** including controlling agency and locum costs.

Strategy, Transformation, Innovation and Technology
- **Refresh our existing Trust Strategy** to reflect the need to respond to local and national changes to our operating environment and with a specific focus on developing our clinical strategy.
- **Exploring options to continue to develop our specialist portfolio** in the context of potential changes to Specialised Commissioning approaches across the south.
- Maximise our opportunity to continue to **develop our research capacity and capability** associated with the significant grant secured from the National Institute for Health Research to fund a Biomedical Research Centre undertaking cutting edge studies that will improve care and treatment in the future.

- Development of an **Innovation and Improvement Strategy** for the organisation including maximising the opportunities for innovation and transformational change associated with our successful appointment as a **National Digital Exemplar site**, with clear alignment to organisational and STP digital priorities / local digital roadmap.
- Continued development and delivery of our **Transforming Care Programme** focussing on transforming the way in which we deliver care through service and workforce redesign, with a focus over the next two years on real time internal processes to support patient flow alongside engaging in and supporting STP processes to develop effective system care pathways and patient flow.

5. Quality planning

5.1 Approach to quality planning

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

The publication of the Independent Review of Children's Cardiac Services in Bristol in 2016 affirmed the Trust's record on clinical outcomes, whilst raising important questions about transparency and how we communicate effectively with patients and their families. Parents have played an important role in bringing about significant changes in our practice and in improving our provision of care, which has already addressed some of the recommendations in the report. We will continue to build on this work by implementing all the recommendations pertaining to the Trust and by strengthening our partnership between families and staff, which is the basis of delivering safe and effective care of a high quality. The Trust's quality strategy makes an important contribution to the Trust's ongoing learning.

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

• Ensuring timely access to services	• Improving patient and staff experience
• Delivering safe and reliable care	• Improving outcomes and reducing mortality

Running through each of these are the threads of research, innovation and improvement. Our quality improvement priorities are underpinned by our commitment to address the aspects of care that matter most to our patients in collaboration with our strategic partners. They also take into account national quality and commissioning priorities, our quality performance during 2016/17 and feedback from our public and staff consultations and are supported by our organisational values – respecting everyone, working together, embracing change and recognising success. We are committed to the continued focus on delivering our quality strategy, through our quality improvement plan and particularly focussing on areas highlighted in our recent CQC inspection as requiring improvement. We will also be focussing in 2017/18-2018/19 on ensuring we continue to develop the outstanding practice recognised by the CQC and on maintaining our overall rating of Outstanding as a Trust.

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

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

- Cancel fewer operations
- Reduce patient waiting times
- Improve the safety of patients by reducing avoidable harm
- Strengthen our patient safety culture
- Create new opportunities for patients, families and staff to give us feedback about their experiences, and in a way which enables concerns to be addressed in real-time
- Develop a customer service mind set across the organisation, including how we handle and respond to complaints
- Take a lead role in the development of a new national system of rapid peer review of unexpected patient deaths, implementing learning about the causes of preventable deaths
- Significantly improve staff satisfaction, making UH Bristol an employer of choice

Our plans will be built on a foundation of:

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

Table 1. Our key quality improvement priorities for 2017/18/19

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

Despite our quality strategy and work to improve our patient flow, we continue to identify ongoing risks in relation to access and patient flow. The challenges we face in delivery of our performance standards are outlined in the section 6. In recognising the impact that limited access to services and particularly the cancellation of planned surgery or outpatient appointments places on the quality of care we provide for our patients, our actions to address these through our Transforming Care Programme and performance improvement plans will remain a key priority for the next two years.

5.3 Approach to quality improvement

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

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

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

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

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

We recognise that we need to support our staff in continuous improvement and we plan to achieve this through "Transforming Care" - our overarching programme of transformational change designed to address specific priorities for improvement across all aspects of our services. Our transformation improvement priorities for 2017/19 will be structured around the six "pillars" of delivering best care, improving patient flow, delivering best value, renewing our hospitals, building capability and leading in partnership.

The Trust is also developing an Innovation and Improvement Strategy and is planning to develop a QI Academy to bring together and make more easily accessible existing QI training, development and support opportunities for front line staff, with the aim of increasing capability and capacity within and across front line teams from awareness to practitioner to expert.

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

[1] The National Institute for Health and Care Excellence

[2] i.e. clinical guidelines, quality standards and technology appraisal guidance

[3] The National Confidential Enquiry into Patient Outcome and Death

5.4 Quality impact assessment process

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

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

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

5.5 Triangulation of Quality, Workforce and Finance

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

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

Through the independent review against Monitor's 'Well-led framework for governance completed in 2015/16, the Trust Board was provided with assurance that systems and process were in place to ensure that the Board and Senior Leadership Team had good oversight of care quality, operations and finances. The actions identified to further improve the governance systems in the Trust as a result of the review have all been completed.

5.6 Seven day working

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

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

- Standard 2: Time to consultant Review: Additional consultant capacity within general surgery, trauma & orthopaedics and gynaecology services to ensure full compliance with the standard.
- Standard 5: Access to Diagnostics: Formalisation of Interventional Radiology arrangements with North Bristol NHS Trust and development of an in-house non-vascular IR service.
- Standard 6: Access to Consultant-directed Interventions: Investment in consultant capacity to allow for the delivery of two additional weekend endoscopy lists, to address the gap in our service for lower gastrointestinal endoscopy
- Standard 8: On-going Review: Proposals under standard 2 will provide capacity to close gaps in capability in the surgical areas specified.

Service development proposals to address the gaps in seven day coverage were discussed with commissioners through the contract negotiations. Commissioners have indicated that the proposed investments will not be affordable within the 2017/18 – 2018/19 planning round and accept that the Trust will not be able to meet the standards until opportunities to improve compliance through service reconfiguration / commissioners re-prioritisation are assessed.

6. Activity, Capacity and Performance

6.1 Activity and Capacity Planning

The Trust approach to capacity and demand planning for 2017-19 builds on our experience in using the capacity planning tools provided by the Interim Management and Support Team (IMAS) and the methodology used in the last two years to agree contract volumes with commissioners. Each specialty used the IMAS models to estimate the level of capacity required to reduce waiting times to achieve an overall 18-week Referral to

Treatment Time (RTT) wait. Demand is based on actual referral and decision to admit weekly data over the last year and used as the baseline level of recurrent activity required within the contract. The modelling also provides an estimate of the amount of non-recurrent activity required to reduce 18-week RTT waits during 2017/18, and then deliver the required level of recurrent activity to maintain specialty level performance above 92% in 2018/19. Demographic growth has largely been used as the basis for growing the 2016/17 recurrent activity baseline however, where modelling indicates annual growth in excess of demographic changes, a three-year analysis has been used to estimate recurrent growth.

The Trust Service Level Agreement (SLA) proposals have been built-up from this modelling. The level of planned activity for 2017/18 also takes account of the impact of any planned service transfers, service developments and other known planned changes to activity levels. Whilst the SLA has not yet been finalised, Commissioners have confirmed their commitment to commission sufficient activity, both recurrent and non-recurrent, to meet what is required to deliver an 18-week RTT wait. Within the context of the STP, the Trust is working with commissioners to particularly identify areas of exceptional growth and agree shared approaches to demand management that can potentially be underpinned by risk-share contractual arrangements.

The schedule of planned day-case and inpatient activity for 2017/18 is being used to assess the number of beds required in the Trust. Baseline bed requirements have been estimated from the forecast specialty and work-type level spell volumes and current length of stay, taking account of the increased demand for beds in 2016/17 from increases in paediatric emergency admissions and high levels of delayed discharges. Planned bed-days savings from improvements in the delivery of planned and unplanned care resulting from internal and system-wide actions have then been applied with the resulting modelled bed requirements then uplifted to operational bed occupancy of 92.5%. Bed requirements have also been apportioned across quarters according to historic seasonal variation.

Wherever possible, specialties are planning to provide capacity at the 65th centile variation in demand levels to limit the variation in waiting times and waiting list size. However, where there is a greater clinical risk associated with lengthening waits for accessing services, such as where the majority of diagnostic tests are for urgent/emergency care, the 85th centile has been used as planning assumption. The Trust will continue to focus on reducing reliance on waiting list initiatives to deliver core capacity, for example through more substantive appointments where appropriate. This will support financial sustainability and responsiveness to heightened periods of demand. The majority of required activity to meet contract levels will be delivered "in-house" with a small amount of outsourcing, mainly through the Trust's GLANSO independent provider model, to maintain flexibility where demand is more volatile.

Critical to the Trust's delivery of RTT in 2017/18 will be making provision for enough flexibility in operational plans, to enable short-term variability in demand to be met and to avoid a rise in the number of over 18 week waiters. Challenges do remain in providing mitigation for in-year unplanned changes to local and in some cases regional service provision, for example the short-notice closure of the Taunton & Somerset NHS Foundation Trust Dermatology service, including routine, urgent and two-week wait referrals. The Trust will continue to use proactive systems for identifying rising demand and mobilise waiting list initiatives and other ad hoc sources of capacity as it has in previous years to manage such situations.

Trust capacity plans include winter planning resilience measures based on continuous learning from our current winter plans and actions. As the STP process matures and system actions are delivered, these plans will be refined and where required, reflected in contract changes. Learning from the Trust implementation in 2016/17 of a community based "virtual ward" supported by an independent provider, *Orla Healthcare,* and from the CCG-led discussions around primary care streaming models in the Bristol Royal Infirmary (BRI) and Bristol Royal Children's Hospital (BRCH), will be used to inform system based winter planning over 2017-19.

6.2 Non-Financial performance Improvement trajectories

The Trust continued to have challenges in consistently meeting all of the core national access standards in 2016/17, including those that now sit within the NHS Improvement Single Oversight Framework. The following provides analysis of performance during 2016/17 to date as context to the approach the Trust is taking to restore performance during 2017/18 and beyond. The Trust will also seek to an early view on how it is performing against the anticipated holistic measures of urgent and emergency care system health and identify actions that need to be taken by the Trust and the wider system, once these measures have been published.

6.2.1 Referral to Treatment Times (RTT)

The Trust recovered performance against the 92% national Incomplete Pathways standard in January 2016, achieving the standard every month until August 2016. Whilst slightly behind plan in terms of the expected volume of clock stops in the period, analysis demonstrated that the increase in over 18 week waiters during quarter two was mainly a result of an increase in outpatient referrals with those specialties for which the backlogs materially increased between April and the end of August, demonstrating an 11% increase in referrals relative to the same period in the previous year. The heightened level of demand could not be met in specialties for which core capacity was already constrained for other reasons, and options to flex capacity beyond baseline levels was therefore very limited.

