University Hospitals Bristol NHS Foundation Trust

PUBLIC TRUST BOARD

Meeting to be held on Friday 26th May 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*	22
6	Chief Executives Report	Information	*Chief Executive*	23
Care and Quality				
7	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*	27
8	Quality and Outcomes Committee Chair's Report	Assurance	*Quality & Outcomes Committee Chair*	**To be tabled**
9	Independent Review of Children's Cardiac Services progress report	Assurance	*Chief Nurse*	85
Financial Performance				
10	Finance Report	Assurance	*Director of Finance & Information*	124
11	Finance Committee Chair's Report	Assurance	*Finance Committee Chair*	**To be tabled**
12	Capital Investment Policy	Approval	*Director of Strategy and Transformation*	140
13	Treasury Management Policy	Approval	*Director of Finance & Information*	162

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Governance				
14	NHS Improvement Self Assessment *(General Conditions 6 and 7)*	Approval	*Chief Executive*	190
Items for Information				
15	Governors' Log of Communications	Information	*Chairman*	196
Concluding Business				
16	Any Other Urgent Business	Information	*Chairman*	**Verbal**
17	Date and time of next meeting **29th June 2017, 11:00am -1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU**		*Chairman*	**Verbal**

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Friday, 26 May 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, 26 May 2017
Report Title	Patient Story		
Author	Tony Watkin, Patient and Public Involvement Lead		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

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

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

Executive Summary

Purpose

Patient stories reveal a great deal about the quality of our services, the opportunities we have for learning, and the effectiveness of systems and processes to manage, improve and assure quality.

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

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

Key issues to note

This patient story charts the experience of Christine who, having sustained a broken wrist in April this year, attended the BRI Emergency Department with subsequent visits to the fracture clinic.

Christine will reflect on the quality of both the clinical and non-clinical care provided in the Emergency Department including the personal qualities of the staff which made her feel valued and re-assured. Christine will explain how the team responded to her needs and how this "competent, expert care and treatment" continued in the Fracture Clinic where she received a reassuring demonstration of how the cast cutter worked – allaying fears that were heightened by conversations amongst other patients in the waiting room. In contrast, Christine will talk about the importance of reflecting this level of nuanced care upon arrival at the BRI Welcome Centre and the importance of this first point of "customer care" contact for many patients.

In referring to an experience elsewhere, Christine will draw comparisons which illustrate the detrimental impact a poor patient experience had on her confidence in how a service is run and her subsequent engagement in that service.

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
Jill Youds	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
Tony Watkin	Patient and Public Involvement Lead (for Item 3)
Mike Deane	Health Care Change Maker (for Item 3)
David Wynick, Consultant	Director of Research (for Item 8)
Hamish Hewitt	FEE Governance Officer (Member of the Public)
Rebecca Lambert	Pre-reg pharmacist at UHB
Jeanette Jones	JUC Governor Lead
Sue Sulvey	Public Governor
Fiona Reid	Head of Communication
Rashid Jooman	Patient Governor
Ray Philpps	Public Governor
Mo Schiller	Public Governor
Malcom Watson	Public Governor
Angelo Micciche	Patient Governor
Florene Jordan	Staff Governor
Garry Williams	Patient Governor
Kathy Baxter	Patient Governor
Graham Briscoe	Public Governor
Pauline Beddoes	Public Governor

Minutes:

Zainab Gill	Corporate Governance & FOI Administrator

The Chair opened the Meeting at 11:00am

Minute Ref	Item Number	Action
59/04/17	**1. Welcome and Introductions**	
	The Chairman welcomed everyone to the meeting. Apologies were noted from David Armstrong and Pam Wenger.	
60/04/17	**2. Declarations of Interest**	
	There were no declarations of interest.	
61/04/17	**3. Patient Experience Story**	
	The meeting began with a patient story, introduced by Carolyn Mills Chief Nurse. In this story the Board heard about Mike Deane's story which explored 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.	

Minute Ref	Item Number	Action
	The Board were moved by Mike Deane's story and thanked him for attending. The Board discussed diagnosis of long term conditions and considered whether they were providing appropriate information when a long term diagnosis is made and before the patient's next clinician visit. The Board were in agreement that although they provided further information to patients about their condition on an ad-hoc basis it was an area where the Trust needed to improve and ensure that all information provided is relevant and easily accessible. **Members RESOLVED to:** • **Receive** the patient story.	
62/04/17	**4. Minutes of the last meeting**	
	The minutes of the meetings held on the 30h March 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 30th March 2017.	
63/04/17	**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.	
64/04/17	**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: The Board were saddened to hear about the death of professor Peter Wells, who had started his career in the Trust and had pioneered the early development of ultra sound as a diagnostic tool in medicine. <u>Bristol to Paris</u> Robert Woolley reported to the Board that cyclists had departed from the front of the BRI on the Above and Beyond Bristol to Paris cycle challenge. Including Trust staff, local business and members of the public, in an attempt to raise money for the Trust's charity Above and Beyond. The Board wished them well on their journey.	

Minute Ref	Item Number	Action
	Sustainability and Transformation Partnership (STP) Robert Woolley confirmed to the Board that they had now received the NHS England Five Year Forward View Next Steps emphasising the continuation of the original national strategy and the central importance of Sustainability and Transformation Partnership to its implementation. The Board were advised that the Trust and its Partners were consistent with the requirements of the 5 Year Forward View and the Board would continue to receive updates on working arrangements. The Board noted that some STP footprints had been put into the "capped expenditure process" which meant that NHS Regulators, were concerned about the affordability of Commissioner and Provider plans in a given area. NHS England had requested a further local submission to identify any additional savings that could be made to ensure that the plans taken together are affordable. Robert Woolley confirmed that the three local CCGs would lead the process and any submissions to NHS England. The Board were made aware of the potential financial risks for the Trust and that the Trust was supporting this process as necessary. It was agreed that an update would be provided to the Board in due course. Global Digital Exemplar funding Robert Woolley reported to the Board that the Trust had been advised received Treasury approval for the Global Digital Exemplar funding, following the Trusts prior selection to be one of 16 Exemplars, which had been subject to the Trust meeting the requirements. The Trust had been offered £10 million which they had to match. The funds had now been agreed and would be released by the Treasury early this financial year. The Board noted that the Trust was now able to move forward with their plans and the Board would receive reports in relation to this, in due course. The Board congratulated the Trust on its achievement and formal thanks was noted to all staff, especially the Informatics Team who had worked partially hard in ensuring that the Trust met the requirements. **Members RESOLVED to:** • **Receive** the Chief Executive report for information.	
65/04/17	**7. Board Assurance Framework 2016/17 (Quarter 4)**	
	Members received the Board Assurance Framework setting out the key risks to delivery of the Trust's strategic objectives. There were no changes of significance to note. The Board noted that the Board Assurance Framework had been reviewed in detail in sub-groups, prior to submission to Trust Board.	

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Receive** the Board Assurance Framework 2016/17 (Quarter 4) for assurance.	
66/04/17	**8. Research and Innovation Report**	
	Sean O'Kelly presented this report, David Wynick attending the meeting to help provide clarity on any questions the Board may have. The paper provided an update on performance and governance for the Board. Highlights from the report were as follows: - The Trust had continued 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 their league. In order to maintain performance, project work was underway within Research & Innovation with relevant research teams to review and streamline and set up activities. - Following on from the Trust's focussed efforts to increase performance of their trials recruiting patients to time and target, there had been a further improvement for closed commercial trials achieving 47% (from 40% previous quarter). This placed the Trust at 17/22 in their league. - The Trust had received funding allocation from the West of England Clinical Research Network. There had been a 2% cut in this, but alongside this the Trust had received a small increase in research capability funding, which allowed for stability in 2017/18. - The NIHR Biomedical Research Centre had now commenced (start date 1st April 2017). The contract had been signed and the partnership agreement was in preparation. Initial appointments were under way. Julian Dennis queried benchmarking against other Trusts and accepted that not all aspects of Research and Innovation could be benchmarked due to variations between Trusts. David Wynick confirmed that table 1 in the report on page 1, provided details on areas that the Trust could benchmark against and their performance in these areas. Guy Orpen asked for more information around strategy development in this area and how this was being approached. David Wynick explained that a paper would be brought to the next Board Seminar meeting and	

Minute Ref	Item Number	Action
	that the Trust was now in a position to bid/apply for more complex tenders. Guy Orpen queried the Collaborations for Leadership in Applied Health Research (CLAHRC) which would soon be up for re bid and asked whether the Trust had begun preparing for rebidding for this tender. David Wynick confirmed that the Trust was in full preparation for rebidding and would be focussing on implementation, public health and prevention. He further confirmed that until the formal paperwork is received the Trust was not in a position to proceed. *David Wynick left the meeting* *Lisa Gardner left the meeting* **Members RESOLVED to:** • **Receive** the Research and Innovation Report for assurance.	
67/04/17	**9. Trust Art Strategy**	
	Robert Woolley presented this paper to the Board for approval. He explained that the report articulated the case for development of a Trust arts strategy. It was 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. The Trust has recognised the importance of incorporating art into its physical environment, which had proven to have a positive effect on clinical outcomes and there was evidence to suggest the improvement in patient doctor relationships. The Board were advised that in 2016, a sub-group of the Senior Leadership Team was formed called the Image, Design, Environment and Arts Reference Group. Working with Above and Beyond, the group has researched the approach to the arts taken by other Trusts and had supported the proposition that a Trust arts strategy be formally commissioned by the Board, as set out in the paper, to guide the development of a wide-ranging programme of arts activities. Informal discussions with Above and Beyond had 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 would be pursued. As a rule, the Trustees would not fund recurrent staffing costs.	

Minute Ref	Item Number	Action
	The Board welcomed the paper and the particular focus on patient participation and not just the image and decoration. The Board were pleased with the strategy described in the report and its potential positive effects on patient care. **Members RESOLVED to:** • **Receive** the report ; and • **Support** 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.	
68/04/17	**10. Quality and Performance Report**	
	Mark Smith, Chief Operating Officer and Deputy Chief Executive presented this report, It was noted that 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. *Members noted:* • 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. Mark Smith explained that performance continued to be materially impacted by external late referrals made to the Trust. The Board noted that the implementation of a new policy of "day 38" in April 2017 had not happened nationally. The national implementation date is still to be confirmed but when in place this would mean that any referrals made by another provider after day 38 would result in the breach being reallocated in full to the referring organisation if UH Bristol treated the patient within 24 days of receipt. The Board were advised that NHS Improvement had scheduled a meeting with all organisations to help try to implement this policy locally. • 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 number of patients on the new outpatient waiting list stayed similar to last month despite a sharp rise in referrals to outpatients.	

Minute Ref	Item Number	Action
	The rise in demand, which was across all sources of referrals, was offset by increased attendances in the period. The Board noted that a recovery plan was being worked on and would be brought to the Quality and Outcomes Committee in May 2017. Mark Smith advised that compared nationally the Trust's RTT position was stable as there was an on-going decline nationally in this target. • The Committee noted the ongoing risks to restoring achievement of the 6-week wait for a diagnostic test, due to increased demand for Cardiac CT scans in February and March. Mark Smith confirmed that Owen Ainsley, the divisional director for this area, would be investigating this further. • 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 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. • 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. • 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. • 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. • 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. The Board noted that the Quality and Outcomes Committee had received assurance in relation to the fractured neck of femur target. Sean O'Kelly highlighted the time to treatment had slightly improved.	

Minute Ref	Item Number	Action
	Sean O'Kelly provided a brief update in relation to the WHO surgical checklist compliance, which had been showing as red on the dashboard since introducing the Bluespier system. He advised that he had investigated this issue at Heygroves Theatre and found two issues which were having an impact on the target; one relating to cancelation recordings on Bluespier and the other relating to non- recording on Bluespier of the WHO surgical checklist. He assured the Committee that the division had been completing the checklist, however this was not being reflected on Bluespier. the division had appointed a Bluespier trouble shoot coordinator to help **Members RESOLVED to**: • **Receive** the Quality and Performance Report for assurance.	
69/05/17	**11. Quality and Outcomes Committee Chair's Report**	
	Members received a written report following the meeting of the Quality and Outcomes Committee held on the 26th April 2017. Members also received a verbal account of the meeting held on the 26th April 2017 from Alison Ryan, Non-executive Director and Chair of the Quality and Outcomes Committee (QoC), covering the following key areas: - The Committee discussed the Trust's performance in relation to the 7 day mortality and emergency recall, it was noted that the Trust' statistics are in line with national averages , however there are many complexities in the figures and the Quality Intelligence Group was seeking to understand them better. - The Committee had received an update on progress against the 19 recommendations arising from the British Orthopaedic Associate Review in May 2016, reviewed a detailed fractured neck of femur performance report providing assurance to members on the ongoing work to increase productivity of trauma theatres and ensure that time to surgery is delivered within agreed clinical standards. The Committee were assured of the importance being given to the issue by the Division and that the Clinical leadership understood the underlying factors and were addressing them. It agreed a further review in 6 months. - The Committee had reviewed two serious incidents; one related to a patient fall and one the recognition of a deteriorating patient. There were no trends in the serious incidents, however that they related to human error.	

Minute Ref	Item Number	Action
	- The Committee received for assurance the four action plans submitted to the Care Quality Commission (CQC) following the Trust's inspection in November 2016. - The Committee received assurance on the proposed amendments to the key performance indicators (KPIs) used to monitor Trust's performance across quality, access and workforce domains of Trust business and that an improvement had been made in all KPI's. Jill Youds asked for assurance in terms of the e-appraisal system and how receptive and engaged staff were towards the new system. Alex Nestor provided assurance in terms of the involvement from staff across the Trust in the development of the policy and process. Alex Nestor confirmed that the second part of the phase would help to measure the quality of the system and succession planning. Emma Woollett asked a question in relation to histopathology and whether the additional levels of weekend working were in the original agreement. Mark Smith advised that weekend working was not a part of the original agreement, and was extra work that had been offered by clinicians to help support additional cases. **Members RESOLVED to**: • **Receive** the Quality and Outcomes Committee Chair's Report for assurance.	
70/04/17	**12. Independent Review of Children's Cardiac Services progress report**	

Minute Ref	Item Number	Action
	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 service published on 30 June 2016. The key highlights from the report were that the April 2017 Steering Group approved the closure of twelve recommendations, which were: • recommendation 9 • recommendation 11 • recommendation 12 • recommendation 13 • recommendation 14 • recommendation 16 • recommendation 21 • recommendation 27 • recommendation 28 • CQC action 1, 4 and 5 action 5 The Board were pleased to note the progress on the report and looked forward to receiving assurance that all actions would be completed by June 2017. **Members RESOLVED to:** • **Receive** the Independent Review of Children's Cardiac Services progress report.	
71/04/17	**13. Finance Report** **(The Board agreed to take questions for item 13 and 14 together.)**	
	Paul Mapson, Finance Director presented the Finance Report at month 12. The position as reported in the papers had changed as a result of additional "incentive" and "bonus" sustainability and transformation funding allocated of £1.564m to the Trust as notified by NHS Improvement on the 24 April 2017. The revised summary income and expenditure statement reported a net surplus of £16.606m (before technical items) at the year-end compared with the control total of £15.900m. This position includes £13.670m sustainability and transformation funding. The net position excluding sustainability and transformation funding, is a surplus of £2.936m compared with a plan of £2.900m. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	

Minute Ref	Item Number	Action
72/04/17	**14. Finance Committee Chair's Report**	
	Members received reports from the meetings of the Finance Committee held on 25th April 2017. Members also received a verbal account of the meeting held on the 25th April 2017 from Jill Youds Non-executive Director covering the following key areas: - The Committee had congratulated the Trust on its financial position at year end. - The Committee were pleased to note the 93% achievement of the Trust's CQUIN income target which contributed an additional £1.0m income. - The Committee had begun to plan for the year ahead and had begun to consider summer planning and ensuring there is appropriate cover during the summer period. - The Committee had received the Divisional Financial Reports and in particular had reviewed the Women and Children's activity to help them deliver their performance this year. - The Committee had received an analysis showing the delivery of savings since 2013/14 until 2016/17.The analysis confirmed that clinical Divisions have traditionally delivered 80% of the savings targets and carried the undelivered targets into the next financial year. - The Committee received an update in relation to the Trust's contract and activity income and noted that contract income was £0.022m lower than plan in March and is £2.023m lower than plan for the year. - The Committee had received a summary of a recent report from NHS Improvement on Corporate Services. The report showed how the Trust's corporate services benchmarked against other similar acute Trusts. Procurement was noted as one area which benchmarked as low cost and this would be addressed by the procurement strategy due mid 2017. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's report for assurance	
73/04/17	**15. Transformation Care Programme Report**	

Minute Ref	Item Number	Action
	Members received the report, introduced by Robert Woolley, which updated the Board on progress with Trust-wide programmes of work under the Transforming Care programme. The Highlights from the report included : - 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. - In support of our Quality Strategy, the Trust has been developing methods to promote innovation and to make improvement a part of everyone's work. In support of this the Trust has launched a Quality Improvement Academy to make training in improvement skills available to all staff. - A programme to define and embed principles of customer service supports the quality strategy and quality improvement priorities for 2017/18 and aims to help build on the Trust's "Outstanding" CQC rating. - Making better use of IT is increasingly embedded into all of the Trusts programmes of work as a key enabler. The Global Digital Exemplar (GDE) programme gives the Trust an opportunity to accelerate this work. Through GDE we will be introducing new IT tools and devices into many clinical areas, and the opportunity is to use this to accelerate and embed transformational changes in ways of working. Alison Ryan asked a question in relation to follow up outpatient appointments which had been discussed in the recent Quality and Outcomes Committee and innovative ways to use technology in sophisticated to follow ups. Robert Woolley advised that follow ups are benchmarked and the Trust performs well against similar organisations but that this approach was a part of the STP. John Moore asked whether the transformation team were involved in working with clinical teams and external organisations to ensure they are discharging patients appropriately. Robert Woolley advised that the Trust was addressing this issue and was working on this with community organisations, under the "flow academy programme" which had been designed to help organisations work together on discharging patients appropriately.	

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Receive** Transformation Care Programme Report for assurance**.**	
74/04/17	**16. Emergency Preparedness, Resilience and Response Annual Report**	
	Mark Smith presented this report, which highlight the Trust's position in relation to emergency preparedness, resilience and response over the past 12 months. The Board noted that between April 2016 and March 2017 the Trust had moved to being partially compliant with the NHS England Core Standards for Emergency Preparedness, Resilience and Response from a position of non-compliance previously. The Board were pleased to further note that the report provided an overview of this position and the work programme to move to full compliance over the forthcoming year. Julian Dennis highlighted the importance to focus on the evacuation plan. Mark Smith assured the Board that this would be picked on in due course. **Members RESOLVED to:** • **Receive** the report for assurance.	
75/04/17	**17. Annual Operating Plan Update**	
	Paula Clarke, presented this report. She reminded the Trust Board that the Board had approved the two year Operational Plan on 22nd December 2016 and the 30th March 2017. These changes and other less material updates had been incorporated into the full version of the Operational Plan, ensuring that the Trust had a full and final version reflecting the latest submitted position for 2017/18-2018/19. The Board were asked to approve the revised version of the full Operational Plan, noting that this will support the Trust to publish their Plan in line with best practice. **Members RESOLVED to:** • **Receive** the Annual Operating Plan Update; and • **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.	
76/04/17	**18. Annual Review of Code of Conduct for Board of Directors**	

Minute Ref	Item Number	Action
	(including Fit and Proper Persons Self Certification)	
	The report contained 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 provided assurance that all members of the Board have signed the annual declaration of compliance with these standards. **Members RESOLVED 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.	
77/04/17	**19. Annual Review of Directors Interests**	
	Robert Woolley presented this report to the Board. He explained that the Board of Directors had reviewed their interests in accordance with the Trust Policy. The Board noted that the Audit Committee had reviewed during the year the processes around the declaration of interests and gifts and hospitality and received assurances of the improvements made to system. The Board further noted that 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. **Members RESOLVED to:** • **Note** the report; and • **Receive** the Register for Interest for the Board of Directors for 2017/18.	
78/04/17	**20. Register Of Seals**	
	Members received the report of all applications of the Trust Seal since the previous report in January 2017. There were no comments or questions. **Members RESOLVED to:** • **Receive** the report.	
79/04/17	**21. Audit Committee Chairs Report**	
	Members received reports from the meetings of the Audit Committee held on the 11th April 2017.	

Minute Ref	Item Number	Action
	Members also received a verbal account of the meeting held on the 11th April 2017 from John Moore, Non- Executive, Chair of the Audit Committee covering the following key areas: - The Committee had 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. - The Committee had received an update on the internal audit report relating to Quality and Outcomes Committee (QoC) and the information received by the QOC, highlighted triangulation between sub committees and the Board. **Members RESOLVED to:** • **Receive** the Audit Committee Chairs Report for assurance	
80/04/17	**22. 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.	
81/04/17	**23. Any Other Business**	
	There was no other business to discuss at the meeting.	
82/04/17	**24. Date of Next Meeting**	
	26th May 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 April 2017
Action tracker

Completed actions following meeting held April 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	**Completed**

Cover report to the Public Trust Board meeting to be held on Friday, 26 May 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**	26 May 2017
Report Title	Chief Executive Report		
Author	Sean O'Kelly, Medical Director		
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 May 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 – MAY 2017

1. INTRODUCTION

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

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **received** an update on the financial position for 2017/2018.

The group **agreed** an approach to communicate and brand the Care Quality Commission Outstanding rating.

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 Women's and Children's and Trust Services.

The group **approved** the Annual Quality Report 2016/2017 for onward submission to the Trust Board.

The group **agreed** a Leadership Behaviours and Expectations Framework and to the development of a roll-out plan.

The group **agreed** the proposal that a project be initiated to develop a 5 – 10 year UH Bristol Strategic Workforce Planning Framework.

4. RISK, FINANCE AND GOVERNANCE

The group **approved** the proposed response to NHS England proposals for Congenital Heart Disease Services.

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

The group **supported** a proposal and actions required to implement Freedom to Speak Up Staff Advocates.

The group received and **noted** an assurance report and action plan regarding estates maintenance and risks/business continuity plans at the Bristol Children's Hospital.

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

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

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.

Sean O'Kelly
Medical Director
May 2017

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Friday, 26 May 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**	26 May 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)**
		23rd May 2017		

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

May 2017

Executive Summary

Performance against the national access standards was more mixed this month, with evidence of improvement in some areas, but some significant challenges remaining in others. Whilst performance against the 92% Referral to Treatment (RTT) time standard remained the same in percentage terms, both the total number of ongoing pathways and the number of patients waiting over 18 week decreased, with reported performance of 91.1% above the recovery forecast of 90.9%. Performance against the 62-day GP cancer standard also improved and was above the 85% national standard for internally managed pathways. Final reported performance for quarter 4 exceeded national average performance, as it did in quarter 3. Overall performance against the diagnostic 6-week waiting times standard was below that of March, although there was a significant reduction in the number of over 6 week waiters for Sleep Studies. Disappointingly, performance against the A&E 4-hour standard continued to be below the new in-month performance trajectory. 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.

There was a slight rise in the number of patients on the new outpatient waiting list, in the main due to the shorter working month. However, encouragingly, the number of patients on the elective waiting list fell slightly in April, following three consecutive months of the waiting list rising. The total number of ongoing RTT pathways fell by just over 2000 pathways, with a fall in the over 18 week waiters by 186, which means that a sizeable volume of demand has been met in the month. However, the elective waiting list remains larger than the same period last year and continues to put 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 the high demand for Cardiac CT scans for which a sustainable capacity solution needs to be put into place.

The overall level of emergency admissions into the Bristol Children's Hospital (BCH) fell in April relative to the same period last year. This led to an improvement in 4-hour performance at the BCH, with the 95% A&E 4-hour standard being achieved for the first time since August 2016. Whilst there has been a slight rise in the level of emergency admissions via the Bristol Royal Infirmary (BRI) Emergency Department (ED), the overall level of emergency admissions into the BRI fell in April, relative to the same period last year. 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 remains high relative to the last two years. This is despite the percentage of emergency admissions for patients aged 75 years and over, which is a proxy for patient acuity, being below the level seen in the previous two years, for two consecutive months. The number of days patients spend outlying from their correct specialty ward remained low in April. This may in part explain why flow out of the ED, and hence 4-hour performance, is worse than expected for the level of demand, 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 the quality of care patients receive, and will in time decrease length of stay.

There were no significant changes in performance against the headline measures of quality that sit within the Trust Summary Scorecard in the month. 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 sustained reduction in outlier bed-days, another noteworthy improvement in measures of quality in the period was a further month of 100% compliance against the NEWS deteriorating patient indicator. Performance against the metrics

related to the management of patients who have sustained a fractured neck of femur fell below the level seen in the previous two months. Performance against these metrics continue to be the focus of significant attention.

This month there has been a further improvement in a number of the workforce metrics, including agency rates, which is now Green rated. Levels of staff sickness have, encouragingly, shown a further decrease this month and maintained a Green rating. 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 system risks which impact on patient flow, workforce indicators and 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. April for A&E, RTT and 6-weeks and March 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, as it was in March. However, the recovery trajectory of 90.9% was met. Although the 85% national standard for 62-day GP cancer was not met in March, 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 have informed the latest revision of the Trust's urgent care plan.

Access Key Performance Indicator		Quarter 3 2016/17			Quarter 4 2016/17			Quarter 1 2017/18		
		Oct 16	Nov 16	Jan 17	Feb 17	Mar 17	Dec 16	Apr 17	May 17	Jun 17
A&E 4-hours	Actual	82.9%	78.5%	79.6%	80.4%	80.7%	83.3%	82.3%		
	STF trajectory	93.3%	90.0%	89.3%	88.5%	87.4%	91.0%	82.5%	83.5%	85.0%
62-day GP cancer	Actual	79.5%	85.2%	81.5%	84.3%	78.8%	81.2%			
	STF trajectory*	85.0%	85.1%	86.9%	83.6%	85.7%	85.9%	81.0%	81.0%	81.0%
Referral to Treatment Time (RTT)	Actual	91.2%	92.0%	92.0%	92.2%	92.0%	91.1%	91.1%		
	STF trajectory*	93.4%	93.4%	92.8%	92.8%	92.8%	93.0%	92.0%	92.0%	92.0%
6-week wait diagnostic	Actual	98.9%	99.0%	98.2%	98.4%	98.7%	98.7%	98.6%		
	STF trajectory*	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.0%	99.0%	99.0%

*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:

RED to GREEN:

- Agency

RED to AMBER:

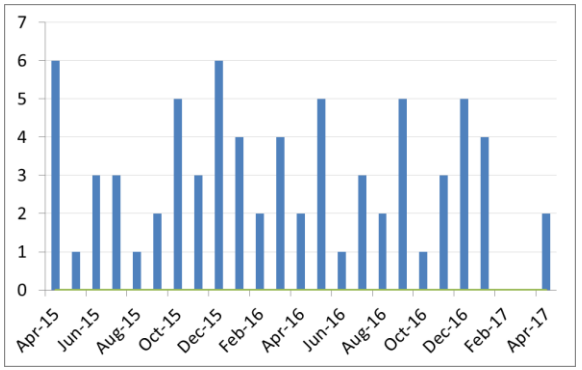
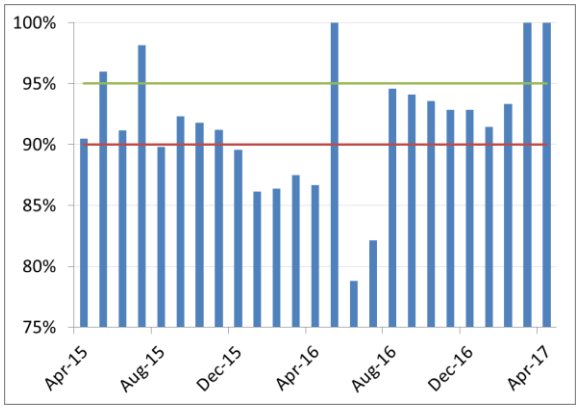
- Referral to Treatment Times

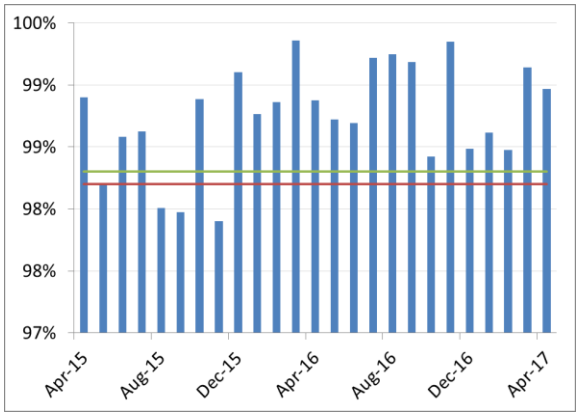
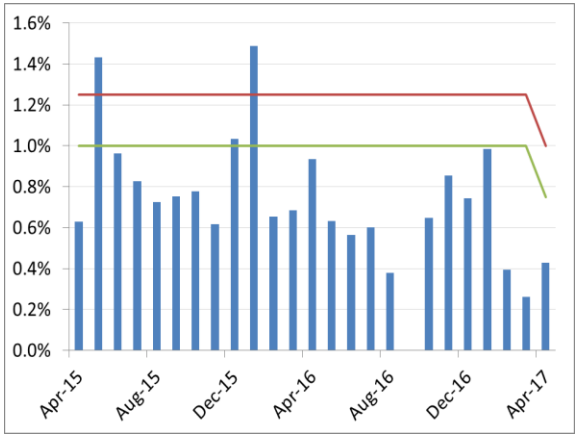
Please note: the Outliers indicator has been left as having a GREEN rating because although a target is still to be agreed performance remains better than that reported in March 2017.

Overview

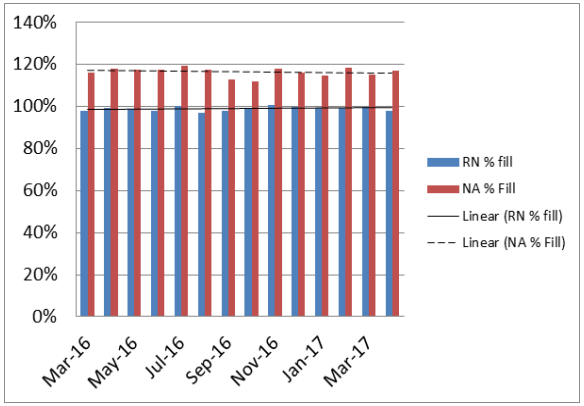
The following summarises the key successes in April 2017, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 1 2017/18.

