University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Public Meeting of the Trust Board of Directors, to be held on 28 June 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item	*Sponsor*	*Page*
1. Introduction and Apologies To **note** apologies for absence received.	Chairman	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Board Meeting Agenda.	Chairman	
3. Minutes To consider the Minutes of meetings of the Trust Board of Directors dated 26 May 2011 and 03 June 2011 for **approval**.	Chairman	3
4. Matters Arising To review the status of matters arising from previous meetings.	Chairman	20
5. Chief Executive's Report To receive this report by the Chief Executive, including the activities of the Trust Management Executive to **note**.	Chief Executive	21
Quality, Performance and Compliance		
6. Summary Quality and Performance Report To receive the standing Summary Quality and Performance Report to **note**. a. Overview – Director of Strategic Development b. Quality – Medical Director and Chief Nurse c. Workforce – Director of Workforce & Organisational Development d. Access – Interim Chief Operating Officer	Executive Leads	25
7. Histopathology Action Plan Update To receive this report by the Chief Executive to **note**.	Chief Executive	97
8. Quality Strategy To receive this report by the Chief Nurse and consider the recommendations for **approval**.	Chief Nurse & Medical Director	113
Finance and Governance		
9. Committee Chairs' Reports To receive reports on the activity of Board Committees by their respective Chairs and consider any recommendations for **approval:** a. Finance Committee dated 21 June 2011, including the Finance	Lisa Gardner	135

Report b. Audit Committee dated 13 June 2011 c. Quality and Outcomes Committee dated 27 June 2011	John Moore Paul May	
Strategy and Business Planning		
10. Communications Plan Summary Report To receive this report by the Chief Executive to **note**.	Chief Executive	151
Monitor Reports		
11. Results of Q4 Monitor Assessment of NHS Foundation Trusts Compliance To receive this report by the Chief Executive to **note**.	Chief Executive	159
Risk		
12. Corporate Risk Register To consider the Corporate Risk Register in the context of the preceding items on the Agenda.	Chief Nurse	165
Information and Other		
13. Any Other Business To consider any other relevant matters not on the Agenda.	Chairman	
14. Date of Next Meeting Joint Board & Membership Council, Wednesday 27 July 2011 at 10:30 in Lecture Theatre 1 of the University Hospitals Bristol NHS Foundation Trust Education Centre, Upper Maudlin Street, Bristol, BS2 8AE.	Chairman	

Minutes of a Public Meeting of the Trust Board of Directors, held on 26 May 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Board Members Present	
• John Savage – Chairman • Emma Woollett – Vice Chair • Iain Fairbairn – Senior Independent Director • Paul May – Non-executive Director • Kelvin Blake – Non-executive Director • Lisa Gardner – Non-executive Director • John Moore – Non-executive Director	• Robert Woolley – Chief Executive • Steve Aumayer – Director of Workforce and Organisational Development • Paul Mapson – Director of Finance • Deborah Lee – Director of Strategic Development • Sean O'Kelly – Medical Director • Alison Moon – Chief Nurse
Present or In Attendance	
• Jim O'Connell – Interim Chief Operating Officer • Vicki Mathias – Bristol Evening Post • Neil Auty – Tertiary Patient Governor • Elizabeth Corrigan – Governor Representative, Public Governor • Mo Schiller – Public Governor • Joan Bayliss – LINKS/Voluntary Sector Governor • John Steeds – Patient Governor • Florene Jordan – Staff Governor – Nursing/Midwifery • Clive Hamilton – Public Governor	• Wendy Gregory – Patient & Carer Governor • Anne Skinner – Patient Governor • Bob Skinner – Foundation Trust Member • Chris Swonnell – Clinical Audit Coordinator & Staff Governor • Jeanette Jones – Partnership Governor, Joint Union Committee • Sarah Pinch – Head of Communications • Charlie Helps – Trust Secretary • Victoria Church – Management Assistant to the Trust Secretary

Item	*Action*
1. Introduction and Apologies There were no apologies to note. The Board received and considered a verbal report by the Chairman who informed the Board of changes in the Membership Council as a result of the recent Governor elections, and congratulated the newly elected Governors and those who remain in post. He formally welcomed Neil Auty, the new Governor Representative, who was taking over from the previous incumbent of this role, Elisabeth Corrigan. The Chairman noted with sadness the departures from the Membership Council of those Governors who were reaching the end of their tenure, and thanked them for their invaluable contribution to the Trust.	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Board Meeting Agenda.	

No declarations of interest were made.	
3. Minutes The Board considered the Minutes of the previous meeting held on 28 April 2011 and resolved to **approve** these as an accurate record of matters transacted.	
4. Matters Arising All items on the Board Schedule of Matters Arising were noted as complete.	
5. Chief Executive's Report The Board received and considered a report by the Chief Executive, including the activities of the Trust Management Executive to **note**. The key themes arising from the Trust Management Executive were: • The new Trust Management Executive group has been established by the Chief Executive to serve as the most senior decision-making and supervisory group reporting to the Chief Executive. The group's function is to achieve the strategies, aims and objectives of the Trust Board of Directors delegated to the Chief Executive, and any other matters specified by the Chief Executive. This includes: on-going management of the Trust; development and implementation of strategy, operational plans, policies, and budgets; achievement of agreed operating and financial performance targets; management of risk. The group includes Heads of Division and Divisional Managers in the executive decision-making processes of the Trust, and is supported by new working groups for operational management, risk management, and for clinical quality. Taking account of the new ways of working with Trust Headquarters and the Divisions, it is expected that the structures would provide efficiencies and enhanced ways of working. • Trust staff are to be offered options including a Mutually Agreed Resignation Scheme, as part of an endeavour to make savings on the Trust's wages bill. This has been agreed with Union representatives. Robert reported on other Trust news, including: a) For the second year running the Trust has been included in the '40 Top Hospitals' awards by CHKS which samples around 120 acute hospitals. This award reflects our good performance, outcomes, efficiency, patient experience, quality of care generally, and overall quality of service b) System C has been awarded the contract for provision of a new Patient Administration Electronic Patient Records System. Phase 1 of the system roll-out will be implemented in Spring 2012 c) The "Safe and Sustainable" consultation on a New Vision for Children's Congenital Heart Services in England listed University Hospitals Bristol NHS Foundation Trust in all four of its options. d) A public consultation event has been scheduled at Taunton Rugby Club for Tuesday 7 June, from 15:00 to 17:00, and transport would be available for those wishing to travel to Taunton to attend the event. More public events are planned and the public and Trust staff were encouraged to show their support by attending where possible. The out-going Governor Representative and Public Governor, Elizabeth Corrigan, stated that Southampton University Hospitals NHS Trust was voicing dissatisfaction due to not being listed in the four "Safe and Sustainable" consultation options. Robert Woolley responded that	

Southampton was included in one of the four options issued for public consultation. The Trust had engaged with Southampton and specialised commissioners for the South of England to review projected activity flows to a smaller number of centres, in the light of the proposed designation standards.

Kelvin Blake added that Trust representation at the "Safe and Sustainable" events was important. Responding to the Trust Management Executive's discussion around the Mutually Agreed Resignation Scheme, he agreed that the flexibility offered to staff was welcome, but sought reassurance that safety would not be compromised by the scheme. Robert Woolley responded that the due diligence process would effectively ensure that the Trust did allow gaps in services to arise from the scheme.

There being no further questions or discussions, the Board resolved to ***note*** *the Chief Executive's Report.*

Quality, Performance and Compliance

6. Summary Quality and Performance Report

The Board received and considered this report by members of the Trust Executive to **note**.

a. Overview

Deborah Lee, the Director of Strategic Development, introduced the Performance Report and explained that overall, the 'health' of the organisation had improved, with the majority of the indicators showing an improvement on the previously reported period. At the end of April 2011 the Trust was on track to achieve an 'Amber-Green' risk rating.

All standards in Monitor's Compliance Framework during Quarter 1 had been achieved, with the exception of the underperformance of the 62-day referral to treatment cancer standard for GP referred patients. However, it was expected that the standard would be met for the Quarter as a whole, which would return the Governance Risk Rating to 'Green'.

The rise in the Hospital Standardised Mortality Ratio seen in the December and January had since returned to its more usual lower level in February. The Medical Director, Dr Sean O'Kelly, had undertaken a review of individual cases and the comparative data to ensure that there were no unidentified causes.

The Chair of the Quality and Outcomes Committee, Paul May reported that that a report on the Hospital Standardised Mortality Ratio had been received by the Quality and Outcomes Committee at its meeting on 25 May. He was assured by the Medical Director that if the situation changed it would be brought back to the attention of the Board and the Committee.

b. Quality

The Chief Nurse, Alison Moon, presented the Quality element of the Summary Quality and Performance Report.

Alison recounted the patient experience contained in the report and the consequent challenges the team at the Bristol Haematology and Oncology Centre had faced in administering treatment.

The issues that the team had encountered included:

1) Administering an anaesthetic to an adult to allow for the daily administration of radiotherapy was an unusual procedure requiring input from several different departments across two clinical Divisions.

2) This was a complex procedure to complete in an unfamiliar environment, and it was noted that the Adult Anaesthetic Team was not accustomed to performing general anaesthetics in Scanners or Linear Accelerators, (radiotherapy machines) where space was very constrained and staff were required to leave the patient during treatment. There were complex patient safety considerations to be taken into account. 3) Treatment might have caused delays in operating lists in other theatres around the Trust as staff would need to be released to conduct this procedure. 4) It was potentially difficult to intubate the patient due to physiological considerations. It was also noted that that repeated administration of anaesthesia could potentially compromise health and could jeopardise the opportunity to complete a course of treatment. 5) Staff safety could be compromised in situations where violence or aggression was a factor. This example of a patient experience highlighted the importance of effective cross-Divisional working. Alison noted the importance of the case was about the learning achieved from the circumstances in developing the team. A Standard Operating Procedure would be in place by the end of July 2011 for any patient requiring a general anaesthetic under these circumstances. John Moore commented that system issues were important and noted that a new management group is in place to look specifically at patient experience. At this point, the Chairman heard comments from attendees present. The Public Governor, Mo Schiller, required confirmation that pressure-relieving mattresses were used in the Trust. Alison Moon confirmed that they were, along with seating pressure cushions, and that the focus on reducing the incidence of pressure sores was continuing as a priority. Iain Fairbairn expressed pleasure at the successes achieved in improving the Accident and Emergency 4-hour waiting times performance and enquired whether lessons had been learnt from interventions in this regard. Jim O'Connell responded that a number of interventions were beginning to demonstrate success and would be continued. These included management interventions at the "front-door", in the patient flow, and in discharges. The Chairman noted the Chief Executive's earlier reassurances that preparations would be in place to ensure that the winter pressures and the Christmas period do not adversely affect performance, and Deborah Lee added that there were plans to ensure the period felt like 'business as usual'. Due to the local "health system's" failure to achieve this in previous years, the Primary Care Trust had already begun to take proactive steps to prepare for the winter and Christmas periods. The number of cases with over 14-days length of stay trend rose again over the recent Bank Holiday weekends, and this revealed a correlation with partnership working issues. Emma Woollett added that we are a '24-7' organisation, and there ought to be no differences in the running of the Trust from other days of the year. Jim O'Connell stated that the System Group had discussed how to plan better for future pressures and the normal running of the Trust over Bank Holidays and religious festivals was under constant review. John Savage commented that the Board had previously received assurances that these problems would not happen again. Lisa Gardner and John Moore requested that all performance graphs show at least two years of comparative data to enable trend and pattern analysis.	Director of Strategic

c. Workforce Steve Aumayer, the Director of Workforce and Organisational Development introduced the Workforce elements of the Summary Quality and Performance report, informing the Board that workforce costs were not available for this period due to annual adjustments. Significant points of note from the Workforce report included: • There was a significant decrease in sickness absence rates in April; • Appraisal rates had continued to improve during April; • Statutory and Mandatory Training showed improvement in April, and this included Child Protection Level 4 training; • Bank and Agency staff use had decreased by 35.3 Full-Time Equivalents and was 1.5% above target; • Overtime was lower than targeted in April (i.e. better than target). Steve concluded that all measures were moving in the right direction and it was a pleasing start to the year, mainly due to the hard work of the Divisions. Non-executive Directors Paul May, John Moore and Emma Woollett congratulated the Workforce team for their work regarding the improved quality of training within the Trust and the increase in appraisal rates. In response to a question by Iain Fairbairn regarding the definition of what constituted a completed appraisal, Steve Aumayer confirmed that there was a current focus on the appraisee agrees with it. Kelvin Blake commented that he felt the Trust was moving in the right direction, and asked what the improvements were attributable to. Steve Aumayer replied that it was the consequence of stronger leadership and a more disciplined application of existing policies, with the offer of appropriate support and encouragement in the application of each policy. John Moore said that appraisal is central to transformation and creating a team, and encouraged Steve Aumayer to consider a new target for appraisal rates. **d. Access** The Interim Chief Operating Officer, Jim O'Connell, informed the Board that new access standards were coming into play in quarter 2, and that he had been working with Deborah Lee and the clinical Divisions to put systems and processes in place to prepare for this change to the performance regime (15 minutes to assessment). He said that he expects to report on progress at the 28 June meeting of the Trust Board of Directors. Other relevant Access issues highlighted included: a) Cancelled operations – shows significant improvement to 0.97% with a target of 0.8% which appears to be achievable, b) 62-day Cancer target – assessment of pathways, including for colonoscopy cancellations and had spoken to the Cancer Network to see if the voluntary cancellations should be included in statistics, c) Elective Care limited stay – work being done to improve, with detail of tertiary patients, and this will be brought to the next Quality and Outcomes Committee Meeting on 27 June 2011 for discussion. Emma Woollett raised a concern regarding issues of engagement and communication with the patient flow programme. Jim O'Connell responded that there was commitment at Head of Division level, but the challenge lay in communicating the approach to individuals. He emphasised that he shared	Development

Emma Woollett's view and that there is a continued focus on the programme.