Overall growth in referrals was up 3% in quarter one but down 2% in quarter two 2016/17, relative to the same period last year, highlighting the need for the Trust to have the ability to flex operational capacity to meet changing levels of demand. Specialties showing persistent increases in demand include Cardiology, Dermatology, Neurology, Pain Relief and a number of Paediatric specialties. The Trust is continuing to work with commissioners on ways of managing and smoothing demand, with active programmes of work across the community underway for Neurology and Dermatology in particular, but also other projects involving more directed use of independent providers and advice & guidance services. The capacity and demand modelling undertaken for 2017/18 has built in appropriate levels of recurrent growth to enable services to invest in adequate levels of capacity to support sustainable achievement of 18-week RTT waits, but to also address residual backlogs through non-recurrent activity. The expectation is, therefore, that the 92% RTT national standard will be achieved at a Trust aggregate level in 2017/18 and at an RTT specialty-level in 2018/19.

6.2.2 Cancer standards

The Trust continued to perform well against the majority of the national cancer standards however achievement of the 62-day GP cancer standard remained elusive due to the high proportion of breaches of the standard outside of Trust control. The predominant cause of breaches continued to be late referral from other providers (34%) with a further 19% of breaches resulting from periods of medical deferral and/or clinical complexity, and 10% due to patient choice. In the first half of 2016/17, the number of unavoidable breaches increased due to delayed histology

reporting following the transfer of the service to North Bristol Trust at the beginning of May. These delays have largely been addressed and are not expected to recur in 2017/18. A local CQUIN was agreed in 2016/17 which incentivises timely referral by local providers, along with reallocation of breaches arising from referrals made outside of agreed pathway milestones. Collaborative work on improving shared pathways will continue into 2017/18. Without improvements in the timeliness of late referrals, the Trust does not expect to be able to comply with the 85% national standard in either 2017/18 or 2018/19. However, the expectation is that with improvements in timeliness, the 85% standard would be achieved in aggregate in each quarter going forward.

During the first quarter of 2016/17, the Trust unusually struggled to achieve the 31-day waits for patients needing surgical treatments due to an increase in the number of emergency admissions requiring admission to Adult Intensive Care Unit (ICU) in March and April. To treat the patients whose surgery had been delayed, theatres recovery was temporarily used as an extension to the High Dependency Unit. Whilst the same approach could again be taken in periods of extremis, the Trust is investigating a model for managing adult critical care demand across a broader bed-base, incorporating both Adult ICU and the Cardiac Intensive Care Unit (CICU) to offer greater flexibility and greater operational efficiency. Opportunities for more effective delivery of critical care capacity across BNSSG are also being considered under the STP. The Trust expects to be able to continue to achieve the 2-week wait, the 31-day first definitive and 31-day subsequent treatment standards in aggregate in each quarter of 2017/18 and 2018/19.

6.2.3 Diagnostic waiting times standards

Performance against the 99% 6-week diagnostic waiting times standard has been highly variable to date in 2016/17, primarily due to high levels of demand not being able to be met in a given month and capacity lost for unforeseen circumstances, such as junior doctor industrial action. Activity schedules and operational capacity plans for 2017/18 have assumed historic (high) levels of recurrent growth will continue and services will, wherever possible, ensure that core capacity can deliver the required level of flexibility to routinely meet fluctuations in demand. With further annual growth assumed into 2018/19, the Trust expects to achieve the 99% national standard in each month in the next two years.

6.2.4 A&E 4-hour standard

Achievement of the A&E 4-hour standard continues to be a challenge in 2016/17 with the Trust achieving its recovery trajectory between April and August but struggling thereafter with the start of the seasonal rise in demand. Levels of emergency admissions during the first half of 2016/17 were 5.1% higher (4.8% Bristol Royal Infirmary; 5.7% Bristol Children's Hospital) than the same period in 2015/16, exceeding last year's planning assumptions. Delayed discharges remains at double the level committed to as part of the community-wide improvement plan with bed pressures remaining the primary cause of the Trust's inability to meet a maximum 4-hour wait. The Trust plans to continue to direct organisational priority to reducing bed occupancy, such as through the roll-out of the Orla "virtual ward", improvements to the discharge planning process, targeted reductions in length of stay and supporting partner organisations within the STP to reduce delayed discharges and avoid admissions. The current year-on-year scale of deterioration in A&E 4-hour performance equates to 5.2%. Although the impacts of the STP remain to be tested and confidence in deliverability secured, the Trust expects the scale of these impacts to enable this annual deterioration to be offset and reversed by the latter half of 2017/18, with further recovery on top of that during 2018/9. It should be noted that achievement of 90% against the A&E 4-hour standard in quarter 2 is felt to be aspirational at present but is in line with NHS Improvement guidance for securing STF in the period.

The revised 2017/18 A&E 4-hour performance trajectory, submitted on 13 April 2017 outlines recovery of 95% performance by month 12 as follows;
Table 2:

	Y1 M01 Plan	Y1 M02 Plan	Y1 M03 Plan	Y1 M04 Plan	Y1 M05 Plan	Y1 M06 Plan	Y1 M07 Plan	Y1 M08 Plan	Y1 M09 Plan	Y1 M10 Plan	Y1 M11 Plan	Y1 M12 Plan
Accident and Emergency - >4 hour wait	1,940	1,950	1,699	1,166	1,084	1,117	1,185	1,147	1,121	1,132	899	613
Accident and Emergency - Total Patients	11,088	11,818	11,327	11,660	10,839	11,174	11,850	11,469	11,209	11,316	11,242	12,267
Accident and Emergency - Performance %	**82.5%**	**83.5%**	**85.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**92.0%**	**95.0%**

7. Workforce

7.1 Strategic Context

Our Workforce and Organisational Development Strategy 2014 to 2020 was formulated through extensive stakeholder engagement. This recognised the importance of recruitment to key staff groups in a tight labour market, maintaining and developing the quality of services with fewer available resources and aligning our staffing levels with the capacity demands and financial resource to ensure safe and effective staffing levels. We continue to develop our strategy in response to our changing environment, increasingly focussing on transformational change to release productivity savings, engaging staff in the process, as described in the Carter (February 2016) report and subsequent Model Hospital work and aligning our objectives with the BNSSG STP.

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

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

The Trust has appointed an Apprenticeship Co-ordinator to facilitate the implementation of a wider Trust apprenticeship offer from May 2017 in line with the Government levy and workforce target. Models of delivery are currently under review, including an option for an STP wide approach. For existing staff, development needs are reviewed as part of the annual appraisal, and in addition, the Trust has focussed enhanced staff development opportunities on difficult to recruit and high turnover areas, such as theatres and intensive care. Collaborative working with the University of the West of England has supported the allocation of continuing professional development modules for nursing and allied health professional staff.

Seven day working has been highlighted in The Five Year Forward View, although the challenge is to do this in an affordable way. Requirements to achieve these standards are included in our workforce plans as part of our operating planning process and the details of specific areas of focus are outlined above in Section 5.6.

7.2 Workforce Planning Approach – Operating Plans

The annual workforce planning process at UH Bristol forms an integral part of the annual Operational Plan cycle. Each Division within the Trust is required to provide a detailed workforce plan, developed by appropriate service leads and clinicians, aligned to finance, activity and quality plans. An assessment of workforce *demand* is linked to commissioning plans reflecting service changes, developments, CQUINS, service transfers and cost improvement plans. As outlined above, the IMAS capacity planning tool is used to model the capacity and demand requirements at a service level, which then informs the workforce requirements associated with any changes, ensuring the alignment of workforce with finance.

We have agreed nurse to patient ratios to provide safe staffing levels, which are reflected in the plans. Workforce *supply* plans include an assessment of workforce age profiles, turnover, sickness absence and the impact these will have on vacancy levels and the need for temporary staff. Throughout the course of the year, actual performance against the Operating Plan, including workforce numbers, costs and detailed workforce KPIs are reviewed through Quarterly Divisional Performance reviews held with the Executive team, ensuring the ongoing triangulation of workforce, finance and quality through the year.

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

All NHS organisations are required to demonstrate progress against a number of indicators of workforce equality through the nine point Workforce Race Equality Standard (WRES) metric. The Trust published its first report on its position in respect of these indicators in July 2015 and continues to work to deliver the WRES as part of the Equality & Diversity objectives signed off by the Board.

7.3 Managing agency and locum use

Our underpinning strategy to manage agency and locum use is focussed on managing both *demand* and *supply*. The underpinning approach to manage the *demand* for temporary staffing is to focus on the drivers of demand, which include sickness absence, vacancies and turnover through a range of actions which are reported monthly to Quality and Outcomes Committee. Direct actions to manage *demand* for agency include increased efficiency and effectiveness of rostering by fully implementing a different nursing and midwifery e-rostering system and an electronic acuity and dependency tool both from April 2017, continuing to monitor and challenge rostering and operating plan KPIs through the monthly Nursing Controls Group, robustly escalating requests for agency usage and focus on demand for enhanced observation through recruiting to the designated funded establishment. Actions to manage *supply* include improving the ratio of bank fill to agency by external and internal marketing campaigns, incentive payments and the establishment of a locum bank in 2017. We will also continue to work with agencies to fully implement the caps to avoid unnecessary spend.

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

7.4 Workforce Numbers

The anticipated workforce plan, derived from the operating planning process described above, expressed in whole-time equivalents (wte) for 2017/18 and how this compares to the previous year is set out in the tables below.

Table 3 – WTE for 2017/18 compared to 2016/17 (Changes in funded establishment)

DEMAND (Changes in Funded establishment) Staff Group	Funded Establishment 2016/17 FOT wte	Service Developments wte	Service Transfers wte	Savings Programme wte	Activity /Capacity Changes wte	Funded Establishment March 2018 wte	Change wte
Medical and Dental	1,238	1	0	1	8	1,248	9.8
Qualified Nursing and Midwifery staff	2,459	6	3	(4)	15	2,480	20.6
Qualified Scientific and Professional Staff	1,101	4	0	(0)	9	1,114	12.6
Support to clinical staff	2,499	1	5	(4)	16	2,514	14.5
NHS Infrastructure Support (Admin and Estates)	1,080	8	0	(18)	(1)	1,074	-6.7
Total	**8,378**	**20**	**8**	**(25)**	**48**	**8,428**	**51**

Table 4 – WTE for 2017/18 compared to 2016/17 (Changes in staff employed/bank/agency)

SUPPLY Change	March 2017 Forecast			March 2017	Changes March 2017 to March 2018			2017/18	March 2018 Planned			March 2018
Staff Group	Employed wte	Bank wte	Agency wte	Forecast Total Staffing wte	Employed wte	Bank wte	Agency wte	Total Changes wte	Employed wte	Bank wte	Agency wte	Planned Total Staffing wte
Medical and Dental	1,242		10	1,253	0		(5)	(5)	1243		5	1,248
Qualified Nursing and Midwifery staff	2,301	112	52	2,465	19	4	(9)	14	2320	116	43	2,480
Qualified Scientific and Professional Staff	1,031	14	14	1,058	64	(1)	(8)	55	1095	13	5	1,114
Support to clinical staff	2,323	191	24	2,538	43	(57)	(10)	(24)	2366	134	14	2,514
NHS Infrastructure Support (Admin and Estates)	1,018	68	15	1,100	(2)	(18)	(5)	(26)	1015	49	9	1,074
Total	**7,915**	**385**	**114**	**8,414**	**124**	**(72)**	**(37)**	**14**	**8,039**	**313**	**77**	**8,428**

The workforce plan summarised in the tables above aligns with the NHSI templates, reflecting the overall strategy to increase our ratio of substantive staffing relative to agency and bank usage. This will be delivered through increased recruitment, reduced turnover, reduced sickness absence, and filling vacancies, supported by improved rostering efficiency. These numbers are similar to year two of our workforce plan, with little change assumed for 2018/19.