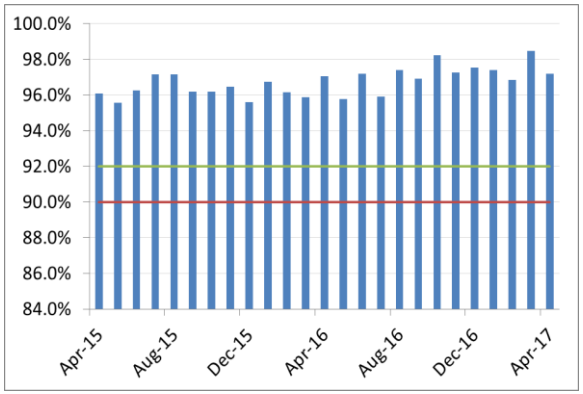
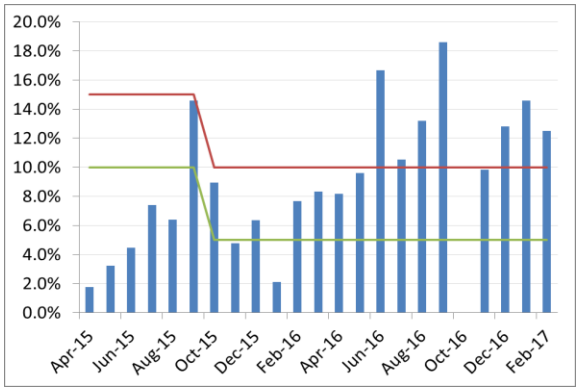
Successes	Priorities
• There was 100% (27/27) compliance with NEWS for deteriorating patients, acted upon in April 2017. This is second consecutive month that the 95% improvement goal has been achieved; • There were in-month reductions in sickness absence, turnover, vacancies and agency usage, and three out of five workforce KPIs for April were rated green, two amber and none were red; • Achievement of the A&E 4-hour 95% standard at the Bristol Children's Hospital for the first time since August 2016; • Although the 92% Referral to Treatment Time (RTT) standard was not achieved, the number of over 18 week waiters fell in the month, with performance ahead of trajectory.	• Understanding and acting upon the reasons for the slight reduction in VTE risk assessments and thrombo-prophylaxsis in relevant divisions; • The focus on the reduction of turnover, agency usage and sickness absence continues to be 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 May and June; • Sustain performance against the 62-day GP cancer waiting times standard above the national average during quarter 1; • Recovery of performance against the 6-week diagnostic waiting times standard by the end of September, with incremental improvement each month.
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.	• In April 2017 the Complaints Responded to within Trust Timeframe performance figure was 56.3% (29/38). This is the lowest reported figure since May 2016; • In April 2017 there was one MRSA bloodstream cases reported. The monthly set target is zero reported cases; • The reduced levels of sickness absence, agency and turnover agreed as workforce targets as part of the 2017/18 operating planning cycle will be challenging to sustain; • Ongoing patient flow 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 is above the normal seasonal level; • 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 May due to a doubling of demand and a current inability to establish enough ad hoc capacity to meet this.

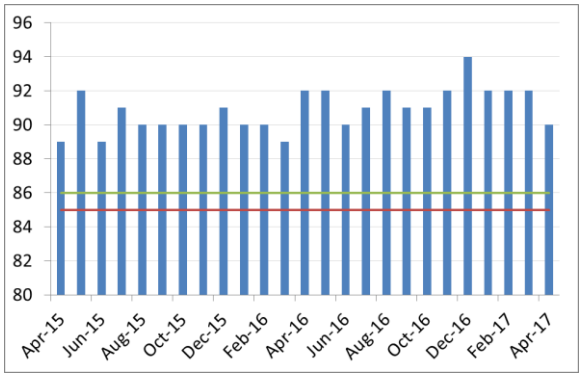
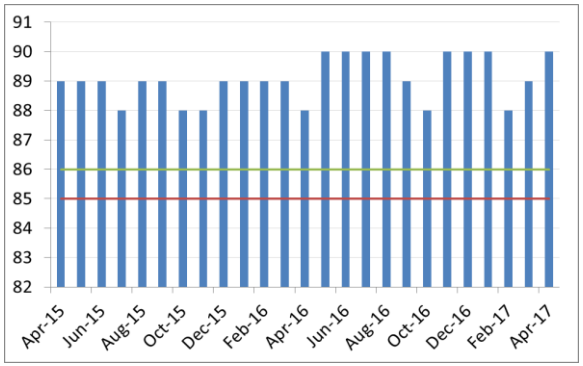
Description	Current Performance	Trend	Comments
Infection control The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16).	There were two cases of *Clostridium difficile* (C. diff) attributed to the Trust in April 2017.	**Total number of C. diff cases**  A total of 2 cases (unavoidable + avoidable) have been reported in the year against a limit of 45 for April 2017 to March 2018.	The annual limit for the Trust for 2017/18 is 45 avoidable cases. The monthly assessment of cases continues with the Clinical Commissioning Group (CCG). At the end of April, the Trust had two cases of *Clostridium difficile* awaiting assessment by the CCG.
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 April 2017 was 100% against a three-year improvement goal of 95%. This maintains the position reported in March of 100%.	**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 April 2017, the percentage of patients with no new harms was 99% (8 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 April 2017 Safety Thermometer point prevalence audit showed five new catheter associated urinary tract infections, one fall with harm, one new pressure ulcer and two 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 April 2017, 0.43% of patients reviewed (4 out of 930) had one or more omitted critical medications in the past three days. The target for omitted doses is no more than 0.75%. The 0.43% for April 2017 is a slight deterioration from the March 2017 figure of 0.26% (3 out of 1148).	**Percentage of omitted doses of listed critical medicines** 	The target for omitted doses in 2017/2018 has been revised and is now set at 0.75% (previous target was 1%). The Trust achieved this revised target in April 2017. Actions being taken are described in the actions section (Actions 2A and 2B)

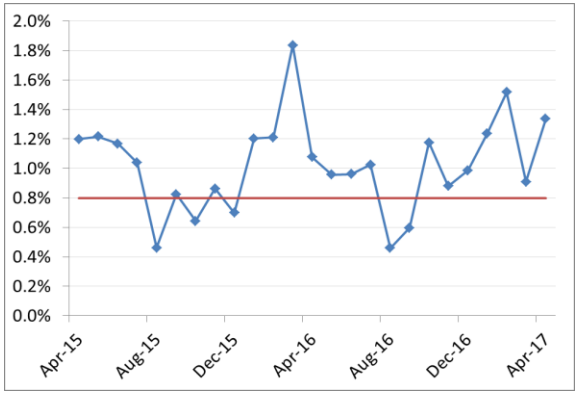
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Overall compliance is 87% (excluding Child Protection Level 3). Compliance with each of the reporting categories is provided below.
<table>
<tr><th>April 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>82%</td></tr>
<tr><td>Annual (IG)</td><td>75%</td></tr>
<tr><td>Induction & Orientation</td><td>98%</td></tr>
<tr><td>Induction & Orientation (Medical & Dental)</td><td>42%</td></tr>
<tr><td>Resuscitation</td><td>75%</td></tr>
<tr><td>Safeguarding</td><td>90%</td></tr>
</table>
</td>
<td>Divisional action plans are in development to achieve 90% for Safeguarding, Resuscitation, and Fire Safety and 95% for Information Governance.</td>
<td>This month overall compliance has reduced as a result of changes in reporting to include Dementia Awareness and changes in Resuscitation requirements.

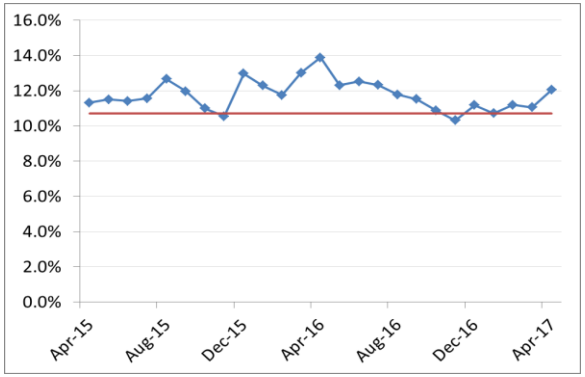
Performance against trajectories and targets for Fire and Information Governance are included in appendix 2.</td>
</tr>
<tr>
<td>Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.</td>
<td>The report shows that in April 2017 the Trust had rostered 215,914 expected nursing hours, with the number of actual hours worked of 222,883. This gave a fill rate of 103%.*
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>64,188</td><td>56,401</td><td>+7,787</td></tr>
<tr><td>Specialised Services</td><td>38,162</td><td>39,093</td><td>-930</td></tr>
<tr><td>Surgery Head & Neck</td><td>44,425</td><td>40,992</td><td>+3,433</td></tr>
<tr><td>Women’s & Children’s</td><td>76,107</td><td>79,428</td><td>-3321</td></tr>
<tr><td>Trust</td><td>222,883</td><td>215,914</td><td>+6,968</td></tr>
</table>
* This figure does not match the figure in the dashboard (which is the Unify return), the latter being due to an issue in some areas following a change in e-rostering systems.</td>
<td>The percentage overall staffing fill rate by month
 
</td>
<td>Overall for the month of April 2017, the Trust had 97% cover for Registered Nurses (RN) on days and 99% RN cover for nights. The unregistered level of 114% for days and 121% for nights reflects the activity seen in April 2017. This was due primarily to Nurse Assistant specialist assignments to safely care for confused or mentally unwell adult patients, particularly at night. Close monitoring continues (Action 4).</td>
</tr>
</table>

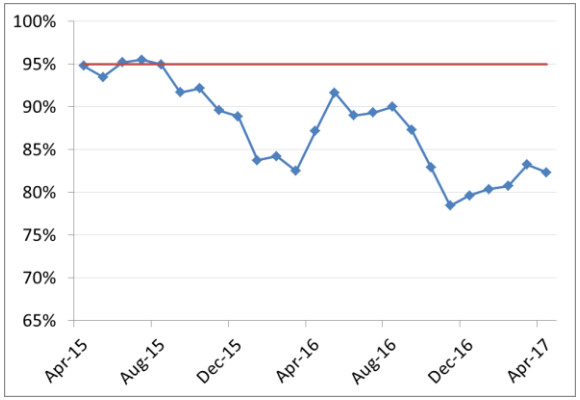
Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for April 2017 was 97.2%. 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.	Dissatisfied cases are now measured as a proportion of complaints sent out in any given month and are reported two months in arrears. This means that the latest data in the board dashboard is for the month of February 2017. Performance for February was 10.0% against a target of 5%. As of 17th March 2017, 4 of the 40 responses sent out in February had resulted in dissatisfied replies.	**Percentage of compliantaints dissatisfied with the complaint response each month** 	Our year to date performance for 2016/17 is 11.31% (reported in arrears), compared with 9.1% for 2015/16 (as reported in the Trust's Annual Quality Report. Informal Benchmarking with other NHS Trusts suggests that the rates of dissatisfied complainants are typically in the range of 8% to 12%. Actions continue as previously reported to the Board (Actions 5A to 5E).

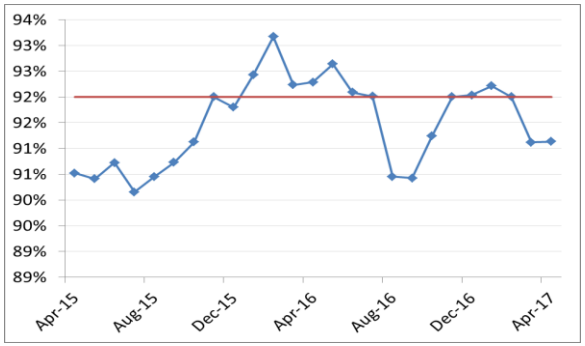
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as “key drivers” of patient satisfaction via analysis and focus groups.</td>
<td>For the month of April 2017, the score was 90 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 90 in April 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>

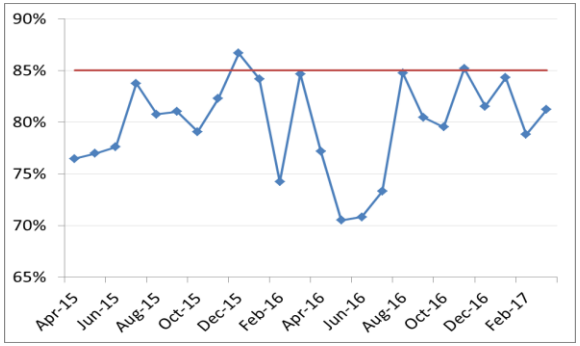
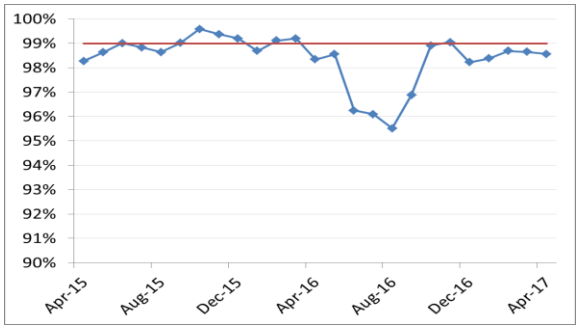
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In April the Trust cancelled 80 (1.34% 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 ward bed available</td><td>25 (31%)</td></tr>
<tr><td>Surgeon ill/unavailable</td><td>13 (16%)</td></tr>
<tr><td>No HDU/ITU/CICU bed available</td><td>11 (14%)</td></tr>
<tr><td>Emergency patient prioritised</td><td>10 (13%)</td></tr>
<tr><td>Equipment failure</td><td>7 (9%)</td></tr>
<tr><td>Other causes (6 reasons)</td><td>14 (18%)</td></tr>
</table>
Four patients cancelled in March were readmitted outside of 28 days. This equates to 93.7% 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
 

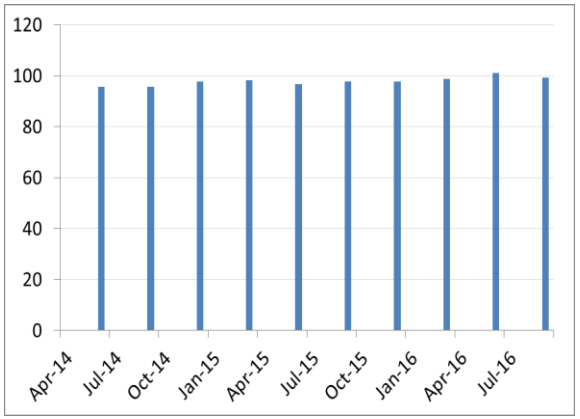
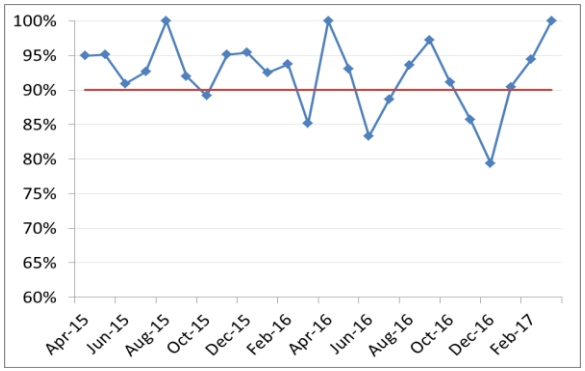
The national 0.8% standard is currently not forecast to be met in May due to continued high bed occupancy levels.</td>
<td>Emergency pressures continues to be the predominant cause of cancellations, with ward and critical care bed availability, and emergency patients needing to be prioritised, making-up 58% of all cancellations. However, there were more potentially avoidable causes of cancellations in April than seen in previous month. 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 April 12.0% of outpatient appointments were cancelled by the hospital, which is above the Red threshold of 10.7%. This is a 0.9% increase on last month. The level of cancellation remains lower than the same period last 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 has been refreshed for 2017/18, prioritising those actions that are likely to reduce the current underlying rate of cancellation by the hospital. These actions are based upon our current analysis of the causes of cancellations (Actions 7A to 7D).</td>
</tr>
</table>

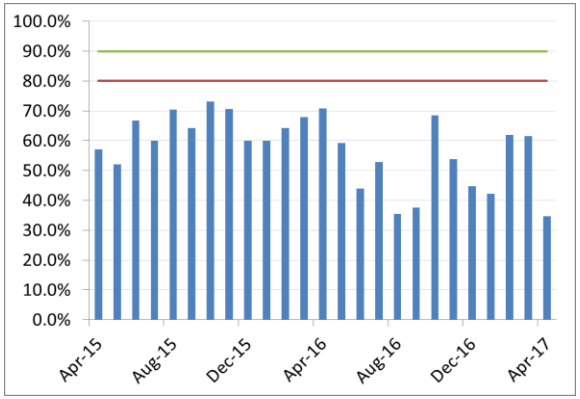
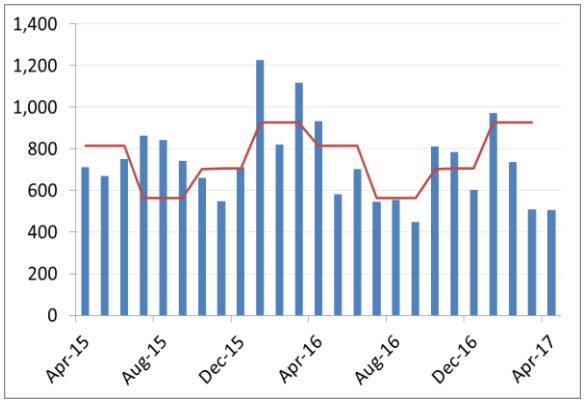
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% national standard was not achieved in April. Trust-level performance deteriorated to 82.3%, and was marginally below the in-month trajectory (82.5%). Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Apr 2016</th><th>Mar 2017</th><th>Apr 2017</th></tr>
<tr><td>Attendances</td><td>5,594</td><td>5,572</td><td>5,510</td></tr>
<tr><td>Emergency Admissions</td><td>1,875</td><td>1,910</td><td>1897</td></tr>
<tr><td>Patients managed < 4 hours</td><td>4464
79.8%</td><td>4117
73.9%</td><td>3811
69.2%</td></tr>
<tr><th>BCH</th><th>Apr 2016</th><th>Mar 2017</th><th>Apr 2017</th></tr>
<tr><td>Attendances</td><td>3,036</td><td>3,735</td><td>3,277</td></tr>
<tr><td>Emergency Admissions</td><td>753</td><td>869</td><td>714</td></tr>
<tr><td>Patients managed < 4 hours</td><td>2824
93.0%</td><td>3735
88.9%</td><td>3277
96.8%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments
 

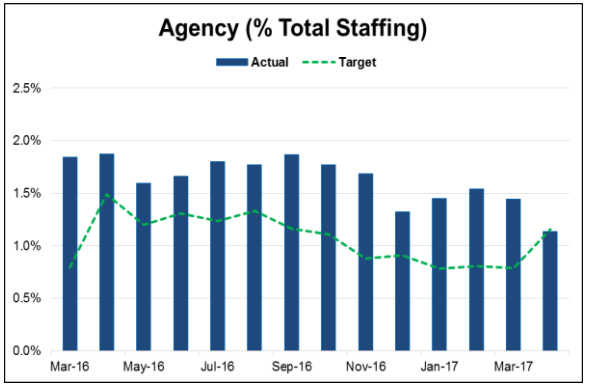
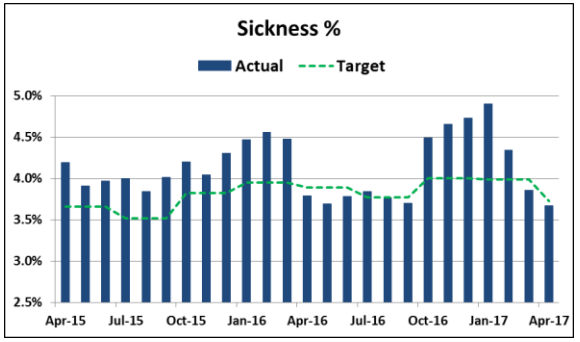
The trajectory of 83.5% is not forecast to be met in May.</td>
<td>Whilst emergency admissions via the BRI ED are 1.2% up on the same period last year, total emergency admissions into the BRI are down by 2.3%. The number of 14 day stays is significantly above last year's levels, with bed occupancy remaining un-seasonally high as a result. The reduction in outlier bed-days, combined with lower patient acuity, should help to reduce length of stay. But the time taken to access the 'right' bed may continue to lengthen waits in the ED. 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 April. However, performance at 91.1% was above the recovery trajectory of 90.9%, and for this reason this indicator is AMBER rated (see Appendix 3). The number of patients waiting over 40 weeks RTT has increased, mainly due to capacity pressures in Women's & Children's. There were five over 52-week waiters due to a range of issues, mostly due to patient choice.
<table>
<tr><th></th><th>Feb</th><th>Mar</th><th>Apr</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>106</td><td>133</td><td>153</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>3</td><td>2</td><td>5</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 

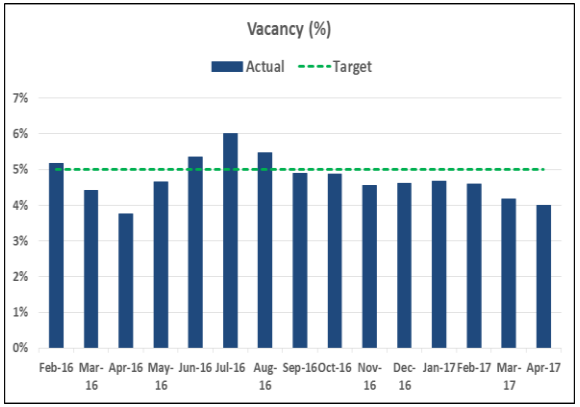
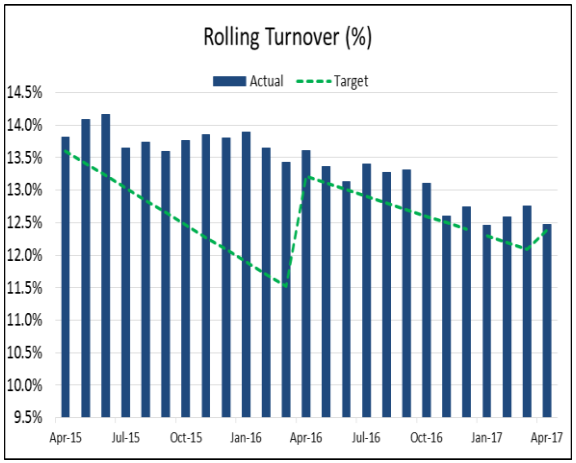
Forecast performance for May is 91.4%, with performance due to be restored above 92% by the end of July.</td>
<td>Whilst percentage performance remains the same as in March, the total number of patients on an incomplete RTT pathway has decreased, as has the number of patients waiting over 18 weeks. However, the size of the elective waiting list remains high, which poses risks to early recovery of the 92% standard. The RTT recovery plan has been refreshed and will continue to be monitored through fortnightly meetings with Divisions (Action 9A to 9C).</td>
</tr>
</table>

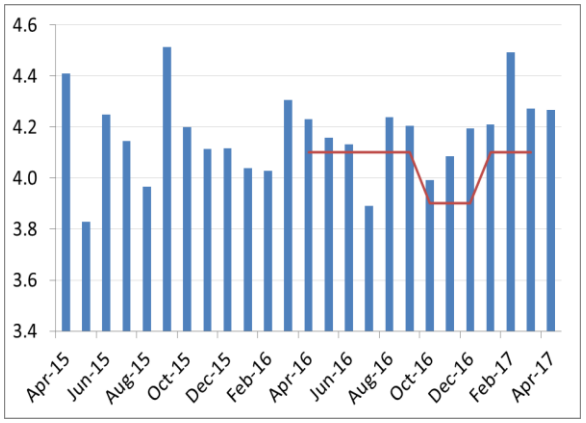
Description	Current Performance	Trend	Comments
Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.	March's performance was 81.2% against the 85% 62-day GP standard, and a trajectory of 85.9%. The 85% standard was met for internally managed pathways with performance at 88.1%. The main reasons for failure to achieve the 85% 62-day GP standard for individual patients is shown below. **Breach reason** / **Mar 17** Late referral by/delays at other provider: 9.5 Medical deferral/clinical complexity: 6.5 Patient choice: 3.0 Delayed outpatient appointment: 0.5 Insufficient surgical capacity: 1.0 Delayed pre-operative assessment: 1.0 **TOTAL**: **21.5**	**Percentage of patients treated within 62 days of GP referral**  Performance against the 90% 62-day screening standard in March was 83.3%. There was one breach of standard in the month, which was due to patient choice.	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 84.9%. There were few avoidable breaches of standard in the month. An improvement plan continues to be implemented to minimise avoidable delays (Action 10A to 10C).
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 98.6% in April, which is below the 99% national standard, and the previously agreed recovery trajectory. The number and percentage of over 6-week waiters at month-end, is shown below: **Diagnostic test** / **Feb** / **Mar** / **Apr** MRI: 15 / 5 / 9 Sleep: 31 / 32 / 11 Endoscopies: 19 / 23 / 30 CT: 40 / 60 / 72 Echo: 0 / 0 / 0 Other: 3 / 1 / 1 **TOTAL**: **108** / **121** / **123** Percentage: **98.7%** / **98.7%** / **98.6%** Recovery trajectory: 98.2% / 98.7% / 99.0%	**Percentage of patients waiting under 6 weeks at month-end**  Achievement of the recovery trajectory at the end of May is at risk due to a steep rise in demand for Cardiac CT scans.	The number of patients waiting over 6 weeks for a Sleep Studies test continued to reduce in April. There has been a doubling of demand for Cardiac CT scans due to implementation of recent NICE guidelines. These high levels of demand cannot be met in the short-term, with ad hoc sessions. A medium term capacity plan has been established. Additional capacity is also being established to replace capacity lost in the stress echo service in April and early May, and to keep pace with heightened demand (Actions 11A and 11D).

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 March (latest data), 42 out of 42 patients (100%) were treated within 90 minutes of arrival in the hospital. Performance for 2016/17 as a whole ended above the 90% standard at 91.7%.	**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 March.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In April 2017 we achieved 34.6% (9/ 26 patients) overall performance in Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 57.7% (15/26 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number of patients</th></tr>
<tr><td>Patients not well enough to attend theatre with 36 hour timeframe.</td><td>3</td></tr>
<tr><td>Operations cancelled as previous procedures overran due to complexity of cases.</td><td>3</td></tr>
<tr><td>Patient needed MRI scan and specialist input before surgery.</td><td>1</td></tr>
<tr><td>Patient had a complex fracture requiring specialist input</td><td>1</td></tr>
<tr><td>Procedure delayed due to lack of theatre capacity.</td><td>2</td></tr>
</table>
</td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.
 