John Savage commented on the real progress that is being achieved and the Executive should feel satisfied with the results of their efforts.

*There being no further questions or discussions, the Board resolved to **note** the Summary Quality and Performance Report.*

7. National Inpatient and National Staff Surveys 2010

The Board received and considered these linked reports by the Chief Nurse and Director of Workforce and Organisational Development to **note**.

Alison Moon explained that in 2010/11, the Trust received detailed feedback from more than 10,000 patients, which compared to the National Inpatient Survey, which reflected the views of fewer than 500 patients. The third report – a local analysis of the 2010 National Inpatient Survey data – focussed on key messages from the data and included a detailed comparative analysis at Appendix B. The report also explained what the Trust was already doing, as a result of the Patient and Public Involvement Strategy and other relevant workstreams, and in relation to the key improvement themes suggested by the data.

Alison Moon introduced the National Inpatient Survey results which the Board discussed. Paul May stated that the survey was historic, and that there was value in real-time surveys. He added that it tied-in with the National Survey, which could be used a baseline, and that the Quality and Outcomes Committee would use this data for that purpose. It was noted that the Outpatient Survey would give a different perspective of the patient experience.

Kelvin Blake noted some inconsistences in some of the reported 'Medicines' data (the last 'bullet-point' of page 91), but recognised the usefulness of the reports. Basing his thoughts on anecdotal evidence, he said that patients wanted to leave hospital when they were ready to, and that people had told him it feels like nurses had other priorities, and medicines were not dispensed quickly enough on discharge, which he felt required attention. Alison Moon agreed that this focus was correct and a key piece of work was under way in this respect.

Deborah Lee noted that the Division of Diagnostics and Therapies was not included in the surveys, as the Division does not have beds. Alison Moon agreed and said the Division was included in the Patient Experience Group and would have their own set of targets.

Emma Woollett stated that she felt the values scores must considered in absolute terms, not just relative to other Trusts. In these terms, some scores which were unacceptable to the Trust should not be overlooked or justified simply because they were not out of line with national scores. John Moore added that he was most reassured by the fact that the Executives had not been surprised by any data on the Inpatient Survey.

Selby Knox raised the issue of the availability of hand-gel and its crucial role in infection control. Alison Moon responded that 96% of patients saw that hand-gel was available, but the Staff Survey showed a lower number, which was disappointing. For safety reasons, hand-gel has been removed from main entrances and placed only in care areas, but some signage had not been removed, and might have created a perception that the gel was missing.

Remarking on the issue of availability of hand-gel, the Patient Governor, Anne Skinner, who was present, added that the patients on Ward 78

remarked how every member of staff washed their hands and that this was because of "top leadership". Lisa Gardner remarked that this was not the first time the issue of hand-washing facilities was noted by the Board, and that capital investment had been made in improved facilities, yet they still appeared to fall short. She emphasised that she would appreciate finding the cause of this issue. Robert Woolley confirmed that he had asked the Chief Nurse and Director of Infection Prevention and Control to separate out the reporting and will take judgment on whether this is a clinical care issue or a matter of supporting staff. The Tertiary Patient Governor, Neil Auty, who was present, asked if there was a single individual responsible for discharging patients, to which Alison Moon responded that there was a consultant in charge of every patient, and one member of the ward team who will co-ordinate the discharge. Robert Woolley added that discharge was the responsibility of the team as a whole. Alison Moon continued, saying that the ward sister/charge nurse is crucial to the quality of service, and should have lead responsibility, but the question remained as to how to release the ward sister to oversee quality. She confirmed that plans are being advanced in this regard. Steve Aumayer introduced the Inpatient Survey results, and the main points were described as: a) The Inpatient engagement score was encouraging, and compared with last year, there had been a gradual improvement, in comparison to other Trusts. b) The Trust was looking at its absolute scores, and was less interested in its ranking in the national results c) There was a decrease in staff reporting errors and near-misses, which was a concern d) The Trust was in the top 20% for reporting procedures and fairness e) Appraisal scores demonstrated quality f) Action plans were available at the end of the report Neil Auty asked if the 'Whistle-blowing' hotline had seen a change in uptake, but Steve Aumayer replied that it had not, as it had only been in-place a few months and data could only be gathered after a few months. This will come back for discussion at the Audit Committee at a future date. It was noted that any Whistle-blowing reports are to be reported in full confidence to the Chief Executive and the Senior Independent Director. Paul May commented that Non-executive Directors support the "learning organisation". **Linked Report** Alison Moon and Steve Aumayer linked the two reports, stating that it was clear that improved Human Resource practices improved patient outcomes. Anne Skinner remarked that she was aware of a person leaving their employ elsewhere to work at University Hospitals Bristol NHS Foundation Trust. The Board welcomed the professional approach adopted in shaping services around the input received from patients. *There being no further questions or discussions, the Board resolved to* ***note*** *the National Inpatient and National Staff Surveys 2010.*	Chief Nurse Trust Secretary
8. Equality and Diversity Annual Report	

The Board received and considered this report by the Director of Workforce and Organisational Development to **note**. Steve Aumayer introduced the report, saying that the governance of equality and diversity was strengthened by the introduction of the Trust-wide Steering Group. A review of the Electronic Staff Record data showed increased confidence in the organisation with staff reporting a disability up from 3% to 12%. Training had improved in more areas, and was now integrated into generic training, including general and medical induction. Emma Woollett commented that the report demonstrated how dealing with these issues strengthened the Trust, but asked what the plans were for the funding of the role going forward. Steve Aumayer responded that funding was provided by the Above and Beyond charity in the last year, but it was not in place in full for the current year. However, Above and Beyond were interested in funding specific pieces of work, and by using other sources of funding, the role would remain in-place. Paul May welcomed the "refreshing" report, and recognised that getting Equality & Diversity right related directly to the quality of care provided by staff. He suggested that carers and the design of buildings could receive more emphasis in the Report, but was delighted that 1.5 pages of report covered training. Steve Aumayer responded that a group was currently working on improvements to the Estates function. The Patient Governor, Wendy Gregory, who was present, commented on the relevance of carers as an outreach issue when looking at particular categories of people and the possibility of engaging them in a training programme earlier. Kelvin Blake commented about work still to be done, and Steve Aumayer replied that the Trust saw value in making changes in thinking towards Equality and Diversity. Bringing people to see the facilities was one suggestion to implement this change. Deborah Lee said that there had been a change in the black and minority ethnic group demographic for children from 10% to 20% in secondary schools, and 30% in primary schools, and that the Trust must plan services accordingly. Steve outlined that there had been a step forward from the previous year, but there was still a long way to go to be where the Trust would like to be. *There being no further questions or discussions, the Board resolved to **note** the Equality and Diversity Annual Report.*	
9. Annual Quality Account The Board received and considered this report by the Chief Nurse to **note**. Alison Moon noted the cosmetic changes from the previous version seen by the Board, and confirmed that there were no significant changes to the material content of the document. *There being no further questions or discussions, the Board resolved to **approve** the Annual Quality Account.*	
Finance and Governance	
10. Committee Chairs' Reports The Board received and considered reports on the activity of Board	

Committees by their respective Chairs to **note**.

a. Finance Committee dated 23 May 2011, including the Finance Report

Lisa Gardner reported on the main issues discussed at the Finance Committee meeting held on Tuesday 26 April 2011:

- The meeting, whilst not quorate, received the full set of financial and other reports as set out in the Agenda and circulated to all Board Members
- The Trust has delivered a surplus of £12.039m for the year ended 31 March 2011 (results subject to Audit). The Financial Risk Rating for the year is 4 (actual = 4.05) – this is in line with the Annual Plan forecast and represents a good result for the year
- The out-turn position has been secured through continuing good performance in maintaining a low incidence of C Difficile cases and the Trust receiving CQUINs (Commissioning for Quality and Innovation) income of £1.04m for the year. The overspending for the year on Divisional Services totalled £8.655m with significant adverse movements in March taking place against Specialised Services and Surgery, Head and Neck
- University Hospitals Bristol achieved cash releasing efficiency savings in excess of £18.86m in 2010/11. This equates to 83% of the plan for the year of £22.822m income generation schemes contributed £4.23m. Reductions in pay costs of £7.42m were achieved and a further £7.21m was saved on supplies and services
- The Committee received a progress report on cash releasing efficiency savings plans for 2011/12. Risk assessed plans total £18.336m (an improvement of £4.3m in the three weeks to mid-April) against a target of £26.596m. A further assessment is to be made on receipt of revised Divisional CRES plans to be submitted on 06 May
- The Committee considered the draft report to accompany the Trust's Quarter 4 submission to Monitor. The Committee recommended that the Trust completes In Year Finance Declaration 1 – i.e. the Board anticipates that the Trust will continue to maintain a financial risk rating of at least 3 over the next 12 months
- The Committee received the quarterly update report on financial institutions used for the investment of temporary cash surpluses. The Committee was advised that Moody's Investor Services is reviewing their opinion on the Clydesdale Bank
- The Board was asked to approve the following recommendations (1) Clydesdale Bank is, for the time being, removed from the list of approved financial institutions, and (2) the Finance Committee be authorised to determine the longer term status of Clydesdale Bank for the investment of temporary cash surpluses in the light of the outcome of the review by Moody's Investor Services
- The Committee received the Full Business Case for the Bristol Royal Infirmary Redevelopment together with an update on the 2011/12 Financial Position from the Chief Executive and Finance Director. This is to be considered for approval elsewhere on the Board agenda
- From a financial perspective the important challenge was the delivery of the CRES programme on a recurring basis – to ensure affordability of the scheme. With minimal flexibility available in 2011/12 then there is a need to ensure progress is made to keep the Trust 'on plan'. This applies in particular

to the need for Trust wide workforce plans which should seek to reduce headcount and retain the ability to ensure services are delivered.

- The Committee endorsed the actions proposed in Section 3.7 of the report (Finance Committee Agenda Item 4) as being essential to safeguard the Trust's financial health

The Finance Director, Paul Mapson, informed the Board that it was not currently possible to assess the income figures for April.

Iain Fairbairn enquired of Paul Mapson if the contract position would affect patterns of services; this was to be addressed at item 11.

b. Audit Committee dated 09 May 2011

The Chair of the Audit Committee, John Moore, gave a verbal update on the last meeting of Audit Committee, and specifically discussed:

- the revised Audit Code
- the revised Terms of Reference
- particular attention had been paid to the Annual Plan
- Internal and External Audit reports – extra work was required on the Internal Audit; two 'Red-ratings' had been noted for Patient Safety Training and Estates, it was agreed that an external review of the latter would be established
- A draft Internal Audit of Divisional Governance was also presented by the Executive

c. Quality and Outcomes Committee dated 25 May 2011

Ways of Working/Structure

Paul May provided a diagram which showed his explanation of the role and function role of the Quality and Outcomes Committee within the Trust's Corporate Governance and Executive Management structures. The key issues that were identified for future attention included:

- A protocol for the Board to commission specific detailed work by the Committee over and above its standing agenda
- Statistical real-time data converted into headline patient issues
- Developing additional ways of engaging with governors on quality matters
- Establishing key measures, baselines, benchmarks and targets for improvement
- Effective delivery arrangements for change, management and improvements via the existing Executive structure

Terms of Reference

The Committee agreed that the quorum should be set at two members.