7.5 Workforce transformation and productivity programmes

Our approach is to engage and involve staff in solutions which will require different ways of working, such as clinical teams joining up to deliver pathways of care, new roles, changes in skill mix, and development of new competences, in support of our STP, with a greater likelihood of posts bridging the primary care / acute interface. Examples of plans for workforce transformation include the following:

Medical:

- The STP Trauma and Orthopaedics Transformation Project includes service redesign options. Gaps in Trauma and Orthopaedics junior doctors are being filled by clinical teaching fellows, which are more attractive to applicants as they combine teaching/research with clinical work, and remaining gaps will be filled by physicians' associates.

Nursing

- Development of Advanced Nurse Practitioners in areas such as Emergency care and Care of the Elderly, to provide career progression, respond to gaps in medical capacity, and improve retention;
- Changes to theatre skill mix to improve recruitment and retention with development opportunities;
- Exploring further options for assistant practitioner and nurse associate roles.

Scientific, professional and technical

- Consultant radiographer posts to help to mitigate the risk of shortages of radiologists, and improve radiographer retention;
- Work with education providers to train our first Assistant Practitioner in Nuclear Medicine
- Develop Radiographic Assistants apprenticeships in 2018 and Trail blazer apprenticeships for radiographers for 2019.
- More advanced practice for Pharmacist prescribers and consultant pharmacists and Specialist Pharmacists in the Emergency Department, combined with a general shift in pharmacy skill mix and use of IT to redirect capacity from infrastructure support into more patient focussed activities. We are also linking with commissioners to introduce a Clinical Commissioning Pharmacist.

Administrative and Clerical staff

Administrative, Clerical and Estates staff

- In 2017/18, we are implementing significant changes in our ward catering processes to drive efficiencies and improve productivity.
- Our administrative and clerical staff programme is focussed on common processes, quality approach to recruitment, training and standards for our ward clerks and booking clerks, standardisation of job descriptions, efficiencies in the administrative and clerical Bank, all of which aim to improve the quality and efficiency of our clinical services and support enhanced professionalism across our administrative and clinical teams.

7.6 Workforce KPIs

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

- **Staff Turnover Rate;** During 2016/17 turnover levels are now in line with benchmarks for similar Trusts, following 18 months of being above benchmark. This improvement derives from turnover gradually increasing nationally, whilst rates at UH Bristol have remained stable. We have set a target for 2017/19 to reduce from 13.3% to 12.0% by March 2017 and 11.7% by March 2018 (excluding fixed term contracts and doctors in training). This is in line with our Quality Strategy which sets a target of 11.1% by 2020.
- **Vacancy Percentage** Recruiting to vacancies, particularly hard to recruit and specialist areas which are covered by high cost agency workers, remains an important element in our agency reduction plan. The UH Bristol vacancy rate for 2015/16 was 5.1%, and the average year to date vacancy rate (October 2016) of 5% compares favourably with other Teaching Trusts. Our internal target is to sustain 5% through 2017/18 and 2018/19.
- **Sickness Absence** We are aiming for a year on year improvement in our sickness absence rates, with a forecast out turn of 4%% in 2016/17, reducing to 3.8% in 2017/18 and 3.7% in 2018/19.

7.7 Junior Doctor Contract

The Trust has established a Junior Doctor Contract Implementation Group (JDCIG) including the newly appointed Guardian of Safe Working Hours. Engagement is taking place with junior doctors via the Local Negotiating Committee and the Junior Doctors Committee and a Junior Doctor

Representative is now attending the JDCIG. All Trust junior doctor rotas have been mapped to a local Trust implementation plan in accordance with national guidance. The new contract is due to go live in a phased approach between December 2016 and October 2017. Challenges include monitoring requirements, rostering systems and rota rule changes resulting in the need for significant redesign and additional resource to achieve compliance in a short timescale. The Trust is currently reviewing options to ensure the contract is implemented without adverse service and patient safety impact. The cost of implementation is currently not confirmed, which creates a significant risk to the financial plan.

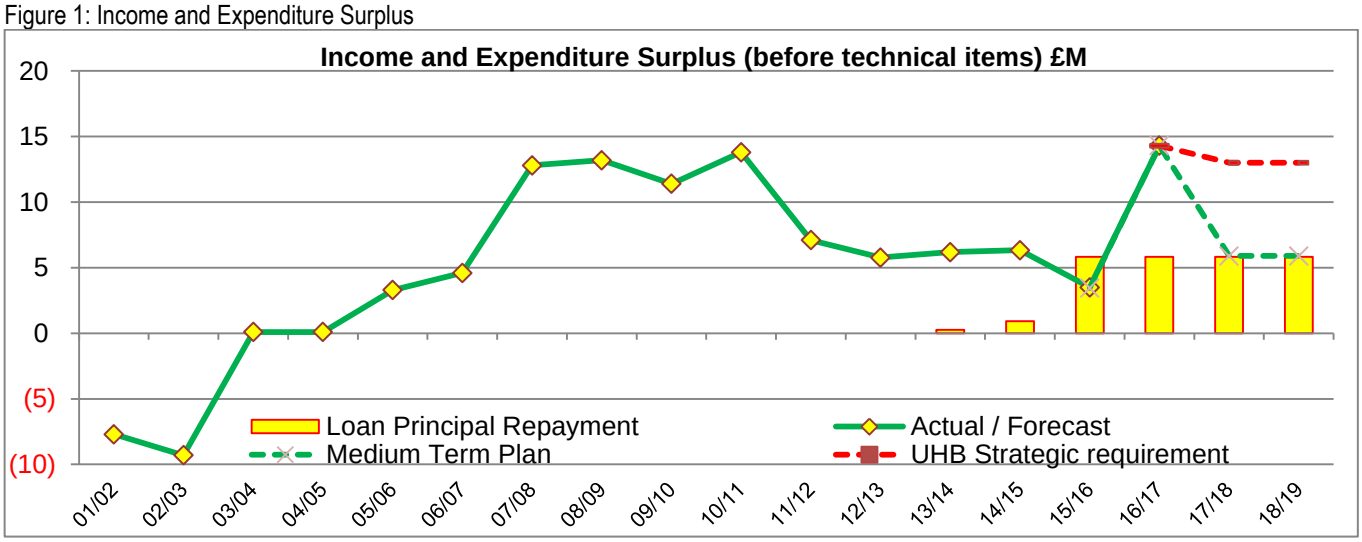
8. Financial planning

8.1 2016/17 Forecast Outturn

8.1.1 Net surplus

The Trust is forecasting a 2016/17 net income & expenditure surplus of £14.2m before technical items in line with the Control Total excluding Sustainability & Transformation performance (S&T) funding. This will be the Trust's fourteenth year of break-even or better. A summary of the Trust's financial position is provided below in figure 1.

Figure 1: Income and Expenditure Surplus



The Trust remains one of the best performing Acute Trusts in terms of financial performance. To achieve this, however, non-recurrent measures of at least £10.0m will be required to deliver the Control Total.

8.1.2 Savings

The Trust's 2016/17 savings requirement is £17.4m. Savings of £13.2m are forecast to be delivered by the year end. The forecast shortfall of £4.3m is due to unidentified schemes of £3.2m and scheme slippage of £1.1m. The forecast shortfall of recurrent savings delivery in 2016/17 of £3.8m will be carried into the 2017/18 underlying position.

8.1.3 Capital expenditure

The Trust is forecasting capital expenditure of £30.0m for 2016/17 against an NHS Improvement plan of £35.0m due to scheme slippage. The Trust's carry forward commitments into 2017/18 are £16.1m.

8.1.4 Use of Resources Rating

The Trust is forecasting a Use of Resources Rating (UoRR) of one, the highest rating. The Trust has strong liquidity with forecast net current assets of £33.1m and achieves 13.8 liquidity days and a liquidity metric of one.

The Trust's forecast EBITDA performance of £47.0m (7.5%) delivers capital service cover of 2.6 times and a metric of one.

The Trust's forecast net income and expenditure margin is 2.5% and achieves a metric of one. The I&E margin variance also achieves a metric of one. The forecast agency expenditure metric scores a rating of two.
The position is summarised below.

Table 5: 2016/17 Forecast Outturn Use of Resources Rating

	Metric	Rating
Liquidity	13.8	1
Capital service cover	2.6 times	1
Net I&E margin	2.5%	1
I&E margin variance	(0.27)%	2
Agency expenditure variance against ceiling	21.8%	2
Overall UoRR rounded		1

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

8.2 2017/18 Financial Plan

8.2.1 Introduction

The original Operational Plan was submitted to NHS Improvement on 23rd December 2016 which was approved by the Trust Board on 22nd December 2016. The revised financial plan has been subsequently updated to incorporate the offer from NHS Improvement of a revised Control Total of £12.957m on 20th March 2017.

The Control Total offer is in line with Trust Board expectations so it has been assumed that the offer will be accepted and the Trust's financial plan therefore moves from the original £10.1m deficit to a £12.957m surplus (rounded to £13.0m). This reconciliation is shown below:

		Net Surplus / (Deficit) £M
Per 23rd December 2016 Operational Plan submission		(10.1)
Add Sustainability & Transformation (S&T) funding	13.3	
Add abatement of core fines		2.5
		5.7
Add further stretch in financial plan		0.3
Revised planned net surplus for the year		**13.0**

It should be noted that the 2017/18 financial plan is based on Service Level Agreements (SLAs) with Commissioners which concluded with signed SLAs in December. The plan is based on the following key drivers:

Acceptance of the revised 2017/18 Control Total advised by NHS Improvement of £12.957m net surplus;

The Trust's savings requirement for 2017/18 is £11.9m or 2.5% of recurring budgets;

A gross inflation uplift of 2.1% to include a 1% pay award, the impact of the new Junior Doctors contract, Apprenticeship Levy at £1.15m net and a 40% increase in the cost of Clinical Negligence Scheme for Trusts (CNST) premiums. The 2.1% uplift is considered inadequate hence an additional cost pressure at £1.5m has been included in the plan primarily due to the new Junior Doctors contract requirements;

A new HRG4+ National Tariff structure providing a favourable impact of £8.7m. However, this position is offset by the adverse impact of Commissioner actions. For example, NHS England does not accept that 80%-85% of CQUIN net income is baselined in provider's financial positions. The adverse impact of this approach is c.£3.0m against budget but £5.0m against current out-turn. In addition further losses from Pharmacy gain share are estimated at £0.2m;

Service Level Agreement (SLA) proposals have been negotiated with Commissioners and financial agreement has been reached. SLAs were signed by Christmas. This includes Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCGs) and associates and NHS England (Specialised and Non-Specialised);

The Trust has had no communication from Health Education England (HEE) of the likely funding proposals for education funding in respect of inflation, efficiency or placement volumes. This is unsatisfactory and creates further risk to the financial plan. Representations are being made by the Trust; and

The Trust has a significant capital expenditure programme investing £474m from April 2008 until March 2022. With the incorporation of the revised Control Total, an additional £8.3m will be added to Strategic Capital. The additional £8.3m is broadly derived from the planned 2017/18 surplus of £13.0m exceeding the long term loan cash repayment requirement of £5.8m plus an additional £1.1m from cash balances. This will generate a capital programme of £48.0m after an estimated slippage of £3.9m into 2018/19.