</td>
<td>Seven patients did not receive any ortho-geriatrician review due to sickness and the clinician having to cover the Older Person Assessment Unit.
Actions are being taken to establish a future service model across Trauma & Orthopaedics, and ensure that consistent, sustainable cover is provided (Actions 12A to 12E).</td>
</tr>
<tr>
<td>Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.</td>
<td>In April 2017 there were 506 outlier bed-days*
<table>
<tr><th>Outlier bed-days</th><th>April 2017</th></tr>
<tr><td>Medicine</td><td>264</td></tr>
<tr><td>Surgery, Head & Neck</td><td>183</td></tr>
<tr><td>Specialised Services</td><td>43</td></tr>
<tr><td>Women's & Children's Division</td><td>15</td></tr>
<tr><td>Diagnostics and Therapies</td><td>1</td></tr>
<tr><td>Total</td><td>506</td></tr>
</table>
* The target for 2017/2018 is still to be determined. However, this indicator continues to be rated GREEN because the improved performance seen in March 2017 has been sustained.</td>
<td>Number of days patients spent outlying from their specialty wards
 
</td>
<td>The Trust maintained the performance improvement reported in March with a small decrease in bed-days relative to March’s figure of 510.
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 27 FTE, down from 1.4% to 1.1% of total staffing. Nursing agency usage reduced by 29.1 FTE to 60 FTE. **April 2017** / **FTE** / **Actual %** / **KPI** **UH Bristol** / **96.7** / **1.1%** / **1.2%** Diagnostics & Therapies / 8.8 / 0.9% / 0.7% Medicine / 31.4 / 2.4% / 1.5% Specialised Services / 4.8 / 0.5% / 1.7% Surgery, Head & Neck / 20.1 / 1.1% / 1.0% Women's & Children's / 11.1 / 0.6% / 0.5% Trust Services / 14.9 / 2.0% / 2.2% Facilities & Estates / 5.7 / 0.7% / 1.4%	**Agency usage as a percentage of total staffing by month** 	A summary of compliance with agency caps is attached in Appendix 2. See action 14 for a summary of key actions to target agency use.
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2015/16. The red threshold is 0.5% over the monthly target.	Sickness absence reduced from 3.9% to 3.7%. There have been reductions across all Divisions with the exception of Trust Services. **April 2017** / **Actual** / **KPI** **UH Bristol** / **3.7%** / **4.0%** Diagnostics & Therapies / 2.5% / 2.9% Medicine / 3.6% / 4.5% Specialised Services / 3.1% / 3.6% Surgery, Head & Neck / 3.9% / 3.7% Women's & Children's / 3.7% / 4.2% Trust Services / 3.6% / 3.1% Facilities & Estates / 5.4% / 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.*	See action 15 for the sickness action plan.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>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%.</td>
<td>Overall vacancies reduced from 4.2% to 4.0. Registered nursing vacancies increased from 4.3% (106.3 FTE) to 4.6% (112.29). Ancillary vacancies increased from 6.3% (54.6FTE) to 6.6%. (56.5 FTE).
<table>
<tr><th>April 2017</th><th>Rate</th></tr>
<tr><td>UH Bristol</td><td>4.0%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>6.8%</td></tr>
<tr><td>Medicine</td><td>5.2%</td></tr>
<tr><td>Specialised Services</td><td>3.8%</td></tr>
<tr><td>Surgery, Head & Neck</td><td>5.0%</td></tr>
<tr><td>Women's & Children's</td><td>1.5%</td></tr>
<tr><td>Trust Services</td><td>-0.3%</td></tr>
<tr><td>Facilities & Estates</td><td>6.1%</td></tr>
</table>
</td>
<td>Vacancies rate by month
 
</td>
<td>See Action 16 for further details of the plans that continue to be implemented to reduce the vacancy rate.</td>
</tr>
<tr>
<td>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.</td>
<td>Turnover reduced from 12.8% to 12.5%. There were reductions in all Divisions except Women’s & Children’s. Registered nurse turnover increased from 13% to 12.9%.
<table>
<tr><th>April 2017</th><th>Actual</th><th>KPI</th></tr>
<tr><td>UH Bristol</td><td>12.5%</td><td>12.4%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>11.0%</td><td>11.5%</td></tr>
<tr><td>Medicine</td><td>13.6%</td><td>14.6%</td></tr>
<tr><td>Specialised Services</td><td>12.2%</td><td>12.3%</td></tr>
<tr><td>Surgery, Head & Neck</td><td>12.1%</td><td>11.4%</td></tr>
<tr><td>Women's & Children's</td><td>12.4%</td><td>11.4%</td></tr>
<tr><td>Trust Services</td><td>11.7%</td><td>12.7%</td></tr>
<tr><td>Facilities & Estates</td><td>14.7%</td><td>14.6%</td></tr>
</table>
</td>
<td>Staff turnover rate by month
 
</td>
<td>See Action 17 for further details of the plans that continue to be implemented to reduce turn-over.</td>
</tr>
</table>

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 April 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 the same length of stay reported for March. The percentage of patients discharged in the month who were long-stay stay patients (14 day plus stays) was high, but below the very high levels reported in quarter 4. But despite this there was only a small decrease 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 May, and remain high until the current cohort of long-stay patients are discharged.	The total number of Green to Go patients in hospital is now just less than double the jointly agreed planning assumption of 30 patients. The number of 14-day plus stays is at a very high level. However, the percentage of emergency patients admitted aged 75 years and over has remained below last year's levels, which suggests patient acuity has dropped and we should start to see a reduction in 14 day plus stays. 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 review completed. Actions being fed into Urgent Care Group.	As above	Sustained improvement to 95% by 2018.
	1G	Procurement of e observations system to enable automatic calculation of NEWS and notification of elevated NEWS to responder.	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 0.75%
	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 0.75%
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 Ongoing	Oversight of training compliance by the Education Group. Monthly and quarterly Divisional Performance Review meetings. Oversight of training compliance by the Education Group.	Trajectories to achieve compliance for Safeguarding, Resuscitation, Information Governance and Fire Safety by March 2017 have not been achieved. Performance against trajectory and target are included in Appendix 2. Divisional action plans are in place to achieve compliance (date to be confirmed). Target audiences for Dementia

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
					Awareness Training are under review and will be agreed at the end of May by the Education Group.
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 Mid July	Monthly Divisional Review Meetings; Clinical Strategy Group.	Sustained reduction in critical care related cancellations in 2017/18. As above.
	6B	Specialty specific actions to reduce the likelihood of cancellations.	Ongoing	Monthly review of plan with Divisions by Associate Director of Operations.	As above.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Outpatient appointments cancelled by hospital	7A	Explore option of increasing required notice of annual leave from six to eight weeks to reduce the number of cancelled clinics	To be confirmed	Senior Leadership Team	Amber threshold expected to be achieved again by the end of September.
	7B	Full service-level review of the electronic Referral Service (eRS) Directory of Services, to limit the number of required re-bookings	To be confirmed	Outpatient Steering Group	
	7C	Implement changes to the way capacity is managed to support eRS appointment bookings and limit cancellations.	To be confirmed	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. Escalation capacity has remained open during quarter 4 and agreement has been given for this to be included in Medicine's substantive bed base. Orla Healthcare went into administration at the end of April 2017 and no longer provide a service to UH Bristol. Options for replacement of this service are being developed.	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: Integrated Discharge Service (IDS) continues to pursue flexible use of available care home and reablement capacity to facilitate discharge on a daily basis. Work is being undertaken within the IDS to improve and optimise internal processes with the service being part of the Flow Coaching Programme supported by the West of England Academic Health Science Network (AHSN) which is being formally launched on 23 Mat	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)	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		2017.			
	8C	Additional GP Support Unit and Urgent care capacity: Future requirements for GPSU will be incorporated into the proposed model for Front-Door Primary Care Streaming which has to be operational by October 2017 at the latest. The UCSG will undertake a further review of all direct access admission pathways during quarter 2 2017/18 to ensure that these are as effective as possible and reduce the reliance on the Emergency Department (ED) as a gateway for all admissions. The pilot for medically expected patients to be admitted via Ambulatory Care Unit has been extended.	End September 2017		
	8D	Proposals for a different Urgent and Emergency Care staffing model is being developed for presentation to the UCSG and SLT in July 2017.	Ongoing		
	8E	Commissioning of Pulse to provide domiciliary care packages, to support early supported discharge: Pulse commissioned and operational from 20th February	End July 2017	Contract monitoring	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		2017 and has reduced the number of patients delayed waiting for a package of care. Formal evaluation to be presented to SLT in July for decision about continuation of the initiative.			
	8F	Review of formal feedback from NHS Improvement Critical Friend Visit, to feed into refresh of the action plan. Formal feedback reviewed and has been incorporated into the Urgent Care Steering Group action plan which will be presented to the May 2017 meeting.	End May 2017	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. Acute physicians are now in post and early indications are that there has been an increase in the 0-2 day length of stay and a reduction in overall length of stay. The Medicine Division is developing an urgent and emergency care strategy which will now look to develop the acute medicine model further for	End July 2017	Review and monitoring of agreed actions by EAPIG.	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		presentation to the UCSG and SLT in July 2017.			
	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. Professional standards approved at April UCSG and will be taken to June SLT for formal sign off.	End June 2017		
	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. Event held and learning has been incorporated into actions in the UCSG work plan.	Complete		
	8J	Consideration of strategic solutions to potential bed capacity shortfalls for 2017/18, including ways of increasing early supported	End June	Review of options to be considered at Senior Leadership Team	Achievement of STF trajectory in 2017/18

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		discharge. Paper detailing the next steps for out of hospital care options presented to SLT in April. Detailed analysis and work with system partners is now been undertaken to develop potential future models of care which are formally costed and assessed.			
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 92% standard from the end of July onwards.
	9B	RTT Plan for the first half of 2017/18, focusing on areas of recent growth and those specialties whose backlogs are still above sustainable levels	Complete	RTT Steering Group	
	9C	Refresh of IMAS Capacity and Demand modelling for key specialties (including Clinical Genetics, Paediatric Cardiology and Sleep Studies	End June	Modelling to be reviewed by Associate Director of Performance	
Cancer waiting times	10A	Implementation of Cancer Performance Improvement Plan, including ideal timescale pathways, and reduced waits for 2-week wait	Ongoing	Oversight of implementation by Cancer Performance Improvement Group, with escalation to Cancer Steering	Achieve 85% for internally managed pathways and 85% with application of CQUIN. Sustain performance above

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		appointments.		Group.	national average each quarter.
	10B	Development of a strategic plan for achieving 62-day GP national standard of 85% by the end of 2017/18.	Complete	Cancer Steering Group	Achievement of 85% standard by the end of 2017/18
	10C	Agreement to implement strategic plan for achieving 62-day GP standard.	End June	Senior Leadership Team	As above.
Diagnostic waits	11A	Additional Sleep Studies waiting list sessions to be established to minimise residual backlog of long waiters.	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.
	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).
	11C	Reasons for the increase in demand for Cardiac CT and Stress echo to be investigated.	End May	Divisional Review Meeting	As above.
	11D	Additional stress echo sessions to be established to replace lost capacity in May and meet high levels of demand.	End May	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 May.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Effective					
Fracture neck of femur Best Practice Tariff (BPT)	12A	**Middle grade orthogeriatric support** – to submit a proposal to establish a dedicated middle grade orthogeriatric role (ST3+) to provide additional support to the orthogeriatric consultants and wards. This post will also contribute to improvements in cross-cover.	Pending approval at Surgical Division executive review on the 18/05	Proposal for investment included in BOA business case. Recruitment lead time difficult to determine as this may be a difficult role to recruit to	Successful funding bid and subsequent recruitment to post
	12B	**Consultant orthogeriatric consultant cover** – to support a return to work for the consultant that has been on extended long term sick.	April 2017	Reduction in variability in cross-cover arrangements.	Improvements in time to review by an orthogeriatrician.
	12C	**Establishment of an elderly trauma and hip fracture ward** – to cohort frail elderly trauma patients on A604. To facilitate direct admission from ED to ring-fenced fractured neck of femurs beds.	This is contingent upon amending care pathways and admission protocols.	There also needs to be sufficient capacity to maintain ring fenced admission beds and medical ward capacity to accommodate step down patients	Improvements to the quality and coordination of patient care.
	12D	**Physiotherapy the day after surgery** – to ensure that there is physiotherapy support available to the orthopaedic wards on Sundays	A meeting is scheduled between the Surgical Division and the D&T Division to discuss the proposed levels of investment	There are potential benefits associated with reduction in patient length of stay with earlier mobilisation.	Improvements against the new quality standard measure of therapy review the day after surgery.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	12E	**Time to surgery** – to improve trauma throughput and to expedite the surgery of fractured neck of femurs patients within 36 hours.	Anticipated improvements against standard by June 2017	The number of patients that do not meet this standard is relatively small. There is work being undertaken to refine the process for escalation of patients that are not anticipated to meet the standard to ensure that proactive steps are taken	Improvements against time to theatre standard
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" - improved rostering and booking for wards/bank. • KPIs agreed and in place.	Ward areas - end April 2017; Bank - end May 2017 End June 2017	KPI Performance monitored through Nursing Controls Group. Nursing agency: oversight by Savings Board. Medical agency: oversight through the Medical Efficiencies Group.	A KPI has been agreed for 2017/18 of 1% through the Divisional Operating Planning Process. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings. Marketing activity now being actively deployed.
		Controls and efficiency: • New agency rules in place for Nursing from April • Nurse agency suppliers still under consideration through the wider BNSSG group. • Operating plan agency trajectories monitored by divisional reviews.	Ongoing End June 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. • Extended Temporary Staffing Bureau opening hours.	Ongoing May 2017 End May 2017		

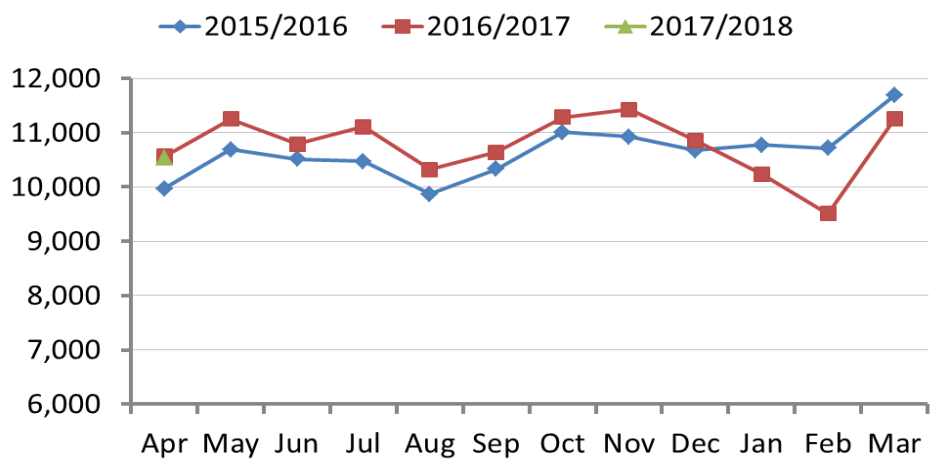
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Sickness Absence	15	**Supporting Attendance Policy:** Revised policy to Policy Group April 2017; implementation and training from July/August 2017.	July/August 2017	Oversight by Workforce and Organisational Development (OD) Group via the Staff Health and Well Being Sub Group	A KPI has been agreed for 2017/18 of 3.8% Divisional Operating Planning Process. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance review meetings.
		Supporting Attendance Surgeries: To expedite cases where possible.	Ongoing		
		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 2016/17. • Radiology recruitment website	Ongoing May 2017	Divisional Performance and Operational Review Meetings.	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		mirroring nurse recruitment launched in May. • Divisional Nurse Recruitment Leads in bed-holding divisions. • "Head-hunter" agency approach has been extended to hard to fill areas e.g. Sonography and Trauma & Orthopaedics nursing.	April 2017-18 From April 2017		
Turnover	17	**Complete review of appraisal**: Including: • Updated policy • E-Appraisal • Revised Training	May 2017	Transformation Board.	A KPI has been agreed for 2017/18 of 12% through the Divisional Operating Planning Process. 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 (SLT) updated March 2017. SLT Sub-group developing Framework.	Framework being developed for SLT in May 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.

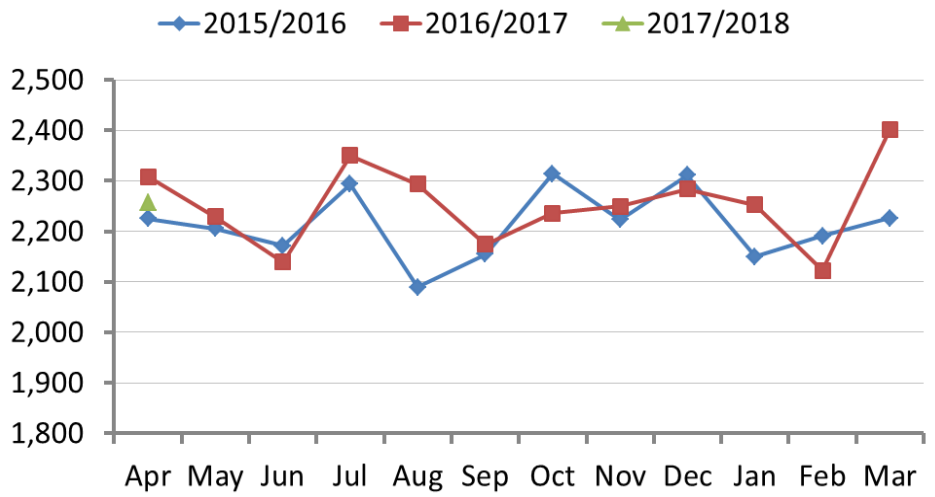
Emergency Department (ED) attendances



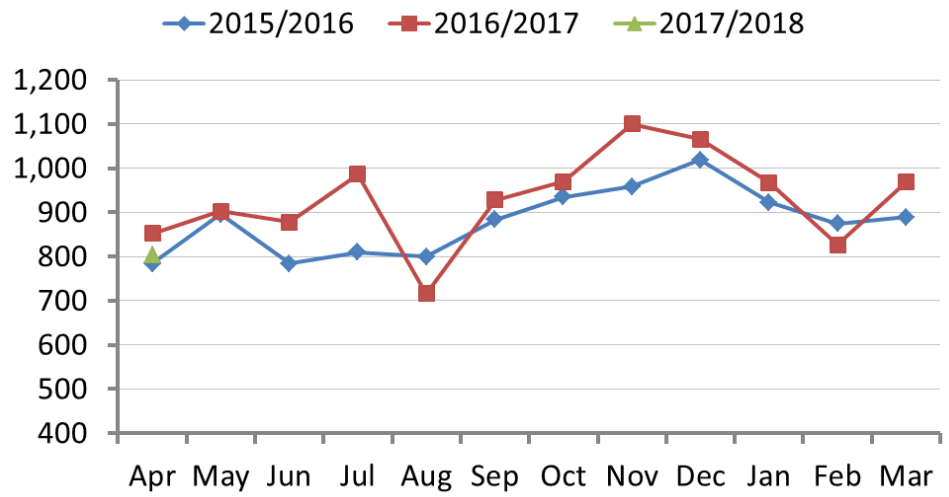
Summary points:

- Emergency attendances are similar to last year's levels;
- The total number of emergency admissions into the BRI and BCH are now below the same period last year;
- The number of new outpatient attendances has dipped below the number delivered in the same period last year, mainly due to Easter falling within the month;
- The number of elective admissions remains at last year's levels despite the impact of bank holidays and higher level of cancellations;
- The number of patients waiting over 18 weeks for treatment has decreased, as has the total number of pathways; the elective waiting list remains high, which means there continues to be a 'bulge' in the waiting list that will need to be met to prevent an increase in over 18 week waiters in future months (see Assurance and Leading Indicators section).

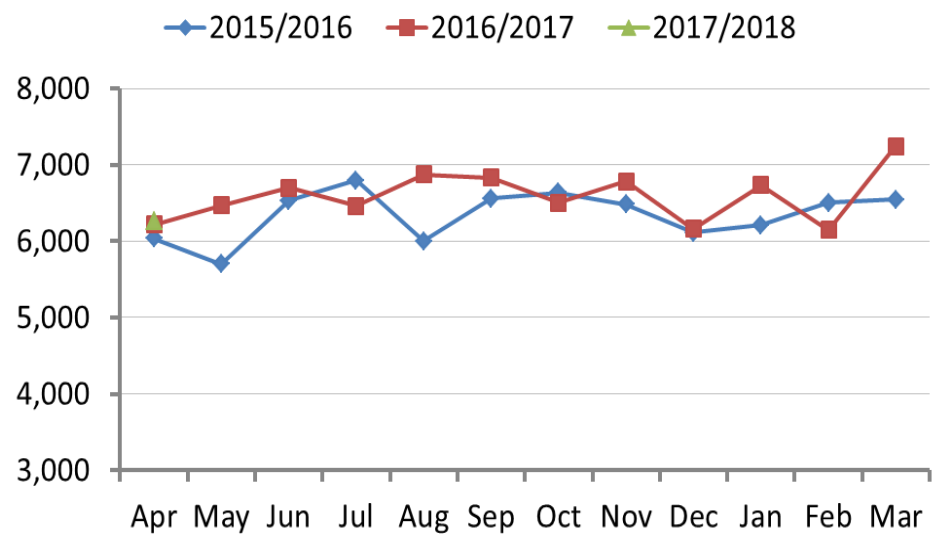
Emergency admissions (BRI)



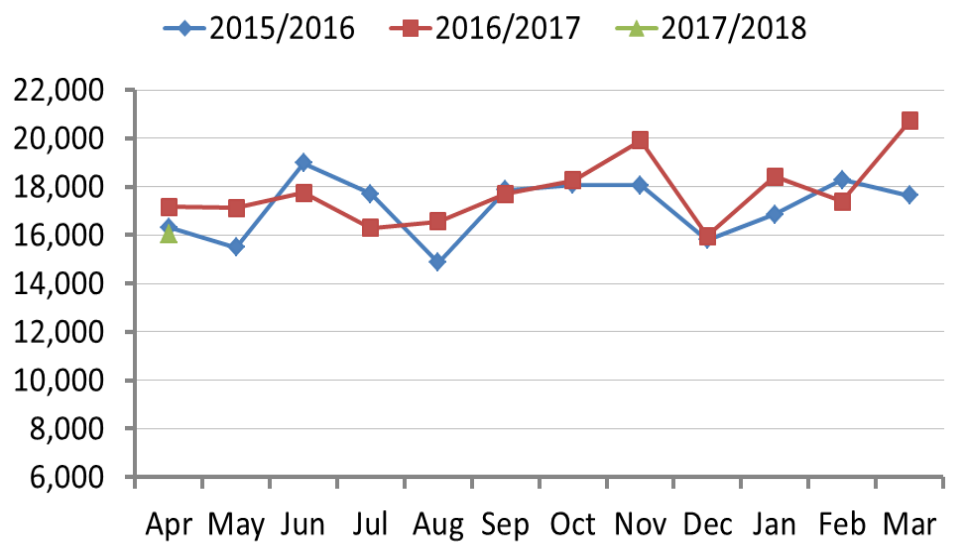
Emergency admissions (BCH)



Elective admissions



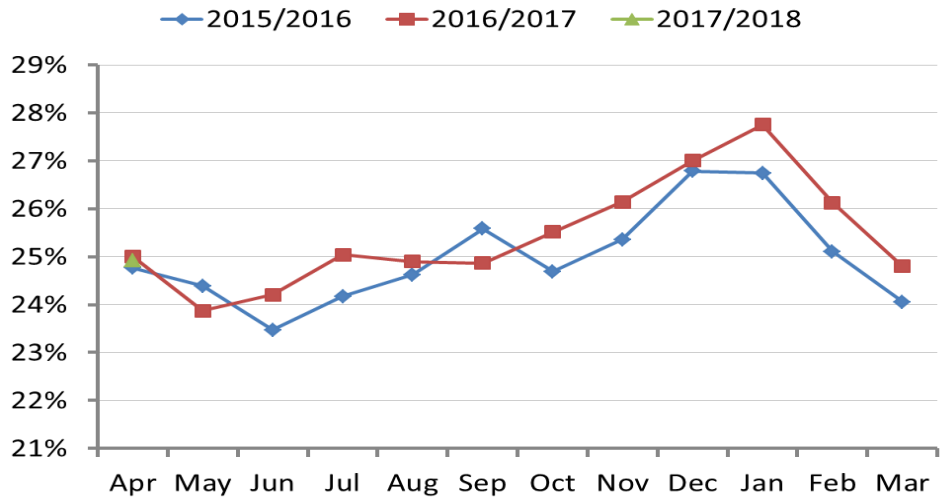
New outpatient attendances



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.

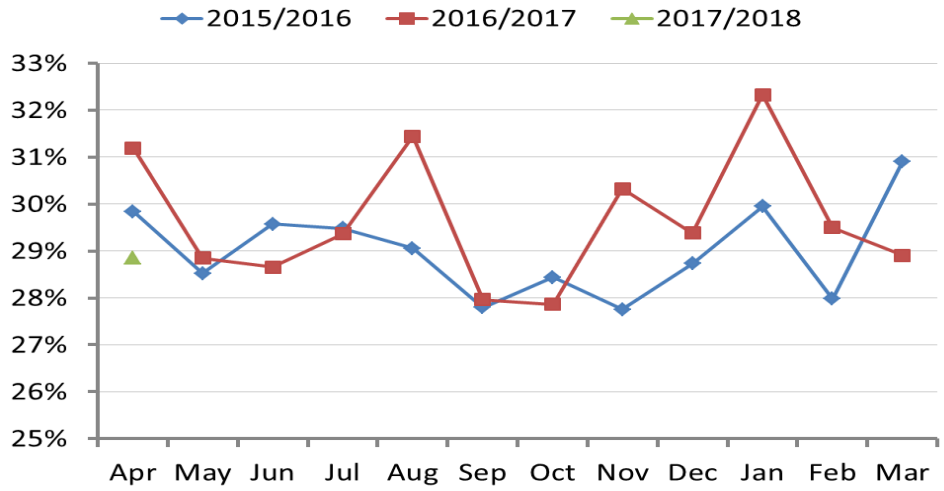
Percentage ED attendances resulting in admission



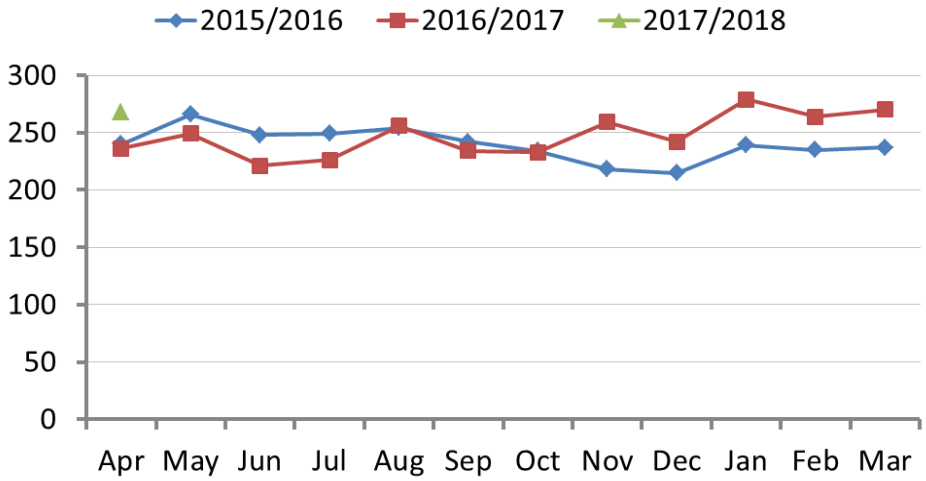
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission is at the seasonal norm; the percentage of patients admitted aged 75 years and over continues, however, to be below the levels seen in the last two years;
- Although patient acuity appears to have fallen, the number of over 14 days stays is above the last two years' levels; consistent with this, BRI bed occupancy levels also remain high;
- The number of patients on the outpatient waiting list has risen slightly; this is likely a result of a lower than normal level of outpatient attendances due to the bank holidays, but despite a below average level of referrals; the elective waiting list has fallen, helped by a 'normal' level of elective admissions delivered in a month with bank holidays;
- The number of patients referred by their GP with a suspected cancer (2-week waits) has increased sharply, as has the number of cancer treatments.

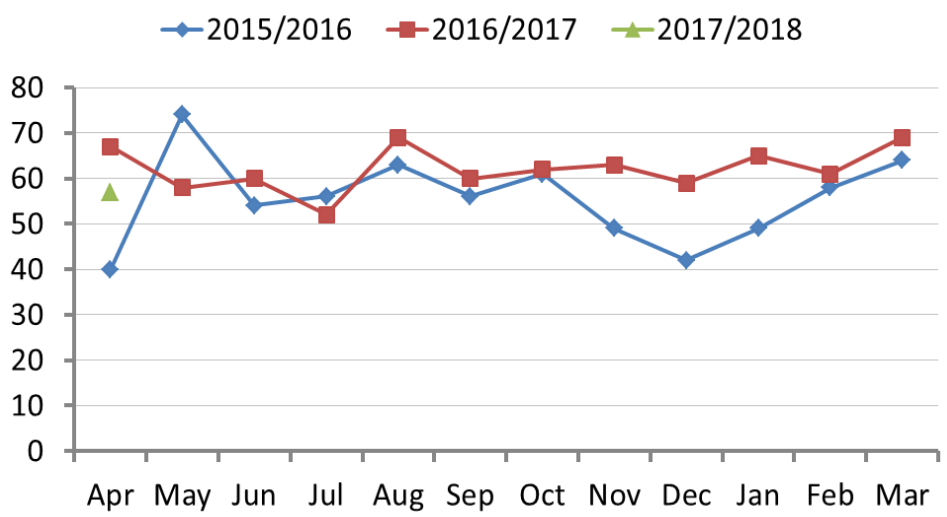
Percentage of Emergency BRI spells patients aged 75 years and over



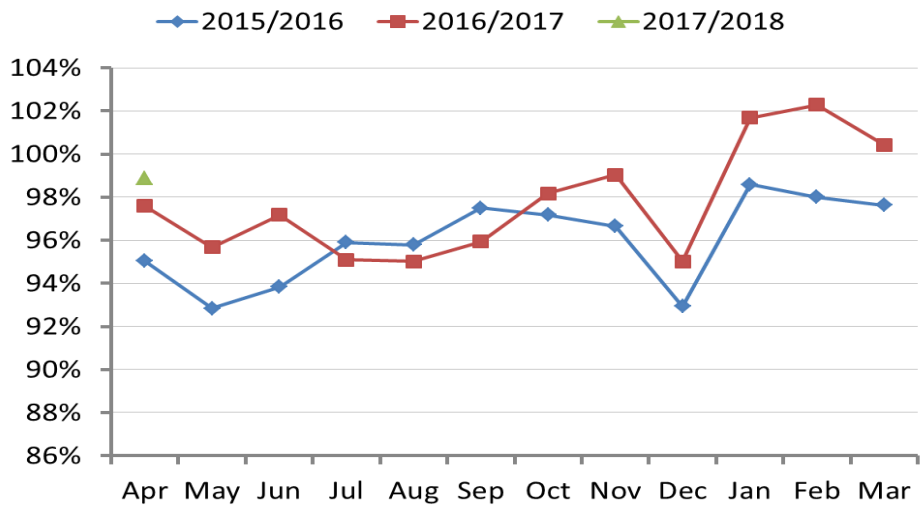
Over 14 day stays



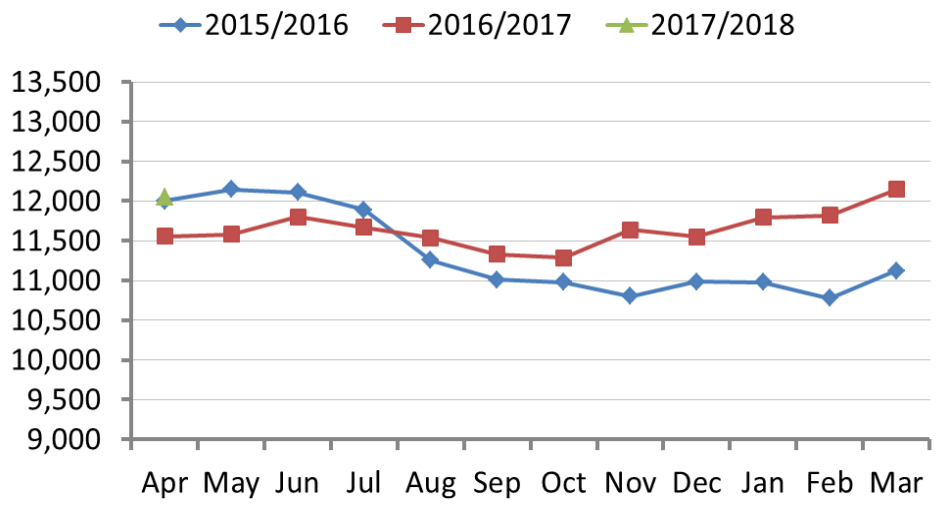
Delayed discharges (Green to Go)