Quality and Performance

It was agreed that if any of the four categories listed under 'Quality and Performance' were not represented by their designated Executive Lead, they would not be discussed. In light of this, no comments were made regarding the 'Access' element of the Performance Report.

Overview

Although performance issues are apparent from the detail of the report, they are not always highlighted by exception reports. In future a cross referencing system will be provided.

Quality The Committee noted that Pressure Sores continued to be an area of concern for the Trust and the Committee will review the detail in 3 months' time after the next formal audit. Other items of note included: • The Executive was congratulated on the success of the Trust Walk-rounds. • The Length of Stay issue will be researched and compiled into a report for inclusion at the 27 June Quality and Outcomes Committee meeting. The Patient Experience reports have been considered and the following actions will be undertaken: a) Assurance that the actions reported are implemented effectively by the new Patient Experience Group. b) In all future reports there would be a section outlining the "lessons-learnt" by staff, which will be categorised as 'specific' or 'Trust-wide'. c) A request for the Trust Management Executive to consider communicating patient experience and complaints to the Trust workforce via Newsbeat or computer browser pop-ups, or other means, to reinforce the importance of high standards of working with the Organisation. d) The Committee reported that positive Divisional Action targets marked a major step forward. **Workforce** No specific issues were noted for Workforce, but the Committee agreed that steady progress was being made. **Board Papers – National Inpatient and Staff Surveys** It was felt that the two surveys should not be discussed in detail in the Committee, but it was agreed that both provided a solid foundation towards further improvement. Although the detail was historic, it would be used by the Committee in conjunction with the Trust's new real-time statistical survey work, to inform future issues for action. Additional work on the real-time staff survey also needed to be considered. The linked report aimed to show how the Trust values could be developed into behaviours.	
Draft Quality Strategy The Quality Strategy will be brought to the June Board meeting, following consultation on the detail.	Chief Nurse
Final Quality Account In the past, the 'Audit and Assurance Committee' fully considered the report, but going forward it was recognised that the report would be considered by the Quality and Outcomes Committee.	Quality and Outcomes Committee
Quality Intelligence Report Two detailed reports were not fully considered. The Committee sought executive summaries of these reports in future.	
Serious Incident Report The Serious Incident Report was deferred until the next Quality and Outcomes Committee meeting, where the Committee would seek assurance that the system and process of Root Cause Analysis was robust and fully implemented, and that any learning points for the Trust were recognised and acted on.	Quality and Outcomes Committee

It was noted that the investigation into the serious incident in this example was complete and that the Committee's role was not part of the management process. *There being no further questions or discussions, the Board resolved to **note** the Committee Chairs' Reports.*	
11. Revised Budget 2011/12 The Board received and considered this report by the Director of Finance for **approval**. The Finance Director, Paul Mapson, reported that the first version of the estimated budget was received by the Trust Board in March 2011. The revised version reflected the budget for the subsequently agreed Monitor Plan, and reflected a lower-level of income from commissioners. The key issue was the savings plan for forthcoming year and a necessity to manage pay costs more effectively. It was also noted that a new-style budget monitoring report will be brought to the Board from June 2011. Deborah Lee commented that if the Trust achieves Commissioning for Quality and Innovation standards (CQUINs) and does not incur penalties, it will have delivered better care to patients, and that this is the underlying premise of the revised budget. There were questions regarding the achievability of Cash Releasing Efficiency Plans put by Non-executive Directors, including Paul May and Kelvin Blake who added that Cash Releasing Efficiency Savings remained the key task; he asked specifically how efficiency savings related to quality improvements. Robert Woolley agreed that the objective of engaging all staff in quality improvement, as referred to by Kelvin Blake, was precisely the objective identified by the Trust Executive. *There being no further questions or discussions, the Board resolved to **approve** the Revised Budget 2011/12.*	Director of Finance
12. Annual Review of the Foundation Trust Constitution The Board received and considered this report by the Trust Secretary for **approval**. Robert Woolley introduced the report, which outlined changes following the Governor's annual review of the Constitution. Alison Moon stated that she supported the minimum age of membership increasing from 7 years, but Elizabeth Corrigan said that the Youth Council gave 7 years as an appropriate age. *There being no further questions or discussions, the Board resolved to **approve** the Annual Review of the Foundation Trust Constitution.*	
13. Review of Terms of Reference – Audit Committee The Board received and considered this report by the Trust Secretary for **approval**. It was agreed that a quorum of two Non-executive Directors was appropriate. *There being no further questions or discussions, the Board resolved to **approve** the Review of Terms of Reference – Audit Committee.*	
14. Review of Terms of Reference – Quality and Outcomes Committee	

The Board received and considered this report by the Trust Secretary for **approval**. It was agreed that a quorum of two Non-executive Directors was appropriate. *There being no further questions or discussions, the Board resolved to **approve** the Review of Terms of Reference – Quality and Outcomes Committee.*	
15. Annual Review of the Register of Directors' Interests The Board received and considered this report by the Trust Secretary to **note**. The Register of Directors' Interests was provided to the Board. It reflected the most recently updated entries provided by Directors, at the request of the Trust Secretary's office on 05 April 2011 and closed on 18 May 2011. *There being no further questions or discussions, the Board resolved to **note** the Annual Review of the Register of Directors' Interests.*	
16. Annual Review of Compliance with the Monitor Foundation Trust Code of Governance The Board received and considered this report by the Chief Executive for **approval**. The purpose of the report was to present an assessment of the Trust's compliance with the Monitor Foundation Trust Code of Governance for the 2010/11 reporting year, for consideration by the Trust Board of Directors for approval. Emma Woollett received assurance about the ability of Directors and Governors to access independent advice. *There being no further questions or discussions, the Board resolved to **approve** the Annual Review of Compliance with the Monitor Foundation Trust Code of Governance.*	
Monitor Reports	
17. Monitor Annual Plan The Board received and considered this report by the Chief Executive for **approval**. The Trust Board had been briefed previously as to the approach and progress on the Annual Plan 2011/12, including at its meetings in February, March and April 2011. In addition, the Membership Council had previously been briefed on progress and the Governors' Strategy Group consulted on detailed aspects of the Plan; Non-executive Directors had been asked for their comments on the draft Annual Plan on 13 May 2011. The Board noted an 'Amber-Green' rating due to a reduction in the Clostridium Difficile target and, and an 'Amber-Green' risk around Accident and Emergency, due to narrow window of 15 minutes for time to critical assessment. Paul Mapson provided the risk rating for Finance as '3', but noted that in the Monitor Compliance Framework the Trust was rated as '3' in one section, and '4' in another, which pointed to a possible discrepancy in the Monitor Framework. Monitor had been notified of, and were reviewing the discrepancy, and the Trust had agreed to work to the '3' rating until notification was received from Monitor. Following an enquiry by Kelvin Blake regarding the possibility of the objectives being brought forward to 2011/12 from 2012/13, Robert Woolley	

responded that the objectives had been assessed on that basis. *There being no further questions or discussions, the Board resolved to **approve** the Monitor Annual Plan.*	
Information and Other	
18. Any Other Business There were no other items of business transacted.	
19. Date of Next Meeting 28 June 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE.	

University Hospitals Bristol NHS
NHS Foundation Trust

Minutes of a Private Board Approval of Annual Accounts Meeting of the Trust Board of Directors, held on 03 June 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Board Members Present	
• John Savage – Chairman • Iain Fairbairn – Senior Independent Director • Paul May – Non-executive Director • Kelvin Blake – Non-executive Director • Lisa Gardner – Non-executive Director • John Moore – Non-executive Director	• Steve Aumayer – Director of Workforce and Organisational Development • Paul Mapson – Director of Finance • Dr Sean O'Kelly – Medical Director • Alison Moon – Chief Nurse
In Attendance	
• Jim O'Connell – Interim Chief Operating Officer • Charlie Helps – Trust Secretary • Victoria Church – Management Assistant to the Trust Secretary	

Item	*Action By*
1. Chairman's Introduction and Apologies The Chairman noted apologies from Prof. Selby Knox – Non-executive Director, Emma Woollett – Non-executive Director, John Moore – Non-executive Director, Robert Woolley – Chief Executive and Deborah Lee - Executive Director.	
Annual Report and Accounts	
2. Annual Report and Accounts 2010/11 The Board received the Annual Report and Accounts 2010/11 and considered the recommendations for **approval**. The Chairman, John Savage, elaborated that the purpose of this Private Trust Board Meeting was to approve the Annual Report and Accounts for the financial year ended 31 March 2011, which included the External Auditor's Annual Governance Report and Head of Internal Audit Opinion. The full report and accounts had previously been brought before the Audit Committee for review on Wednesday 1 June 2011. Iain Fairbairn, who had chaired the Audit Committee on behalf of John Moore, briefed the Board that no significant concerns had been raised at the meeting which had constituted a thorough assessment of the documents presented. In the course of assessing the Annual Report and Accounts, the Audit Committee had discussed: • Monitor guidance regarding impairments and depreciation, • A discrepancy being noted between Monitor and accounting guidance with reference to the FTCs and the Letter of Representation, and,	

Item	*Action By*
• The Education Centre lease. The Audit Committee had also considered the representations made by Internal Auditor, External Auditor, accounting leads from the Trust, and the Head of Finance. As per the minutes of the Audit Committee, it was concluded that the Committee would recommend the Annual Report and Accounts for approval by the Trust Board of Directors. *There being no further questions, the Board resolved to **approve** the Annual Report and Accounts 2010/11. It was noted that the Report would not be available for publication until it had been laid before Parliament.*	
Information and Other	
3. Any Other Business There were no items of other business.	
4. Date of Next Meeting Tuesday 28 June 2011 at 10:00 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE.	

Ref	Date of meeting originating action	Minute number	Description	Action by	Date to come back to Trust Board	Date Action completed	Comments
4	26/05/2011	6	Summary Quality and Performance Report - Quality An update on Pressure Sores will be reported back to Board in three months	Chief Nurse	22/09/2011		
5	26/05/2011	6	Summary Quality and Performance Report - Quality Length of Stay scheduling will be brought back to the June Board meeting	Chief Nurse	28/06/2011		
6	26/05/2011	6	Summary Quality and Performance Report Lisa Gardner and John Moore requested that all performance graphs show at least two years of comparative data to enable trend and pattern analysis.	Dir Strategic Development	28/06/2011		
7	26/05/2011	7	Summary Quality and Performance Report Lisa Gardner remarked that this was not the first time the issue of hand-washing facilities was noted by the Board, and that capital investment had been made in improved facilities, yet they still appeared to fall short. She emphasised that she would appreciate finding the cause of this issue. Robert Woolley confirmed that he had asked the Chief Nurse and Director of Infection Prevention and Control to separate out the reporting and will take judgment on whether this is a clinical care issue or a matter of supporting staff.	Chief Nurse	28/06/2011		
11	26/05/2011	11	Revised Budget It was also noted that a new-style budget monitoring report will be brought to the Board from June 2011.	Director of Finance	28/06/2011		

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Trust Board Meeting, to be held on 28 June 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Chief Executive's Report - Item 5
Purpose
To report to the Board on matters of topical importance to the Trust, including a report of the activities of the Trust Management Executive.
Abstract
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 Trust Management Executive in the month.
Recommendations
The Board is recommended to **Note** the report and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda.
Executive Report Sponsor or Other Author
Robert Woolley, Chief Executive.
Appendices
List your appendices, including your Report in the following format: • Appendix A – Report from Trust Management Executive.

APPENDIX A

TRUST MANAGEMENT EXECUTIVE

REPORT TO TRUST BOARD - JUNE 2011

1. INTRODUCTION

This report summarises the key business issues addressed by the Trust Management Executive in the month.

2. COMMUNICATIONS

The Trust Management Executive **approved** the revised communications strategy, confirming its support for the identified corporate priorities. The Group discussed key themes around change management, staff engagement and the external marketing of the Trust's services. The Group **agreed** that it should receive a progress report on the current review of patient information in the Trust, acknowledging that this work sits outside the remit of this communications strategy.

A communications plan to support the project to improve patient flow across the Trust was **approved**, subject to a review of the escalation protocol for managing long-stay patients.

3. QUALITY, PERFORMANCE AND COMPLIANCE

The Trust Management Executive **approved** the revised Quality Strategy for onward submission to the Trust Board, subject to presentational changes to clarify its relationship to the clinical services strategy and to make explicit the requirement to undertake quality impact assessments of savings proposals prior to implementation.