8.2.2 Financial Plan

The 2017/18 financial plan of a £10.2m deficit is summarised in the table below.

Table 6: Financial Position

Surplus / (Deficit)	Operational Plan £M	
Underlying position brought forward	17.8	
Loss of Sustainability & Transformation Funding	(13.3)	Trust rejecting NHS Improvement's Control Total net surplus of £22.8m.
Impact of national core fines	(2.5)	Trust will be subject to fines as a result of rejecting the Control Total.
Revised Underlying position b/fwd	1.9	
Cost Pressures		
Capital Charges	(0.4)	Strategic schemes completion (net of £0.9m).
Car park	(0.2)	Loss of residences income.
CNST cost increase – net of Tariff	(0.3)	40% increase offset in part by Tariff.
Risk provision for cost pressures	(0.5)	Unavoidable recurrent costs only.
Divisional underlying shortfall	(13.0)	
SLA Contracting Issues		
CQUINS	(3.0)	Net loss of baseline income to deliver 2017/18 CQUINS.
Pharmacy gain share	(0.9)	Withdrawal of gain share by NHS England.
Sexual Health Tender	(0.4)	Tender reduces the SLA price.
Tariff impact	8.7	Estimated Tariff gain.
2017/18 Underlying position	(8.1)	
Non Recurrent		
Change costs / spend to save	(0.5)	To fund schemes generating recurring savings.
Risk provision for cost pressures	(0.5)	Unavoidable non-recurrent costs only.
Transition costs for strategic schemes	(0.3)	In support of the car park and other capital schemes.
Clinical IT programme	(0.8)	Funds the IT Programme support costs.
Net I&E Deficit exc. technical items	(10.1)	As per the 23rd December submission.
Acceptance of revised Control Total		
Add S&T funding	13.3	Receipt of S&T funding.
Add abatement of core fines	2.5	National core fines no longer payable.
Further Stretch		
Increase in target for CQUINS income	4.0	Sets a higher CQUIN baseline to 82%
Pharmacy gain share loss agreement	0.7	Re-assessed at a loss of £0.2m compared with a loss of £0.9m previously.
Use of Strategic reserve	1.3	Corporate share of SLA changes.
Annual leave accrual	1.0	Anticipated non-recurring reduction.
Other	0.3	Further measures.
Net I&E Surplus exc. technical items	13.0	Revised 30th March submission.
Donated asset depreciation	(1.5)	
Net impairments	(1.4)	
Net I&E Surplus inc. technical items	10.1	

8.2.3 Income
The agreed 2017/18 SLA is summarised in the table below. The Trust's total income plan is £638.2m, this compares to a forecast outturn in 2016/17 of £635.0m.

Table 7: 2017/18 Income build up

		£M	£M
Rollover Income	Recurrent income from 2016/17		631.3
Tariff	Gross inflation excluding CNST	10.0	
	Efficiency	(9.5)	
			0.5
Impact of Guidance	Tariff impact	8.7	
	Spending commitments funded by Tariff (CNST)	2.1	
			10.8
Activity Changes	Service transfers	3.3	
	External revenue proposals	0.3	
	Recurrent activity (including undelivered QIPP)	1.8	
	Non-recurrent activity	4.3	
	Remove prior year non-recurring activity	(3.9)	
			5.8
Other	High cost drug / devices assessment (including NICE)	3.3	
	Pharmacy gain share loss (estimated)	(0.2)	
	Other	6.2	
			9.3
	Total 2017/18 Income		657.7

8.2.4 Costs
The 2017/18 level of cost pressures for the Trust is very challenging and should be considered in the context of operational pressures on spending, the full delivery of savings plans and transformation initiatives. Firm control will continue to be required to avoid the Trust's medium term plans being undermined beyond 2017/18. The main assumptions included in the Trust's cost projections are:

Pay award at 1.0%, apprenticeship levy at £1.15m net and £1.5m for the new Junior Doctors contract;
A reduction in agency costs of £6.1m due to improved controls and compliance with agency price caps;
Drugs at 2.8%, clinical supplies 1.8%, CNST at 40.0%, and capital charges inflation at 3.0%;
Savings requirement of £11.9m;
Loss from Sexual Health service tender of £0.4m;
Recurrent unavoidable cost pressures of £0.5m;
Payment of loan interest at £2.6m;
Depreciation of £22.8m; and
Capital charges growth of £1.3m.

The 2017/18 position includes net non-recurring costs of £1.1m as follows:

- £ 0.5m Change / invest to save costs;
- £ 0.3m Transitional costs relating the car park scheme;
- £ 0.8m Clinical Systems Implementation Programme (CSIP);
- £ 0.5m Non recurrent unavoidable cost pressures; and
- £(1.0m) Annual leave accrual reduction

8.2.5 Cost Improvement Plans
The delivery of Cost Improvement Plans (CIPs) is an essential element in the Trust delivering its 2017/18 financial plan, including the conversion of non-recurring schemes to recurring schemes. The Trust sets CIP targets for 2017/18 in the light of national tariff efficiency requirements for Commissioners at 2.0% and a further 0.5% to cover cost pressures. This generates a CIP requirement for 2017/18 of £11.9m.

The Trust has an established process for generating CIPs operated under the established Transforming Care programme. The key transformational work streams which support CIP are as follows:

Theatre Productivity transformation programme to focus on improving theatre efficiency;

The Model of Care Programme which is our patient flow programme and focuses on reductions in length of stay along with improved productivity and reductions in cancellations;
The Diagnostic Testing project which addresses the processes for delivering efficient diagnostic testing across the Trust for Pathology and Radiology services; and
Outpatient productivity which focusing on the efficient utilisation of outpatient capacity.

The Trust also runs a programme of Specialty Productivity reviews which focus on clinical productivity across the areas above including consultant job planning reviews and links to capacity and demand. The challenge is to identify quantifiable savings from these transformation work streams.

The Trust has established a further group of work streams dedicated to delivering transactional CIPs, for example:

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

The Trust's risk assessed CIP plan is summarised below. The total of unidentified savings is currently £0.6m.

Workstreams	£M
Allied Healthcare Professionals Productivity	0.3
Medical Staff Efficiencies Productivity	0.3
Nursing & Midwifery Productivity	0.4
Diagnostic testing	0.2
Technology / Admin & Senior Managers Productivity	0.1
Reducing and Controlling Non Pay	4.5
Medicines savings (Drugs)	0.7
Trust Services efficiencies	0.5
Outpatient Productivity	0.4
Facilities and Estates productivity	0.6
Theatre productivity	0.2
Other	3.1
Subtotal – savings identified	11.3
Unidentified savings	0.6
Total – savings requirement	11.9

8.2.6 Carter review
The Trust has an action plan to address the key recommendations of the Carter Report. The Trust has already been actively engaged with regards to Medicines/Pharmacy and Estates & Facilities efficiencies. The report highlighted the current local collaborative medicines procurement process as an example of good practice. Each of the Trust's savings workstream is establishing a clear action plan to take forward the recommendations in the Carter Report particularly those concerned with developing efficiencies in relation to the use of staffing resources.

The Trust welcomes the 'Model Hospital' aspects of the Carter approach as the Trust recognises the considerable benefits this might bring in the future. As yet this is still relatively underdeveloped but as it improves, the Trust will actively use this as a further means of identifying opportunities for efficiency savings.

With regard to benchmarking the Trusts performance against peer Trusts, which is a key element of the Carter approach, the Trust is actively using Reference Costs to identify areas of potential efficiency improvement. The Trust will continue to use the benchmarking portal released by the Carter team and the Trust will increase the benchmarking it carries out with a view to identifying examples of best practice from other Trusts. The ongoing challenge is to transfer knowledge gained from benchmarking into practical implementable cost reduction. The 2017/18 CIP Programme will continue to be taken forward by the established Savings Board, with opportunities for collaboration with partnering Trusts being actively explored through the developing Sustainability & Transformation Plan (STP) structures.

8.2.7 Capital expenditure
The Trust has a significant capital expenditure programme investing £474m from April 2008 until March 2022 in the development of its estate. In 2017/18, the Trust's planned gross capital expenditure totals £51.9m and incorporates slippage of £16.1m from 2016/17.

The capital programme assumes up to £3.9m slippage into 2018/19. This will be reviewed later in the year when the position is firmed up. The net 2017/18 capital expenditure plan is therefore £48.0m and is summarised below:

Table 8: Source and applications of capital

Source of funds	2017/18 Plan £M	Application of funds	2017/18 Plan £M
Cash balances	25.3	Carry forward schemes	16.1
Depreciation	22.8	Estates replacement	2.5
Disposals	0.0	IM&T	6.3
Donations	0.0	Medical equipment	5.6
Public Dividend Capital	3.8	Operational capital	5.5
		Phase 5	15.9
Net cash retention	(3.9)	Net slippage	(3.9)
Total	48.0	Total	48.0

8.2.8 Use of Resources Rating

The planned net surplus of £13.0m is the driver behind the Trust's overall Use of Resources Rating (UoRR) of one. The components of the UORR are summarised below:

Table 9: UORR Performance

	Metric	Rating
Liquidity	5.4	1
Capital service cover	2.6 times	1
Net I&E margin	2.0%	1
I&E margin variance from plan	0.0%	1
Agency expenditure against ceiling	0.0%	1
Overall UORR rounded		1

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

8.2.9 Summary Statement of Comprehensive Income

The 2017/18 Statement of Comprehensive Income (SoCI) and closing cash balance is summarised below:

Table 10: SoCI and closing cash balance

	2017/18 Plan £M
Income	657.7
Operating expenditure	(609.9)
EBITDA (excluding donation income)	47.8
Non-operating expenditure	(34.8)
Net surplus / (deficit) excluding technical items	13.0
Net impairments	(1.3)
Donation income	0.0
Donated asset depreciation	(1.6)
Net surplus / (deficit) including technical items	10.1
Year-end cash	51.8

8.3 2018/19 Financial Plan

8.3.1 Income

The anticipated income changes from 2017/18 in 2018/19 are summarised below:

Table 11: 2018/19 Income build up

		£M	£M
Rollover Income	Recurrent income from 2017/18		657.5
Tariff	Gross inflation excluding CNST	10.8	
	Efficiency	(10.4)	
			0.4
Impact of Guidance	Spending commitments funded by Tariff (CNST)		2.6
Activity Changes	External revenue proposals	0.0	
	Recurrent activity (including undelivered QIPP)	6.3	
	Remove prior year non-recurring activity	(4.3)	
			2.0
Other	High cost drug / devices assessment (including NICE)		3.1
	Total 2018/19 Income		665.6