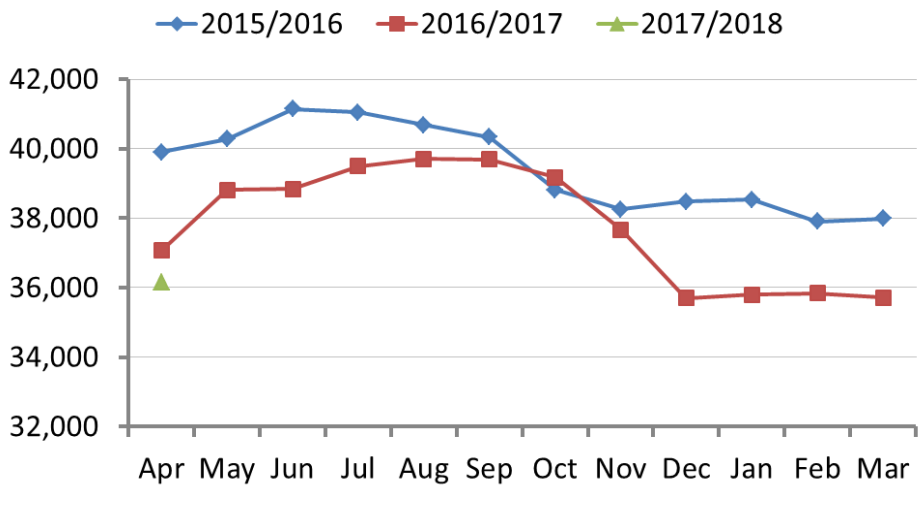
BRI Bed Occupancy



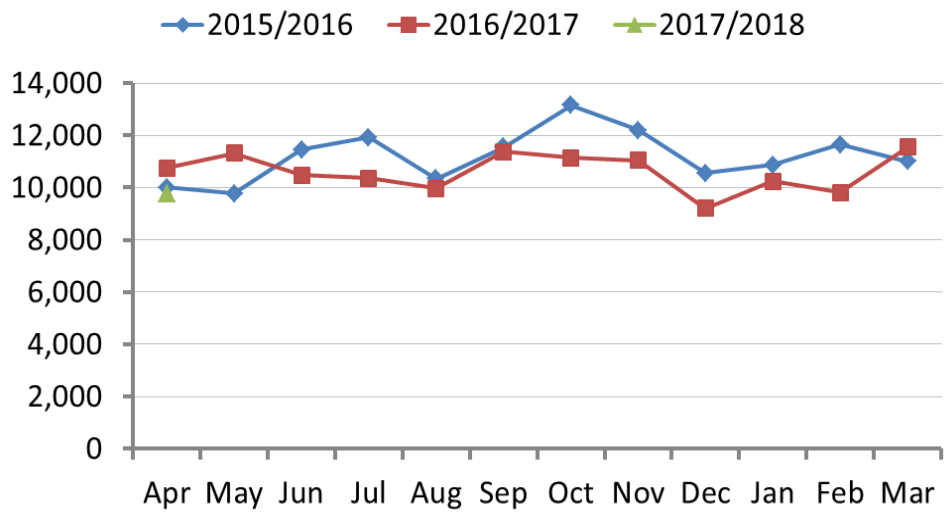
Elective waiting list size



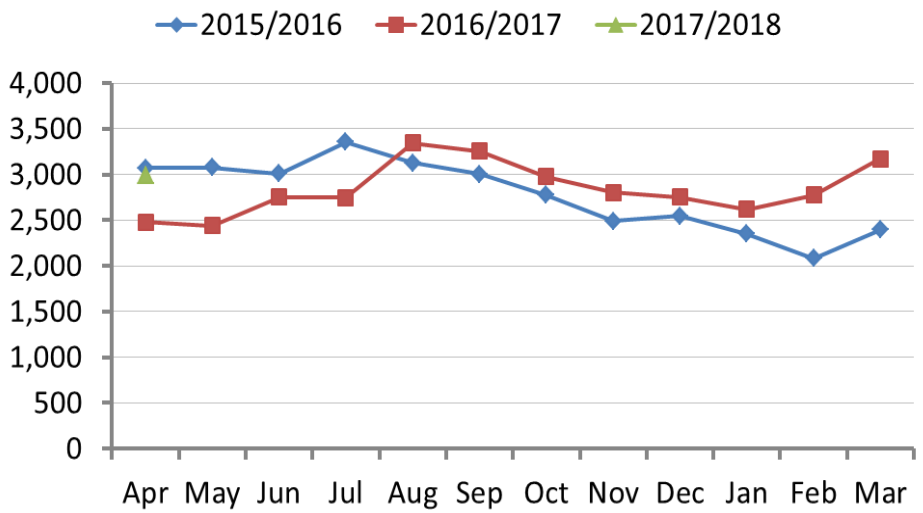
Outpatient waiting list size



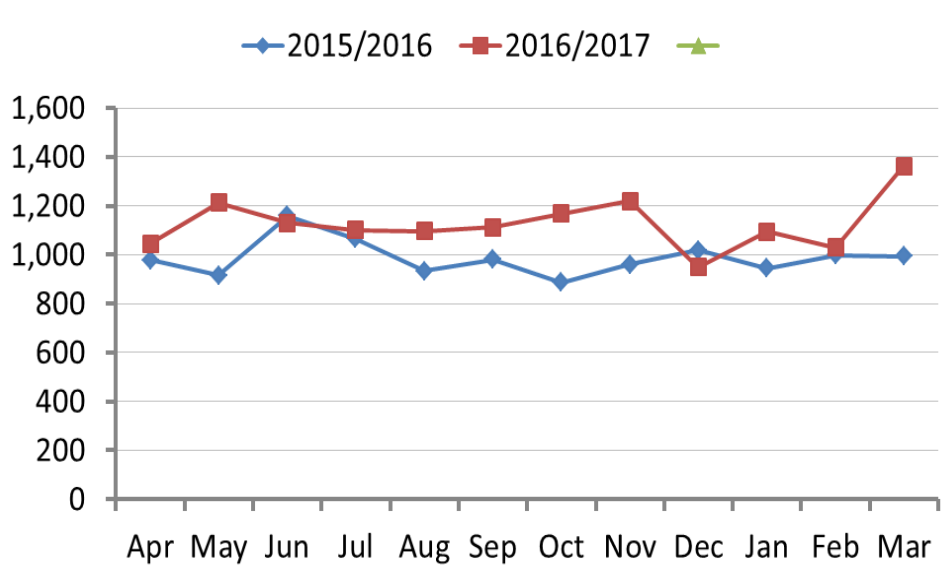
Number of RTT pathways stopped (i.e. treatments)



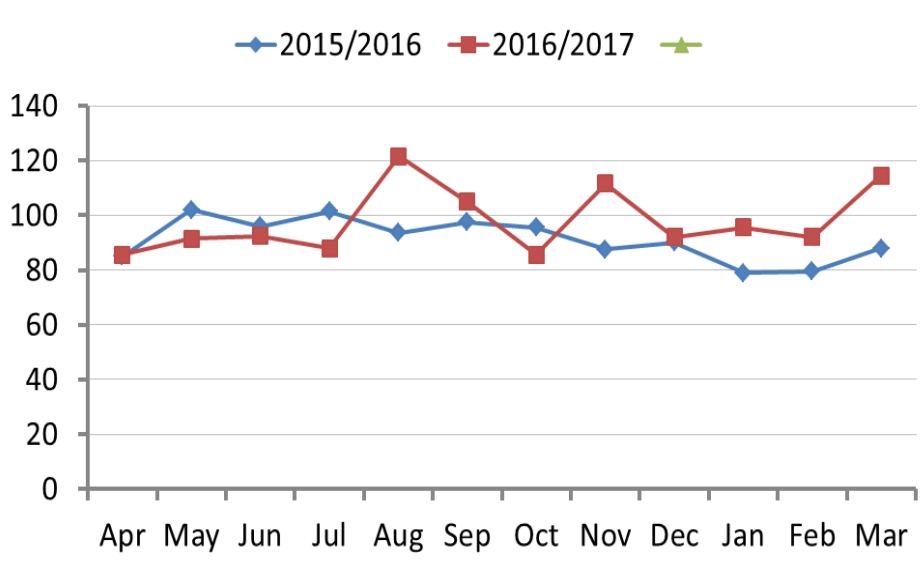
Number of RTT pathways over 18 weeks



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	16/17	17/18 YTD	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
								Patient Safety													
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	0	0	0	0	0	0	1	1	1	1	1	1	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	1	1	0	0	0	0	0	0	1	0	0	0	0	1	0	1	0	1
	DA03	C.Diff Cases - Monthly Totals	31	2	5	1	3	2	5	1	3	5	4	0	0	2	10	9	4	2
	DA02	MSSA Cases - Monthly Totals	37	0	3	3	7	4	2	0	6	2	3	3	2	0	13	8	8	0
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	1	2	3	4	5	5	8	9	10	10	10	-	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	96.6%	98.4%	97.3%	98%	96.9%	98.4%	94.9%	97%	96.5%	95.7%	95.5%	95.4%	97%	98.4%	96.8%	96.4%	96%	98.4%
	DB02	Antibiotic Compliance	88.3%	87.7%	85.3%	83.9%	88.2%	86.5%	86.8%	90.9%	90.3%	91.2%	91.7%	92%	88.1%	87.7%	87.4%	90.8%	90.8%	87.7%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	95%	95%	96%	97%	95%	95%	96%	96%	96%	94%	95%	96%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	98%	98%	98%	98%	97%	97%	97%	98%	97%	97%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	96%	96%	96%	97%	97%	96%	96%	97%	96%	96%	95%	96%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	52	2	8	2	6	8	1	4	5	3	5	2	5	2	15	12	12	2
	S02a	Number of Confirmed Serious Incidents	41	-	7	2	5	7	1	4	5	3	3	1	-	-	13	12	4	-
	S02b	Number of Serious Incidents Still Open	8	2	-	-	-	-	-	-	-	-	2	1	5	2	-	-	8	2
	S03	Serious Incidents Reported Within 48 Hours	94.2%	100%	100%	100%	83.3%	87.5%	100%	100%	100%	100%	100%	100%	100%	100%	86.7%	100%	100%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	90.4%	100%	100%	100%	100%	87.5%	100%	75%	80%	66.7%	100%	100%	100%	100%	93.3%	75%	100%	100%
	S04	Serious Incident Investigations Completed Within Timescale	98%	100%	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%	100%	100%	100%	93.3%	100%	100%
Never Events	S01	Total Never Events	2	0	0	0	1	0	0	1	0	0	0	0	0	0	1	1	0	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	14866	-	1216	1258	1173	1139	1263	1220	1389	1185	1335	1211	1332	-	3575	3794	3878	-
	S06b	Patient Safety Incidents Per 1000 Beddays	47.82	-	46.88	50.22	45.32	44.67	50.77	45.61	52.93	46.21	48.94	48.67	48.47	-	46.88	48.25	48.69	-
	S07	Number of Patient Safety Incidents - Severe Harm	95	-	8	9	10	10	2	10	12	10	10	7	5	-	22	32	22	-
Patient Falls	AB01	Falls Per 1,000 Beddays	4.23	4.85	3.93	4.59	4.6	3.84	4.42	4.86	4.04	3.74	3.74	4.9	3.89	4.85	4.29	4.22	4.16	4.85
	AB06a	Total Number of Patient Falls Resulting in Harm	36	2	4	3	3	3	3	2	2	4	3	3	5	2	9	8	11	2
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.148	0.078	0.154	0.04	0.077	0.196	0.161	0.075	0.114	0.195	0.11	0.201	0.182	0.078	0.144	0.127	0.163	0.078
	DE02	Pressure Ulcers - Grade 2	40	1	3	1	2	5	4	1	3	5	3	3	3	1	11	9	9	1
	DE04A	Pressure Ulcers - Grade 3 or 4	6	1	1	0	0	0	0	1	0	0	0	2	2	1	0	1	4	1
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	99.1%	98.9%	99.1%	99%	99.1%	99.1%	99%	99%	99.4%	99%	99.1%	98.9%	99.1%	98.9%	99.1%	99.1%	99%	98.9%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	96.4%	94.5%	96.3%	96.6%	97.3%	95.7%	94.1%	97%	96.5%	97%	97.8%	98%	96.6%	94.5%	95.8%	96.8%	97.4%	94.5%
	tbc	Number of Hospital Associated Thromboses	No RAG																	
	tbc	Number of Potentially Avoidable Hospital Associated Thromboses	No RAG																	
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	89.6%	89.9%	94%	86.3%	89.4%	89.8%	89.7%	86.5%	87.1%	94.3%	92.7%	89.1%	90.2%	89.9%	89.6%	89.4%	90.6%	89.9%
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	86.9%	-	-	80.8%	-	-	88%	-	-	91.2%	-	-	87.9%	-	88%	91.2%	87.9%	-
Safety	Y01	WHO Surgical Checklist Compliance	99.1%	99.5%	100%	98.9%	99.6%	99.9%	100%	99.6%	-	97.7%	98.4%	98%	97.8%	99.5%	99.9%	98.7%	98.1%	99.5%

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual 16/17	Annual 17/18 YTD	Monthly Totals May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	Quarterly Totals 16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Patient Safety																				
Medicines	WA01	Medication Incidents Resulting in Harm	0.37%	-	0.51%	0%	0.55%	0%	1.01%	0.55%	1.19%	0%	0%	0.53%	0%	-	0.51%	0.64%	0.16%	-
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.59%	0.43%	0.63%	0.56%	0.6%	0.38%	0%	0.65%	0.86%	0.74%	0.98%	0.39%	0.26%	0.43%	0.33%	0.75%	0.52%	0.43%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.9%	97.9%	97.7%	98.3%	98.4%	98.6%	98.6%	97.6%	97.5%	97.4%	98%	97.3%	98.3%	97.9%	98.6%	97.5%	97.9%	97.9%
	AK04	Safety Thermometer - No New Harms	98.9%	99%	98.7%	98.7%	99.2%	99.2%	99.2%	98.4%	99.3%	98.5%	98.6%	98.5%	99.1%	99%	99.2%	98.7%	98.7%	99%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	92%	100%	100%	79%	82%	95%	94%	94%	93%	93%	91%	93%	100%	100%	90%	93%	95%	100%
Out of Hours	TD05	Out of Hours Departures	7.8%	8.5%	7.5%	7.2%	7.9%	8.8%	7.4%	7.2%	7.8%	8.1%	8.4%	9.2%	6.5%	8.5%	8%	7.7%	8%	8.5%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	22.1%	22%	22.4%	23.4%	23.1%	21%	22.1%	21.8%	22.3%	22.1%	21.6%	21.4%	21.1%	22%	22.1%	22.1%	21.3%	22%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	11293	885	955	989	1006	907	932	974	970	935	905	816	934	885	2845	2879	2655	885
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.7%	107.1%	104%	103.1%	104.3%	102.7%	101.9%	102.6%	105.3%	104.2%	103.6%	104.5%	104.1%	107.1%	103%	104%	104%	107.1%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	100.3	-	-	101.2	-	-	99.4	-	-	-	-	-	-	-	99.4	-	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	91.3	-	87.5	90.2	100.6	89	81.5	91.5	110.6	91.7	87.6	87.7	-	-	90.4	97.9	87.7	-
Mortality Review	tbc	Number of Deaths																		
	tbc	Number of Deaths Subject to Casenote Review																		
	tbc	Number of Deaths Reviewed Under Serious Incident Framework																		
	tbc	Number of Deaths With More Than 50:50 Chance of Being Avoidable																		
Readmissions	C01	Emergency Readmissions Percentage	1.77%	-	1.56%	1.7%	1.76%	2%	2.29%	1.48%	1.7%	1.93%	1.75%	1.84%	1.47%	-	2.01%	1.7%	1.68%	-
Sepsis (Inpatients)	tbc	Percentage of Sepsis Sample Screened																		
	tbc	Antibiotics Commenced Within 60 Minutes of Diagnosis																		
	tbc	72 Hour Review of Antibiotics for Patients Admitted with Sepsis																		
Sepsis (Emergency Department)	tbc	Sepsis screening																		
	tbc	Antibiotics Commenced Within 60 Minutes of Diagnosis																		
	tbc	72 Hour Review of Antibiotics for Patients Admitted with Sepsis																		
Maternity	tbc	Number of Term Babies Born Under 2.5kg																		

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			16/17	17/18 YTD	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Clinical Effectiveness																				
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	70.5%	57.7%	74.1%	72%	73.5%	61.3%	58.3%	73.7%	69.2%	51.7%	69.2%	81%	80.8%	57.7%	65.2%	63.5%	76.7%	57.7%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	74%	73.1%	81.5%	72%	79.4%	64.5%	58.3%	89.5%	69.2%	86.2%	61.5%	71.4%	73.1%	73.1%	68.5%	81.1%	68.5%	73.1%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	51.9%	34.6%	59.3%	44%	52.9%	35.5%	37.5%	68.4%	53.8%	44.8%	42.3%	61.9%	61.5%	34.6%	42.7%	54.1%	54.8%	34.6%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	61.4	44.1	44.4	72.2	53.5	49.4	51.7	53.2	48.8	43.3	37.3	67.4	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	58.6%	-	67.6%	65.9%	59%	51.4%	63.4%	56.8%	61.8%	35.3%	52.4%	50%	64.3%	-	58.3%	51.4%	55.5%	-
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90.2%	-	88.2%	93.2%	92.3%	85.7%	92.7%	97.3%	88.2%	94.1%	90.5%	84.1%	88.6%	-	90.4%	93.3%	87.7%	-
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.8%	56.3%	68.8%	61.5%	76.5%	71.4%	80%	60%	65.2%	81.8%	51.7%	72.2%	61.5%	56.3%	76.5%	68.2%	60%	56.3%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	90.4%	87.2%	95.8%	94.1%	98%	96.3%	93.2%	93.1%	88.9%	89.1%	80.8%	80.1%	84%	87.2%	96%	90.2%	81.6%	87.2%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	97.2%	97.3%	97.8%	98.1%	98.1%	97.8%	100%	96.8%	94.1%	97.6%	97.6%	88.9%	100%	97.3%	98.6%	96.3%	96.2%	97.3%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	94.7%	100%	100%	100%	100%	100%	85.7%	100%	100%	71.4%	100%	100%	100%	100%	92.3%	88.2%	100%	100%
	AC04	Percentage of Dementia Carers Feeling Supported	75%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	8178	506	583	702	545	554	447	811	784	602	972	735	510	506	1546	2197	2217	506
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	92	90	91	92	91	91	92	94	92	92	92	90	91	92	91	90
	P01g	Patient Survey - Kindness and Understanding	-	-	96	94	93	96	96	95	96	97	96	95	96	97	95	95	95	97
	P01h	Patient Survey - Outpatient Tracker Score	-	-	90	90	90	90	89	88	90	90	90	88	89	90	90	90	89	90
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35.5%	34.6%	42.4%	40.5%	36.5%	36.8%	30.7%	33.7%	35.9%	30.6%	31.7%	34.8%	36.8%	34.6%	34.6%	33.5%	34.5%	34.6%
	P03b	Friends and Family Test ED Coverage	16.4%	15.9%	13.5%	15.5%	12%	16.8%	15.5%	17.3%	18.9%	15.4%	21.2%	17.7%	18.4%	15.9%	14.7%	17.2%	19.1%	15.9%
	P03c	Friends and Family Test MAT Coverage	22.5%	23.6%	26.3%	19%	24.4%	20.4%	21.1%	22.6%	22.1%	19.8%	24.6%	29.7%	25.3%	23.6%	21.9%	21.6%	26.4%	23.6%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	97.2%	97.2%	95.8%	97.2%	95.9%	97.4%	96.9%	98.2%	97.3%	97.5%	97.4%	96.9%	98.5%	97.2%	96.7%	97.7%	97.6%	97.2%
	P04b	Friends and Family Test Score - ED	78.2%	83.2%	78.1%	74.4%	71.8%	79.6%	78.6%	79.3%	78.9%	74.1%	80.8%	79.6%	80.2%	83.2%	77.1%	77.6%	80.2%	83.2%
	P04c	Friends and Family Test Score - Maternity	96.8%	96.9%	98.9%	95.5%	96.2%	97.8%	97.3%	97.7%	94.3%	94.5%	98.2%	96.2%	97.4%	96.9%	97%	95.6%	97.3%	96.9%
Patient Complaints	T01	Number of Patient Complaints	1875	247	146	198	200	155	162	140	139	118	129	144	168	247	517	397	441	247
	T01a	Patient Complaints as a Proportion of Activity	0.232%	0.402%	0.218%	0.296%	0.315%	0.246%	0.24%	0.204%	0.19%	0.19%	0.186%	0.222%	0.22%	0.402%	0.266%	0.195%	0.21%	0.402%
	T03a	Complaints Responded To Within Trust Timeframe	86.1%	76.3%	73.1%	73.8%	86.8%	90.6%	86%	92.3%	93.4%	97.4%	87.5%	87.5%	83.3%	76.3%	88.1%	94.2%	86%	76.3%
	T03b	Complaints Responded To Within Divisional Timeframe	86.6%	76.3%	92.3%	95.2%	89.5%	94.3%	81.4%	92.3%	85.2%	76.9%	85.4%	85%	72.9%	76.3%	88.8%	84.9%	80.9%	76.3%
	T04c	Percentage of Responses where Complainant is Dissatisfied	11.31%	-	9.62%	16.67%	10.53%	13.21%	18.61%	0%	9.84%	12.82%	14.58%	10%	-	-	14.18%	7.91%	-	-
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	0.98%	1.34%	0.96%	0.96%	1.03%	0.46%	0.6%	1.18%	0.88%	0.99%	1.24%	1.52%	0.91%	1.34%	0.69%	1.01%	1.2%	1.34%
	F01a	Number of Last Minute Cancelled Operations	734	80	59	61	63	30	39	73	57	58	79	89	63	80	132	188	231	80

Please note:

As reported last month, a number of changes have been made to the quality dashboard for 2017/18 as agreed by the Quality and Outcome Committee. These new measures will mostly report two months in arrears or quarterly. The dashboard for these new measures will start to be populated from next month as data becomes available.

RESPONSIVE

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 16/17	Annual 17/18 YTD	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	Quarterly Totals 16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.7%	91.1%	92.6%	92.1%	92%	90.5%	90.4%	91.2%	92%	92%	92.2%	92%	91.1%	91.1%	91%	91.8%	91.8%	91.1%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	2442	2753	2749	3344	3256	2978	2805	2751	2619	2777	3171	2985	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	11	5	0	0	0	0	1	0	1	1	3	3	2	5	1	2	8	5
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	696	153	22	14	27	33	27	53	78	93	86	106	133	153	87	224	325	153
New Outpatient Wait List	L02L	New Outpatient List - Numbers Waiting 12+ Weeks	-	-	-	-	9866	10227	10748	11415	11791	11486	10016	10375	9952	9473	8445	8906	-	-	-	-
	L02M	New Outpatient List - Percentage Waiting 12+ Weeks	-	-	-	-	24.3%	25.1%	26%	27.3%	28.1%	27.2%	24.2%	26.1%	25.2%	25%	22.9%	23.1%	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	-	-	94.8%	-	94.6%	93.5%	95.4%	93.7%	91.6%	94.3%	96.2%	96%	95.9%	95.5%	96.3%	-	93.6%	95.5%	95.9%	-
	E01c	Cancer - Urgent Referrals Stretch Target	-	-	68.4%	-	68%	65.3%	67.6%	68.4%	67%	55.1%	71%	60.8%	75.3%	76%	79.7%	-	67.6%	62.4%	77.2%	-
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	-	-	96.7%	-	96.2%	96.7%	99.1%	96.5%	97.4%	97.8%	98.3%	96.1%	96.5%	96.8%	97.4%	-	97.6%	97.4%	96.9%	-
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	-	-	98.7%	-	100%	97.3%	97.5%	97.7%	99.1%	97.5%	100%	99.1%	100%	100%	98.4%	-	98.1%	98.9%	99.5%	-
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	-	-	94.4%	-	94%	97.7%	97.1%	92.6%	98.4%	96.4%	98%	95.9%	93.8%	92.3%	96.5%	-	96.1%	96.8%	94.3%	-
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	-	-	96.6%	-	98.4%	96.8%	96.7%	95.2%	92%	95.4%	98.1%	98.2%	96.9%	97.6%	96.7%	-	94.5%	97.3%	97%	-
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	-	-	79.3%	-	70.5%	70.8%	73.3%	84.8%	80.5%	79.5%	85.2%	81.5%	84.3%	78.8%	81.2%	-	80.1%	82.4%	81.5%	-
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	-	-	69.4%	-	35.3%	85.7%	66.7%	55.6%	44.4%	100%	83.3%	100%	57.1%	100%	83.3%	-	55.6%	94.3%	77.8%	-
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	-	-	87.9%	-	86.6%	96.9%	89.3%	91.1%	92.5%	88%	90.1%	82.1%	93.2%	77.8%	88.4%	-	90.8%	86.5%	86.8%	-
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	-	-	62	-	7.5	7	3	2.5	5	4	6.5	4	5.5	4.5	7.5	-	10.5	14.5	17.5	-
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	0.98%	1.34%	0.96%	0.96%	1.03%	0.46%	0.6%	1.18%	0.88%	0.99%	1.24%	1.52%	0.91%	1.34%	0.69%	1.01%	1.2%	1.34%
	F01a	Number of Last Minute Cancelled Operations	-	-	734	80	59	61	63	30	39	73	57	58	79	89	63	80	132	188	231	80
	F02c	Number of LMCs Not Re-admitted Within 28 Days	3	3	72	4	2	2	4	3	0	3	6	4	4	6	15	4	7	13	25	4
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.36%	1.05%	1.82%	1.14%	1.5%	1.12%	1.33%	2.11%	1.61%	1.38%	0.67%	1.16%	1.13%	1.05%	1.31%	1.7%	0.99%	1.05%
	F07a	Number of Admissions Cancelled Day Before	-	-	1020	63	112	72	92	73	87	131	104	81	43	68	78	63	252	316	189	63
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	-	-	72.4%	-	55.2%	66.7%	70.5%	76.6%	75%	73.5%	57.1%	64.7%	69%	86.1%	83.3%	-	74%	65%	79.2%	-
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	-	-	91.7%	-	93.1%	83.3%	88.6%	93.6%	97.2%	91.2%	85.7%	79.4%	90.5%	94.4%	100%	-	92.9%	85.4%	95%	-
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	97.79%	98.56%	98.55%	96.25%	96.09%	95.51%	96.88%	98.91%	99.05%	98.23%	98.38%	98.69%	98.65%	98.56%	96.17%	98.74%	98.58%	98.56%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	11.5%	12%	12.2%	12.4%	12.2%	11.6%	11.4%	10.7%	10.2%	11%	10.7%	11.2%	11.1%	12%	11.7%	10.6%	11%	12%
	R05	Outpatient DNA Rate	5%	10%	7.3%	7.1%	6.8%	7.5%	8%	7.1%	7.9%	7.7%	6.9%	7.8%	7.3%	6.9%	6.9%	7.1%	7.7%	7.4%	7%	7.1%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.03	2.03	2.24	2.2	2.3	2.23	2.23	2.22	2.25	2.17	2.17	2.2	2.29	2.3	2.27	2.2	2.24	2.18	2.28	2.2
ERS	BC01	ERS - Available Slot Issues Percentage	-	-	25.9%	24.4%	-	-	-	-	-	-	-	-	26.1%	25.2%	26.4%	24.4%	-	-	25.9%	24.4%

RESPONSIVE (continued)

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 16/17	Annual 17/18 YTD	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	Quarterly Totals 16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	23	22	29	31	25	30	28	28	29	29	29	19	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	6	4	5	6	5	4	2	3	4	2	16	8	-	-	-	-
	Q01B	Acute Delayed Transfers of Care - Beddays	-	-	10232	655	811	711	776	963	889	927	802	834	891	750	809	655	2628	2563	2450	655
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	-	-	2167	306	152	238	183	193	184	233	138	131	106	183	252	306	560	502	541	306
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	-	-	47	50	43	56	44	55	54	51	59	52	47	43	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	-	-	11	10	9	13	16	6	8	8	6	9	22	14	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	-	-	1621	1437	1563	1679	1505	1706	1864	1691	1937	1575	1716	1400	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	-	-	291	532	343	344	396	372	249	270	189	334	450	503	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.17	4.27	4.16	4.13	3.89	4.24	4.2	3.99	4.08	4.19	4.21	4.49	4.27	4.27	4.11	4.09	4.32	4.27
	J04D	Percentage Length of Stay 14+ Days	-	-	7%	7.3%	6.9%	7.5%	6.5%	6.7%	7%	6.3%	6.6%	7.2%	6.9%	7.9%	7.4%	7.3%	6.7%	6.7%	7.4%	7.3%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	-	-	249	221	226	256	234	233	259	242	279	264	270	268	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	1.4%	4.2%	3.1%	6.2%	5.1%	6.2%	4.8%	5.6%	2.8%	2.8%	2.2%	4.1%	1.4%	5.8%	4.4%	3.1%	1.4%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	39%	63.6%	29%	52.4%	29.2%	25%	37.2%	30.3%	52.6%	33.3%	55%	57.1%	44.1%	63.6%	30.5%	40.2%	50%	63.6%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	85.01%	82.31%	91.66%	88.99%	89.33%	90.01%	87.33%	82.94%	78.45%	79.64%	80.37%	80.73%	83.25%	82.31%	88.89%	80.35%	81.53%	82.31%
	This is measured against the national standard of 95%																					
ED - Time in Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	-	-	85.01%	82.31%	91.66%	88.99%	89.33%	90.01%	87.33%	82.94%	78.45%	79.64%	80.37%	80.73%	83.25%	82.31%	88.89%	80.35%	81.53%	82.31%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	77.42%	69.16%	87.73%	81.8%	83.73%	83.71%	80.78%	73.39%	71.69%	73.47%	68.86%	68.15%	73.89%	69.16%	82.77%	72.85%	70.4%	69.16%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	89.89%	96.83%	93.84%	95.11%	93.58%	97.29%	91.57%	90.65%	78.6%	79.38%	90.19%	92.11%	88.92%	96.83%	93.94%	82.63%	90.28%	96.83%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	98.97%	96.52%	99.54%	99.24%	98.65%	98.61%	99.26%	98.06%	99.06%	99.15%	98.56%	99%	99.18%	96.52%	98.84%	98.74%	98.93%	96.52%
	This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets																					
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	40	0	1	0	0	0	1	2	1	11	19	5	0	0	1	14	24	0
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	97.6%	98.9%	98.2%	94.7%	97%	97.9%	97.3%	98.3%	97.9%	97.9%	98%	98.5%	98.8%	98.9%	97.4%	98%	98.4%	98.9%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	92.8%	92.1%	94.2%	92.1%	91.7%	91.8%	91.2%	91.8%	92.7%	93.7%	93.6%	94.1%	93.9%	92.1%	91.6%	92.7%	93.8%	92.1%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.6%	50.8%	51.7%	51.7%	51.1%	56.5%	55.2%	52.8%	48.2%	50.5%	53.3%	54.3%	51%	50.8%	54.2%	50.5%	52.8%	50.8%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.5%	97.8%	98.9%	98.5%	98.3%	98.9%	98.5%	98%	98.5%	98.3%	98.7%	98.1%	98.1%	97.8%	98.6%	98.3%	98.3%	97.8%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.6%	2.6%	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%	2.6%
	B05	ED Left Without Being Seen Rate	5%	5%	2.2%	2.8%	2%	2.5%	2.9%	1.8%	2.2%	2.6%	2.2%	2.4%	1.4%	1.8%	2%	2.8%	2.3%	2.4%	1.8%	2.8%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1216	111	72	114	77	125	140	161	119	114	138	83	11	111	342	394	232	111
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.1%	1.4%	4.2%	3.1%	6.2%	5.1%	6.2%	4.8%	5.6%	2.8%	2.8%	2.2%	4.1%	1.4%	5.8%	4.4%	3.1%	1.4%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	39%	63.6%	29%	52.4%	29.2%	25%	37.2%	30.3%	52.6%	33.3%	55%	57.1%	44.1%	63.6%	30.5%	40.2%	50%	63.6%