The following items were **noted** in reports from the subsidiary management groups:

- two applications for Biomedical Research Unit status would be submitted into the second stage of national consideration this month
- further work on defining the model for the centralisation of Urology services in Bristol would be undertaken following a review by commissioners
- a proposal for new corporate arrangements to support delivery of the Trust's Teaching and Learning strategy was in preparation, along with a review of Education Centre utilisation, and work in train to overhaul and simplify the arrangements for performance management of staff.

The Group **noted** the updated action plan in response to the findings of the Histopathology Inquiry and **agreed** that delivery of planned actions to the identified deadlines remained a key priority.

Positive performance against the 4 hour Accident and Emergency wait time target in quarter 1 was **noted**, alongside risks to delivery of the 62 day cancer and Clostridium Difficile targets. It was **agreed** that corrective action already in hand would be further reviewed by the Acting Chief Operating Officer and Deputy Chief Nurse.

4. RISK, FINANCE AND GOVERNANCE

The Trust Management Executive received a summary report of financial performance to Month 2 and **noted** concern about slippage in the delivery of savings plans, which would be further considered at Divisional monthly performance reviews.

The Group **noted** progress reports from Heads of Division of about local review of risk registers.

The Group **approved** proposed arrangements for conducting corporate reviews of serious incidents.

5. STRATEGY AND PLANNING

The Trust Management Executive formally **approved** the 2011/12 Operating Plans for the following Divisions:

- Surgery, Head and Neck
- Women's and Children's Services
- Trust Services

The group also **agreed** that further information was required in support of the approved Division of Medicine Operating Plan, which would be reviewed by the Service Delivery Group.

The Group **approved** a capital appeal framework from Above and Beyond in support of planned new developments at the Bristol Royal Infirmary, Bristol Royal Hospital for Children and Bristol Haematology and Oncology Centre, and noted that a similar framework had been requested from the Grand Appeal.

6. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
16 June 2011

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Trust Board Meeting, to be held on 28 June 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Summary Quality and Performance Report - Item 6
Purpose
To brief the Board on the Trust's performance against Quality, Workforce and Access standards
Abstract
The monthly Quality & Performance Report details the Trust's current performance against national frameworks, and against a range the Quality, Workforce and Access standards. Exception reports are provided, for areas requiring further attention, along with examples of learning and improvement from complaints, incidents and patient stories.
Recommendations
The Board is asked to **note** the current performance of the Trust and to ratify the actions being taken to improve performance.
Executive Report Sponsor or Other Author
'**Health of the Organisation**' – Deborah Lee (Director of Strategic Development) '**Quality**' – Alison Moon (Chief Nurse) & Sean O'Kelly (Medical Director) '**Workforce**' – Steve Aumayer (Director of Workforce & Organisational Development) **'Access'** – Jim O'Connell (Acting Chief Operating Officer) **Other Authors:** Xanthe Whittaker (Head of Performance Assurance / Deputy Director of Strategic Development) Anne Reader (Assistant Director of Governance & Risk Management) Heather Toyne (Assistant Director of Workforce Planning).
Appendices
Appendix A – Summary Quality and Performance Report

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
		27 June 2011			

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

June 2011

CONTENTS

PERFORMANCE OVERVIEW:

A Performance Overview _____

B Organisational health barometer _____

C Monitor's Compliance Framework _____

1. QUALITY

1.1 Actual patient experience _____

1.2 Quality dashboard _____

1.3 Summary _____

1.4 Changes in the period _____

1.5 Exception reports _____

1.6 Supporting Information _____

Quality achievements _____

Examples of learning from recent complaints and incidents _____

2. WORKFORCE

2.1 Summary _____

2.2 Exception Reports _____

2.3 Supporting Information _____

3. ACCESS STANDARDS

3.1 Summary _____

3.2 Access dashboard _____

3.3 Changes in the period _____

3.4 Exception reports _____

3.5 Supporting Information _____

PERFORMANCE OVERVIEW

SECTION A – Performance Overview

Summary

Overall, the 'health' of the organisation has improved slightly, with performance against the majority of indicators either improving or staying the same. The number of RED rated indicators increased by one, as did the number of GREEN rated indicators. This net change in indicators included the Number of C. diff (*Clostridium difficile*) and MRSA (Meticillin Resistant *Staphylococcus aureus*) cases measure going RED. Although this combined indicator of healthcare associated infections is above trajectory for May, both indicators are still within their target trajectory for the quarter.

Performance against all three measures of Efficiency improved, with two of the four indicators now being GREEN rated. This included elective length of stay, which was previously RED rated. Performance against the two measures of High Quality Care, Inpatient Falls and Hospital Acquired Pressure Sores, also improved relative to last month, although the number of grade 3 and 4 pressure sores remains RED rated. The Hospital Standardised Mortality Ratio (HSMR) has remained at its lower level, and has maintained its GREEN rating. The improved performance against the 4-hour standard has also been maintained. Financial performance remains strong with three of the four indicators being GREEN rated.

At the end of May the Trust is expecting to retain an AMBER-GREEN governance risk rating against Monitor's Compliance Framework, due to a down-turn in performance against one of the cancer standards in the latter half of the quarter.

SECTION B – Organisational Health Barometer

Providing a Good Patient Experience

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
A01	Patient Climate Survey (Overall CQUIN Score)	75.5	74.0	N/A	Green: >= 73.0 Red: <72.0	↓	Current month is April 2011
A02	Number of Patient Complaints	107	104	221	Green: <120 Red: >=135	↓	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	5	18	23	Green: 0 Red> >0	↑	

Delivering High Quality Care

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
B01	Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4)	4	2	2	Green: 0 Red: > 1	↓	No RAG rating for YTD. Current month is April 2011.
B02	Number of Inpatient Falls Per 1,000 Beddays	5.44	4.13	4.13	Green < 5.6 Red: >= 5.6	↓	Current month is April 2011.

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
C01	Number of Serious Incidents (SIs)	2	5	7		↑	
C02	Number of C.Diff and MRSA cases	1	12	13	Below Trajectory	↑	MRSA and C.Diff cases combined

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
D01	18 Weeks Admitted Pathways	93.0%	92.4%	92.7%	Green: >=90% Red: <85%	↓	
D02	Number of Cancer Standards Failed	1	0	0	Green: 0 Red: >=2	↓	Previous is Quarter 4 (Jan-Mar 2011), Current and YTD is April 2011.
D03	A&E 4 Hour Standard	96.97%	98.79%	97.87%	Green: >=98% Red: <95%	↑	This standard now excludes the Walk In Centre (WIC). It is only the combined totals for the three Trust Emergency Departments.

PERFORMANCE OVERVIEW

Being Effective

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
E01	Hospital Standardised Mortality Ratio (HSMR)	68.8	65.5		Green: <80 Red: >=90	↓	Previous and Current totals are February and March 2011.
E02	30 Day Emergency Readmissions						New measure is being finalised in line with Payment By Results guidelines

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
F01	Elective Length of Stay Reduction	4.34	3.40	3.86	Green: <= 3.64 Red: >= 3.83	↓	
F02	Emergency Length of Stay Reduction	5.31	5.27	5.29	Green: <= 5.07 Red: >= 5.34	↓	
F03	Theatre Productivity - Percentage of Sessions Used	93.8%	94.7%	94.0%	Green: >= 90% Red: < 90%	↑	This is % of sessions with activity (elective or non-elective) within the hrs of 8.30-5.00. These figures include all theatres BCH/BEH/HGT/STM/ QDU & BDH.
F04	New to Follow-Up Ratio	2.36	2.35	2.25	Green: <1.93 Red: >2.04	↓	Green = CQUIN, Red = Contract Limiter. Data is up to end of March 2011. This measure is still to be re-aligened once Contract Limiters have been agreed.

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
G01	Workforce Costs	0.9%	4.2%	2.6%	above current month and ytd budget	↑	Workforce costs shown as level above(+)/below(-) budget.
G02	Staff Sickness	3.7%	3.8%	3.7%	Red: Above Forecast (over 0.2% of target)	↑	

Promoting Research

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
H01	NIHR Income (£000s)	£570.1	£33.4	£603.5	Green: > YTD Last Year Red: < YTD Last Year	↓	
H02	Weighted Patients Recruited Into NIHR Trials	1,724	1,885		Green: > YTD Last Year Red: < YTD Last Year	↑	Previous and Current are rolling 3 month totals (Jan-Mar 2011 and Feb-Apr 2011 respectively). YTD measure is being re-defined following new year set-up.

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
J01	Monitor Governance Risk Rating	1	1	N/A	Green: < 1 Red: > = 3	→	

Delivering Our Contracts

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
K01	Financial Performance Against CQUINs (£millions)				Green: >=75%, Red<50% of potential reward		CQUIN arrangements for 2011/12 are still being finalised.
K02	Contract Penalties Incurred (£millions)	£0.0	£0.0	£0.0	Green: No penalties Red: >25% of total	→	

Managing Our Finance

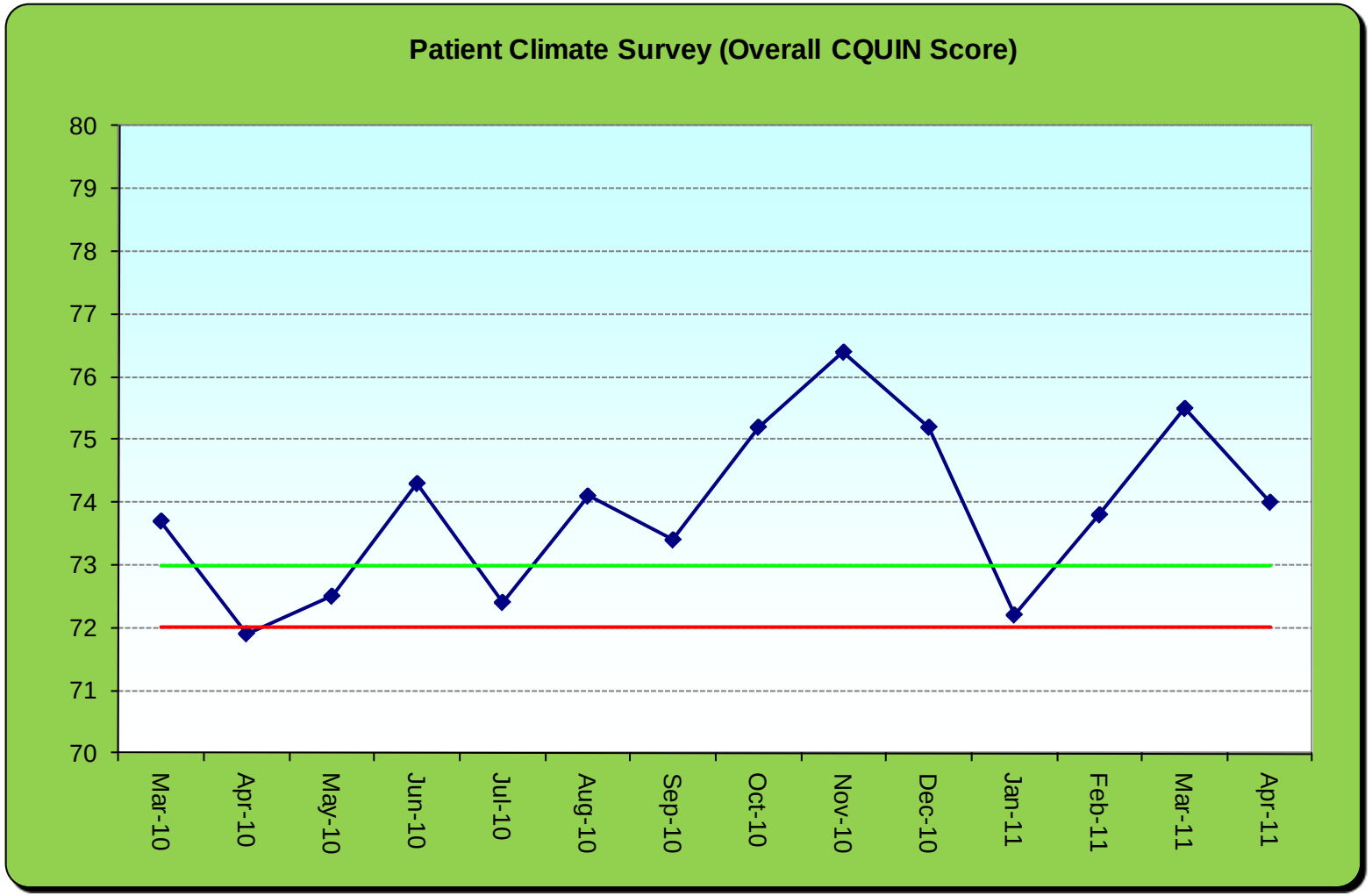
ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
L01	Monitor Financial Risk Rating	3	3	3	Green: >3 Red: <3	→	For all four financial measures, Current is Current Year To Date (i.e. April 2011) so will be the same as the "YTD" column. As this is month 1 of a new financial year, there is no "Previous" data.
L02	EBIDTA (Compared To Plan)	100%	100%	100%	Green: 100% Red: <95%	→	
L03	CRES Achievement	50%	85%	67%	Green: >=90% Red: <75%	↑	
L04	Liquidity (in Days)	40.2	38.9	38.9	Green: 25+ days Red: <=14 days	↓	