8.3.2 Summary Statement of Comprehensive Income

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

Table 12: SoCI and closing cash balance

	2018/19 Plan £M
Income	665.6
Operating expenditure	(618.6)
EBITDA (excluding donation income)	47.0
Non-operating expenditure	(36.4)
Net surplus / (deficit) excluding technical items	10.6
Net impairments	0.0
Donation income	0.0
Donated asset depreciation	(1.5)
Net surplus / (deficit) including technical items	9.1
Year-end cash	55.5

8.3.3 Use of Resources Rating

The planned net surplus of £10.6m is the driver behind the Trust's overall Use of Resources Rating (UoRR) of one. The components of the UORR are summarised below:

Table 13: UORR Performance

	Metric	Rating
Liquidity	7.9	1
Capital service cover	2.5	2
Net I&E margin	1.6%	1
I&E margin variance	0.0%	1
Agency expenditure against ceiling	0.0%	1
Overall UORR rounded		1

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

8.4 Financial Risks

- The main risks to the delivery of the 2017/18 plan include:
- Risk of failure to deliver A&E access trajectory resulting in the loss of S&T performance funding. This is rated high;
- CQUIN schemes are not deliverable at the stretch target. Achieving the stretch target will be challenging. This risk is currently assessed as high;
- The risk of managing national and local cost pressures. The previous good track record of the Trust means that this risk is moderate;
- Delivery of the Trust's savings requirement is considered a high risk. Close monitoring of achievement and effective mitigation of any under-achievement will be in place; and
- Planned activity is not delivered hence compromising the Trust's Operational Plan including the potential need to use premium cost delivery methods. Overall this is assessed as moderate.

9. Membership and elections

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

In 2016, 15 governor roles were available for re-election, across the public, patient and staff constituencies. In total, 29 people stood for election in May 2016; 10 governors were elected in a ballot and four were re-elected unopposed. The nursing and midwifery seat remained vacant.

Turnout was largely in line with the 2013 and 2014 elections. Elections were re-run in June for two vacancies, staff governor role (nursing and midwifery) and patient governor for carers of patients under 16 years. One staff governor was elected unopposed. The patient governor seat remains vacant as no candidate came forward.

There will be further elections in May 2017 – when there will be 13 public, patient and staff seats up for election. Planning for the elections is currently underway.

9.2 Governor recruitment, training and development and member engagement activities

The 2016 election programme undertook a refreshed approach to the promotion of the governor role, and a comprehensive campaign to generate interest, which included mailing all Foundation Trust members who had shown interest in becoming a governor; updating the prospective governor information pack; promotion of the role across the Trust through different communication channels, and externally, including coverage in the Bristol Post; and three 'prospective governor information events'.

Governors are provided with a comprehensive programme of training and development that begins upon appointment with an induction. In additional to regular focus groups on Trust strategy, quality and performance, and membership/constitution, we run four governor development seminars each year, which have included training from NHS Providers/Govern Well and updates from leads within the organisation on topics such as patient safety, annual planning, risk management, patient and public involvement. We use the governor development sessions and governor focus groups to ensure that the Council of Governors is sighted on the same issues as the Board. Our governor skills audit enables us to better understand the experience and skills of each governor and allows us to tailor training to areas of specific need.

Engagement between governors and members is actively encouraged. Governors not only support the facilitation of Foundation Trust membership events, but also support other Trust events where members of the public are invited (e.g. Doors Open Day, Healthy Cities Week), and take part in patient and public involvement activities such as face-to-face interviews – as an opportunity to talk to their constituents.

9.3 Membership strategy – plans for next 12 months

The Trust has a Membership Engagement and Governor Development Strategy that was refreshed in 2015. The strategy includes an overview of the intended approach to membership, which focuses on growing member numbers, particularly in under-represented communities, and improving the frequency and quality of opportunities for engagement with members. The membership team holds regular member events throughout the year, each with a focus on a particular health topic and with time for Q&A and feedback and attended by a broad demographic. Foundation Trust members are also contacted at least monthly by e-newsletter or three times a year by mail with updates from in and around the Trust. Improvements are underway to membership marketing materials ahead of a more targeted recruitment campaign focusing on the under-represented communities through the rest of 2016 and into 2017 as part of the 2017 election campaign. The Membership Engagement and Governor Development Strategy is due to be reviewed in December 2016.

10. Conclusion

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

Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	18
Meeting Title	Trust Board	**Meeting Date**	28 April 2017
Report Title	Annual Review of Code of Conduct for Board of Directors *(including Fit and Proper Persons Self Certification)*		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

This report contains the Board of Directors' Code of Conduct and declaration of the Fit and Proper Persons requirement in line with the Care Quality Commission Fundamental Standards of Care, and provides assurance that all members of the Board have signed the annual declaration of compliance with these standards.

Key issues to note

All members of the Board of Directors have completed and signed the annual declaration against the standards of the Code of Conduct and Fit and Proper Persons requirement. Copies of signed declarations are available to the public on request from the Trust Secretariat.

During 2016/17 the Trust approved the *"Fit and Proper Persons Policy"* which University establishes its commitment to ensuring that all persons appointed as directors, or performing the functions of, or functions equivalent or similar to those of a director satisfy the Fit and Proper Person Requirements as directed by the Care Quality Commission (CQC) Regulation 5.

The Fit and Proper Person Test is outlined in full in Regulation 5 of the 2014 Regulations and states that providers must not appoint a person to a director level post (including permanent and interim posts) or to a non-executive director post unless he or she:

- Is of good character;
- has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed; and
- is able by reason of his or her health and after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed.

Recommendations

Members are asked to:

- **Note** the report; and
- **Receive** assurance that the Board of Directors comply with the required standards of the Code of Conduct and Fit and Proper Persons Policy.

Intended Audience
(please select any which are relevant to this paper)

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

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

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

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

Impact Upon Corporate Risk
N/A

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

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

Annex (i)

University Hospitals Bristol NHS Foundation Trust

Board of Directors Code of Conduct

1. Introduction

High standards of corporate and personal conduct are an essential component of public services. As a Foundation Trust, University Hospitals Bristol NHS Foundation Trust is required to comply with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant code of practice.

The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all Directors (in addition to the standard for employees set out in the policy defined in Standards of Business Conduct). This document therefore includes the Department of Health Code of Conduct/Code of Accountability for Boards, specifically for Chairs and Non-Executive Directors, and the Code of Conduct for NHS Managers specifically the Chief Executive and Executive Directors.

This code, with the Code of Conduct for Governors and the NHS Constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour.

2. Principles of public life

All Directors and employees are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

Selflessness - Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity - Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity - In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability - Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness - Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty - Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

3. General principles

Foundation Trust Boards of Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public. The Board of Directors therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct. The Board of Directors expects that this Code will inform and govern the decisions and conduct of all Directors.

4. Confidentiality and access to information

Directors and employees must comply with the Trust's confidentiality policies and procedures and must not disclose any confidential information, except in specified lawful circumstances. The Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be adhered to at all times.

5. Register of interests

Directors are required to register all relevant interests on the Trust's register of interests in accordance with the provisions of the constitution. It is the responsibility of each Director to update their register entry if their interests change. A pro forma is available from the Trust Secretary. Failure to register a relevant interest in a timely manner will constitute a breach of this Code.

6. Conflicts of interest

Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a Director or for doing (or not doing) anything in that capacity.

If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the corporation, the Director must declare the nature and extent of that interest to the other Directors. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement.

The Chair and Trust Secretary will advise Directors in respect of any conflicts of interest that arise during Board and Committee meetings, including whether the interest is such that the Director should withdraw from the meeting for the period of the discussion. In the event of disagreement, it is for the Board to decide whether a Director must withdraw from the meeting.

7. Gifts & hospitality

The Board will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of the Trust funds for hospitality and entertainment will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector.

The Trust has adopted a policy on register of interests and gifts and hospitality which will be followed at all times by Directors and all employees. Directors and employees must not accept gifts or hospitality other than in compliance with this policy.

8. Whistle-blowing

The Board acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The Board has adopted a Speaking Out policy on raising matters of concern which will be followed at all times by Directors and all staff.

9. Personal conduct

Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute. Specifically Directors must:

- Act in the best interests of the Trust and adhere to its values and this Code of Conduct;
- Respect others and treat them with dignity and fairness;
- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion;
- Be honest and act with integrity and probity;
- Contribute to the workings of the Board as a Board member in order for it to fulfil its role and functions;
- Recognise that the Board is collectively responsible for the exercise of its powers and the performance of the Trust;
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate;
- Recognise the differing roles of the Chair, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors;
- Make every effort to attend meetings where practicable;

- Adhere to good practice in respect of the conduct of meetings and respect the views of others;
- Take and consider advice on issues where appropriate;
- Acknowledge the responsibility of the Council of Governors to represent the interests of the Foundation Trust's members and partner organisations in the governance and performance of the Trust, and to have regard to the views of the Council of Governors;
- Not use their position for personal advantage or seek to gain preferential treatment nor seek improperly to confer an advantage or disadvantage on any other person; and
- Accept responsibility for their performance, learning and development

10. Compliance

The members of the Board will satisfy themselves that the actions of the Board and individual Directors in conducting Trust business fully reflect the values, general principles and provisions in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All Directors, on appointment, will be required to give an undertaking to abide by the provisions of this Code of Conduct including their compliance with; the Department of Health Code of Conduct and Accountability (Appendix 1); Code of Conduct for NHS Managers (Appendix 2); and the Nolan principles of governance.

Board members will be required to re-affirm their compliance with the Codes on an annual basis.

Please could you sign and return this document to confirm your continued compliance with these codes and support to the Nolan principles of governance.

Signed:…….. (signature) ……..…Date:

Print Name:…… (CAPITALS)

Designation:……(CAPITALS)

Appendix 1
Code of Conduct/Code of Accountability
for NHS Boards

CODE OF CONDUCT

1. Public service values

Public service values must be at the heart of the National Health Service. High standards of corporate and personal conduct based on recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is funded from public money, it must be accountable to Parliament for the services and for the effective and economical use of taxpayers' money.

There are three crucial public service values that must underpin the work of the NHS:

Accountability – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgments on propriety and professional codes of conduct.

Probity – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.

Openness – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients and the public.

2. General principles

Public service values matter in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The success of this Code depends on a vigorous and visible example from Boards and the consequential influence on the behaviour of all those who work within the organisation. Boards have a clear responsibility for corporate standards of conduct and acceptance of the Code should inform and govern the decisions and conduct of all Board directors.

3. Openness and public responsibilities

Health needs and patterns of provision of health care do not stand still. There should be a willingness to be open with the public, patients and with staff as the need for change emerges. It is a requirement that there is a consultation on major changes before decisions are reached. Information supporting those decisions

should be made available to the public in a way that is understandable, and positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000.