EFFICIENT

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	16/17	17/18 YTD	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1
Sickness	AF02	Sickness Rate	3.9%	3.7%	3.7%	3.8%	3.8%	3.8%	3.7%	4.5%	4.7%	4.7%	5%	4.4%	3.9%	3.7%	3.7%	4.7%	3.9%	
		For 2017/18, the Trust average for the year is 3.8%. Divisional targets are: 2.7% (DAT), 5.7% (FAE), 4.5% (MDC), 3.6% (SPS), 3.6% (SHN), 3.7% (WAC), 3.1% (THQ). Different targets were in place in previous years.																		
		There is an amber threshold of 0.5 percentage points above the target. These annual targets vary by quarter.																		
Staffing Numbers	AF08	Funded Establishment FTE	8446.1	8367.1	8239	8304	8334.2	8364.5	8364.5	8393.1	8402.2	8407.6	8434.2	8436	8446.1	8367.1	8364.5	8407.6	8446.1	
	AF09A	Actual Staff FTE (Including Bank & Agency)	8566.5	8510.5	8277.5	8315.7	8322.1	8398.3	8436.4	8427.7	8468.8	8412.7	8458.1	8496.4	8566.5	8510.5	8436.4	8412.7	8566.5	
	AF13	Percentage Over Funded Establishment	1.4%	1.7%	0.5%	0.1%	-0.1%	0.4%	0.9%	0.4%	0.8%	0.1%	0.3%	0.7%	1.4%	1.7%	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	427.9	446.7	370	394.7	429.9	437.9	410.7	376.3	387	358.5	378.3	398.9	427.9	446.7	410.7	358.5	427.9	
	AF11A	Percentage Bank Usage	5%	5.2%	4.5%	4.7%	5.2%	5.2%	4.9%	4.5%	4.6%	4.3%	4.5%	4.7%	5%	5.2%	4.9%	4.3%	5%	
		Bank Percentage is Bank usage as a percentage of total staff (bank+agency+substantive). Trust annual average for 17/18 is 3.9% with separate divisional averages.																		
Agency Usage	AF05	Workforce Agency Usage	123.7	96.7	131.9	138.3	149.8	148.5	157.4	149.1	142.7	111.5	122.5	131	123.7	96.7	157.4	111.5	123.7	
	AF11B	Percentage Agency Usage	1.4%	1.1%	1.6%	1.7%	1.8%	1.8%	1.9%	1.8%	1.7%	1.3%	1.4%	1.5%	1.4%	1.1%	1.9%	1.3%	1.4%	
		Agency Percentage is Agency usage as a percentage of total staff (bank+agency+substantive). Trust annual average for 17/18 is 1.0% with separate divisional averages.																		
Vacancy	AF06	Vacancy FTE (Funded minus Actual)	349.8	331.4	380	439.2	494.8	452.7	404.5	404.5	379.6	383.7	389.4	384	349.8	331.4	404.5	383.7	349.8	
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.2%	4%	4.7%	5.3%	6%	5.5%	4.9%	4.9%	4.6%	4.6%	4.7%	4.6%	4.2%	4%	4.9%	4.6%	4.2%	
		Vacancy is Funded Establishment minus Staff as a percentage of Funded Establishment. Before Apr-15, this was all Funded Establishment; from Apr-15 it was substantive staff only. Green is < 5% with Red >= 5%																		
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	146	121	191	137	169	367	205	128	109	133	165	111	146	121	205	133	146	
	AF10	Workforce Turnover Rate	12.8%	12.5%	13.3%	13.1%	13.4%	13.3%	13.3%	13.1%	12.6%	12.7%	12.5%	12.6%	12.8%	12.5%	13.3%	12.7%	12.8%	
		Turnover is a rolling 12 months. It's number of permanent leavers over the 12 month period, divided by average staff in post over the same period. Average staff in post is staff in post at start PLUS stafff in post at end, divided by 2.																		
Essential Training 2016/17	AF21a	Core Essential Training (Three Yearly)	85%	85%	88%	88%	88%	85%	88%	88%	88%	89%	89%	89%	85%	85%	88%	89%	85%	
	AF21b	Essential Training Compliance - Annual Training (Fire & IG)	-	-	56%	63%	66%	67%	73%	75%	-	-	-	-	-	-	73%	-	-	
	AF21f	Essential Training Compliance - Fire Safety	83%	82%	-	-	-	-	-	-	80%	81%	82%	82%	83%	82%	-	81%	83%	
	AF21g	Essential Training Compliance - Information Governance	76%	75%	-	-	-	-	-	-	76%	76%	76%	77%	76%	75%	-	76%	76%	
	AF21c	Essential Training Compliance - Induction	97%	98%	96%	95%	96%	94%	96%	96%	96%	96%	96%	97%	97%	98%	96%	96%	97%	
	AF21d	Essential Training Compliance - Resuscitation Training	75%	75%	78%	79%	79%	77%	81%	81%	81%	83%	85%	85%	75%	75%	81%	83%	75%	
	AF21e	Essential Training Compliance - Safeguarding Training	91%	90%	88%	88%	89%	86%	88%	89%	90%	90%	90%	90%	91%	90%	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 April 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%	84%	76%	87%	87%	87%	80%	84%
Annual Fire	82%	77%	83%	80%	85%	85%	84%	82%
Annual IG	75%	71%	69%	72%	75%	79%	80%	74%
Induction & Orientation	98%	99%	98%	98%	98%	97%	98%	97%
Induction & Orientation (Medical & Dental)	42%	17%	N/A	48%	33%	42%	N/A	44%
Resuscitation	75%	67%	N/A	85%	80%	78%	60%	70%
Safeguarding	90%	93%	88%	92%	91%	90%	91%	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	Apr-17
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Compliance	85%	86%	87%	85%	86%	87%	88%	88%	89%	87%	87%

Safeguarding Adults and Children

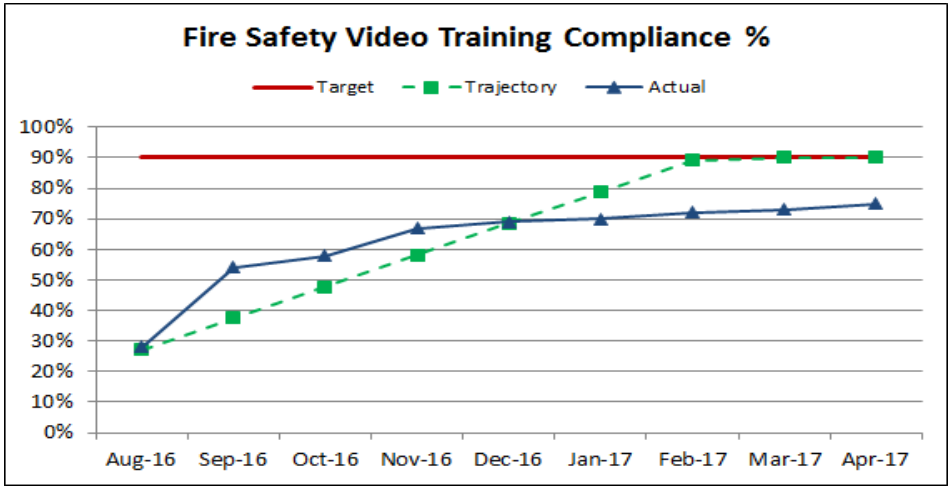
	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Safeguarding Adults L1	**90%**	95%	89%	90%	91%	85%	90%	91%
Safeguarding Adults L2	**91%**	93%	79%	94%	93%	92%	90%	87%
Safeguarding Adults L3	**78%**	67%	N/A	77%	100%	64%	88%	58%
Safeguarding Children L1	**91%**	95%	88%	93%	94%	89%	92%	N/A
Safeguarding Children L2	**90%**	92%	87%	92%	89%	90%	88%	95%

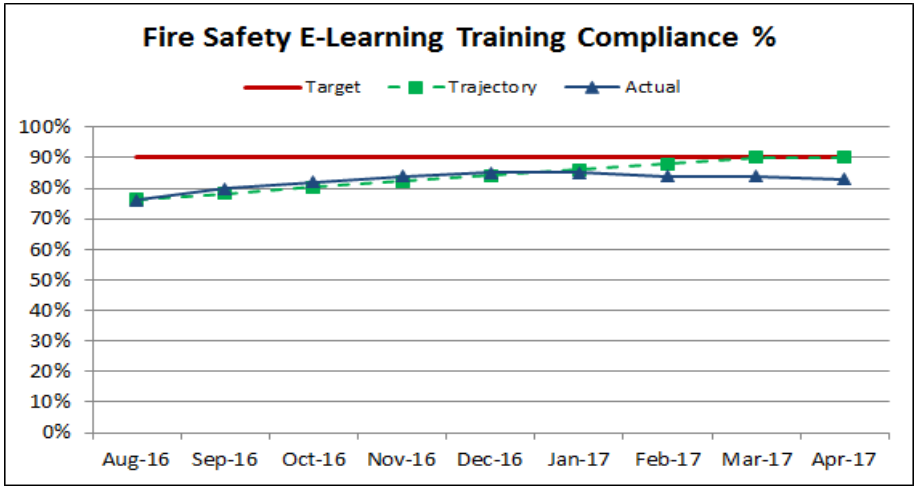
Child Protection Level 3

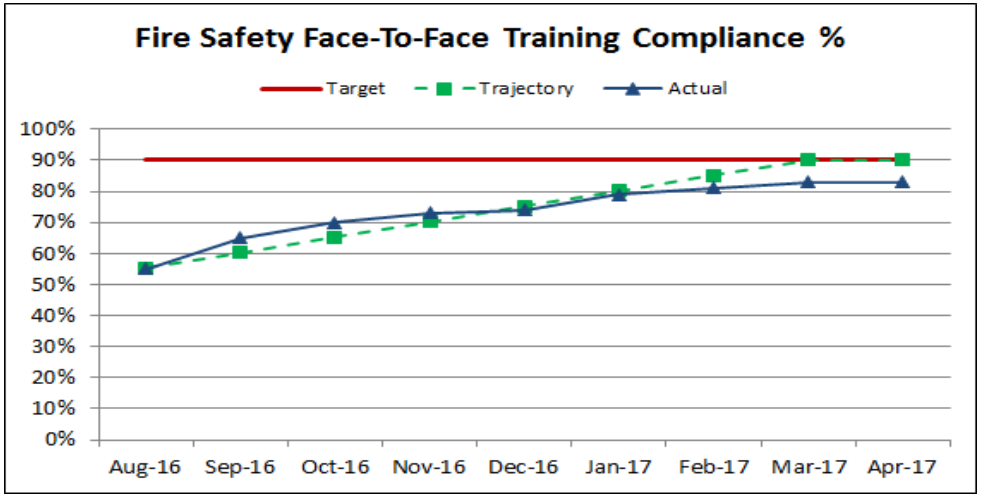
	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women`s & Children`s
Core	**76%**	84%	59%	83%	73%	66%	78%
Specialist	**72%**	N/A	N/A	N/A	N/A	100%	72%

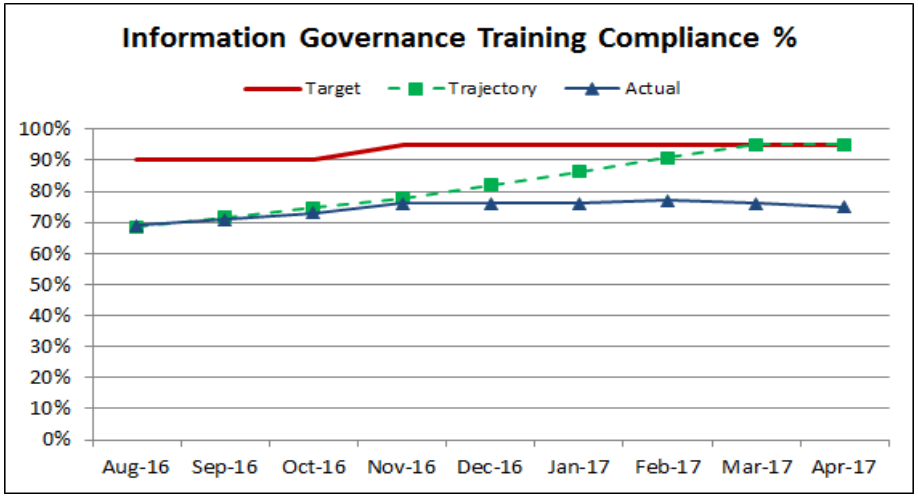
Appendix 2 (continued)

Performance against Trajectory for Fire and Information Governance









Note: there are two types of fire training represented in these graphs, two yearly and annual, with different target audiences. In addition, there are a number of staff who require an additional training video under the previous fire training requirements. The agreed Trust target for all essential training continues to be 90%, except Information Governance, which has a national target of 95%.

Appendix 2 (continued)

Agency shifts by staff group for 13th March 2017 to 9th April 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	1	41	0	216	869	1127
Health Care Assistant & other Support	78	8	12	4	2	104
Medical & Dental	0	0	0	0	24	24
Scientific, therapeutic / technical Allied Health Professional (AHP) & Healthcare Science	0	0	14	0	20	34
Administrative & Clerical and Estates	1224	0	0	0	0	1224

Appendix 3

Access standards – further breakdown of figures

A) 62-day GP standard – performance against the 85% standard at a tumour-site level for Quarter 4 20162017, including national average performance for the same tumour site

Tumour Site	UH Bristol	Internal operational target	National
Brain*	100%	-	86.5%
Breast*†	100%	-	95.6%
Gynaecology	91.1%	85%	77.6%
Haematology (excluding acute leukaemia)	100%	85%	81.0%
Head and Neck	80.0%	79%	62.5%
Lower Gastrointestinal	71.4%	79%	69.7%
Lung	51.5%	79%	71.8%
Other*	100%		71.1%
Sarcoma*	100%	-	71.8%
Skin	95.9%	96%	96.1%
Upper Gastrointestinal	69.6%	79%	72.6%
Urology*†	22.2%	-	74.3%
Total (all tumour sites)	81.5%	**85.0%**	**80.9%**
Improvement trajectory	**85.0%**		
Performance for internally managed pathways	**86.2%**		
Performance for shared care pathways	**60.0%**		
Performance with breach reallocation/CQUIN applied	**84.9%**		

*10 or fewer patients treated in accountability terms

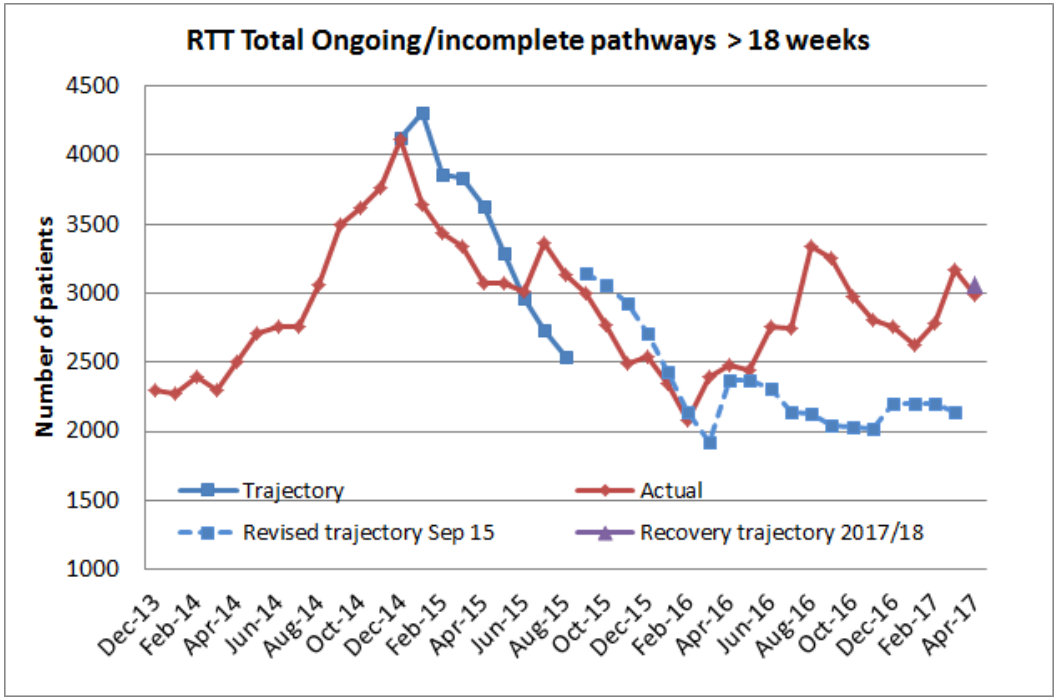
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

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 April 2017

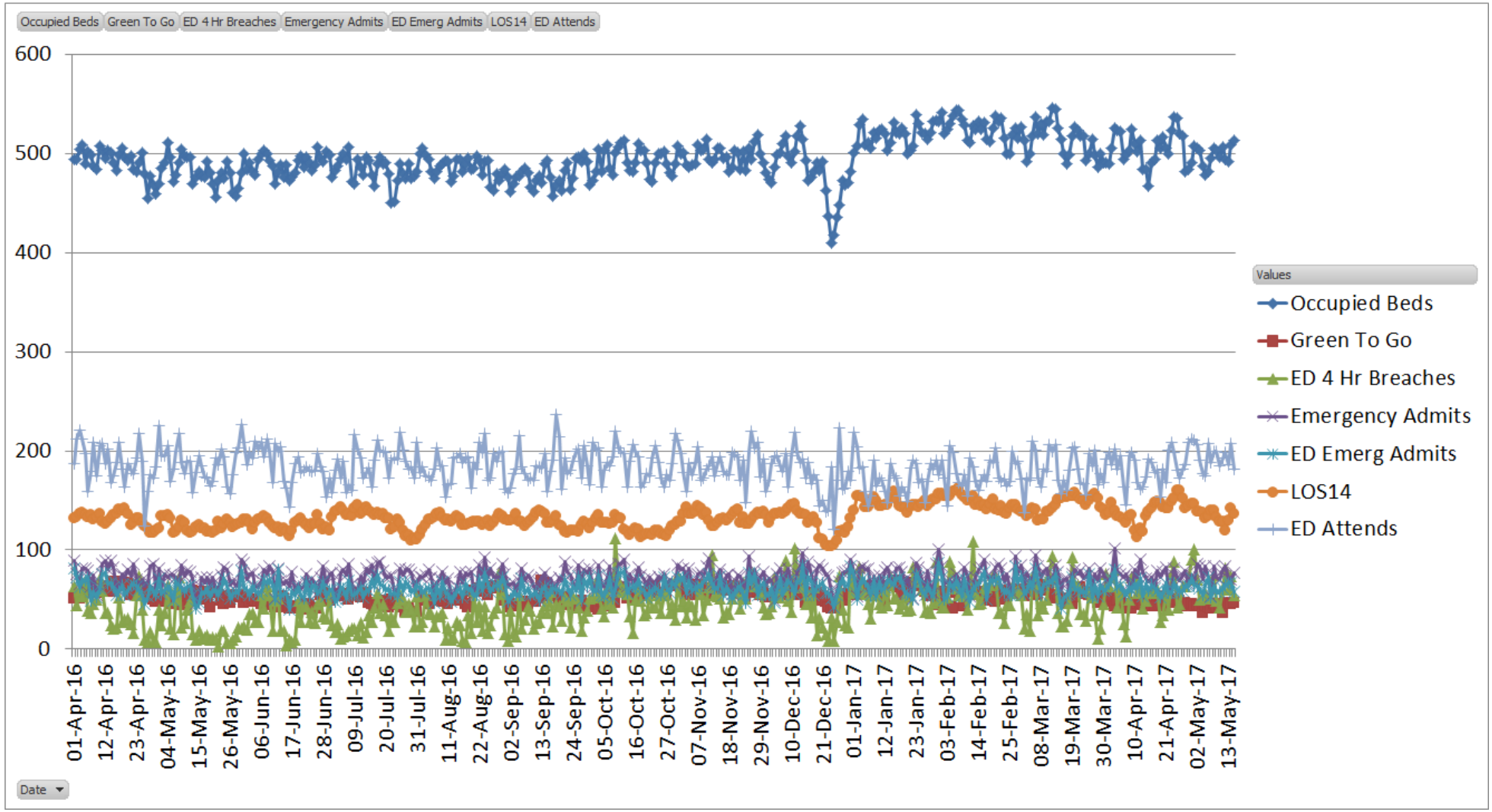
RTT Specialty	Ongoing Over 18 Weeks	Ongoing Pathways	Ongoing Performance
Cardiology	276	2,074	86.7%
Cardiothoracic Surgery	22	264	91.7%
Dermatology	77	2,289	96.6%
E.N.T.	41	2,177	98.1%
Gastroenterology	31	439	92.9%
General Medicine	0	40	100.0%
Geriatric Medicine	1	182	99.5%
Gynaecology	115	1,512	92.4%
Neurology	84	382	78.0%
Ophthalmology	293	4,783	93.9%
Oral Surgery	136	1,767	92.3%
Other	1,789	15,252	88.3%
Rheumatology	2	568	99.6%
Thoracic Medicine	5	916	99.5%
Trauma & Orthopaedics	113	1,017	88.9%
Urology	0	1	100.0%
Grand Total	**2,985**	**33,663**	**91.1%**



	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17
Non-admitted pathways > 18 weeks	1677	1594	1528	1592	1826	1705			
Admitted pathways > 18 weeks	1128	1157	1091	1185	1345	1280			
Total pathways > 18 weeks	2805	2751	2619	2777	3171	2895			
Actual target % incomplete < 18 weeks	92.0%	92.0%	92.2%	92.0%	91.1%	91.1%			
Recovery forecast	91.4%	91.6%	92.0%	92.0%	92.0%	90.9%	91.4%	91.8%	92.0%

Appendix 3 (continued)

BRI Flow metrics



Cover report to the Public Trust Board meeting to be held on Friday, 26 May 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**	26 May 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 six further recommendations:

- The board is asked to note the very high risk non completion of two recommendations 4 and 5/ Consultant recruitment is ongoing at both UHB & UHW to support delivery and closure of this recommendation. However due to the timescales for consultant recruitment/start dates this is

not going to be achieved by the end of June 2017. It has been agreed that as these actions relate to the delivery of a network service improvement they will move into the cardiac network work plan for ongoing monitoring and sign off. The lead for delivery of this these will be Dr Andy Tometski the lead clinician of the network.

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 Status report

Continued progress was made at the last steering group in signing off of completed recommendations. Please see detail is in the tables below.

Table 1: 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	3	2	2	11	0	0	11 of 32
Apr'17	3	2	2	11	0	0	11 0f 32

Table 2: 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	0	0	1	4	0	0	4 of 32
Apr'17	0	0	1	4	0	0	4 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	0	2	1	2	0	0	2 of 32
Apr'17	1	1	1	2	0	0	2 of 32

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

	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	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
Apr'17	1	0	0	3	0	0	3 of 32

2.0 Exception report for red rated actions

Recommendation 7 – (Management of follow up appointments) the actions to deliver the recommendation have been completed, including a validation of the outpatient backlog. Sign off as complete is pending the women's and children's delivery group being provided with a recovery trajectory. The risk relating to delivery of the recommendation remains on the risk register rated a 6. Aim to sign off as complete at the June steering group meeting.

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 to risk assess cancelled operations is planned prior to the next

delivery group; the timescale for delivery has been extended to June 2017 and it is anticipated that the recommendation will be able to be closed at the June meeting.

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 above 98% 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 30 – Moved to red in view of a further delay to completion, delay only relates to the requirement to approve and close recommendation 26 in order to inform and provide assurance on the completion of recommendation 30; will be presented to the May delivery group with a recommendation for closure for the June steering group.

3.0 Risks to Delivery

No further risks to delivery were added to the project risk register:

- Risks relating to recommendation 2 and 24 were supported for closure following completion of the work required to address the requirements of the recommendation and provide assurance to the steering group
- The risk remains relating to recommendation 7, actions have been described to achieve a resolution however the risk remains until a trajectory to address the follow up backlog has been approved by the Women's and Children's delivery group at the May meeting.
- Risks remain relating to recommendations 4 and 5, recruitment is ongoing at both UHB & UHW to move forward with the work required to achieve the recommendations. The fetal survey is with the families with feedback expected within May'17. Given the timescales for consultant recruitment and the impact these vacancies will have on the ability to progress some changes it is proposed that the ongoing work will sit within the network work plan for completion.

7.0 Recommendations closed

The May 2017 Steering Group approved the closure of six recommendations:

- recommendation 2
- recommendation 3
- recommendation 17
- recommendation 24
- recommendation 26
- recommendation 29

Appendix 1

PROGRESS REPORT AGAINST UH BRISTOL RECOMMENDATIONS FROM THE INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SERVICES – April 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. April'17 Process in place to record all cancelled patients, presented to cardiac clinicians weekly at JCC meeting. All discussions when patients are cancelled are captured here. Further work to provide assurance that the meeting oversees the record of cancelled patients. RT to ensure that all clinicians are aware of the importance of reviewing the list. Reviewing JCC attendance to ensure appropriate oversight. Plan to close recommendation at May delivery mtg	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. **Approved as closed by Steering group 4/4/17**	**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 before rtc in May '17 April'17 Significant work undertaken to identify capacity gap (backlog and ongoing), locum advert going out, outpatient space being identified, additional clinics being planned. Trajectory of the outcome of this work for May delivery mtg with a view to closing recommendation.		**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 **Approved as closed by Steering group 4/4/17**	**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. Mar'17 EOI unsuccessful, plan outstanding final actions at present, to review current resource and finalise a plan for April '17 mtg- added to risk register in view of no plan Apr'17 current paediatric resource reviewed, additional resource added into fetal service already so the team are able to absorb this additional workload with minimal additional support from paediatric team. Original bid reviewed and agreement received to fund additional paediatric admin and nursing time on a fixed term basis from within the division to allow for a full review of all data teams to establish whether any further economies or efficiencies can be identified. Data team have approved that this will be sufficient for the current workload and supporting the fetal team. Commitment from management team to review the team resource on a quarterly basis and external review pending Aug'17. Further sign off received at joint cardiac board (26/04/17) to ensure no impact on adult services. Sign off by lead consultant for cardiac data confirmed additional input is sufficient for current requirements with ongoing review required. RTC agreed by delivery group.		
		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 –			**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		

				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. **Approved as closed by Steering group 4/4/17**			evaluate **Rec 5 Approved as closed by Steering group 4/4/17** April'17 template front sheets presented to group; have been to listening events and cardiac governance for review and comment which have been incorporated. To go back to governance on Friday 28th for final approval and agreement on a go live date, location on website (BRHC or Network or both). Links added to patient letters to guide families to website. Patient information leaflets updated and in circulation. RTC approved by delivery group pending governance sign off for visual pathways and caveats as above.		
		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. **Approved as closed by Steering group 4/4/17**	**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. April'17 letter sent to all families, questionnaire going out to respondees by end April. Improvements will be identified and planned and are anticipated to be sufficient to sign off recommendation by June however both sites have fetal vacancies and therefore this will impact on the timescale for the delivery of the total plan.		
		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. Apr'17 Further audit in May to come to delivery group end of May. RT to highlight to cardiologists and IJ to highlight to intensivists.					**5-** Improved pathways of care paed. cardiology services between Wales and Bristol – timescale change request to May '17 April '17 improvements identified, corresponding with Wales re implementation, awaiting a response. Recommendation on target to close at May delivery meeting		

	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	**Green-complete**	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
							Requirement for additional staff will feed into business round 2016-17	Assistant General Manager for Paediatric Cardiac Services	Apr' 17	**Green-complete**	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 Apr'17 review complete, additional resource funded by division, RTC submitted
3	That the Trust should review the information given to families at the point of diagnosis (whether antenatal	Specialist Clinical Psychologist	Apr '17	**Green-complete**			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

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	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.						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	**Green-complete**	Pathways of Care devised – update to come to Mar'17 mtg re opportunities to link with Network website to enable interactive 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 April'17 visual pathway designs received, RTC approved caveated by sign off by cardiac

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											governance meeting
							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 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	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 two hospitals / commissioning bodies Risk that operational challenges in delivery of the fetal cardiology service in UHW prevent focus on 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
							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 appoint	**Green - Complete**	Feb mtg – outline plan for foetal sessions, process to manage referral through acceptance criteria in short

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	baby will be transferred to Bristol at some point following the birth				achievement of this recommendation business plan				ed lead, but have not yet resolved operational issues		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 out having been for FI feedback which has been incorporated. April'17 letter sent to all identified families to pre-warn and request agreement to receive survey, survey out this week. On target for June closure
							Undertake patient survey and focus groups (FI).	CHD Network Manager	~~Jan '17~~ Revised to Jun 17due to delay	**Amber – behind plan**	As above

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
									in engagement with UHW and the operational challenges in their fetal service		
							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	**Amber – behind plan**	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 priority in its development to achieve better co-ordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol.	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 two hospitals / commissioni	Final completion delayed to May 17 due to initial delay getting engagement from UHW	Network Manager and Network Clinical Director to contact Welsh Commissioners and University of Hospital of Wales to meet to discuss and agree process including method of monitoring its implementation	CHD Network Manager	Nov 16	**Green-complete**	
							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

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
					ng bodies Risk that lack of paediatric cardiology lead in UHW delays the ability to undertake actions		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 April'17 work ongoing, improvements identified, awaiting contact from UHW on target for May closure
7	The paediatric cardiac service in Bristol should carry out periodic audit of follow-up care to ensure that the care is in line with the intended treatment plan, including with regards to the timing of follow-up appointments.	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 view of	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 minutes November

	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 to validate backlog to establish risk – item added to risk register					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. April'17 validation ongoing, capacity gap identified, locum advert, space being identified. Trajectory will be in place for May closure.
8	The Trust should monitor the experience of children and families to ensure that improvements in the	Nurse Project Lead	Oct '16	**Approved as closed by Steering Group (09/01/17)**			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

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	organisation of outpatient clinics have been effective.			**22/11/16- approved for closure by W&C delivery group**			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**	Reference 2. Outpatients and Clinical Investigations Unit Service Delivery Group 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)
							Systems in place for regular and specific monitoring, and reviewing and acting on results (FI)	Outpatients & CIU Service Delivery Group	Oct '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**
9	In the light of concerns about the continuing pressure on cardiologists and the facilities and resources available, the Children's Hospital should benchmark itself against comparable centres and make the necessary changes which such an exercise demonstrates as being necessary.	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 Dependent on the action required to address the gaps it may not be possible to have implemented all the changes in the timescale.	Request to delay to Feb '17 due to late return of benchmarking Request to delay to Mar'17 as some benchmarking data received late; analysis ongoing with visits to be planned by Mar'17	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 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)

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
11	That the paediatric cardiac service benchmarks its current arrangements against other comparable centres, to ensure that its ability, as a tertiary 'Level 1' centre under the NCHD Standards, to communicate with a 'Level 2' centre, are adequate and sufficiently resourced. Benchmarking would require a study both of the technical resources underpinning good communication, and the physical capacity of clinicians to attend planning meetings such as the JCC (Links to recommendation no. 5)	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						
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	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	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

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	operators or team members.					for any others requiring this information to be included.					(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 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	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;

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
						patients adequately					all documentation has been produced to support the process however we have been unable to evidence that the process is being followed robustly April'17 process in place to risk assessment cancelled patients, assurance process during May with a view to closing at May mtg.
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

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
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	**Red – second revision of timescales**		Mar '17 Delayed to allow audit to demonstrate improvement Mar'17 Request to delay to May '17 to enable the demonstration of robust and consistent implementation	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~~ Revised to May 17	**Red – second revision of timescales**	Repeat audit results expected at Mar'17 delivery group with a view to proposing closure of recommendation (JM/BS) Mar'17 audit shows improvement however not 100% compliance at present therefore further communication to clinicians and reaudit prior to closure April'17 reaudit planned for May 17 with a view to closure at May delivery group; comms going out to all teams re the

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											importance of these records and location on electronic patient record system
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 to return to delivery group April 17 (MG/VG)
CQ C. 5	Providing written material to families relating to diagnosis and recording this in the records. (links to	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.							