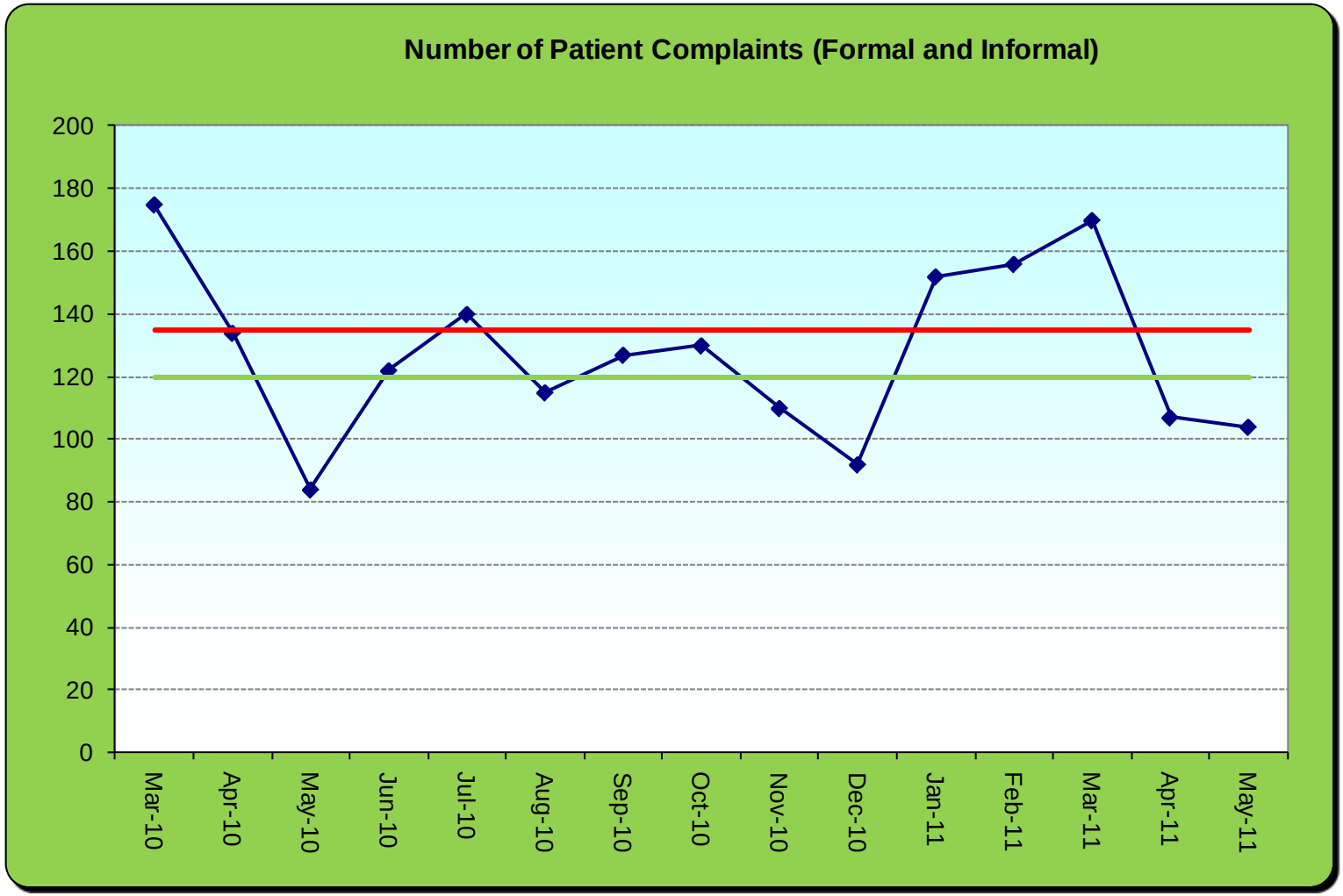
Notes

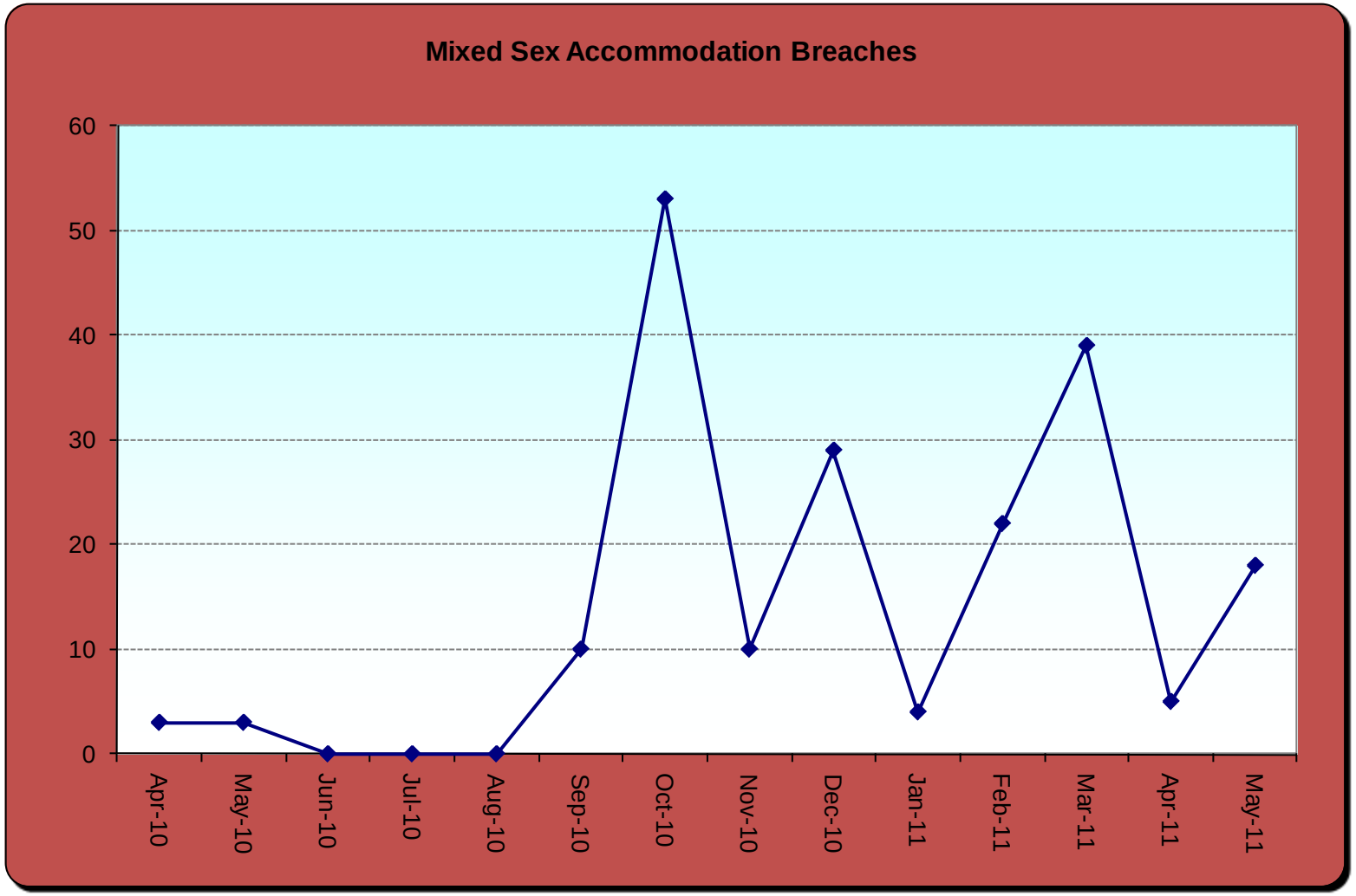
Unless otherwise stated, Previous is April 2011 and Current is May 2011

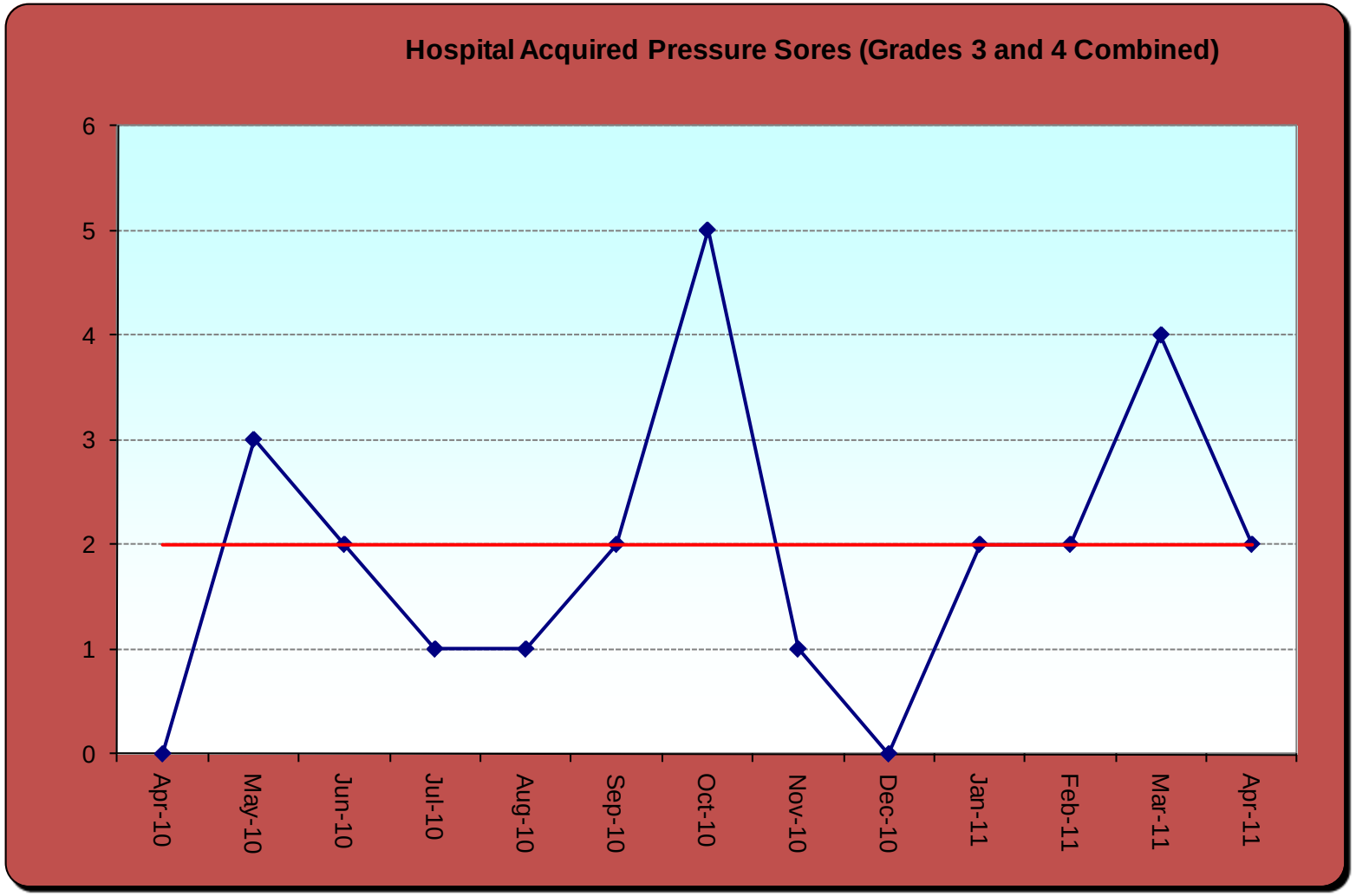
YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2011 up to and including the current month