NHS business should be conducted in a way that is socially responsible. As large employers in the local community, NHS organisations should forge open and positive relationships with the local community and should work with staff and partners to set out a vision for the organisation in line with the expectations of patients and the public. NHS organisations should demonstrate to the public that they are concerned with the wider health of the population including the impact of the organisations activities on the environment.

The confidentiality of personal and individual patient information must be respected at all times.

4. Public service values in management

It is unacceptable for the Board of any NHS organisation, or any individual within the organisation for which the Board is responsible, to ignore public service values in achieving results. Chairs and Board Directors have a duty to ensure that public funds are properly safeguarded and that at all times, the Board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda of all NHS Boards.

Accounting, tendering and employment practices within the NHS must reflect the highest professional standards. Public statements and reports issued by the Board should be clear, comprehensive and balanced, and should fully represent the facts. Annual and other key reports published in good time and made publically available, to allow full consideration by those wishing to attend public meetings on health issues.

5. Public business and private gain

Chairs and Board Directors should act impartially and not be influenced by social or business relationships. No one should use their public position to further their private interests. Where there is a potential for private interests to be material and relevant to NHS business, the relevant interests should be declared and recorded in the Board minutes, and entered into a register which is available to the public. When a conflict of interest is established, the Board Director should withdraw and play no part in the relevant discussion or decision.

6. Hospitality and other expenditure

Board Directors should set an example to their organisation in the use of public funds and the need for good value in incurring public expenditure. The use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. NHS Boards should be aware that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by

the internal and external auditors and that ill-considered action can damage respect for the NHS in the eyes of the community.

7. Relations with suppliers

NHS Boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. NHS Boards should be aware of the risks of incurring obligations to suppliers at any stage of a contracting relationship.

8. Staff

NHS Boards should ensure that staff have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The Board must establish a climate:

- That enables staff who have concerns to raise these reasonably and responsibly with the right parties;
- That gives clear commitment that staff concerns will be taken seriously and investigated; and
- Where there is an unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation

9. Compliance

Board Directors should satisfy themselves that the actions of the Board and its Directors in conducting Board business fully reflect the values in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All Board Directors of NHS Trusts are required, on appointment, to subscribe to the Code of Conduct.

CODE OF ACCOUNTABILITY

This Code is the basis on which NHS Trusts should seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health.

1. Status

NHS Trusts are established under statute as corporate bodies to ensure that they have separate legal personalities. Statutes and regulations prescribe the structure, functions, and responsibilities of their Boards and prescribe the way their Chairs and Directors are to be appointed.

2. Code of Conduct

All Chairs and Non-Executive Directors of NHS Boards are required, on appointment, to subscribe to the Code of Conduct. Breaches of this Code of Conduct should be drawn to the attention of the Regulator.

NHS Managers are required to take all reasonable steps to comply with the requirements set out in the Code of Conduct for NHS Managers. Chairs and Non-Executive Directors of NHS Boards are responsible for taking firm, prompt, and fair disciplinary action against any Executive Director in breach of the Code of Conduct for NHS Managers.

3. Statutory Accountability

The Secretary of State for Health has statutory responsibility for the health of the population of England and uses statutory powers to delegate functions to NHS Trusts that are thus accountable to him and to Parliament.

NHS Trusts provide services to patients (these may be acute services, ambulance services, mental health or other specialist services i.e., for children) and must ensure that they are of high quality and accessible.

4. National standards of quality and safety

NHS Trusts providing care in hospitals are required to register with the Care Quality Commission (CQC). The CQC ensure that hospitals provide people with safe, effective, caring, responsive and well-led, and ensure services meet fundamental standards of quality and safety. Boards are required to ensure that hospitals continue to meet these fundamental standards of care.

5. Financial accountability

NHS Trusts are subject to external audit. NHS Boards must cooperate fully with the Regulators and the Auditors when required to account for the use they have made of public funds, the delivery of patient care and other services, and compliance with statutes, directions, guidance and policies of the Secretary of State.

6. The Board of Directors

NHS Boards comprise Executive Directors together with Non-Executive Directors and an independent Non-Executive Director Chair. Together, they share corporate responsibility for all decisions of the Board. Boards are required to meet regularly and to retain full and effective control over the organisation. NHS Improvement (Monitor), Independent Regulator of NHS Foundation Trusts, provides the line of accountability from local NHS Foundation Trusts to the Secretary of State for the performance of the organisation.

The duty of an NHS Board is to add value to the organisation, enabling it to deliver healthcare and health improvement within the law and without causing harm. It does this by providing a framework of good governance within which the organisation can thrive and grow. Good governance is not restrictive but an enabling ingredient to underpin change and modernisation.

The role of the Board is to:

- Be collectively responsible for adding value to the organisation for promoting the success of the organisation by directing and supervising the organisations affairs;
- Provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed;
- Set the organisations strategic aims, ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives and review management performance;
- Set the organisations strategy, values and standards and ensure that its obligations to patients and the local community are understood and met

Further information is provided in the Healthy NHS Board: Principles of Good Governance.

7. The role of the Chair

The overarching role of the Chair is one of enabling and leading, so that the attributes and specific roles of the Executive Directors and the Non-Executive Directors are brought together in a constructive partnership to take forward the business of the organisation.

The key responsibilities of the Chair are:

- Leadership of the Board, ensuring its effectiveness on all aspects of its role and setting its agenda;
- Ensuring the provision of accurate, timely and clear information to Directors;
- Ensuring effective communication with staff, patients and the public;
- Arranging the regular evaluation of the performance of the Board, its committees and individual Directors;
- Facilitating the effective contribution of Non-Executive Directors and ensuring constructive relations between Executive and Non-Executive Directors

A complementary relationship between with the Chair and Chief Executive is important. The Chief Executive is accountable to the Chair and Non-Executive Directors of the Board for ensuring that the Board is empowered to govern the organisation and that the objectives it sets are accomplished through effective and properly controlled executive action. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board.

Further information is provided in the Healthy NHS Board: Principles of Good Governance.

8. Non-Executive Directors

Non-Executive Directors are appointed by the Council of Governors to bring independent judgment to bear on issues of strategy, performance, key appointments and accountability. The duties of the Non-Executive Directors are to:

- Constructively challenge and contribute to the development of strategy;
- Scrutinise the performance of management in meeting agreed goals and objectives and monitor reporting of performance;
- Satisfy themselves that quality and financial information is accurate and that controls and systems of risk management are robust and defensible;
- Determine appropriate levels of remuneration of Executive Directors and have a prime role in appointing, and where necessary, removing senior management, and in succession planning; and
- Ensure the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses

Non-Executive Directors also have a key role in a small number of permanent Board committees such as the Audit Committee, Remuneration and Nominations Committee, Quality and Outcomes Committee, and Finance Committee.

Further information is provided in the Healthy NHS Board: Principles of Good Governance.

9. Reporting and controls

It is the Boards duty to present through the timely publication of an annual report, annual accounts and other means, a balanced and readily-understood assessment of the organisations performance to:

- The Department of Health
- Monitor
- Care Quality Commission
- External Auditors
- Council of Governors
- The Local Community

Detailed financial guidance, including the role of the internal and external auditors, issued by Monitor must be observed. The Standing Orders and terms of reference of the Board should prescribe the terms on which committees and sub-committees of the Board may be delegated functions, alongside the schedule of decisions reserved by the Board.

10. Declarations of interest

It is a requirement that the Chair and all Board Directors should declare any conflict of interest that arises in the course of conducting NHS business. All NHS Trusts maintain a register of members' interests to avoid any danger of Board Directors being influenced, or appearing to be influenced, by their private interests in the exercise of their public duties. All Board members are therefore expected to declare any personal or business interest which may influence, or may be perceived to influence, their judgment. This should include, as a minimum, personal direct and indirect family interests, and should normally also include such interests of close family members. Indirect financial interests arise from connections with bodies

which have a direct financial interest, or from being a business partner of, or being employed by, a person with such an interest.

11. Employee Relations

NHS Boards must comply with legislation and guidance from Department and Health and regulators, respect agreements entered into by themselves or on their behalf, and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. Fair and open competition should be the basis for appointment to posts in the NHS.

The terms and conditions agreed by the Board for senior staff should take full account of the need to obtain maximum value for money for the funds available for patient care. The Board should ensure through the appointment of a Remuneration and Nominations Committee, that executive Board Directors remuneration can be justified as reasonable. Board Directors remuneration for the NHS Foundation Trust should be published in its annual report.

Based on the document 'Code of Conduct, Code of Accountability for NHS Boards' originally published by the Department of Health April 1994
First revision April 2002
Second revision July 2004
Third revision April 2013

Appendix 2
Code of Conduct for NHS Managers
Department of Health, published October 2002

1. Introduction

As part of the response to the Kennedy Report, the Code of Conduct for NHS Managers has been produced by a Working Group chaired by Ken Jarrold CBE

The Code sets out the core standards of conduct expected of NHS managers. It will serve two purposes:

- to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make.
- to reassure the public that these important decisions are being made against a background of professional standards and accountability.

The environment in which the Code will operate is a complex one. NHS managers have very important jobs to do and work in a very public and demanding environment. The management of the NHS calls for difficult decisions and complicated choices. The interests of individual patients have to be balanced with the interests of groups of patients and of the community as a whole. The interests of patients and staff do not always coincide. Managerial and clinical imperatives do not always suggest the same priorities. A balance has to be maintained between national and local priorities.

The Code should apply to all managers and should be incorporated in the contracts of senior managers at the earliest possible opportunity.

2. Code of Conduct for NHS Managers

As an NHS manager, I will observe the following principles:

- make the care and safety of patients my first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for my own work and the proper performance of the people I manage;
- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;
- take responsibility for my own learning and development

This means in particular that I will:

- respect patient confidentiality;

- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public and patients;
- be guided by the interests of the patients while ensuring a safe working environment;
- act to protect patients from risk by putting into practice appropriate support and disciplinary procedures for staff; and
- seek to ensure that anyone with a genuine concern is treated reasonably and fairly

I will respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies. In my capacity as a senior manager within the NHS I will seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin. I will also seek to ensure that:

- the public are properly informed and are able to influence services;
- patients are involved in and informed about their own care, their experience is valued, and they are involved in decisions;
- relatives and carers are, with the informed consent of patients, involved in the care of patients;
- partners in other agencies are invited to make their contribution to improving health and health services; and
- NHS staff are:
    - valued as colleagues;
    - properly informed about the management of the NHS;
    - given appropriate opportunities to take part in decision making.
    - given all reasonable protection from harassment and bullying;
    - provided with a safe working environment;
    - helped to maintain and improve their knowledge and skills and achieve their potential; and
    - helped to achieve a reasonable balance between their working and personal lives

I will be honest and will act with integrity and probity at all times. I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer. I will seek to ensure that:

- the best interests of the public and patients/clients are upheld in decision-making and that decisions are not improperly influenced by gifts or inducements;
- NHS resources are protected from fraud and corruption and that any incident of this kind is reported to the NHS Counter Fraud Services;
- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded; and
- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear

I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:

- the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;
- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and
- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery

I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers and the Department of Health in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets. For the avoidance of doubt, nothing in paragraphs two to four of this Code requires or authorises an NHS manager to whom this Code applies to:

- make, commit or knowingly allow to be made any unlawful disclosure;
- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law

If there is any conflict between the above duties and obligations and this Code, the former shall prevail.