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	review recommendation 3)										
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 - PROGRESS REPORT AGAINST UH BRISTOL RECOMMENDATIONS FROM THE INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SERVICES

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

TW Consent delivery timeframe April 2017

<table>
<tr><th>MONTH</th><th>Oct '16</th><th>Nov '16</th><th>Dec '16</th><th>Jan '17</th><th>Feb '17</th><th>Mar '17</th><th>Apr' 17</th><th>May '17</th><th>Jun '17</th></tr>
<tr><td rowspan="3">Recommendations</td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="3">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

Closed by Steering Group April 2017</td><td>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

Closed by Steering Group April 2017</td><td rowspan="3"></td><td rowspan="3"></td><td rowspan="2"></td><td rowspan="3">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

Request to close by Steering Group May 2017</td><td rowspan="3"></td></tr>
<tr><td>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

Closed by Steering Group April 2017</td></tr>
<tr><td></td><td></td><td>CQC1- Recording the percentage risk of mortality or other major complications</td><td></td><td></td></tr>
</table>

				discussed with parent/carers on consent forms Closed by Steering Group April 2017					

	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	Green		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	Deputy Medical Director	Jan '17	Green	E-learning lead is currently on long term	Request to delay to Feb '17. Actions are complete, but	**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

	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**
	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				sick which has led to a delay in updating e-learning material	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					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 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	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**								

	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**
	informed about material risks										
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 April – May update business case successful, cover provided adhoc whilst recruitment ongoing to provide permanent solution. RTC completed for May Steering
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	**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

	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 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					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? These 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 – April 2017

MONTH	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '17	Jun '17
Recommendations			**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 – recommendation supported for closure 4/4/17*	**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 April'17 all documentation complete, some documents require ratification however these have already had executive oversight therefore RTC to be submitted to Steering 2/5/17			**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 April'17 QAC approved training option and evaluate impact, CS to investigate other options; HM to discuss procurement/trust wide process with CM for agreement to progress to mediation. Recommendation requirements met therefore RTC to be submitted to Steering 2/5/17		**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 and supported for closure 4/4/17
			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 **April '17 work all completed, documents produced to support closure of recommendation however review by VRG and ratification through Clinical Quality Group required before finalised, rec moved to red in view of second move of deadline required however signoff anticipated at May '17 mtg**						

	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,	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	Women and Children's Head of	Dec '16	**Green – complete. 10.01.17 5/8**	Document approved within the Division via

	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**
	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.						quality and equitable service for all patients / families in the event of bereavement.	Governance		**members approved, remainder virtually.**	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. **Supplementary**	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 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**	Draft guidance presented; comments from group members to be incorporated 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**
										17 meeting Now rated red as not approved at meeting Mar mtg – action complete	represented at March 2017 meeting SOP completed; to go to Mar QAC and implement; audit initially at 6/12 but then annually. Laura Westaway identified lead for audit.
							26.6 Develop the above **staff** guidance for **adult** patients and families (minus CDR) - **Supplementary**	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). - Supplementary**	Head of Quality (Patient Safety)	Apr '17	**Green – action complete**	Leaflet produced but ongoing discussion around the process of sharing a draft RCA with family Links to rec 30 Apr'17 guidance complete, for ratification at CQG 4/4/17
							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	**Green – action complete**	As above Apr'17 guidance complete, for ratification at CQG 4/4/17
							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	**Green – action complete**	Ongoing work on how to achieve this Apr'17 process complete, for ratification at CQG 4/4/17
27	That the design of the processes we refer to should take	Chief Nurse	Apr '17	**Green - completed**			**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**	Guidance for the Preparation and Conduct of

	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**
	account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue.									**approved 10.01.17 pending any further comments within 1 week.**	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 element' can be introduced into the handling of those	Chief Nurse	Apr '17	**Green - completed**		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 Safety Manager	Nov '16 Nov '16	**Green- complete Action approved 10.01.17**	Reports of the Reviews undertaken and available in evidence folder
							28.2 Develop guidance for when to access	Head of			

	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**
	complaints or investigations which require it.						'independent advise / review' for - Complaints - SI RCAs	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 the options for more effective handling of complaints, including	Chief Nurse	Apr '17	**Blue-on target**			29.0 Visit the Evelina to understand their model for mediation and possible replication at UHBristol. A report will be presented following the visit to consider next steps and possible resource implications.	SRO for I&C	Feb 17	**Green - Complete**	Medical Mediation Foundation meeting completed on

	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 introduction of an independent element, serious consideration be given to offering as early as possible, alternative forms of dispute resolution, such as medical mediation.						- Action reviewed and agreed to receive a presentation from the Medical Mediation Foundation who provide the Evelina service.				9/3/17. Feedback written up and sent to BRHC Quality Assurance Committee 17/3/17 for recommendation re next steps; April'17 QAC approved training option and evaluate impact. CS to continue work to investigate other options, including work with patients Association; Recommendation requirements met therefore RTC to be submitted to Steering 2/5/17
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	Chief Nurse	Dec '16	**Red – Delivery revised twice**		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	**Green - completed**	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

	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**
	designing those changes and overseeing their implementation.										available for April 17 Del group RTCApr'17 adult sheet produced to go alongside the paediatric ones already in place and agreed by BRHC QAC,, sent to VRG and to go to CQG 4/4/17 for ratification; agreed RTC May 17 once feedback and ratification & closure of rec 26.
							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 place and in use – more detailed audit to sit within the complaints work plan & feed into Patient Experience Group
							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

	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
							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. Supplementary	Head of Quality (Patient Experience and Clinical Effectiveness)	April '17	**Green-complete**	Mar mtg – action out with 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 Delivery timeframe – April 2017

MONTH	Sept'16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '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 IR risk register in view of delayed completion of action by NHSE April 17 RTC submitted Asst Director of Nursing NHSE SW attending May steering to present request to close				

	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	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**
	protected, and should 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 April'17 RTC submitted, asst nurse director from NHSE SW attending May steering to present
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
							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	Medical Director	Dec '16	**Green**		To be signed	Adoption of the term "Safety of Patients" in place of "Patient Safety"	Medical Director	Feb '17	**Green-complete**	Steering group Mar 7th agreed

	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**
	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.					off as complete at March 7th meeting	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				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, 26 May 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**	26 May 2017
Report Title	Finance Report		
Author			
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 month 1 financial position of the Trust.

Key issues to note

The Trust is reporting a deficit of £1.713m (before technical items) at the end of April. The Operational Plan is a deficit of £1.843m and therefore the Trust is £0.130m ahead of plan. This position includes £0.466m sustainability and transformation (S&T) funding but is £0.200m behind the planned receipt of £0.666m. Therefore the Trust is reporting a surplus of £0.330m excluding S&T funding. However the divisional position is an overspend of £0.861m after only one month which is of serious concern and risks delivery of the 2017/18 Control Total.

Recommendations
Members are asked to: • **Note** the contents of this 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)**
	22 May 2017			

University Hospitals Bristol
NHS Foundation Trust

REPORT OF THE FINANCE DIRECTOR

1. Summary

The summary income and expenditure statement (appendix 1) shows a deficit (before technical items) of £1.713m. After technical items the deficit becomes £1.836m. This is the first month that the Trust has reported a deficit position since 2002/03 but it is in the context of the Trust's Operational Plan for April being a deficit of £1.843m before technical items. This deficit plan reflects the lower planned volume of elective clinical income in April arising from the Easter break and fewer working days in the month as well as the requirement by NHS Improvement to profile Sustainability and Transformation Funding (S&TF) in such a way that only 5% is assumed in each month of the first quarter.

The £13.313m planned Sustainability and Transformation Funding (S&TF) for the year is dependent on achieving the control total excluding S&TF (70%) and achieving the A&E target (30%). The level of S&T funding included in April is £0.466m.This is only in respect of core S&T funding (based on the NHS Improvement phasing of 5% in April) with zero S&T performance funding due to the delivery of A&E performance in April of 82.3% against a trajectory of 82.5%. This is disappointing given the low trajectory set for April and suggests the ramp up in A&E performance required during the year may not be achieved hence the Trust may receive no performance S&T funding at all in 2017/18.

Excluding S&TF the Trust is reporting a deficit of £2.179m against a planned deficit of £2.509m.

Budgets are managed and profiled within Divisions at cost centre level. A profiling adjustment of £1.060m is required to reflect the April Operational Plan. Divisions and Corporate Services are £0.861m adverse to plan. This is extremely concerning given the £13.0m corporate support funding provided to remove underlying deficits to facilitate balanced Divisional Operating Plans.

The position is summarised in the table below:

(excluding technical items)	Plan	Actual	Variance
	Income/(expenditure)		Favourable/(adverse)
	£m	£m	£m
Corporate Income	47.248	47.054	(0.193)
Divisions & Corporate Services	(45.060)	(45.920)	(0.861)
Financing	(2.925)	(2.847)	0.078
Operating Plan Profile Adjustment	(1.106)		1.106
Surplus/(deficit) including S&TF	(1.843)	(1.713)	0.130
S&T Funding	0.666	0.466	(0.200)
Surplus/(deficit) excluding S&TF	**(2.509)**	**(2.179)**	**0.330**

The Divisional overspend of £0.861m after only one month seriously risks delivery of the Trust's control total. Divisional performance must deliver close to breakeven and hence this level of overspending is entirely inconsistent with Operational Plans and hence the Trust's overall financial plan. Divisions must take action to rectify the current key areas of overspending and deliver their operating plans. The impact of failing to deliver the plan

needs to be understood fully in that if the pre-S&T funding plan is not delivered the Trust loses its core S&T funding (i.e. the 70% and £9.319m) and is subject to core fines – that puts the Trust into an absolute deficit position compared to the current plan of a £13m surplus which would result in the cancellation of the Trust's strategic capital (phase 5) plans.

There are four main areas of concern for April:

- Nursing budgets were overspent by £0.468m in April, Medicine accounted for £0.316m. Of this £0.116m was due to escalation capacity. The level of short term nursing sickness is concerning as it tends to have a direct impact on premium rate agency use (especially at weekends and bank holidays).
- Cardiac Surgery activity performance. Only 77% of planned activity was undertaken in April affecting both Specialised Services (£0.168m) and Surgery, Head and Neck (£0.067m). There were 36 cancelled operations in the month, predominantly relating to theatre staff shortages and case over-runs. This position was in the context of an Operational Plan which assumed an improvement in the level of Cardiac Surgery activity.
- Medical staffing costs were £0.208m overspent in April. Women's and Children's was £0.101m adverse to plan and included costs of covering sickness and maternity leave, unfunded sessions and additional hours payments to deliver activity. Surgery Head and Neck was £0.084m adverse due to agency covering vacancies and additional hours payments to deliver activity.
- Unachieved savings of £0.228m. The savings programme of 2.5% is significantly lower than nearly all Trusts in the country. The performance in April represented only 76% of plan.

2. Division and Corporate Services Performance

The overspend in Clinical Divisions and Corporate Services in April was £0.861m compared with the operating plan of £0.120m. This is summarised in the table below:

	Variance to Budget favourable/(adverse)	Operating Plan favourable/(adverse)	
	To 30 April £m	Plan To April £m	Variance £m
Diagnostic & Therapies	0.016	0.010	0.006
Medicine	(0.429)	(0.117)	(0.312)
Specialised Services	(0.113)	0.015	(0.128)
Surgery, Head & Neck	(0.189)	(0.016)	(0.173)
Women's & Children's	(0.169)	(0.002)	(0.167)
Estates & Facilities	(0.012)	(0.010)	(0.002)
Trust Services	(0.001)	-	(0.001)
Other corporate services	0.036	-	0.036
Totals	**(0.861)**	**(0.120)**	**(0.741)**

Medicine

Nursing pay overspent by £0.316m in April primarily driven by the costs of staffing the escalation capacity at £0.116m, 1-1 and RMN nursing of £0.073m, and sickness absence over budget of £0.056m.

Unmet savings accounted for £0.128m overspend in April, relating to unidentified schemes and a prudent approach taken in respect of the delivery of income savings for April. Full delivery of the income savings is expected and the Division continues to work to identify additional schemes.

Specialised Services

Income from activities was £0.168m adverse in April. In particular cardiac surgery activity performance was only 77% of plan compared with the operating plan assumption of 92%. There were significant numbers of cancellations and the Division needs to ensure activity is planned to recover the position.

Surgery, Head and Neck

Pay expenditure was £0.141m adverse to plan. Significant costs were incurred on additional hours payments and agency for both medical and nursing staff.

Savings plans were £0.066m behind plan, largely due to slippage which is expected to recover.

Women's and Children's

Medical staffing overspend in April was £0.101m arising from unfunded sessions, cover for sickness and maternity leave and additional payments to achieve activity. An urgent review is in progress.

Income from activities was £0.092m adverse to plan of which maternity was £0.183m adverse and Cardiac, Surgical and Medical HDU £0.106m adverse. It is considered that both areas have under reported their activity for April and the data is being validated to ensure all activity is included for May (some estimates of this is included in the reported position already). It is therefore hoped that this position will improve.

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

3. Subjective Analysis

The adverse variance of £0.861m in April is analysed subjectively in the table below:

Favourable/(Adverse)	April £m	2016/17 Outturn £m
Nursing & midwifery pay	(0.468)	(4.606)
Medical & dental staff pay	(0.208)	(1.442)
Other pay	(0.022)	2.107
Non-pay	0.261	(9.492)
Income from operations	(0.177)	0.513
Income from activities	(0.247)	(1.429)
Totals	**(0.861)**	**(14.349)**

Further information is provided below.

Nursing & Midwifery Pay

The nursing and midwifery pay variance for the month is £0.468m adverse. The table below shows analysis between substantive, bank and agency:

Favourable/(Adverse)	April £m	March £m	Feb £m	Jan £m	2016/17 Outturn £m
Substantive	0.599	0.806	0.813	0.581	9.130
Bank	(0.630)	(0.654)	(0.543)	(0.553)	(6.340)
Agency	(0.437)	(0.657)	(0.56)	(0.569)	(7.397)
Total	**(0.468)**	**(0.505)**	**(0.290)**	**(0.541)**	**(4.606)**

This demonstrates that, whilst in several areas nursing controls have substantially improved, the April level of overspend is not improved when compared to 2016/17, despite Operational Plans requiring this substantial improvement. This cannot be allowed to continue into the year or the Trust's financial plan will be compromised and S&T funding put at risk.

The agency escalation policy and controls have been agreed and signed up to by the Heads of Nursing. KPIs have been set and will be reviewed monthly at the Nursing Controls Group chaired by Carolyn Mills.

Short term sickness still remains an issue contributing to the agency usage particularly in the Divisions of Specialised Services, Surgery, Head and Neck and Women's and Children's. Work on turnover and recruitment has resulted in an improved vacancy position, with just the Division of Medicine (2.5%) and the Division of Specialised Services (1.5%) being above their Operating Plan targets. The run rate for nursing agency has improved in all Divisions.

The nursing control dashboard is attached at appendix 3.

Medical & Dental Pay

The adverse variance of £0.208m is analysed below:

Favourable/(Adverse)	April £m
Consultant	
- Substantive costs	0.024
- Additional hours payments	(0.157)
- Locum	0.084
- Agency	(0.020)
Other medical	
- Substantive costs	0.095
- Additional hours payments	(0.192)
- Exception reporting payments	0.000
- Locum	(0.045)
- Agency	0.003
Totals	**(0.208)**

The £0.069m adverse variance against consultant expenditure was primarily due to additional hours payments made to staff to deliver additional activity, with a smaller amount to cover to sickness and vacancies. However it is not easy to see the corresponding increase in income to match against this increased cost.

The £0.139m adverse variance against other medical staff is also primarily due to payments for additional hours, however these hours were worked to cover vacancies and sickness.

Non Pay

In April there remains a significant amount of funding held within other expenditure pending finalisation of funding transfers which affects the variance analysis. However, an analysis is shown below:

Favourable/(Adverse)	April £m	2016/17 Outturn £m
Blood	0.008	(0.552)
Clinical supplies & services	0.025	(1.730)
Drugs	(0.111)	(0.362)
Establishment	0.054	(0.091)
General supplies & services	0.023	(0.124)
Outsourcing	(0.098)	(1.241)
Premises	0.003	0.111
Services from other bodies	(0.209)	(2.788)
Research	0.245	0.030
Other non-pay expenditure	0.321	(2.712)
Totals	**0.261**	**(9.459)**

The Trust continues to outsource work to private sector providers with payments to Glanso for surgical work and South West Eye Surgeons for Ophthalmic work causing an adverse variance of £0.112m. Services to other bodies was £0.209m adverse, however £0.094m relates to the virtual ward run by Orla and should not prove an ongoing issue. There were also adverse variances of £35k relating to MRI scans provided by InHealth and £31k relating to the discharge support service provided by Pulse. The £0.111m adverse variance against drugs is primarily driven by activity levels in Ophthalmology.

4. Clinical Activity and Contract Income

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

	In Month Variance Fav/(Adv) £m	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance Fav/(Adv) £m
Activity Based				
Accident & Emergency	0.051	1.402	1.453	0.051
Emergency Inpatients	(0.141)	7.122	6.980	(0.141)
Day Cases	0.271	2.801	3.073	0.271
Elective Inpatients	0.145	4.042	4.188	0.145
Non-Elective Inpatients	(0.412)	2.631	2.219	(0.412)
Excess Beddays	0.107	0.434	0.540	0.107
Outpatients	0.066	5.587	5.652	0.066
Bone Marrow Transplants	0.265	0.596	0.861	0.265
Critical Care Beddays	(0.264)	3.638	3.374	(0.264)
Other	(0.230)	7.545	7.315	(0.230)
Commissioner Assumed Savings	-	-	-	-
Total Activity Based	**(0.142)**	**35.798**	**35.655**	**(0.142)**
Contract Penalties	(0.015)	(0.081)	(0.096)	(0.015)
Contract Rewards	(0.007)	0.732	0.725	(0.007)
Pass through payments	0.021	6.999	7.020	0.021
Sustainability and Transformation Funding	(0.200)	0.666	0.466	(0.200)
2017/18 Total	**(0.342)**	**44.113**	**43.771**	**(0.342)**
Prior year income	-	-	-	-
Overall Total	**(0.342)**	**44.113**	**43.771**	**(0.342)**

Activity based income was £0.142m adverse to plan in April. Emergency activity was £0.553m below plan, in particular within adult cardiac surgery. Critical care bed days were low in April, particularly within Women's and Children's which was £0.20m below plan, un-coded data is being validated. Maternity pathways were £0.28m below plan but this is considered to be due to incomplete data that will be available in May.

The plan assumes 82% achievement of CQUINs, which is £9.43m. This will be high risk in 2017/18 and hence detailed reports will be periodically provided in future periods on this area.

Given the Trust has accepted the control total, national core penalties and local penalties will not apply. Other national penalties will apply and monitoring will commence next month. £0.99m has been set aside to fund penalties.

Pass through payments for blood products and excluded devices, particularly in cardiology, were lower than plan in April, offset by excluded drugs.

5. Savings Programme

The savings requirement for 2017/18 is £11.878m. In April, achievement of savings is reported as £0.762m against a plan of £1.001m. Divisional performance is summarised in appendix 4. A summary of progress of the key work streams is summarised in the following table. A more detailed report is given under item 2.4 on this month's agenda.

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

	Annual Plan £m	Year to Date		
		Plan £m	Actual £m	Variance fav / (adv) £m
Pay	1.653	0.150	0.126	(0.024)
Drugs	0.400	0.032	0.055	0.023
Clinical Supplies	2.229	0.184	0.142	(0.042)
Non Clinical Supplies	3.178	0.255	0.193	(0.062)
Other Non-Pay	0.217	0.016	0.014	(0.002)
Income	2.582	0.229	0.149	(0.080)
Capital Charges	1.000	0.083	0.083	-
Unidentified	0.619	0.052	-	(0.052)
Totals	**11.878**	**1.001**	**0.762**	**(0.239)**

This demonstrates that the position is adverse on most headings which is of particular concern given the 3 month period available prior to the year start for preparation (unlike in previous years where plans were set in March or April).

Whilst supplies, both clinical and non-clinical are behind plan to date, it is expected that this position will improve and the planned savings will be achieved.

Pay savings continue to be a challenge to realise, particularly within Women's and Children's (£0.009m) and Medicine (£0.06m).

Income savings for April have been prudent given the limited time available to review the data.

Work continues to identify and assess pipeline schemes to remove the unidentified savings. Whilst there is c£3m identified, there is very little that has been sufficiently developed to include in the plan.

6. Use of Resources Rating

The Use of Resources Rating (URR) for the Trust for April is 3, in line with the plan of 3. NHS Improvement applies an over-ride such that should any one metric score a 4, the URR is capped at a 3. The following table summarises the position.

		30 April 2017	
	Weighting	Plan	Actual
Liquidity			
Metric Result – days		13.31	15.22
Metric Rating	20%	1	1
Capital Servicing Capacity			
Metric Result – times		0.99	1.13
Metric Rating	20%	4	4
Income & expenditure margin			
Metric Result		-3.60%	-3.34%
Metric Rating	20%	4	4
Variance in I&E margin			
Metric Result		0.00%	0.24%
Metric Rating	20%	1	1
Variance from agency ceiling			
Metric Result		41.7%	38.5%
Metric Rating	20%	1	1
Overall URR		**2.2**	**2.2**
Overall URR (rounded)		**2**	**2**
Overall URR (subject to override)		**3**	**3**

7. Capital Programme

The capital programme for the year submitted in the Operational Plan is £47.885m. It includes £16.040m slippage from the previous year and £37.379m of new schemes in 2017/18. Delivery of the programme is challenging and slippage of £5.534m is forecast.

At the end of April capital expenditure totalled £0.560m against the profiled Operational Plan submitted to NHSI of £2.149m. The work to develop the spend profiles of schemes with budget managers to inform the internal plan which will be reported in subsequent months.

Operational Plan £m	Subjective Heading	Year ended 30 April 2017		
		Operational Plan £m	Actual £m	Variance £m
	Sources of Funding			
3.800	PDC			
	Donations			
	Cash:			
22.764	Depreciation	1.829	1.831	0.002
21.321	Cash balances	0.320	(1.271)	(1.591)
47.885	**Total Funding**	**2.149**	**0.560**	**(1.589)**
	Expenditure			
(19.438)	Strategic Schemes		(0.054)	(0.054)
(11.152)	Medical Equipment	(1.083)	(0.247)	0.836
(11.616)	Operational Capital	(0.808)	(0.174)	0.634
(8.395)	Information Technology	(0.125)	(0.084)	0.041
(2.818)	Estates Replacement	(0.133)	(0.001)	0.132
(53.419)	**Gross Expenditure**	**(2.149)**	**(0.560)**	**1.589**
5.534	In-year Slippage			
(47.885)	**Net Expenditure**	**(2.149)**	**(0.560)**	**1.589**

Depreciation reflects estimates at October 2017 submitted in the Operational Plan. This will be reassessed following the revaluation of assets in 2016/17, the prioritisation and profiling of the Phase 5 schemes and the spend profiles advised by Divisional Capital Leads.

Expenditure in April relates to those schemes carried forward from last year as new schemes are being worked up with spend expected in later months.

Further information is provided at agenda item 3.1.

8. Statement of Financial Position and Cashflow

Net current assets at 30 April 2017 were £36.490m against the Operational Plan of £33.082m.

Receivables are £3.205m higher than plan primarily due to the outstanding balances relating to the 2016/17 final quarter Sustainability and Transformation Funding. Accrued income balances are £2.547m higher than expected reflecting the NHS England over performance and Sustainability and Transformation Funding relating to April.

Current liabilities are £3.331m higher than plan reflecting expenditure accruals in advance of receiving April invoices.

Therefore the closing cash balance of £66.415m is only £0.055m lower than the £66.470m planned.

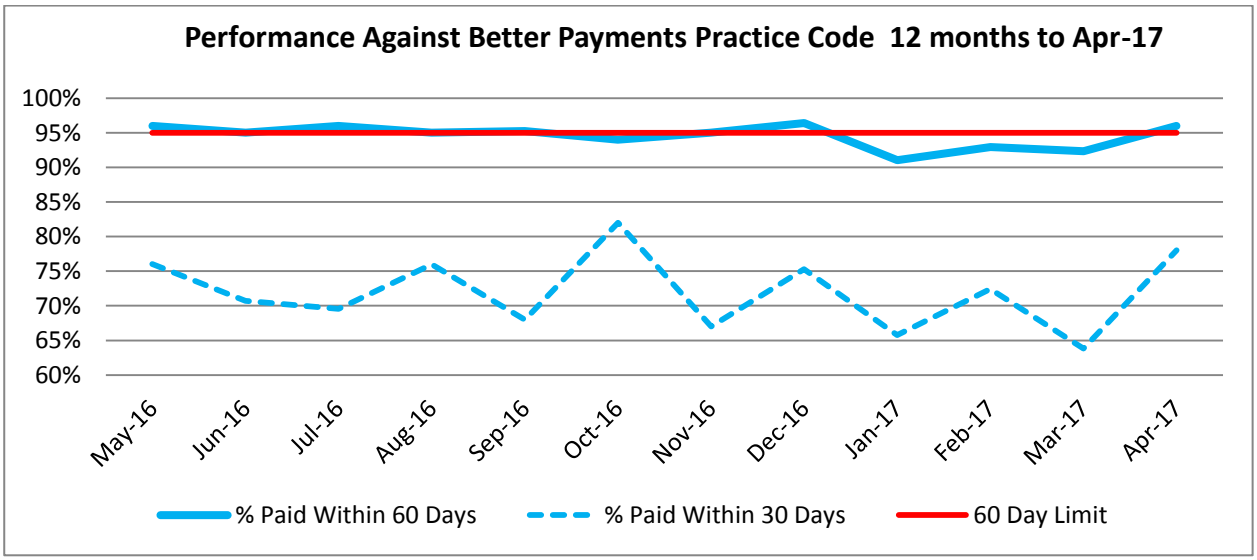
Analysis of the Trust's debtors at the end of April is shown in the table below with further information provided in agenda item 4.1.

	SLA		Non SLA		Total	
	April £m	Movement in month £m	April £m	Movement in month £m	April £m	Movement in month £m
Less than 60 days	11.156	3.291	5.685	(4.040)	16.841	(0.749)
Over 60 days	3.239	(0.181)	3.656	0.161	6.895	(0.020)
Total	**14.395**	**3.110**	**9.341**	**(3.879)**	**23.736**	**(0.769)**

The total value of debtors was £23.736m (£14.395m SLA and £9.341m non-SLA). This represents a decrease in the month of £0.769m (£3.110m SLA increase and £3.879m non-SLA decrease).

Debts over 60 days old have decreased by £0.020m (£0.181m SLA decrease and £0.161m non-SLA increase) to £6.895m (£3.239m SLA and £3.656m non-SLA) and represents 29% of total debtors.