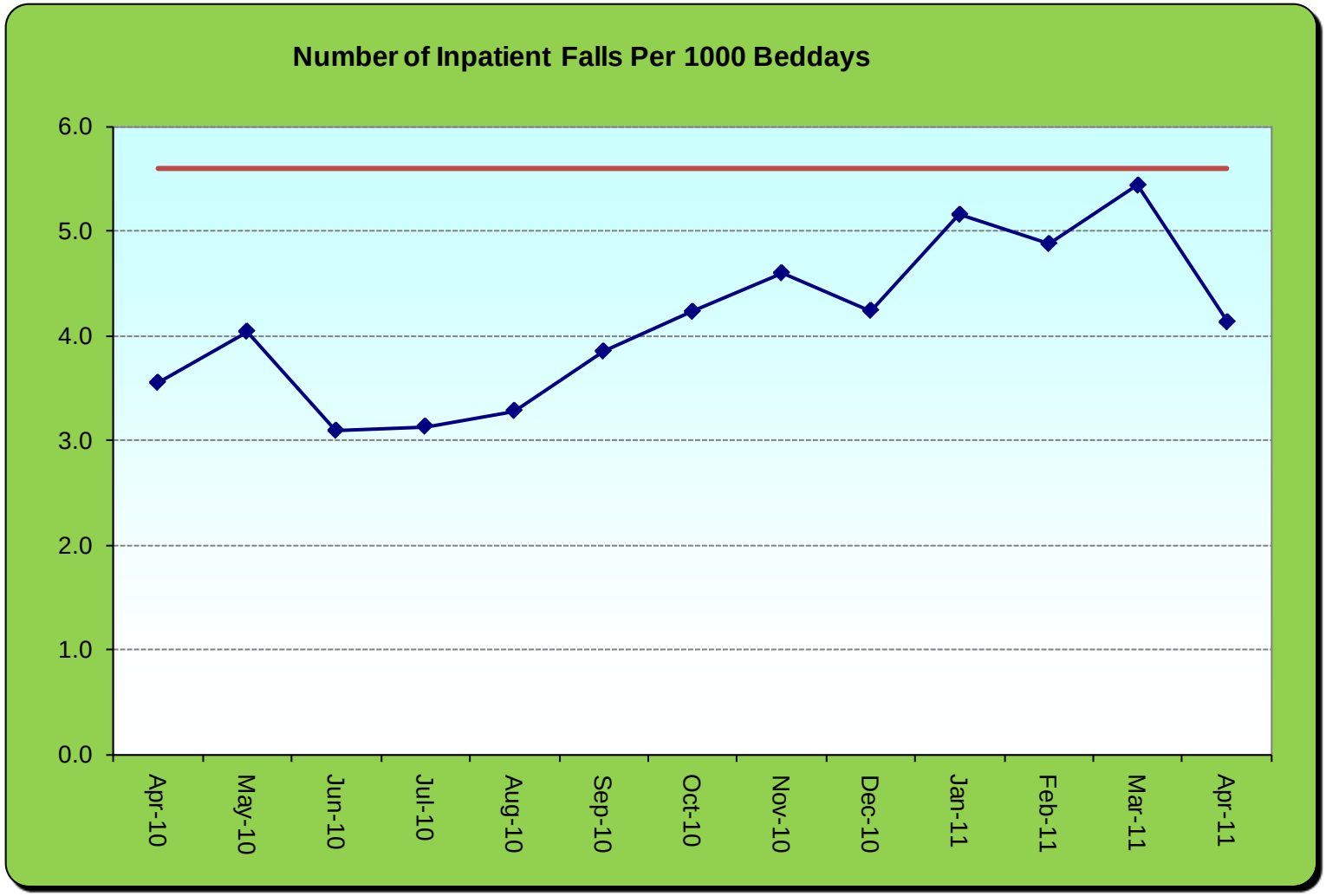
RAG (Red/Amber/Green) rating only applied to YTD where an agreed target number of cases/score exists for the year.

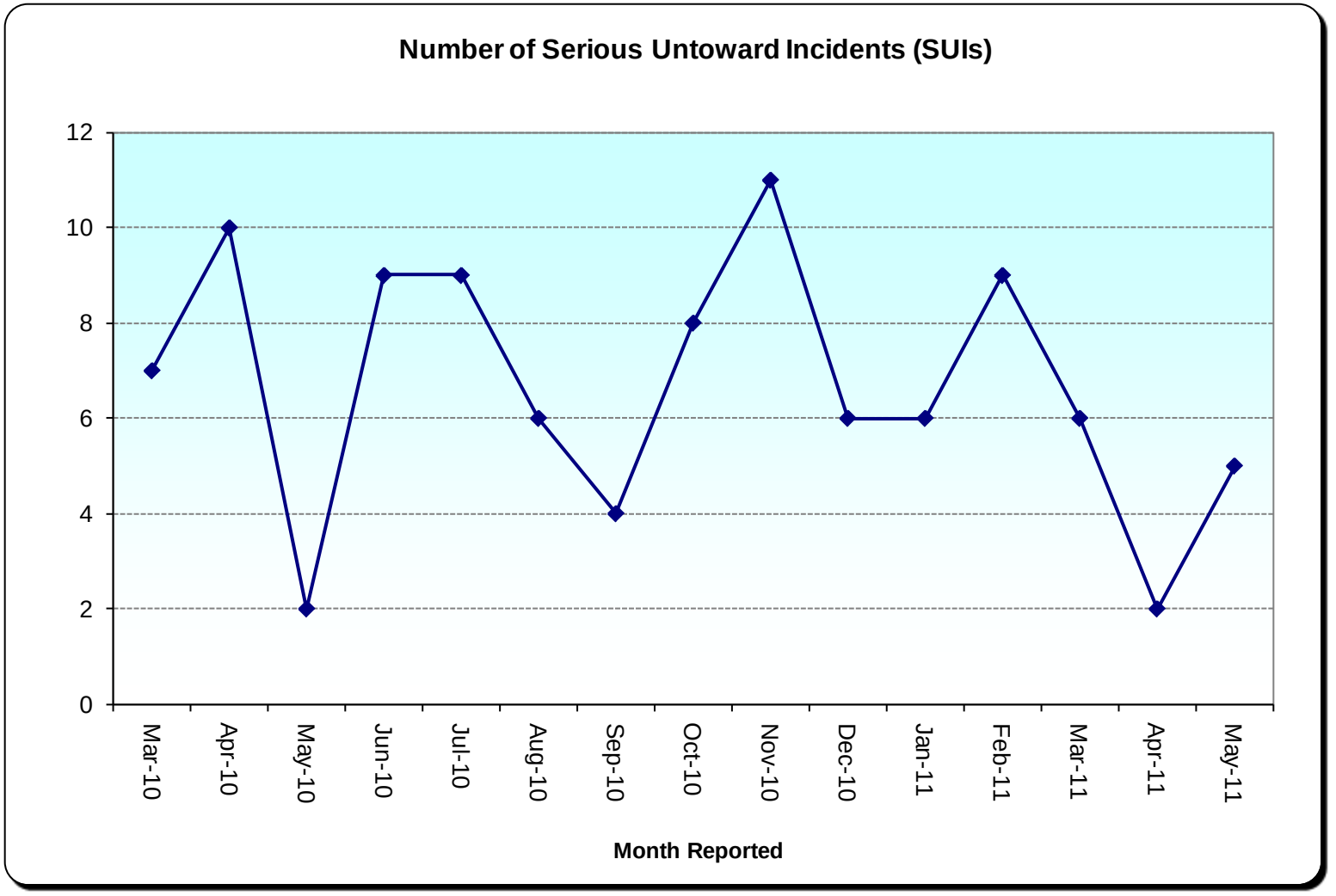

Patient Climate Survey (Overall CQUIN Score)
80
79
78
77
76
75
74
73
72
71
70
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11

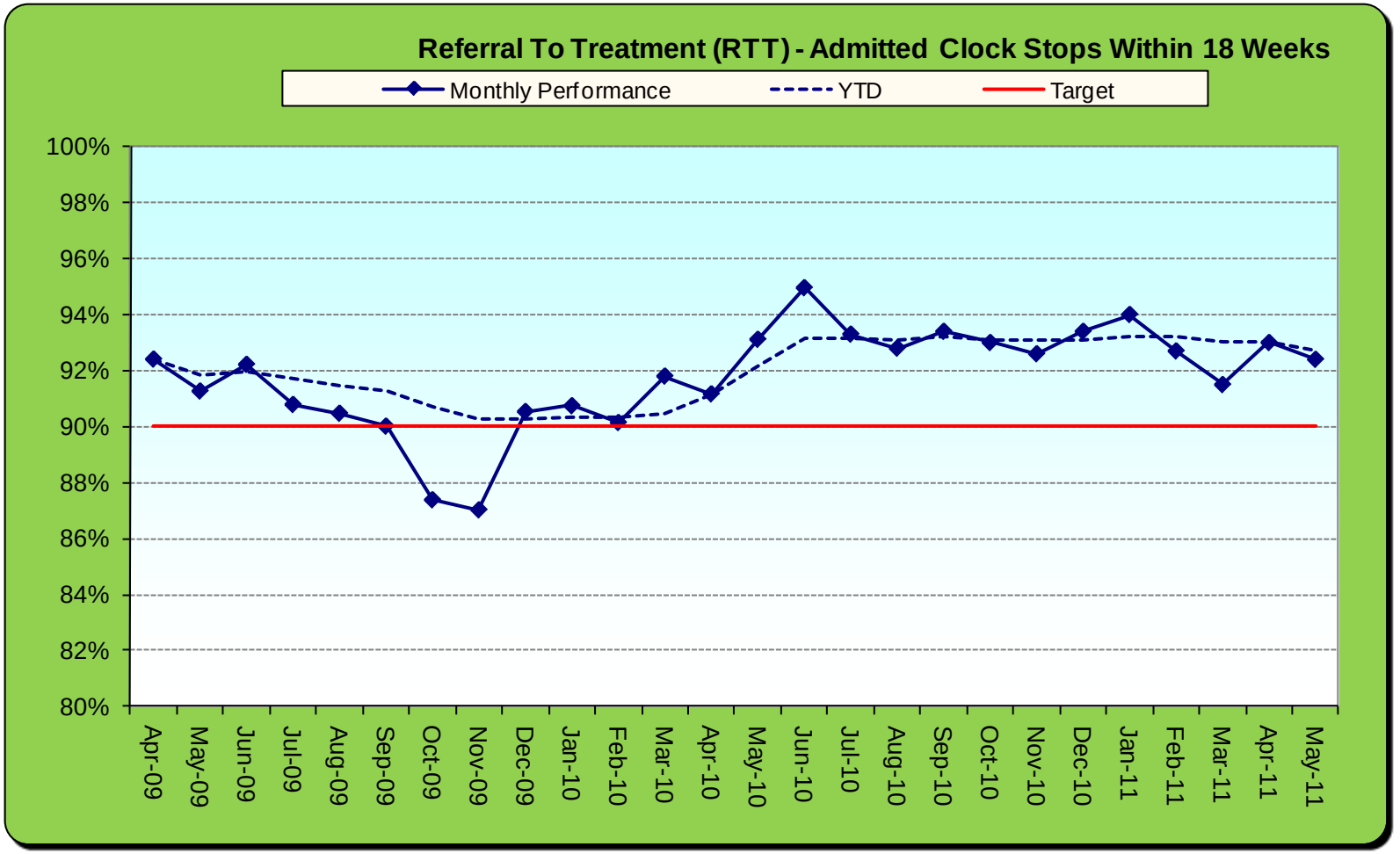

Number of Patient Complaints (Formal and Informal)
200
180
160
140
120
100
80
60
40
20
0
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11


Mixed Sex Accommodation Breaches
60
50
40
30
20
10
0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11


Hospital Acquired Pressure Sores (Grades 3 and 4 Combined)
6
5
4
3
2
1
0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11


Number of Inpatient Falls Per 1000 Beddays
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11


Number of Serious Untoward Incidents (SUIs)
12
10
8
6
4
2
0
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Month Reported