I will show my commitment to working as a team by working to create an environment in which:

- teams of frontline staff are able to work together in the best interests of patients;
- leadership is encouraged and developed at all levels and in all staff groups; and
- the NHS plays its full part in community development

I will take responsibility for my own learning and development. I will seek to:

- take full advantage of the opportunities provided;
- keep up to date with best practice; and
- share my learning and development with others

3. Implementing the Code

The Code should be seen in a wider context that NHS managers must follow the 'Nolan Principles on Conduct in Public Life', the 'Corporate Governance Codes of Conduct and Accountability', the 'Standards of Business Conduct', the 'Code of Practice on Openness in the NHS' and standards of good employment practice.

In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code. In order to maintain consistent standards, NHS bodies need to consider suitable measures to ensure that managers who are not their employees but who manage their staff or services; or manage units which are primarily providing services to their patients, also observe the Code.

It is important to respect both the rights and responsibilities of managers. To help managers to carry out the requirements of the Code, employers must provide reasonable learning and development opportunities and seek to establish and maintain an organisational culture that values the role of managers. NHS managers have the right to be:

- treated with respect and not be unlawfully discriminated against for any reason;
- given clear, achievable targets;
- judged consistently and fairly through appraisal;
- given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development; and
- reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives

4. Breaching the Code

Alleged breaches of the Code of Conduct should be promptly considered and fairly and reasonably investigated. Individuals must be held to account for their own performance, responsibilities and conduct where employers form a reasonable and genuinely held judgement that the allegations have foundation. Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problems. Activity, the purpose of which is to learn from and prevent breaches of the Code, needs to look at their wider causes.

Local employers should decide whether to investigate alleged breaches informally or under the terms of local disciplinary procedures. It is essential however that both forms of investigation should be, and be seen to be, reasonable, fair and impartial. If Chief Executives or Directors are to be investigated, the employing authority should use individuals who are employed elsewhere to conduct the investigation. The NHS Confederation, the Institute of Healthcare Management and the Healthcare Financial Management Association are among the organisations who maintain lists of people who are willing to undertake such a role.

5. Application of the Code

This Code codifies and articulates certain important contractual obligations that apply to everyone holding management positions. These include Chief Executives and Directors who as part of their duties are personally accountable for achieving high quality patient care. The Department of Health will in the next few months issue a proposed new framework of pay and contractual arrangements for the most senior NHS managers. Under this framework the job evaluation scheme being developed

as part of the 'Agenda for Change' negotiations is likely to be used as the basis for identifying which other managerial posts (in addition to Chief Executives and Directors) should be automatically covered by the Code. The new framework will also specify compliance with the Code as one of the core contractual provisions that should apply to all senior managers.

For all posts at Chief Executive and director level and all other posts identified as in paragraph 6 above, acting consistently with the Code of Conduct for NHS Managers Directions 2002, employers should:

- include the Code in new employment contracts;
- incorporate the Code into the employment contracts of existing postholders at the earliest practicable opportunity

Annex (ii)

Self-Certification – April 2017

I declare that I am a Fit and Proper Person to carry out my role, I am of good character, I have the qualifications, competence, skills and experience which are necessary for me to carry out my duties. I am capable by reason of health of properly performing tasks which are intrinsic to the position. I am not prohibited from holding office (e.g., directors disqualification order), within the last 5 years I have not been convicted of a criminal offence and sentenced to imprisonment of 3 months or more, been undischarged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangements/compositions with creditors and has not discharged it, nor is it on any 'barred' list.

The legislations states, for those required to hold a registration with a relevant professional body to carry out their role, they must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where the person no longer meets the requirement to hold the registration, and if they are a health care professional, social worker or other professional registered with a health care or social care regulator, they must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the Chair of UHB.

Print
Name……

Job
Title/Role……

Professional Registrations
held……
……
……

Signature……

Date……

Please return this signed declaration to Pam Wenger, Trust Secretary, University Hospitals Bristol NHS Foundation Trust, Trust Head Quarters, Marlborough Street, Bristol, BS1 3NU or e-mail at pamela.wenger@uhbristol.nhs.uk

Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	19
Meeting Title	Trust Board	**Meeting Date**	28 April 2017
Report Title	Annual Review of Directors Interests		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

To receive the Register of Interest for the Board of Directors for 2017/18.

Key issues to note

The Board of Directors have reviewed their interests in accordance with the Trust Policy and the Register of Interests is attached at Annex (i).

The Audit Committee have reviewed during the year the processes around the declaration of interest and gifts and hospitality and received assurances of the improvements made to system.

NHS England issued new guidance to the NHS in relation to conflicts of interest and there is an expectation that the revised policy should be in place by June 2017. Work is in progress to review the guidance and make the changes to the Trust policy to ensure compliance with this new guidance. Further information is available at:
https://www.england.nhs.uk/ourwork/coi/

Recommendations

Members are asked to:

- **Note** the report; and
- **Receive** the Register for Interest for the Board of Directors for 2017/18.

Intended Audience
(please select any which are relevant to this paper)

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

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

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

Corporate Impact Assessment
(please tick any which are impacted on / relevant to this paper)

Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

N/A

Resource Implications
(please tick any which are impacted on / relevant to this paper)

Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
11 April 2017				

REGISTER OF INTERESTS, GIFTS AND HOSPITALITY POLICY

1. SITUATION

The Board must ensure that the Trust's governors, directors and staff are familiar with the Trust's policy for registering and managing interests, gifts and hospitality. It is essential therefore that there are clear and robust systems in place for identifying and managing real and potential conflicts of interest of governors, directors and staff to protect the reputation and tangible assets of the Trust, as well as the reputation of individual staff.

It is the responsibility of the Audit Committee to monitor compliance with this policy through regular reporting on counter fraud and whistle-blowing, as well as an annual review of the Registers of Interest, Gifts, Hospitality and Sponsorship.

2. BACKGROUND

The Trust must be impartial and honest in the conduct of its business and must ensure that employees remain beyond suspicion at all times. The Register Interests, Gifts and Hospitality is the method by which the Trust safeguards against conflict or potential conflict of interest where private interests and public duties of members of staff do not concur.

The Trust Board of Directors has a legal obligation to act in the best interests of the Trust in accordance with the Trust's governing document, and to avoid situations where they may be a potential for conflict of interest. There is also a requirement for the Trust Board of Directors to adopt appropriate standards of conduct and to be open and transparent in their decision-making and the manner in which conflicts of interests are managed. These obligations are extended to governors, directors and staff.

The Trust Secretary is required to draw up a register of interests declared by staff, members of the Board and governors and to report on this annually in the public part of the Trust Board meeting. The returns will be maintained in a register which will be open for inspection and accessible under the Freedom of Information Act 2000.

3. ASSESSMENT

The Audit Committee have reviewed during the year the processes around the declaration of interest and received assurance of the improvements made to system.

NHS England have issued new guidance to the NHS in relation to conflicts of interest and there is an expectation that the revised policy should be in place by June 2017. Work is in progress to review the guidance and make the changes to the Trust policy to ensure compliance with this new guidance. Further information is available at: https://www.england.nhs.uk/ourwork/coi/

The Board of Directors have reviewed their interests in accordance with the Trust Policy and the Register of Interests is attached at Annex (i).

RECOMMENDATIONS

Members are asked to:

- **Note** the report; and
- **Receive** the Register for Interest for the Board of Directors for 2017/18.

First Name	Surname	Trust Position	Description of Interest	Remunerated	Date of declaration
John	Savage	Chairman	Executive Chairman of Bristol Chamber of Commerce and Initiative Canon Treasurer of Bristol Cathedral Chapter Chairman of Destination Bristol Chairman Learning Partnership West Financial Director Bristol Cultural Development Partnership Limited Director of Price Associates Limited Candidate for Metro Mayor	No No No No No Yes No	11.04.17
Robert	Woolley	Chief Executive	Director of West of England Academic Health Science Network Member of the South of England Local Education Training Board	No No	07.04.2017
Paul	Mapson	Director of Finance and Information	Nil return	N/A	11.04.17
Carolyn	Mills	Chief Nurse	Nil return	N/A	11.04.17
Sean	O'Kelly	Medical Director	Special Advisor, Care Quality Commission	No	10.04.17

First Name	Surname	Trust Position	Description of Interest	Remunerated	Date of declaration
Paula	Clarke	Director of Strategy and Transformation	Nil return	N/A	19.04.2017
Mark	Smith	Chief Operating Officer and Deputy Chief Executive	Nil Return	N/A	22.03.2017
Alex	Nestor	Acting Director of Workforce and OD	Nil Return	N/A	12.04.2017
Emma	Woollett	Non- Executive Director, Vice-Chair	Director and owner of Woollett Consulting Limited, which undertakes advisory work within the NHS including through an associate relationship with KPMG and chairing NHS Provider courses. Avoids conflict conflict with UHBristol role at all times.	Yes	13.04.2017
John	Moore	Non-Executive Director, Chair of Audit Committee	Owner, Home Instead Senior Care, Bristol (first declared July 2015) (Until May 2015 only - Managing Director at Ezitracker Ltd)	Yes	31.03.2016
Lisa	Gardner	Non-Executive Director, Chair of Finance Committee	Interim Finance Director at Above & Beyond Director of and Company Secretary for Watershed Trading Limited & Watershed Trust	Yes No	11.04.2017
Alison	Ryan	Non-Executive Director, Chair of Quality & Outcomes Committee	Nil Return	N/A	11.04.2017

First Name	Surname	Trust Position	Description of Interest	Remunerated	Date of declaration
David	Armstrong	Non-Executive Director	Corporate Function Manager for Business Processes and Assurance, Ministry of Defence	Yes	31.03.2016
Julian	Dennis	Non-Executive Director	Nil return	N/A	11.04.2017
Guy	Orpen	Non-Executive Director	Deputy Vice-Chancellor and Provost Bristol University (2014)	Yes	12.04.2017

Cover report to the Trust Board meeting to be held on 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	20
Meeting Title	Trust Board	**Meeting Date**	Friday, 28 April 2017
Report Title	Register of Seals		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

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

Key issues to note

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

The attached report includes all new applications of the Trust Seal since the previous report on January 2017.
Recommendations
Members are asked to: • **Note** the report.
Intended Audience (please select any which are relevant to this paper)

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

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

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

Impact Upon Corporate Risk
N/A

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

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

Register of Seals –January 2017 April 2017

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
793	03/02/17	Contract Document x2. Provision of sterile services – Handling plant and associated HVAC works.	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
794	03/12/17	Tenancy at Will. Premises on level 8, queens building BRI. UHB and Chapsticks	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
795	09/03/17	Agreement section 278 and deed of indemnity – Old Bristol General Site	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
796	09/02/17	Agreement (under section 278) relating to BGH. City and County of Bristol/ Lloyds Bank/UHB	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
797	03/03/17	Eye Bank Refurbishment Scheme (Levels 1 and 2)	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
798	03/03/17	CT Simulator Project	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary
799	03/03/17	Radiology Department Refurbishment, Queens Building, Level 3	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance	Pam Wenger, Trust Secretary

Cover report to the Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am – 1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	21
Meeting Title	Audit Committee		
Report Title	Chairs Report		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Reporting Committee	Audit Committee
Chaired by	John Moore, Non Executive Director
Lead Executive Director	Pam Wenger, Trust Secretary
Date of last meeting	11 April 2017

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

This report provides a summary of the key issues considered at the Audit Committee on 11 April 2017.