In April 96% of invoices were paid within the 60 day target set by the Better Payments Practice Code. Performance is shown in the graph below:



Attachments *Appendix 1 – Summary Income and Expenditure Statement*
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Nursing KPIs
Appendix 4 – Key Financial Metrics

Appendix 1

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

Approved Budget / Plan 2017/18	Heading	Position as at 30th April		
		Plan	Actual	Variance Fav / (Adv)
£'000		£'000	£'000	£'000
	Income (as per Table I and E 2)			
570,247	From Activities	44,414	43,488	(926)
88,637	Other Operating Income	7,525	7,829	304
658,884	**Sub totals income**	51,939	51,317	(622)
	Expenditure			
(362,343)	Staffing	(30,684)	(31,382)	(698)
(228,673)	Supplies and Services	(19,067)	(18,801)	266
(591,016)	**Sub totals expenditure**	(49,751)	(50,183)	(432)
(19,819)	Reserves			
	Operating Plan Profile	(1,106)		1,106
48,049	**EBITDA**	1,082	1,134	52
7.29	**EBITDA Margin - %**		2.21	
	Financing			
(22,764)	Depreciation - Owned	(1,897)	(1,832)	65
244	Interest Receivable	20	8	(12)
(264)	Interest Payable on Leases	(22)	(22)	-
(3,061)	Interest Payable on Loans	(255)	(230)	25
(9,247)	PDC Dividend	(771)	(771)	-
(35,092)	**Sub totals financing**	(2,925)	(2,847)	78
12,957	**NET SURPLUS / (DEFICIT) before Technical Items**	(1,843)	(1,713)	130
	Technical Items			
-	Profit/(Loss) on Sale of Asset	-	-	-
-	Donations & Grants (PPE/Intangible Assets)	-	5	5
(1,314)	Impairments	-	-	-
-	Reversal of Impairments	-	-	-
(1,561)	Depreciation - Donated	(130)	(128)	2
10,082	**SURPLUS / (DEFICIT) after Technical Items**	(1,973)	(1,836)	137

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report April 2017– Divisional Income & Expenditure Statement

Approved Budget / Plan 2017/18	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Operating Plan Trajectory Year to Date	Variance from Operating Plan Year to Date
				Pay	Non Pay	Operating Income	Income from Activities	CIP			
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income										
36,008	Contract Income	3,135	3,135	–	–	–	–	–	0		
–	Sustainability and Transformation Funding Variance	–	–	–	–	–	(200)	–	(200)		
–	Contract Penalties	–	–	–	–	–	(36)	–	(36)		
–	Overheads	–	(194)	–	–	–	42	–	42		
567,537	NHSE Income	44,113	44,113	–	–	–	1	–	1		
603,545	**Sub Total Corporate Income**	**47,248**	**47,054**	**–**	**–**	**–**	**(193)**	**–**	**(193)**		
	Clinical Divisions										
(50,626)	Diagnostic & Therapies	(4,294)	(4,278)	79	(63)	(20)	37	(17)	16	10	6
(76,422)	Medicine	(6,749)	(7,178)	(417)	181	(4)	(61)	(128)	(429)	(117)	(312)
(110,649)	Specialised Services	(9,115)	(9,228)	(4)	21	18	(168)	20	(113)	15	(128)
(108,162)	Surgery Head & Neck	(9,081)	(9,270)	(141)	(42)	(11)	71	(66)	(189)	(16)	(173)
(122,633)	Women's & Children's	(10,277)	(10,446)	(159)	107	(1)	(92)	(24)	(169)	(2)	(167)
(468,492)	**Sub Total – Clinical Divisions**	**(39,516)**	**(40,400)**	**(642)**	**204**	**(18)**	**(213)**	**(215)**	**(884)**	**(110)**	**(774)**
	Corporate Services										
(36,286)	Facilities And Estates	(3,071)	(3,083)	13	(1)	(3)	(6)	(15)	(12)	(10)	(2)
(24,565)	Trust Services	(2,232)	(2,233)	34	(3)	(27)	–	(5)	(1)	–	(1)
(6,334)	Other	(241)	(204)	(89)	215	(115)	18	7	36	–	36
(67,185)	**Sub Totals – Corporate Services**	**(5,544)**	**(5,520)**	**(42)**	**211**	**(145)**	**12**	**(13)**	**23**	**(10)**	**33**
(535,677)	**Sub Total (Clinical Divisions & Corporate Services)**	**(45,060)**	**(45,920)**	**(684)**	**415**	**(163)**	**(201)**	**(228)**	**(861)**	**(120)**	**(741)**
(19,819)	Reserves	–	–	–	–	–	–	–	–		
	Operating Plan Profile	(1,106)	–	–	1,106	–	–	–	1,106		
(19,819)	**Sub Total Reserves**	**(1,106)**	**–**	**–**	**1,106**	**–**	**–**	**–**	**1,106**		
48,049	**Trust Totals**	**1,082**	**1,134**	**(684)**	**1,521**	**(163)**	**(394)**	**(228)**	**52**		
	Financing										
(22,764)	Depreciation & Amortisation – Owned	(1,897)	(1,832)	–	65	–	–	–	65		
244	Interest Receivable	20	8	–	(12)	–	–	–	(12)		
(264)	Interest Payable on Leases	(22)	(22)	–	–	–	–	–	–		
(3,061)	Interest Payable on Loans	(255)	(230)	–	25	–	–	–	25		
(9,247)	PDC Dividend	(771)	(771)	–	–	–	–	–	–		
(35,092)	**Sub Total Financing**	**(2,925)**	**(2,847)**	**–**	**78**	**–**	**–**	**–**	**78**		
12,957	**NET SURPLUS / (DEFICIT) before Technical Items**	**(1,843)**	**(1,713)**	**(684)**	**1,599**	**(163)**	**(394)**	**(228)**	**130**		
	Technical Items										
–	Profit/(Loss) on Sale of Asset	–	–	–	–	–	–	–	–		
–	Donations & Grants (PPE/Intangible Assets)	–	5	–	–	5	–	–	5		
(1,314)	Impairments	–	–	–	–	–	–	–	–		
–	Reversal of Impairments	–	–	–	–	–	–	–	–		
(1,561)	Depreciation & Amortisation – Donated	(130)	(128)	–	2	–	–	–	2		
(2,875)	**Sub Total Technical Items**	**(130)**	**(123)**	**–**	**2**	**5**	**–**	**–**	**7**		
10,082	**SURPLUS / (DEFICIT) after Technical Items**	**(1,973)**	**(1,836)**	**(684)**	**1,601**	**(158)**	**(394)**	**(228)**	**137**		

REGISTERED NURSING - NURSING CONTROL GROUP AND HR KPIs

Graph 1 **Sickness**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*3.8%*	*3.8%*	*3.8%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*3.9%*	*3.9%*	*3.9%*
Medicine	Actual	3.4%											
Specialised Services	*Target*	*3.5%*	*3.5%*	*3.5%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.7%*	*3.6%*	*3.6%*	*3.6%*
Specialised Services	Actual	4.0%											
Surgery, Head & Neck	*Target*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*	*3.9%*
Surgery, Head & Neck	Actual	4.6%											
Women's & Children's	*Target*	*3.3%*	*3.3%*	*3.3%*	*3.6%*	*3.6%*	*3.6%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*
Women's & Children's	Actual	4.4%											

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%											
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%											
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%											
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%											

Source: HR

Graph 3 **Turnover**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*	*15.8%*
Medicine	Actual	13.5%											
Specialised Services	*Target*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*	*14.1%*
Specialised Services	Actual	13.6%											
Surgery, Head & Neck	*Target*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*	*11.9%*
Surgery, Head & Neck	Actual	11.8%											
Women's & Children's	*Target*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*	*10.0%*
Women's & Children's	Actual	12.9%											

Source: HR - Registered
Note: M4 figs restated

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*118.8*	*118.8*	*109.8*	*100.8*	*91.8*	*82.9*	*82.9*	*91.8*	*100.8*	*109.8*	*109.8*	*109.8*
Medicine	Actual	207.9											
Specialised Services	*Target*	*61.5*	*75.0*	*68.5*	*64.2*	*64.2*	*59.8*	*59.8*	*54.4*	*65.3*	*62.5*	*58.8*	*58.8*
Specialised Services	Actual	20.7											
Surgery, Head & Neck	*Target*	*64.6*	*69.6*	*79.5*	*85.5*	*80.5*	*89.6*	*89.3*	*55.7*	*64.6*	*69.5*	*69.5*	*64.6*
Surgery, Head & Neck	Actual	158.2											
Women's & Children's	*Target*	*110.0*	*110.0*	*110.0*	*110.0*	*110.0*	*110.0*	*50.0*	*50.0*	*50.0*	*50.0*	*50.0*	*50.0*
Women's & Children's	Actual	85.3											

Source: Finance GL (excludes NA 1:1)

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*14.0*	*14.0*	*13.0*	*12.0*	*11.0*	*10.0*	*10.0*	*11.0*	*12.0*	*13.0*	*13.0*	*13.0*
Medicine	Actual	25.3											
Specialised Services	*Target*	*9.5*	*12.0*	*10.8*	*10.0*	*10.0*	*9.2*	*9.2*	*8.2*	*10.2*	*9.7*	*9.0*	*9.0*
Specialised Services	Actual	2.4											
Surgery, Head & Neck	*Target*	*13.0*	*14.0*	*16.0*	*17.2*	*16.2*	*18.2*	*18.2*	*11.2*	*13.0*	*14.0*	*14.0*	*13.0*
Surgery, Head & Neck	Actual	17.8											
Women's & Children's	*Target*	*11.0*	*11.0*	*11.0*	*11.0*	*11.0*	*11.0*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*
Women's & Children's	Actual	10.0											

Source: Finance GL (excludes NA 1:1)

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

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*6.6%*	*6.6%*	*6.2%*	*5.7%*	*5.2%*	*4.7%*	*4.7%*	*5.2%*	*5.7%*	*6.2%*	*6.1%*	*6.1%*
Medicine	Actual	11.1%											
Specialised Services	*Target*	*4.4%*	*5.4%*	*4.9%*	*4.6%*	*4.6%*	*4.3%*	*4.3%*	*3.9%*	*4.7%*	*4.5%*	*4.2%*	*4.2%*
Specialised Services	Actual	1.5%											
Surgery, Head & Neck	*Target*	*3.7%*	*3.9%*	*4.5%*	*4.8%*	*4.5%*	*5.0%*	*5.0%*	*3.2%*	*3.7%*	*3.9%*	*3.9%*	*3.7%*
Surgery, Head & Neck	Actual	8.5%											
Women's & Children's	*Target*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*	*1.5%*
Women's & Children's	Actual	2.4%											

Source: Finance GL (RNs only)

Graph 7 **Occupied bed days**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	Actual	9,071											
Specialised Services	Actual	4,392											
Surgery, Head & Neck	Actual	4,481											
Women's & Children's	Actual	6,179											

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*												
Medicine	Actual												
Specialised Services	*Target*												
Specialised Services	Actual												
Surgery, Head & Neck	*Target*												
Surgery, Head & Neck	Actual												
Women's & Children's	*Target*												
Women's & Children's	Actual												

Source: Finance temp staffing graphs (history changes)

Key Financial Metrics -April 2017 **Appendix 4**

	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	3,184	4,743	4,997	6,428	8,795	314		7,338	35,799
Actual	3,239	4,749	4,792	6,501	8,689	307		7,379	35,656
Variance Fav / (Adv)	55	6	(205)	73	(106)	(7)	-	41	(143)
Year to date									
Budget	3,184	4,743	4,997	6,428	8,795	314		7,338	35,799
Actual	3,239	4,749	4,792	6,501	8,689	307		7,379	35,656
Variance Fav / (Adv)	55	6	(205)	73	(106)	(7)	-	41	(143)
Contract Income - Penalties									
Current Month									
Plan	-	(16)	(2)	(8)	(4)			(51)	(81)
Actual	-	(5)	(2)	(2)	-			(87)	(96)
Variance Fav / (Adv)	-	11	0	6	4	-	-	(36)	(15)
Year to date									
Plan		(16)	(2)	(8)	(4)			(51)	(81)
Actual		(5)	(2)	(2)	-			(87)	(96)
Variance Fav / (Adv)	-	11	0	6	4	-	-	(36)	(15)

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

Contract Income - Rewards									
Current Month									
Plan	73	108	145	149	169	88	-	-	732
Actual	72	107	144	148	168	87	-	-	726
Variance Fav / (Adv)	(1)	(1)	(1)	(1)	(1)	(1)	-	-	(6)
Year to date									
Plan	73	108	145	149	169	88	-	-	732
Actual	72	107	144	148	168	87	-	-	726
Variance Fav / (Adv)	(1)	(1)	(1)	(1)	(1)	(1)	-	-	(6)

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

Cost Improvement Programme									
Current Month									
Plan	112	190	112	227	165	58	47	90	1,001
Actual	98	74	119	134	146	53	41	97	762
Variance Fav / (Adv)	(14)	(116)	7	(93)	(19)	(5)	(6)	7	(239)
Year to date									
Plan	112	190	112	227	165	58	47	90	1,001
Actual	98	74	119	134	146	53	41	97	762
Variance Fav / (Adv)	(14)	(116)	7	(93)	(19)	(5)	(6)	7	(239)

Cover report to the Public Trust Board meeting to be held on Friday, 26 May 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**	26 May 2017
Report Title	Capital Investment Policy		
Author	Paula Clarke, Director of Strategy and Transformation		
Executive Lead	Paula Clarke, Director of Strategy and Transformation		
Freedom of Information Status		Open	

Strategic Priorities (please 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 Capital Investment Policy is subject to an annual review. The policy has been reviewed by the Capital Programme Steering Group and the Finance Committee in May. Updates to the policy are subject to Trust Board approval.

Key issues to note

Minor amendments have been made to the policy relating to revised financial thresholds in section 6.5 and the non-financial criteria in section 7.2.

Recommendations
Members are asked to: • **Approve** the revised 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)**
	22nd May 2017			Capital Programme Steering Group 10th May 2017.

Capital Investment Policy

Document Data		
Subject:	Procedural Documents	
Document Type:	Policy	
Document Status:	Approved	
Document Owner:	Director of Strategy and Transformation	
Executive Lead:	Director of Strategy and Transformation	
Approval Authority:	Trust Board of Directors	
Estimated Reading Time:	22 Minutes[1]	
Review Cycle:	12	
Next Review Date:	**Date of First Issue:**	**Date Version Effective From:**
25/05/2018	24/06/2008	26/05/2017

Document Abstract
This policy sets out the governance arrangements for capital investments undertaken by the University Hospitals Bristol NHS Foundation Trust (UH Bristol). The policy takes into account NHS Improvement's Single Oversight Framework with effect from 30 September 2016. This policy will be subject to annual review by the Board of Directors.

[1] Divide number of words (4,177) by 240 for average reading time and add 25% for specialist content.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
03/05/17	11	Director of Strategy & Transformation	Minor	Update of section 7.2 to reflect the revised non-financial criteria for prioritisation.
12/10/15	10	Director of Strategy & Transformation	Minor	Additional bullet point included in section 7.1 - 'The cost of the loan principal payments where relevant'
11/05/15	9	Director of Strategy & Transformation	Minor	Thresholds updated to reflect the Trust's 2015/16 planned turnover of £587m; removal of the reference to NHS Improvement's "Risk Evaluation for Investment Decisions" document; updated Annex 2 to reflect the 2015/16 capital prioritisation process.
24/06/08	1		Draft	Draft considered at Trust Board on 1 July

Table of Contents

1. Purpose

This policy sets out the governance arrangements for capital investments undertaken by the University Hospitals Bristol NHS Foundation Trust (UH Bristol).

The policy takes into account NHS Improvement's Single Oversight Framework (SOF) published 30th September 2016. This policy will be subject to annual review by the Board of Directors.

2. Scope

The policy applies to capital investments by UH Bristol regardless of the source of funding. Charitably funded projects must be prepared and managed therefore in accordance with the policy.

Particular consideration is given to capital investments which impact on the Trust's Use of Resources Rating and are classed as major and / or high-risk accordingly.

The full definition of a major or high-risk investment is given in section 4.2.

3. Investment Philosophy and Objectives

The Trust will invest in opportunities that are consistent with its purpose, vision and objectives.

The statutory and principal purpose of the Trust is the provision of goods and services for the health service in England.

In fulfilling its core purpose, the Trust's mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. When appropriate, the Trust will make investment decisions in line with the Trust's business and service intent as set out in the Trust's Clinical Strategy, as summarised below:

- Our strategic intent is to provide excellent local, regional and tertiary services, and maximising the mutual benefit to our patients that comes from providing this range of services;
- Our focus for development remains our specialist portfolio and we aim to expand this portfolio where we have the potential to deliver exceptional, affordable healthcare;
- As a University teaching hospital, delivering the benefits that flow from combining teaching, research and care delivery will remain our key advantage. In order to retain this advantage, it is essential that we recruit, develop and retain exceptionally talented and engaged people;
- We will do whatever it takes to deliver exceptional healthcare to the people we serve and this includes working in partnership where it supports delivery of our goals, divesting or our sourcing services that others are better placed to provide and delivering new services where patients will be better served;

- The Trust's role in community service provision will be focused upon supporting our partners to meet the needs of our patients in a timely way, however, where our patients' needs are not being met, the Trust will provide or directly commission such services;
- Our patients – past, present and future - their families, and their representatives, will be central to the way we design, deliver and evaluate our services. The success of our vision to provide "High quality individual care, delivered with compassion" will be judged by them.

The investment policy sets out the criteria which will be used by the Trust to evaluate potential major and / or high risk capital investment decisions (defined in section 7).

The Trust will also take into account the financial, strategic, quality, operational, regulatory and reputational risk and benefit when evaluating potential investment decisions.

The Trust will not enter into any project that would result in a breach of the terms of its NHS provider licence.

4. Capital Budget Setting

4.1 The Medium Term Capital Programme

The Board of Directors will approve both the size of the Medium Term Capital Programme, taking account of the approved long term financial plan, and the budget allocation between classes of investment in the programme, which will include at a minimum:

- Major strategic projects;
- Operational capital;
- Medical equipment;
- Other equipment
- Information Technology; and
- Works replacement.

A capital planning process will be integrated into the annual business planning round which will determine the approval route for each class of investment.

The Trust will move towards establishing a rolling replacement programme for key assets.

Guidance will be made available about the process to be followed for each class of capital investment. The guidance will also make specific reference to the process for rapid preparation and approval of spend-to-save schemes.

4.2 Identification of Major or High Risk Investments

A proposal will be classed as a major investment if its estimated capital cost including VAT exceeds 1% of Trust's turnover or £6.58million based on the 2017/18 plan of £658million.

High risk investments are defined as:

- Transactions which trigger the requirement to inform NHS Improvement. The criteria for reportable transactions are described in Annex 1; and
- Transactions that may have any one or more of the following characteristics:

  - Significant reputational risk;
  - The potential to destabilise the core business;
  - The creation of material contingent liabilities; and
  - An equity component involving shares.

4.3 Business Case Requirements

All investment proposals will be supported by relevant business case documentation according to the value of the proposed investment as shown in Table 1 below:

Scheme cost as % of Trust turnover	**Documentation required**
Up to 0.25%	Short-form business case
Between 0.25% and 1%	Comprehensive business case
More than 1%	Outline Business Case (OBC) and (subject to OBC approval) a Full Business Case (FBC)

Table 1: Thresholds for business case requirement

Any project requiring financial support for production of the appropriate business case prior to scheme approval must have an approved Project Initiation Document.

Detailed templates and guidance for each form of business case is available from the Director of Strategy & Transformation.

4.4 Project Sponsor

Each capital investment proposal will require Executive Director support who will be the Project Sponsor.

The Project Sponsor is responsible for ensuring that the terms of the Capital Investment Policy and other Trust policies are followed and that business cases follow the appropriate approval route (see section 6).

5. Finance Committee

The Finance Committee will take the role of **capital investment committee** for the purposes of this policy. It will have delegated authority from the Trust Board for:

- Approving the investment and borrowing strategy and associated policies;
- Setting performance benchmarks and monitoring investment performance;

- Reviewing and revising the Capital Investment Policy on an annual basis for Board approval;
- Obtaining assurance that there is compliance throughout the Trust with the Capital Investment Policy;
- Approving capital investments according to the thresholds outlined in section 6.5 including ensuring that the Trust has the legal authority to enter into a particular investment; and
- Approving Project Initiation Documents for all schemes.

6. Approval Route

6.1 Board of Directors

The Board will provide oversight of the Finance Committee. It will have the final decision over all major schemes (greater than 1% of the Trust's turnover) and high risk investments as defined in this policy.

The Board will approve the Capital Investment Policy on an annual basis.

6.2 Finance Committee

The Finance Committee will have delegated authority to approve business cases with a value greater than 0.5% and up to and including 1% of Trust turnover, which do not qualify as high risk investments. It will report its approvals to the Trust Board including an account of the cumulative value of schemes approved in-year.

It will also consider all business cases classed as major and / or high risk and make recommendations for approval or rejection to the Board.

6.3 Senior Leadership Team

The Senior Leadership Team will have delegated authority to approve investments greater than 0.25% and up to and including 0.5% of turnover, which do not qualify as high risk investments.

It will report its approvals to the Finance Committee, including an account of the cumulative value of schemes approved in-year.

It will also consider schemes between 0.25% and 1.0% of Trust turnover and which do not qualify as high risk investments. It will make recommendations about these proposals to the Finance Committee.

The Senior Leadership Team may choose to delegate approval of capital investments to the Capital Programme Steering Group.

6.4 Capital Programme Steering Group

The Capital Programme Steering Group will report to the Senior Leadership Team.

The Group will be responsible for co-ordinating the capital planning process and issuing internal guidance, ensuring that the appropriate initiation and risk assessment documentation is in place for proposed schemes. It will make recommendations about proposals to the Senior Leadership Team and the Finance Committee in line with their respective approval rights. These recommendations will cover both approval of projects and the programming of related expenditure.

The Group will approve capital investments up to and including 0.25% and will report its approvals to the Senior Leadership Team.

The Capital Programme Steering Group will report performance against the capital programme both to the Finance Committee and the Senior Leadership Team.

6.5 Summary

Table 2 shows the thresholds used to determine the business case requirement for schemes which fall within the definition of high risk and / or the definition of a major scheme (see section 4.2). It should be noted that the approval route is the same with all high risk and / or major schemes:

Threshold		Business Case format	Capital Programme Steering Group	Senior Leadership Team	Finance Committee	Trust Board	Council of Governors
Percentage of turnover %	Capital expenditure including VAT £m						
>1%	>£6.58m	OBC + FBC	✓	✓	✓	✓	✓
>0.25% <=1%	>£1.65m <= £6.58m	Comprehensive					
<=0.25%	<=1.65m	Short-form					

Table 2: Business case requirement and approval route (high risk or major capital schemes)

For schemes that fall outside of the definition of high risk and / or involve capital expenditure totalling 1% or less than the Trust's turnover of £658million, table 3 overleaf shows the thresholds, business case requirement and approval route:

Threshold		Business Case form	Capital Programme Steering Group	Senior Leadership Team	Finance Committee	Trust Board
Percentage of turnover	Capital expenditure including VAT* £m					
>0.5% <=1%	>£2.94m <= £5.87m	Comprehensive	✓	✓	✓	
>0.25% <=0.5%	>£1.47m <= £2.94m	Comprehensive	✓	✓		
<=0.25%	<=£1.47m	Short-form	✓			

Table 3: Business case requirement and approval route (all other)

7. Evaluation

Business cases will be evaluated against explicit financial and non-financial criteria outlined below.

7.1 Financial Criteria

Proposals which are not classed as a major investment decision will be assessed for scheme affordability.

Business cases for major capital investment (over 1% of turnover) will be expected to demonstrate as a minimum a neutral recurring revenue position including financing costs as follows:

- The cost of loan principal repayments where relevant;
- 3.5% interest charge if internally funded or financed through Public Dividend Capital; or
- at the cost to the Trust, if financed through borrowing.

The Board may choose to waive the requirement to deliver a neutral recurring revenue position where it deems that exceptional circumstances apply. Such circumstances may include mitigation against significant strategic, statutory, regulatory, operational or reputation risks or a desired investment in a quality improvement.

In this case, the Board will make the final investment decision itself, including explicit approval of the cross-subsidy arrangements which should apply to the capital investment in question.

7.2 Non-Financial Criteria

Strategic Capital

The following non-financial criteria will be used to evaluate all capital investment proposals.

Strategic Fit – the extent to which the proposed investment is consistent with the Trust's Clinical Strategy and strategic aims.

Risk Mitigation - the extent to which the proposed investment addresses existing or anticipated strategic, financial, operational, regulatory, and political or reputational risks.

Major Medical Capital

Technical Resilience - based on age of asset, maintenance costs and business criticality.

Strategic Fit/Quality – the extent to which the proposed investment is consistent with the Trust's Clinical Strategy and strategic aims.

Risk Mitigation - the extent to which the proposed investment addresses existing or anticipated strategic, financial, operational, regulatory, and political or reputational risks.

Operational Capital

Strategic Fit/Quality – the extent to which the proposed investment is consistent with the Trust's Clinical Strategy and strategic aims.

Risk Mitigation - the extent to which the proposed investment addresses existing or anticipated strategic, financial, operational, regulatory, and political or reputational risks.

Scoring templates for the non-financial appraisal of major medical and operational capital is attached at Annex 2.

8. Risk Management

The non-financial evaluation criteria include risk mitigation and therefore take into account the risk of not entering into a proposed investment.

The Trust will also take into account the risk and return (both financial and non-financial) of making a proposed capital investment. The risks will be fully identified and assessed according to the Trust's standard risk assessment tool. A sample due diligence checklist is attached at Annex 3.

The Trust will seek to quantify the risks of a proposed investment in financial terms wherever possible. Business cases for major capital investment will include a quantified risk and mitigation assessment.

The Trust will actively monitor the performance of its investments and ensure that adequate risk mitigation is in place.

9. Appendices

- Annex 1 – Thresholds for reporting investments to NHSI
- Annex 2 – Scoring Matrix for non-financial evaluation for an investment - Operational and Major Medical – Quality and strategy
- Annex 3 – Scoring Matrix for non-financial evaluation for an investment - Operational and Major Medical – Risk
- Annex 4 - Scoring Matrix for non-financial evaluation for an investment - Major Medical – Technical Resilience.
- Annex 5 - Scoring Matrix for non-financial evaluation for an investment – Strategic Capital.
- Annex 6 – Simple due diligence checklist to inform risk assessment.

Annex 1

Thresholds for reporting investments or divestments to NHS Improvement
Source: *Guidance on transactions for NHS Foundation Trusts*, Monitor, March 2015

If a transaction meets any one of the criteria below, it must be reported to NHS Improvement.

Ratio	Description	UK Healthcare	Non Healthcare
Assets	The gross assets* subject to the transaction divided by the gross assets of the foundation trust	> 10 %	> 5 %
Income	The income attributable to: • the assets; or • the contract associated with the transaction divided by the income of the foundation trust	> 10 %	> 5 %
Consideration to total NHS FT capital	The gross capital** or consideration associated with the transaction divided by the total capital*** of the foundation trust following completion.	> 10 %	> 5 %

* Gross assets are the total of fixed assets and current assets.
** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets.
*** Total capital of the Foundation Trust equals tax payers equity.

Small, Material or Significant Transaction

Transactions which do not meet the reporting requirements set out above are classified as "small" transactions. All reportable transactions will be classified as either "material" or "significant" by NHS Improvement. NHS Improvement will classify a transaction as significant, and subject to a detailed review, if the transaction meets one of the following criteria:

- A relative size of greater than 40% in any of the tests set out above;
- A relative size of between 25% and 40% of the tests set out above and an additional risk factor has been identified by NHS Improvement and is considered relevant;
- A relative size of between 10% and 25% of the tests set out above and in NHS Improvement's view, one or more major risk or more than one other risk has been identified by NHS Improvement and is considered relevant.

A non-exhaustive list of examples of risk factors are set out overleaf to provide an indication of what NHS Improvement may consider to be a major risk or otherwise.

Risk factor	Example of major risk	Example of other risk
Leverage	Capital servicing capacity of the enlarged organisation is <1.75 (as defined in the SOF)	Capital servicing capacity of the enlarged organisation is <2.5 (as defined in the SOF)
Acquirer's experience of services provided by target	A significant change in scope of activity of acquirer	A minor change in scope of activity of acquirer
Acquirer quality	Governance at the acquirer is rated "red" or subject to narrative with a "formal investigation" underway	Governance at the acquirer is subject to narrative description of some concerns
Acquirer financial	Use of Resources rating of ≤2 in the acquirer	Use of Resources rating of 2/3 in the acquirer
Target quality	Target is rated "inadequate" by CQC	Target is rated "requires improvement" by CQC
Target financial	Target has significant current and/or historical deficits	Target has minor current and/or historical deficits

Annex 2

Operational and Major Medical Capital prioritisation – Quality and Strategy Criteria
Key – 1 = very low impact to 5 = Significant, specific and tangible impact.

	Weighting	Scores 1 – 5	Rationale
ACCESS			
The extent to which the scheme will deliver improvements in performance on core constitutional standards such as RTT, diagnostic wait, cancer or 4 hour benefits	3		
SAFE, RELIABLE CARE			
The extent to which the scheme maintains or improves the safety of the service provided to patients.	3		
The extent to which the scheme delivers improvements in the provision of reliable care, which could include increased/flexible service hours or flexible service locations	2		
The extent to which the scheme will maintain or improve compliance against NICE, NHS England service specifications and/or other key national guidance/enquiries.	2		
PATIENT AND STAFF EXPERIENCE			
The extent to which this will maintain or improve the ability to treat patients with honesty, respect and dignity	2		
The extent to which the scheme responds directly to patient complaints, taking account of the number of complaints received and percentage of patients that complaint (i.e. 100% patients complain scores higher)	1		
The extent to which the scheme will improve staff experience	3		
The extent to which the scheme will improve staff wellbeing	2		
RESEARCH, INNOVATION AND TRANSFORMATION			
The extent to which the scheme will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	1		
The extent to which the scheme impacts on the delivery of the emerging priorities in the system Sustainability and Transformation Plan (STP)	1		
	TOTAL /100		

Annex 3

Operational and Major Medical Capital prioritisation - Risk Criteria

SCORE	RISK MITIGATION
5	**High and Extreme** risk score (12 to 25) as per Trust's Risk Assessment Matrix
4	**High** risk score (8-10) as per Trust's Risk Assessment Matrix
3	
2	**Moderate** risk score (4 to 6) as per Trust's Risk Assessment Matrix
1	**Low** risk score (1 to 3) as per Trust's Risk Assessment Matrix
0	**No risk**, score 0
Scores	
Weighting	*x 20*
TOTAL /100	

Annex 4

Major Medical Capital Prioritisation - Technical Resilience Score

Age score		
This is based on the age of the asset in relation to its anticipated lifespan		
Relative age	**Score**	
2year+ below	1	
2year to 0 year below	2	
0 years (same as lifespan)	3	
0-2 years above	4	
2years+ above	5	
	Unweighted Score	
	Weighting x5	
	Weighted score	
Reliability score		
This is based on the cost of maintenance which takes account of routine servicing, but also labour and parts associated with failing equipment		
Cost	**Score**	
£0	1	
£0-£1000	2	
£1001-£5000	3	
£5001-£10000	4	
£10000+	5	
	Unweighted Score	
	Weighting x5	

	Weighted score	
Business Criticality	**Score**	
No disruption to service	1	
Disruption to single-patient treatment	2	
Some disruption to service	3	
Significant disruption to service	4	
Closure of service	5	
	Unweighted Score	
	Weighting x5	
	Weighted score	
	TOTAL SCORE /100	

Annex 5

Strategic Capital – Non financial appraisal
Assessment of Strategic Alignment

Key – 1 = very low impact to 5 = Significant, specific and tangible impact.