Referral To Treatment (RTT) - Admitted Clock Stops Within 18 Weeks
Monthly Performance
YTD
Target
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
Jul-10
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Nov-10
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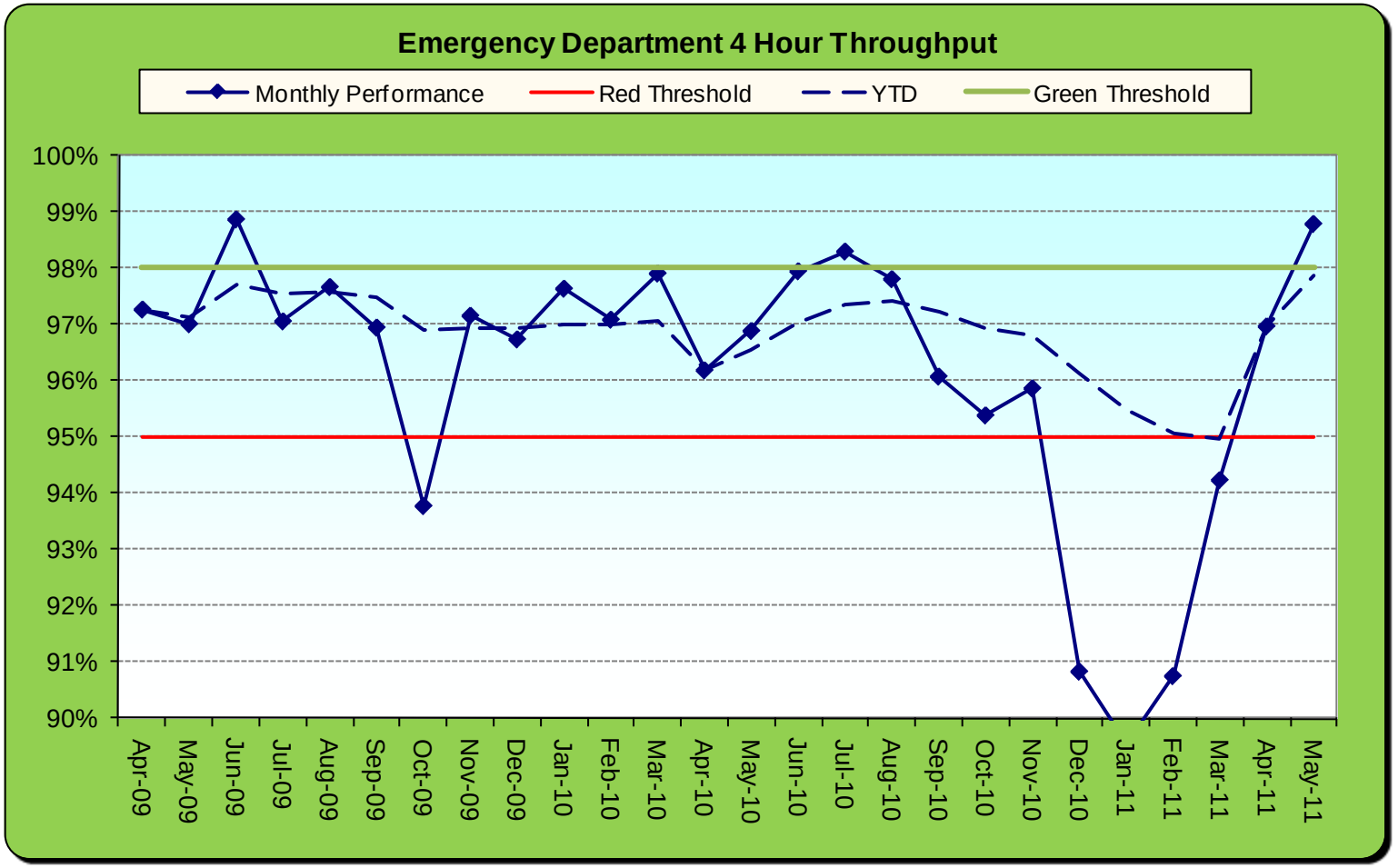
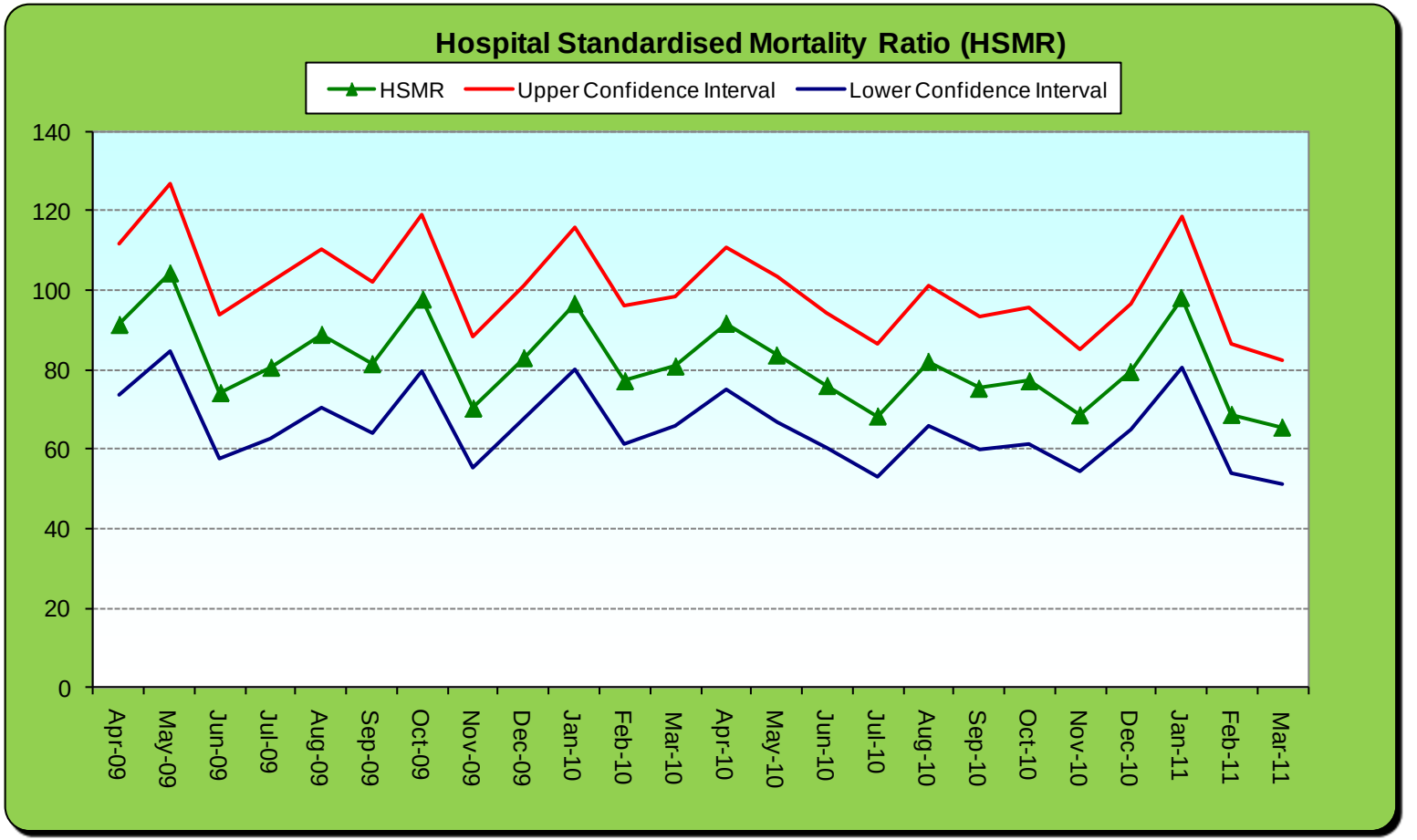
Jan-11
Feb-11
Mar-11
Apr-11
May-11

PERFORMANCE OVERVIEW




Hospital Standardised Mortality Ratio (HSMR)
HSMR
Upper Confidence Interval
Lower Confidence Interval
140
120
100
80
60
40
20
0
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
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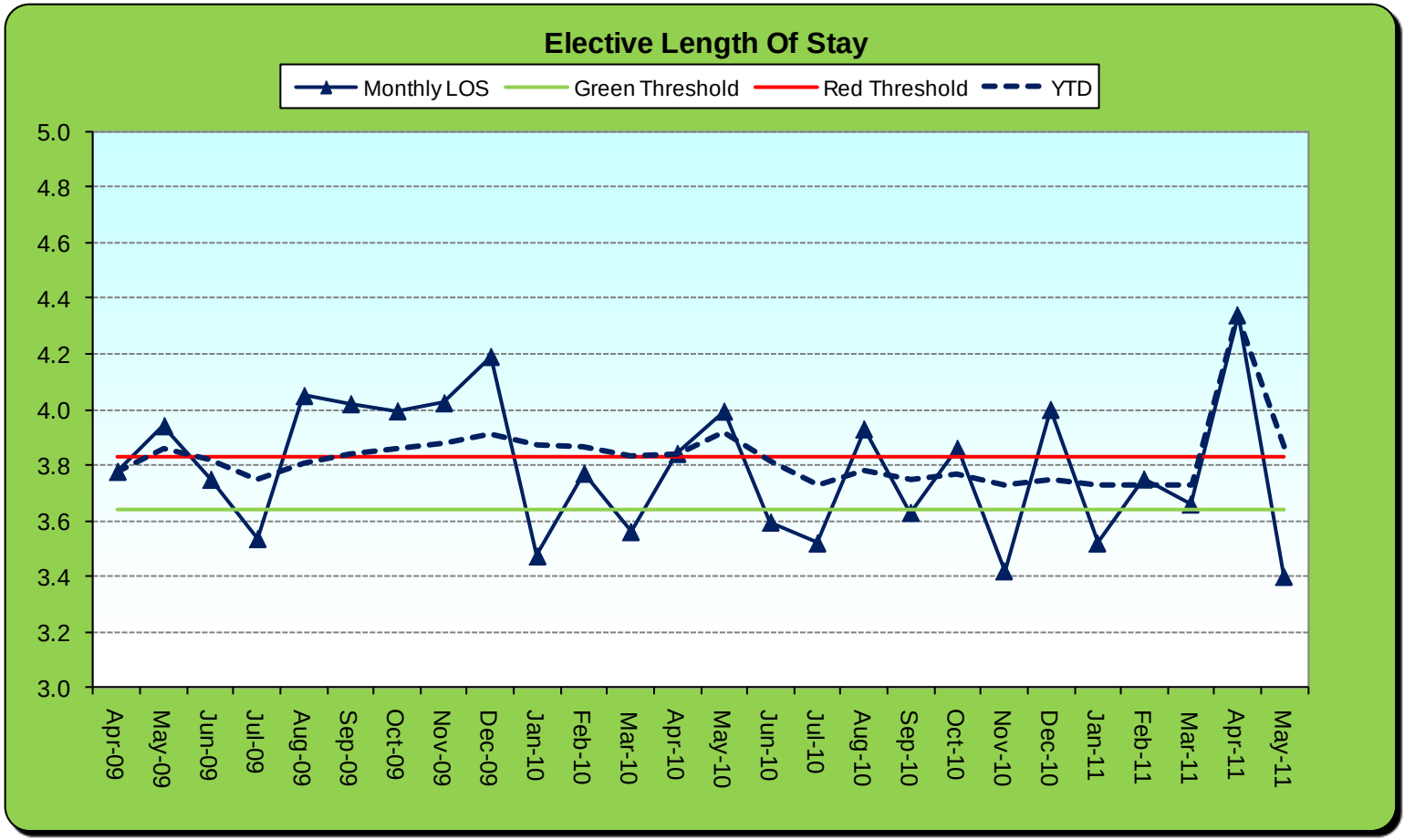
Jan-11
Feb-11
Mar-11