Estates Purchasing Project Group
Members received an update on the project group to ensure effective control of the procure to pay process in Estates. Assurance was provided that the project was progressing well and that it was anticipated that the project would be completed in the next 6 months.

Gifts and Hospitality Register and Register of Interests
Members received the process and flowcharts for the recording of gifts, hospitality and declaration of interests. Members received assurance that the process was clear and that oversight would be undertaken by the Senior Leadership Team.

Counter Fraud
Members received a report in respect of counter fraud activity and received an update on national developments and areas of interest in relation to counter fraud. The key issues included :

- NHS Protect Fraud Self Review Tool (SRT) has been assessed as overall green and submitted; and
- NHS Protect has been subject to a review of its functions and services by the Department of Health (DH). As a result of this and the impact of the comprehensive spending review, NHS Protect was required to change the way in which its services would be delivered. This would have no impact for the Trust.
- The Counter Fraud Work Plan for 2017-18 was approved.

Internal Audit
Members received an update in relation to the audit work completed/currently being undertaken. It was noted that 9 reports have been issued and 4 of those were graded as amber. The amber reports were use of locum doctors, morbidity and mortality review, enhanced observation policy and reporting of sub groups to the Quality and Outcomes

Committee.

- *Use of Locum Doctors:* It was noted that there were some issues identified in relation to the booking of locum doctors and that these would need to be managed by the Temporary Staffing Bureau. An action plan is in place to address the recommendations by September 2017.
- *Morbidity and Mortality Review* – It was noted that since this report the national reporting system had been launched and much of the work would be addressed via the new quarterly reporting. An action plan is in place to address the recommendations by end of April 2017.
- *Enhanced Observation Policy*: It was noted that Trust has established clear controls to ensure Enhanced Observations (EO) are carried out appropriately; however, the policy is not operated in line with the policy consistently throughout the Trust. An action plan is in place to address the recommendations by September 2017.
- *Quality and Outcomes Committee Reporting* – it was noted that this report was at a point in time and since the fieldwork work had been progressed to confirm the reporting arrangements for the respective groups. An action plan is in place to address the recommendations by end of April 2017.

Members received an update on the follow-up from the Estates Review that had taken place in 2015. It was accepted that progress had been made in addressing the recommendations and it was anticipated that the follow-up report would be finalised and considered at the next Audit Committee.

Members received and approved the Internal Audit Plan for 2017/18 – 2019/20 and noted that this has been supported by the Senior Leadership Team.

External Audit Report

Members received the External Audit Report which confirmed that the interim audit had been completed and that there were no significant issues to report.

Board Assurance Framework (BAF) – Quarter 4

Members received and the BAF for assurance before onward consideration by the Board of Directors in April 2017. Members noted that there would be some minor amendments following the Risk Management Group and points of clarification in relation to *Emergency Preparedness, Resilience and Response* (*EPRR*) as this was current reported as partially compliant. The quarter 4 BAF would be reported to the Board.

Corporate Risk Register

Members received the Corporate Risk Register as at the end of March 2017 and noted the scrutiny that had taken place at Risk Management Group. It was noted that the issue in relation to the safe rotas for junior doctors may need to be reviewed.

Risk Management Group

Members received the minutes from the meeting held in January 2017 and an overview of the latest meeting that had taken place in April 2017. Members welcomed receiving the minutes of the Risk Management Group as it demonstrated the comprehensiveness of the agenda and the Group's ability to review and discuss risk issues and to scrutinise the Divisional Risk Registers. It was noted that the Division of Medicine presented their risks at the meeting in April 2017.

Appointment of External Auditors

Members supported the process and recommendation of the External Audit Panel for onward approval by the Council of Governors at the end of April 2017.

Members noted routine assurance reports including:

- Clinical Audit Report
- Single Tender Action
- Losses and Special Payments
- Chair Reports from Finance Committee and Quality and Outcomes Committee. In particular the triangulation between the Audit Committee and the Quality and Outcomes Committee was noted.

Key risks and issues/matters of concern and any mitigating actions	
None identified.	
Matters requiring Committee level consideration and/or approval	
None identified.	
Matters referred to other Committees	
None identified.	
Date of next meeting	24 May 2017

Cover report to the Public Trust Board meeting to be held on Friday, 28 April 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St,

		Agenda Item	22
Meeting Title	Trust Board	**Meeting Date**	28 April 2017
Report Title	Governors Log of Communication		
Author	Kate Hanlon, Interim Head of Governance and Membership		
Executive Lead	John Savage, Chairman		
Freedom of Information Status		Open	

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

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

Executive Summary

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

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

Recommendations
Members are asked to: • **Receive** the report.

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

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

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

Impact Upon Corporate Risk
N/A

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

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

ID	Governor Name		
185	Rashid Joomun	***Theme:*** Clinical Genetics department	***Source:*** Other

Query **20/04/2017**

On a recent walk around with the Division of Specialised Services we visited the Clinical Genetics department at St Michael's Hospital. The location of a maternity hospital as the site for a clinical genetics team is far from ideal and conditions for staff are cramped. Are there any plans for the department to be relocated to a site more conducive to the type of work they do? And furthermore, when will this team benefit from its patient records being available electronically via Evolve?

Division: Specialised Services ***Executive Lead:*** *Medical Director* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

184	Mo Schiller	***Theme:*** Changes to doctors' mess at BRHC	***Source:*** Other

Query **20/04/2017**

Governors are aware of plans to convert the current doctors' mess in the children's hospital into space for another use, and that this has caused concern among doctors working in this hospital. What assurance can governors seek that any proposed changes have been properly assessed and communicated to the doctors involved, and that any proposed alternative space for the doctors mess is fit for purpose?

Division: Women's & Children's Services ***Executive Lead:*** *Medical Director* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

ID	Governor Name		
183	**Mo Schiller**	***Theme:*** Heygroves Theatres	***Source:*** From Constituency/ Members

Query **23/03/2017**

A Foundation Trust member who had surgery in Heygroves Theatres at the end of last year raised with me a concern that the pre-operative area was so cold that she needed to be warmed by a special heat blanket before staff could insert an IV line. I understand that this has been a common problem and am keen to find out why there is an issue with the heating in this area so that it can be resolved for future patients.

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

182	**Bob Bennett**	***Theme:*** Return of NHS equipment	***Source:*** From Constituency/ Members

Query **23/03/2017**

I have been approached by many outpatients regarding the return of NHS equipment such as crutches, walking sticks, commodes etc. as they do not know of any way of returning these items when no longer required. One patient has six walking sticks given to her on many visits to hospital. Can the Trust clarify the process of returning such items for reuse as it is costing the NHS many thousands of pounds in 'lost' equipment.

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

ID	Governor Name		
181	Mo Schiller	***Theme:*** DNAR	***Source:*** Governor Direct

Query **22/03/2017**

Are the executives aware of a pilot study taking place at a small number of trusts to replace DNAR in older or chronically ill patients with RESPECT for the patient/family decision, and would this trust look at making any changes to DNAR following the outcome of this pilot study?

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:***

Response **29/03/2017**

We are aware of ReSPECT and the ReSPECT document was made available in February. As a trust we welcome the opportunity to find out more about ReSPECT from the national working group that was set up in 2015 which represents membership from a wide spectrum of groups. This includes the Resuscitation Council (UK), British Medical Association, Royal College of Nursing, Patient & Public groups, General Medical Council, and Associated Royal Colleges.

ReSPECT stands for Recommended Summary Plan for Emergency Care & Treatment a 'process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.'

The Trust resuscitation group discussed it at the Resuscitation Committee meeting this month and we have expressed our interest in receiving further information from the Resuscitation Council (UK) about the implementation of ReSPECT. We have also liaised with BNSSG to join a small working group as we recognise the importance of collaborative working that will be needed with patients and the wider healthcare community to support the implementation of ReSPECT. The wider healthcare community recognise that this change will take time.

Following this review changes would be made to our DNACPR and TEPP (Treatment Escalation Personalised Plan) processes. However the guidance from the Resuscitation Council recommends that Existing DNACPR forms and TEPP forms will continue to be effective and do not need to be replaced immediately. They recommend that when healthcare communities implement the ReSPECT process there must be a robust plan to ensure that existing DNACPR forms or TEPPs remain valid for a substantial period of overlap. They explain that 'ReSPECT is not just a replacement for a DNACPR form; the aim is to promote recording an emergency care plan by many more people, including many whose ReSPECT forms will recommend active treatment, including attempted CPR if it should be needed.

One of the medical consultant representatives from the Resuscitation Committee is also meeting with me on 12th April to explain ReSPECT in more detail and to look at the how we could introduce ReSPECT at the trust.

We are also aware that the House of Commons Health Select Committee published a report on end-of-life care in 2015 in and the report endorsed the approach that the ReSPECT project had adopted.

Status: *Closed*

ID	Governor Name		
180	**Sue Milestone**	***Theme:*** Welcome Centre	***Source:*** Governor Direct

Query **01/03/2017**

Marks & Spencer and WH Smith in the Welcome Centre are run by WH Smith Motorway Division. How can we assure patients and carers that all the retailers in the Welcome Centre offer the best value for money and range of products? Are the contracts reviewed to ensure pricing and offer is appropriate?

Division: Trust Services ***Executive Lead:*** *Director of Finance* ***Response requested:***

Response **28/03/2017**

The Trust entered into Commercial Lease agreements with each of the retailers in December 2013. As such, there is no legal obligation on the part of the retailer to demonstrate value for money or offer the best range of product. Contracts are not therefore reviewed in relation to pricing and offer.

Pricing and range of products is a commercial decision for each retailer in order to optimise their footfall and turnover. Pricing will involve an element of premium arising from the costs of the lease arrangement in place with the Trust and the convenience offered by the location to staff, visitors and patients.

Status: *Awaiting Governor Response*

179	**Malcolm Watson**	***Theme:*** Staff training	***Source:*** From Constituency/ Members

Query **23/02/2017**

Is any training given or available to staff in respect of communicating with patients who have a disability? This is particularly important in the peri-operation period (pre- and post-op), for example, those with a hearing impairment whose first language may be signing, those with learning difficulties, those with speech disabilities, etc.

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response

Status: *Assigned to Executive Lead*