	Strategic Priorities	Score 1-5	Rationale
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 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		
7.	We will ensure we are soundly governed and are compliant with the requirements of our regulators		
	Strategic Intent – Clinical Strategy		
	• Our strategic intent is to **provide excellent local, regional and tertiary services**, and maximising the mutual benefit to our patients that comes from providing this range of services. • Our **focus for development remains our specialist portfolio** and we aim to expand this portfolio where we have the potential to deliver exceptional, affordable healthcare. • The Trust's role in **community service provision will be focused upon supporting our partners** to meet the needs of our patients in a timely way; however, where our patients' needs are not being met, the Trust will provide or directly commission such services.		
8.	Considering the above, the extent to which the scheme impacts on the delivery of the refreshed Trust Clinical Strategy?		
9.	The extent to which the scheme impacts on the delivery of the emerging priorities in the system Sustainability and Transformation Plan (STP)		
	TOTAL /45		

Scoring matrix for non-financial evaluation of STRATEGIC CAPITAL INVESTMENTS

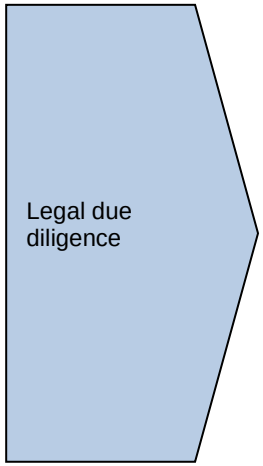
SCORE	STRATEGY FIT	RISK MITIGATION
	Strategic Fit	
5	Score of 40-45 against delivery of strategic priorities.	**Extreme** risk score (15 to 25) as per Trust's Risk Assessment Matrix
4	Score of 30-40 against delivery of strategic priorities.	**High** risk score (8-12) as per Trust's Risk Assessment Matrix
3	Score of 20-30 against delivery of strategic priorities.	
2	Score of 10-20 against delivery of strategic priorities.	**Moderate** risk score (4 to 6) as per Trust's Risk Assessment Matrix
1	Score of 0-10 against delivery of strategic priorities.	**Low** risk score (1 to 3) as per Trust's Risk Assessment Matrix
0	**No impact** on strategic priorities	**No risk**, score 0
Scores		
Weighting	*x 50*	*x 50*
Weighted scores		
Total score		

Annex 6

Due Diligence Checklist To Inform Risk Assessment

Typical due diligence items

Type of process	Area	Example Items
Financial and commercial due diligence	▪ Strategy	▪ Rationale for how proposed investment will deliver value ▪ Strategic and business plans ▪ Business strengths and weaknesses ▪ Competitive dynamics
	▪ Finance	▪ Historical normalised earnings ▪ Most recent 5-year projection ▪ Key assumptions and sensitivity analysis ▪ Working capital strategy
	▪ Operations and manufacturing	▪ Business economics ▪ Customer and supplier relationships/contracts
	▪ Organisation and Management	▪ Management capabilities ▪ Organisation structure ▪ Systems integration ▪ Corporate culture and style
Tax and accounting due diligence	▪ Research and development	▪ Key research efforts ▪ Research relationships and contracts
	▪ Information technology	▪ Security and contingency plans ▪ Types of systems ▪ Outsourced services
	▪ Accounting	▪ Financial reporting systems ▪ Contribution margin ▪ Depreciation schedules
	▪ Finance	▪ Capital structure ▪ Covenants triggered by deal



▪ Tax	▪ Tax liabilities from non-paid taxes ▪ Tax reserve
▪ Insurance	▪ Claims history and policy status ▪ Contingent liabilities
▪ Corporate structure	▪ Shares outstanding and shareholder interests (if relevant) ▪ Legal entities
▪ Legal	▪ Indemnification provisions ▪ Outstanding and pending limitation ▪ Licences, patents and trademarks
▪ Labour	▪ Employment contracts and agreements ▪ Pension provisions and funding levels ▪ Non-paid benefits
▪ Anti-competitive	▪ Potential anti-trust liabilities ▪ Potential remedies/outcomes
▪ Environment	▪ Existing and future liabilities ▪ Successor liability ▪ Remediation plans

This is not an exhaustive list of areas to be covered within due diligence. The scope of due diligence will vary depending on the proposed transaction and should be discussed and agreed with the NHS foundation trust's professional advisers.

Cover report to the Public Trust Board meeting to be held on Friday, 26 May 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**	26 May 2017
Report Title	Treasury Management Policy		
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

The Trust Board is required to regularly review the Trust's Treasury Management Policy and recommend any changes for Board approval.

Key issues to note

The Treasury Management Policy, last reviewed in February 2016, requires a number of minor changes primarily to update terminology. The Finance Department keeps the policy under review and will bring to the Board any future required amendments. The report was reviewed by the Finance Committee meeting on the 25.04.17.

Recommendations
Members are asked to: • approve the minor changes for Board approval and note the ongoing review by the Finance Department.

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

Treasury Management Policy

1. Introduction

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

The policy was last reviewed and amended in February 2016. A review of the policy a year later requires minor changes as follows:

- All references to Monitor have been amended to NHS Improvement with Monitor's Risk Assessment Framework replaced by the Single Oversight Framework (page5).
- Page 11 – Non NHS Debtors Overseas patients has been updated to reflect the change in legislation from 01 April 2017
- Page 14 – Since 18th January 2016 the Government Banking Service (GBS) has been provided by Royal Bank of Scotland (RBS) not Citibank, and GBS payments are now made using RBS Bankline rather than CitiDirect.
- A number of job titles have been changed to reflect current titles.

In addition a number of amendments have been made to the text to improve its understanding which does not change the policy.

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

2. Recommendation

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

Treasury Management Policy

Document Data		
Subject:	Procedural Documents	
Document Type:	Policy	
Document Status:	Draft	
Document Owner:	Kate Parraman, Deputy Director of Finance	
Executive Lead:	Director of Finance	
Approval Authority:	Trust Board of Directors	
Estimated Reading Time:	'20' Minutes[1]	
Review Cycle:	12	
Next Review Date:	**Date of First Issue:**	**Date Version Effective From:**
28/04/2017	28/01/2008	01/06/2017

Document Abstract

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

[1] Divide number of words (1226) by 240 for average reading time and add 25% for specialist content.

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

Contents

Summary

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

1. Introduction

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

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

2. Framework

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

i. Under section 17 of the Health & Social Care Act (Community Health and Standards) Act 2003 ("the Act"), the Trust has discretion to invest money for the purposes of or in connection with its functions, but must ensure this is managed carefully to avoid financial and/or reputational risks.
ii. Under Section 29 of the Act the Trust is required to exercise its function effectively, efficiently and economically.
iii. Under the Terms of the NHS Provider Licence, the Trust shall at all times remain a going concern.
iv. Under NHS Improvement's Single Oversight Framework the Trust is assessed monthly as part of the use of resources rating on five metrics[2], including liquidity and any adverse fluctuations may result in reductions in the risk rating of the Trust.

It is essential that the Trust protects itself by ensuring that no imprudent or inappropriate treasury management or investment 4behavior occurs. This policy will assist by providing a clearly defined risk management framework to be used by those responsible for treasury operations. The framework lays down responsibilities, protocols and procedures for the various aspects of treasury activities and sets out what should be reviewed and when.

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

3. Treasury Management

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

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

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

3.1 Treasury Aims and Objectives

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

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

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

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

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

Treasury activities for purely speculative purposes are strictly prohibited.

3.2 Attitude to Risk in Key Treasury Activities

3.2.1 Funding

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

3.2.2 Investments

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

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

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

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

Cash deposits should only be placed with the National Loans Fund and relationship banks in line with the deposit limits approved by the Trust's Finance Committee. Cash should only be placed with organisations that hold appropriate credit ratings, based on the "safe 6harbour" criteria, with a 6recognized credit rating agency (Moody's, Fitch, or Standard and Poor's). The approved limits, at any one time, are as follows:

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

3.2.3 Permitted Institutions

The Trust will place investments with institutions that:

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

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

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

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

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

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

Table: Investment limits

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

NB Appendix 1 provides definitions of risk ratings

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

3.2.4 Interest Rate Management

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

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

3.2.5 Foreign Exchange Management

The Trust holds no foreign currency cash balances.

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

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

3.2.6 Bank Relationships

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

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

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

3.2.7 Banking Covenants

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

3.3 Treasury Organisation and Responsibilities

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

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

3.3.1 The Trust Board

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

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

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

3.3.2 The Finance Committee

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

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

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

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

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

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

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

3.3.3 The Director of Finance

The Director of Finance shall:

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

3.3.4 Debtors

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

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

Non-NHS Debtors

Non NHS debtors can be split into the following categories;

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

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

The process for recovering Non NHS Debts is primarily an automated dunning process comprising copy invoices, reminder letters and monthly statements of account. This process includes the issuing of court proceedings and the use of a debt recovery agency as appropriate.

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

NHS Debtors

- **NHS Healthcare Service Agreement Charges**

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

Invoices will be raised for the following services:

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

- **Block Invoices**

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

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

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

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

- **Non-contract activity**

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

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

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

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

Invoices will be raised for the following services:

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

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

The process for the recovery of outstanding NHS Provider to Provider debts comprises an automated dunning process consisting of reminder letters and monthly statements of account, complimented by personal contact with debtor organisations, with escalation to Director of Finance level as appropriate.

The quarterly Treasury Management report to the Finance Committee will note the number, value and details of any Director of Finance to Director of Finance meetings.

- **Credit Notes**

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

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

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

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

- **Aged Debtor Review**

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

- **Bad Debt Write Off**

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

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

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

- **Unapplied Cash**

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

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

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

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

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

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

3.3.5 Creditors

Cash Management

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

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

Processing of Payments

- **Non NHS Payables**

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

- **NHS Payables**

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

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

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

Review of Old Invoices

- **Non NHS Payables**

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

- **NHS Payables**

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

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

Negotiations with Suppliers over Disputes

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

3.3.6 Bank Reconciliations

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

3.3.7 Short-Term Investments (Cash Deposits)

Short-term investments or deposits are defined as those of less than 12 months duration. Effective cash monitoring and forecasting on a daily, weekly, monthly and longer term basis by the Head of Treasury Management will identify cash surpluses and an appropriate time to be able to invest them for. The Head of Treasury Management will review and produce forecasts and calculations for investment. The Head of Treasury Management will contact the National Loans Fund and all 'relationship' banks and financial institutions and identify the product that generates the best return for the potential investment, ensuring all limits contained in this policy are met. The Director of Finance or Deputy Director of Finance will review the investment proposals and approve if appropriate to do so. If any of these post holders refuse to authorise the deposit on principal, authorisation from the other post holders should not be sought unless the original authoriser has suggested onward discussion.

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

If longer term investment is required, this must be referred to Finance Committee detailing the reasons why there are such surplus funds, the duration of the proposed investment, and the product proposed. The

Finance Committee can refuse this investment because it may decide that it is more appropriate that the cash be spent on other alternatives (capital, quality bids, and longer term investment).

Approval of New Commercial Deposit Options

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

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

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

Reporting

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

3.3.8 Long Term investments

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

3.3.9 Borrowing

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

Short Term Shortages

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

a. The Head of Treasury Management will notify the Deputy Director of Finance and suggest a course of action.
b. The Deputy Director of Finance will refer to the Director of Finance depending on the seriousness of the issue.
c. Any cash held in investments with no or minimal penalty (other than lost interest) will be called back, short term first, followed by long term.
d. Non-NHS Supplier payments will be delayed until funds become available.
e. Additional pressure will be placed on debtors to make sure all debts are being paid on time or promptly chased.
f. Any cash held in investments where penalties will be incurred will be called back.
g. Non vital non-urgent stock orders will be delayed.
h. All non-vital capital will be delayed where possible.
i. Monitor/NHS Improvement may be approached.

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

Long Term Borrowings

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

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

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

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

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

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

3.4 Treasury Organisation and Responsibilities

3.4.1 Daily Reporting

On a daily basis the Cashier:

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

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

3.4.2 Weekly Cash Reporting

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

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

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

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

3.4.3 Monthly Reporting

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

3.4.5 Quarterly Reporting to the Finance Committee

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

3.5 Performance Management

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

Appendix 1 – Safe Harbour Investments

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

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

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

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

Explanation of Terms

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

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

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

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

Appendix 3 – Contents of Quarterly Treasury Management Report to the Finance Committee

The following information will be reported quarterly to the Finance Committee in a Treasury Management Report:

New banking relationships entered into in the current quarter, proposals presented to Finance Committee and outcome, any pending proposals, any good products seen at any meetings with institutions (3.2.6)
An update on compliance with covenant (3.2.7)
The number, value and details of any debts passed to the Trust's debt administration and collection company, Director of Finance to Director of Finance meetings, arbitration cases issued and court proceedings issued (3.3.4)
The number and value of NHS credit notes raised in the quarter (3.3.4)
Number and value of bad debt write offs in the quarter (3.3.4)
The value of unallocated credits over six month's old taken to central reserves.
Compromise deal agreements following negotiations with suppliers over disputes (3.3.5)
Investments placed, returns earned and new investments set up (3.3.7)
Overdraft usage (3.3.9)
Potential requirements for working capital support identified in the next 12 months (3.3.9)
Borrowings taken out in the quarter, borrowings proposed, pending or approaching in the quarter (3.3.9)
Progress on any existing borrowing, including whether repayments are up to date (3.3.9)
Performance against Key Performance Indicators for any investments and proposed Key Performance Indicators for any new investments.

	Item	Information Provided by	Information Required						
			Initial Set Up	Daily	Weekly	Monthly	Quarterly	Annually	Other Periodically
1.	**Finance Committee Reporting**								
1.1	**Monthly Finance Directors Report (3.4.4)**								
	a. Cash Flow Plan – Monthly for current year	Deputy Director of Finance				✓			
	b. Amounts placed on deposit and interest earned.	Deputy Director of Finance				✓			
	c. Invoiced Aged Debt Report	Deputy Director of Finance				✓			
	d. Performance against Better Payments Practice Code (BPPC) – NHS & Non NHS Suppliers	Deputy Director of Finance				✓			
	e. Capital Report	Deputy Director of Finance				✓			
	f. Statutory Statement of Financial Position	Deputy Director of Finance				✓			
	g. Capital Programme Steering Group (CPSG): (3.2.2)	Chair of the CPSG							
	• Seek approval for annual Capital Programme and sources of financing							✓	
	• Recommend changes to Capital Programme					✓			
	• Report on actions, decisions and progress against the Capital Programme					✓			
	• Report on quarterly post capital spending reviews and assessments of returns on capital spend						✓		
	• Seek approval for strategic capital projects and source of financing					✓			`
1.2	**Quarterly Treasury Management Report (Appendix 3)**								
	a. New banking relationships entered in the current quarter, proposals presented to the Finance Committee and outcome, any pending proposals, any good products seen at meetings with Financial Institutions.	Deputy Director of Finance					✓		
	b. Compliance with covenents	Deputy Director of Finance							
	c. The number, value and details of:	Deputy Director of Finance Services/Head of Contract Income & Costing					✓		
	• Any debts passed to the Trust's debt administration and collection company.								
	• Finance Director to Finance Director Meetings								
	• Arbitration cases issued								
	• Court Proceedings issued								

		Information Provided by	Information Required						
	Item		**Initial Set Up**	**Daily**	**Weekly**	**Monthly**	**Quarterly**	**Annually**	**Other Periodically**
	d. The number and value of NHS and Non-NHS credit notes raised in the quarter	Deputy Director of Finance /Head of Contract Income & Costing					✓		
	e. The number and value of bad debts written off in the quarter	Deputy Director of Finance /Head of Contract Income & Costing					✓		
	f. The value of unallocated credits over six month's old taken to central reserves.	Deputy Director of Finance					✓		
	g. Investments placed, maturity period, returns earned and new investments set up.	Deputy Director of Finance					✓		
	h. Overdraft usage	Deputy Director of Finance							
	i. Potential requirements for working capital support identified in the next 12 months.	Deputy Director of Finance					✓		
	j. Borrowing taken out in the quarter, borrowings proposed, pending or approaching in the quarter	Deputy Director of Finance					✓		
	k. Progress on any existing borrowing including whether repayments are up to date	Deputy Director of Finance					✓		
	l. Performance against Key Performance Indicators for any investments and proposed Key Performance Indicators for any new investments.	Deputy Director of Finance					✓		
1.3	**Other Reporting Requirements**								
	a. Approve Commercial Banking Services Provider (3.3.2)	Deputy Director of Finance							✓
	b. Approve list of permitted Relationship Banks (3.3.2)	Deputy Director of Finance	✓						
	c. Approve new/changes to Relationship Banks (3.3.2)	Deputy Director of Finance				✓			
	d. Approve Bank Mandates for all Accounts (3.3.2)	Deputy Director of Finance	✓						✓
	e. Approve new/changes to Bank Mandates (3.3.2)	Deputy Director of Finance				✓			
	f. Approve list of permitted Investment Banks and Institutions satisfying Treasury Management Policy (3.2.3)	Deputy Director of Finance	✓					✓	
	g. Approve list of permitted Investment Products satisfying Monitor Safe Harbour criteria (3.2.3)	Deputy Director of Finance	✓					✓	
	h. Approve concentration limits for each permitted Investment Institution and product (3.2.3)	Deputy Director of Finance	✓					☐	

		Information Provided by	Information Required						
	Item		**Initial Set Up**	**Daily**	**Weekly**	**Monthly**	**Quarterly**	**Annually**	**Other Periodically**
	i. Approve investments with a maturity period in excess of 36 months (3.2.8)	Deputy Director of Finance				✓			
	j. Approve use of Investment Banks/Institutions and products which do not satisfy the Treasury Management Policy (3.3.7)	Deputy Director of Finance				✓			
	k. Approve Key Performance Indicators for all existing and new investments (3.3.2 and Appendix 4)	Deputy Director of Finance	✓			✓			
	l. Approve external funding arrangements within delegated limits (3.3.2)	Deputy Director of Finance /Chair of Capital Prioritisation Group				✓		✓	
	m. Approve external funding arrangements within delegated limits (3.3.2)	Deputy Director of Finance /Chair of Capital Prioritisation Group				✓		✓	
	n. Approve long term borrowing for Capital and Investment Programmes (3.3.2)	Deputy Director of Finance /Chair of Capital Prioritisation Steering Group				✓		✓	
	o. Approve Supplier dispute compromises over £25,000 (3.3.2)	Head of Accounts Payable				✓			
2.	**Internal Finance Reporting**								
2.1	**Finance Director**								
	i. Approve Supplier dispute compromises over £1,000 and up to £25,000 (3.3.3)	Head of Accounts Payable		✓					
	ii. Monthly meeting with Head of Accounting Services to consider items for Finance Committee (3.3.3)					✓			
	iii. Write off of Bad Debt Schedules – within limits contained in Scheme of Delegation	Head of Treasury Management				✓			
	iv. Review monthly/annual cashflow plan (3.4.3)	Deputy Director of Finance				✓			
	v. Review of Interest Received v Budget (3.5)	Deputy Director of Finance						✓	
2.2	**Head of Finance**								
	i. Approve Supplier dispute compromises up to £1,000 (3.3.5)	Head of Accounts Payable		✓					
	ii. Approve payment of Supplier invoices on terms other than NHS terms and conditions (3.3.5)	Head of Accounts Payable		✓					

		Information Provided by	Information Required						
	Item		**Initial Set Up**	**Daily**	**Weekly**	**Monthly**	**Quarterly**	**Annually**	**Other Periodically**
	iv. Approve us of Bad Debt Provision for Bad Debt write-offs (3.3.4)	Head of Treasury Management		✓					
2.3	**Head of Accounting Services**								
	i. Review of Age Debtor Reports (3.3.4)	Head of Treasury Management					✓		
	ii. Review Proposed Bad Debt Write-offs (3.3.4)	Head of Treasury Management				✓			
	iii. Review and approval of Court Proceedings (3.3.4)	Head of Treasury Management				✓			
	iv. Advise Finance Director of balance of unapplied cash older than 6 months – take to Central Reserves (3.3.4)	Head of Treasury Management					✓		
	v. Review daily cashflow plans with Head of Treasury Management (3.4.2)	Head of Treasury Management			✓				
	vi. Approve short term investments (3.3.7)	Head of Treasury Management			✓	✓			
	vii. Report forecast cash shortages to Head of Finance/ Finance Director (3.3.9)	Head of Treasury Management		✓					
	viii. Review NHS & Non-NHS Age Creditor Reports (3.3.5)	Head of Accounts Payable					✓		
2.4	**Head of Treasury Management**								
	i. Review proposed Court proceedings (3.3.4)	Assistant Head of Treasury Management				✓			
	ii. Review credit notes raised – report items over £50,000 to Head of Accounting Services (3.3.4)	Assistant Head of Treasury Management				✓			
	iii. Review NHS and Non-NHS Aged Debtor Reports (3.3.4)	Assistant Head of Treasury Management				✓			
	iv. Review NHS Aged Creditor Report. Report significant difficulties to Head of Finance (3.3.5)	Assistant Head of Treasury Management				✓			
	v. Report forecast cash shortages to Head of Accounting Services (3.3.9)	Cashier		✓					
	vi. Review daily cashflow plan with Cashier (3.4.1)	Cashier		✓					
	vii. Review daily cashflow plan with Head of Accounting Services (3.4.2)	Cashier			✓				

		Information Provided by	Information Required						
	Item		**Initial Set Up**	**Daily**	**Weekly**	**Monthly**	**Quarterly**	**Annually**	**Other Periodically**
	viii. Approve short term investments/cash deposits (3.3.7)	Cashier		✓					
2.5	**Head of Contract Income & Costing**								
	i. Review Age Debtor Report (3.3.4)	Head of Service Agreements					✓		
	ii. Review Proposed Bad Debt Write-offs (3.3.4)	Head of Service Agreements				✓			
2.6	**Head of Service Agreements**								
	i. Review credit notes raised – report items over £50,000 to Head of Accounting Services (3.3.4)	Head of Service Agreements				✓			
	ii. Review Aged Debtor Report (3.3.4)	Head of Service Agreements				✓			
2.7	**Head of Accounts Payable**								
	i. Review Non-NHS Age Creditor Report. Report significant difficulties to Head of Finance (3.3.5)	-				✓			

Cover report to the Public Trust Board meeting to be held on Friday, 26 May 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	14
Meeting Title	Trust Board	**Meeting Date**	26 May 2017
Report Title	NHS Provider Licence – Self Certification		
Author	Pam Wenger, Trust Secretary		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

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

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	☐		☒

Executive Summary

Purpose

The purpose of this report is to seek the Board's consideration and certification whether or not it has complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

Key issues to note

The Board is able to provide confirmation of meeting General Condition 6 (statement 1 and 2) through the robust risk management system in place throughout the Trust and the implementation of the Fit and Proper Persons Test. This includes:

- the Risk Management Strategy
- the Board Assurance Framework, which is regularly reviewed by the Audit Committee,

Quality and Outcomes Committee and by the Board each quarter;

- the Corporate Risk Register, which is submitted to the Board on a quarterly
- basis following review by the Senior Leadership Team. The wide visibility of this Register allows significant level of management, clinician and Board oversight and challenge of the key operational risks to the Trust.
- Annual Governance Statement which is included in the Annual Report which demonstrates the approach to the management of risk and provides assurances to the Board of Directors.
- During 2016/17, the Trust implemented a policy on Fit and Proper Persons and undertook a review to ensure all Directors comply with the Fit and Proper Persons Test,
- An annual self declaration is also required from each of the Directors and this was reported to the Board in April 2017.
- For the purposes of this declaration, the Trust meets this criteria as it is registered with the CQC and its Directors and Governors meet the 'fit and proper' test.

In relation to Condition 7, all NHS foundation trusts designated as providing commissioner requested services (CRS) must self-certify under Condition CoS7(3).

All services commissioned by NHS Bristol Clinical Commissioning Group are commissioner designated services, although NHS England have not specifically outlined any. A self-certification declaration is recommended to confirm availability of resources on the basis of the financial projections, risks and mitigations outlined in the 2017/18 and 2018/19 Operational Plan.

Recommendations

Members are asked to:

- **Confirm** self-certification against the requirements of General Condition 6 of the Licence; and
- **Confirm** self-certification against the requirements of General Condition 7 of the Licence

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)**

SELF-CERTIFICATION AGAINST BOARD STATEMENTS

BACKGROUND

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

NHS Improvement uses the information provided in these documents primarily to assess the risk that an NHS Foundation Trust may breach its licence in relation to finance and governance. NHS Improvement will also assess the quality of the underlying planning processes.

The Statements require the Board's consideration and certification.

Licence General Condition 6 (*Statement 1)*

The licence contains seven sections detailing conditions in conjunction with:

- General conditions
- Pricing
- Choice and Competition
- Integrated Care
- Continuity of Services
- NHS Foundation Trust conditions
- Interpretation and definitions

The certification due by the end of May requires confirmation of compliance with General Condition 6, which notes that the Licensee should 'take all reasonable precautions against the risk of failure to comply with:

- the conditions of this licence;
- any requirements imposed on it under the NHS Acts; and
- the requirement to have regard to the NHS Constitution'

The steps the Trust is expected to take (paragraph 2(a) and 2(b) of the Licence) are:

1. the establishment and implementation of processes and systems to identify risk and guard against their occurrence; and
2. regular review of whether those processes and systems have been implemented and of their effectiveness.

The Board is able to provide confirmation of meeting this condition through the robust risk management system in place throughout the Trust. This includes:

- the Risk Management Strategy

- the Board Assurance Framework, which is regularly reviewed by the Audit Committee, Quality and Outcomes Committee and by the Board each quarter;

- the Corporate Risk Register, which is submitted to the Board on a quarterly

- basis following review by the Senior Leadership Team. The wide visibility of this Register allows significant level of management, clinician and Board oversight and challenge of the key operational risks to the Trust.

- Annual Governance Statement which is included in the Annual Report which demonstrates the approach to the management of risk and provides assurances to the Board of Directors.

Licence General Condition 6 (statement 2)

The Trust is asked to confirm that it meets the criteria for holding a licence. The two criteria for holding a licence are:

1. the Trust must be registered with the Care Quality Commission (CQC); and
2. the Directors or Governors of the Trust must meet NHS Improvement's 'fit and proper' test.

For the purposes of the NHS Improvement licence, someone who is not a 'fit and proper person' would fall within the following categories:

- be an undisclosed bankrupt;
- have undischarged arrangements with creditors;
- be subject to a moratorium period under a debt relief order;
- have received a prison sentence of three months of longer during the previous five years; or
- be subject to a disqualification order or undertaking.

During 2016/17, the Trust implemented a policy on Fit and Proper Persons and undertook a review to ensure all Directors comply with the Fit and Proper Persons Test, An annual self declaration is also required from each of the Directors and this was reported to the Board in April 2017.

For the purposes of this declaration, the Trust meets this criteria as it is registered with the CQC and its Directors and Governors meet the 'fit and proper' test.

Continuity of Services Condition 7
Only NHS foundation trusts designated as providing commissioner requested services (CRS) must self-certify under Condition CoS7(3).

Commissioner requested services are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and which will be subject to regulation by NHS Improvement. Providers can be designated as providing CRS because:

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable

All services commissioned by NHS Bristol Clinical Commissioning Group are commissioner designated services, although NHS England have not specifically outlined any. A self-certification declaration is recommended to confirm availability of resources on the basis of the financial projections, risks and mitigations outlined in the 2017/18 and 2018/19 Operational Plan

RECOMMENDATIONS

Members are asked to:

- **Confirm** self-certification against the requirements of General Condition 6 of the Licence; and
- **Confirm** self-certification against the requirements of General Condition 7 of the Licence

Cover report to the Public Trust Board meeting to be held on Friday, 26 May 2017 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St,

		Agenda Item	17
Meeting Title	Trust Board	**Meeting Date**	26 May 2017
Report Title	Governors Log of Communication		
Author	Amanda Saunders, 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)**

Governors' Log of Communications

19 May 2017

ID **Governor Name**

187 **Clive Hamilton** ***Theme:*** Performance ***Source:*** Governor Direct

Query **09/05/2017**

18 week Referral to Treatment target for Neurology - noted on page 81 of the March 2017 Board Report (Appendix 3) the neurology pathway is only achieving a 79.9% response to the 92% target and again on page 115 of the April Board report (Appendix 3).

As this pathway is significantly and consistently below target have action plans been developed to bring the referral time into line?

Division: Medicine ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 10/05/2017

Response **19/05/2017**

Neurology performance has been below the 92% national RTT standard due to difficulties and delays in recruiting to key posts within the service. The number of long waiters had now reduced down from a peak in January of 122 to 84 at the end of April. Waiting List initiatives are being offered to the Clinical Fellow for the service, to attempt to further reduce the number of long waiters. This is a part of the Trust's overall RTT Sustainability Plan for 2017/18.

Status: *Awaiting Governor Response*

186 **Florene Jordan** ***Theme:*** Incident reporting ***Source:*** Governor Direct

Query **25/04/2017**

Can governors understand what steps are taken by managers in the Trust when investigating incidents to ensure that the correct contributory factors to the incident are identified and correctly documented?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

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 **26/04/2017**

As part of the Trust's strategic plans we are looking at long term solutions for the accommodation of the Genetics department. While we evaluate the options we have made available additional rooms at South Bristol Community Hospital and the children's hospital to help ease pressures. The genetics department will benefit from Evolve later in the year, once the system has been rolled out through the Bristol Royal Infirmary and Bristol Heart Institute.

Status: *Awaiting Governor Response*

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 **24/04/2017**

The heating in the pre-operative area, located in the King Edward Building, is now connected to the constant temperature hot water supply and commissioned to our requirements. The Trust Estates team is not aware of any current issues, however from time to time, breakdowns do occur, especially with the older parts of the estate linked to this area.

The pre-operative area (or SAS Pod) is a new addition to our estate, located on the roof of the King Edward Building, completed in 2015. Adjustments were made in the first winter of 2015/16 in order to optimise the system which was originally commissioned summer 2015.

When the refurbishment of the whole King Edward Building was completed in winter 2016/17, the heating to the pre-operative area was rebalanced as there were additional demands on the supply. The Capital team has confirmed that this was around Christmas 2016 which may in fact coincide with your operation.

Now having three months data, we believe there is a further local balancing optimisation that would benefit the system including the SAS Pod and we are just commissioning this. Please be assured that this system is monitored and we are able to respond swiftly to any issues, however we continue to strive to optimise our energy as part of on-going savings and sustainability work.

Status: *Closed*

ID	Governor Name		
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.
Follow up question added 10/05/17:
In light of the response received, please can we be advised as to when and how patients are informed of the process for returning items as several patients have informed me that no information was provided, raising the original query.

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **24/04/2017**

Currently there is a process in place via an external contractor for collection and recycling of frames and crutches provided via community services, the Trust is in negotiation to try and expand this collection service for equipment provided by the Trust to inpatients on discharge. Patients can choose to, and do bring back equipment once they have finished with it and this, where appropriate, is recycled.

Status: *Awaiting Governor Response*

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*