Elective Length Of Stay
Monthly LOS
Green Threshold
Red Threshold
YTD
5.0
4.8
4.6
4.4
4.2
4.0
3.8
3.6
3.4
3.2
3.0
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
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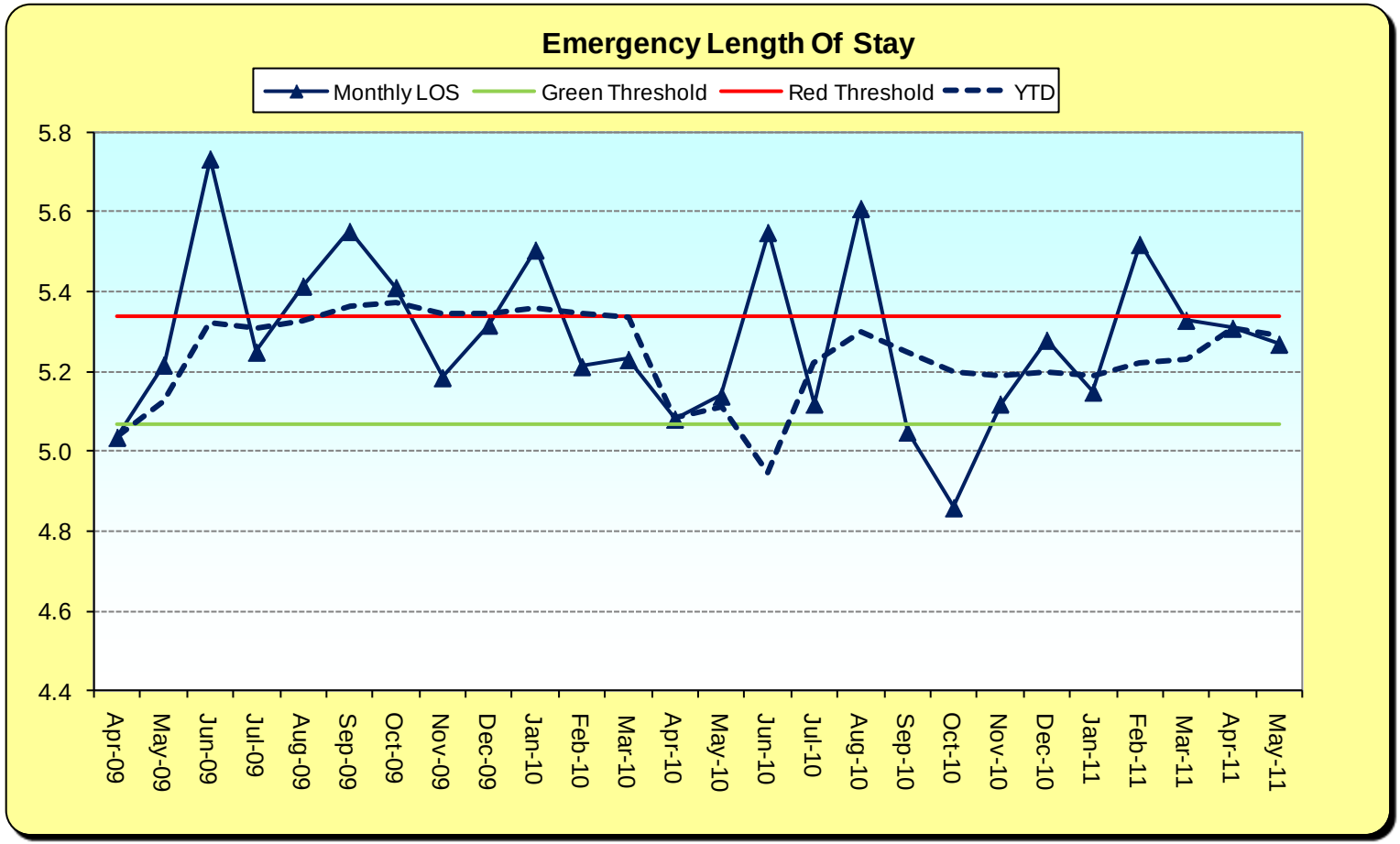
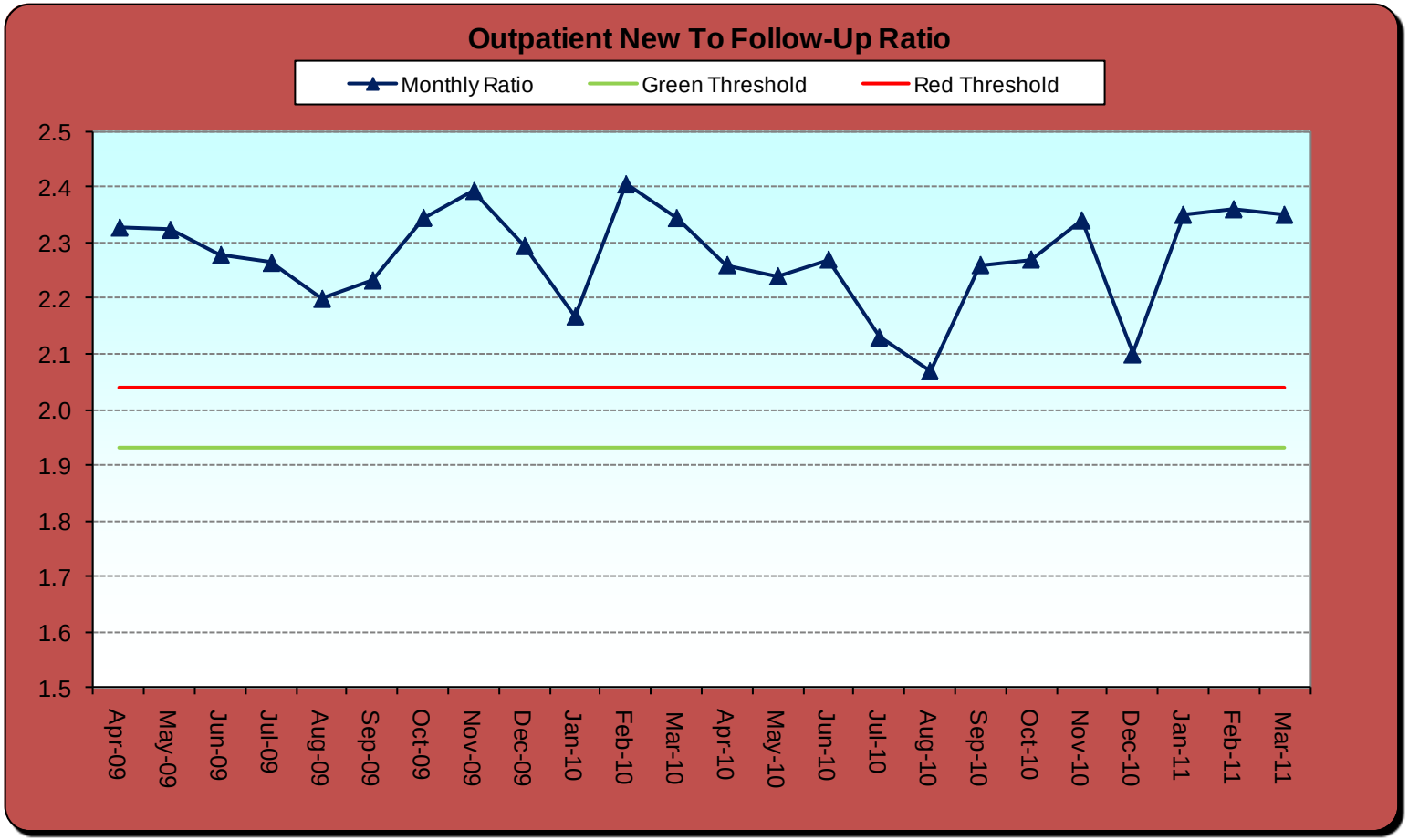
Apr-11
May-11


Emergency Length Of Stay
Monthly LOS
Green Threshold
Red Threshold
YTD
5.8
5.6
5.4
5.2
5.0
4.8
4.6
4.4
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11

PERFORMANCE OVERVIEW



PERFORMANCE OVERVIEW

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Same sex accommodation	*Quality Section*	
Hospital Acquired Pressure Sores (grade 3 and 4)	*Quality Section*	
MRSA + C diff	*Quality Section*	*Clostridium difficile* in exception for May
New to follow-up ratio		Data only available to the end of March; further information to be provided if the exception continues into 2011/12
Weighted patients recruited into NIHR trials		Further information to be provided next month on the reason for this exception.
Cash Releasing Efficiency Savings (CRES) achievement	Please refer to the *Finance Report*	

SECTION C – Monitor's Compliance Framework

At the end of May 2011 the Trust is on track to achieve all of the standards in Monitor's Compliance Framework during quarter 1, with the exception of the one listed below. An exception report is provided for this standard in the *Access* section of this report. Whilst the *Clostridium difficile* target was not achieved in May, the number of cases in the quarter is still within the target trajectory. Please note this assessment is based upon the draft position against the cancer standards and *C. difficile* target for May and the quarter to date.

- 62-day referral to treatment cancer standard for GP referred patients (weighting 1.0) – *Access Section*

This gives the Trust an AMBER-GREEN Governance Risk Rating. This is the second lowest risk rating out of four. However, if the 62-day standard for GP referred patients is achieved for the quarter, this would reduce the Governance Risk Rating to GREEN.

Please see the Monitor dashboard on the following page, for details of current forecast for quarter 1 2011/12.

PERFORMANCE OVERVIEW

Monitor's Compliance Framework - dashboard

	Number	Target	Weighting	Target threshold	Year To Date	Quarterly Performance Q1	Q2	Q3	Q4	Q1 forecast*	Notes	Q1 Governance rating
Monitor Compliance Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	12	12				18	Trajectory: Q1 19; Q2 17; Q3 13; Q4 15	Achieved
	2	Infection Control - MRSA Bloodstream Cases Against Trajectory	1.0	< or = trajectory	1	1				1	Trajectory: Q1 1; Q2 2; Q3 1; Q4 2	Achieved
	3a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	99.0%	99.0%				99.7%		Achieved
	3b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	98.2%	98.2%				97.3%		
	3c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	100.0%	100.0%				99.8%		
	4a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85.0%	86.1%	86.1%				81.7%	62-day GP standard may still be met.	Not currently achieved
	4b	Cancer 62 Day Referral To Treatment (Screenings)		90.0%	96.8%	96.8%				96.0%		
	5	Referral to treatment time for admitted patients (95th percentile) - in weeks	1.0	23	Achieved	Achieved each month				Achieved each month		Achieved
	6	Referral to treatment time for non-admitted patients (95th percentile) - in weeks	1.0	18	Achieved	Achieved each month				Achieved each month		Achieved
	7	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	0.5	96%	97.3%	97.3%				96.6%		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	0.5	93%	96.0%	96.0%				94.2%		Achieved
	8b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	100.0%	100.0%				98.9%		
	9	A&E Total time in A&E 4 hours (95th percentile)	1.0	5%	97.9%	97.9%	Scored from Q2 onwards in combination with four other A&E indicators			98.0%		Achieved
	9a	A&E Total time in A&E 4 hours (95th percentile)	0.5 (failing 2 or less) 1.0 (failing 3 or more)	95%	Not applicable	Not scored in Q1				Not scored in Q1		Not scored
	9b	A&E Time to initial assessment (95th percentile) - in minutes		15	71							
	9c	A&E Time to treatment decision (median) - in minutes		60	21							
	9d	A&E Unplanned reattendance rate (within 7 days)		5%	1.8%							
	9e	A&E Left without being seen		5%	1.2%							
	10	Stroke indicators - to be confirmed	0.5	To be confirmed (TBC)	Not applicable	Standards to be confirmed (TBC)				To be confirmed		Not scored
	11	Self certification against healthcare for patients with learning disabilities (year-end compliance)	0.5	Agreed standards met	Standards met	Standards met				Standards met	Required standard achieved in all six criteria.	Achieved
												1.0
												AMBER-GREEN

Please note: If the same 1.0 weighted indicator is failed in three successive quarters, an automatic RED rating is applied.

*** Forecast based upon actual / draft quarter to date.**

1.1 PATIENT EXPERIENCE

Miss Q is a very independent and articulate 78 year old lady who slipped in a dance class and fractured her right hip in September 2010. She was admitted to the Bristol Royal Infirmary via the Accident & Emergency Department, then via the Surgical Assessment Unit on to a trauma ward and subsequently underwent a right Exeter Total Hip Replacement. Miss Q's complaint contained a number of issues:

1. **Pressure Sore**

   On one occasion, whilst on the trauma ward, Miss Q stated that was unable to get to the toilet so she had a bed pan which had overflowed. Instead of changing the bed, a plastic sheet was put over the wet spot and remained in place overnight, which Miss Q felt contributed to her developing bed sores on her sacrum which took three to four weeks to heal post-discharge, with the help of District Nurses.

   Investigation Outcome
   On admission, an assessment was made and identified that Miss Q was at risk of developing a pressure ulcer. A Waterlow assessment was carried out on the Surgical Assessment Unit and this was scored at 8. This was in fact incorrect, as not all factors had been taken into account and a correct score should have been 15. Despite this, Miss Q was provided with the correct pressure relieving mattress, however further pressure ulcer prevention measures have not been documented. It is totally unacceptable for Miss Q to have been left on a plastic sheet overnight. From the review of Miss Q's discharge documentation there is no suggestion that there was a pressure sore present on discharge from hospital. On receipt of this complaint, the ward sister contacted the district nurses because she was anxious that we may have sent a patient home with a pressure sore and had not notified them. The district nurses confirmed that they did visit to provide wound care as arranged and that subsequently Miss Q contacted them 8 days post discharge and requested a visit as she complained of a sore bottom. When the district nurses visited for the second time, they identified a grade 2 pressure ulcer. This was treated and they advised Miss Q to rest and sleep in her bed rather than in her chair to relieve pressure.

   Action and Learning
   Matron has made it clear to staff that errors in risk assessments are unacceptable and that a correct risk assessment must be completed for every patient on the ward on admission and when their condition changes e.g. post operatively, and care plans are put in place when required to prevent pressure ulcers. In January 2011, the Trust implemented improved pressure ulcer risk assessment paperwork and pressure ulcer prevention care plans to assist nursing staff in reducing the incidence of pressure ulcers developing within the hospital. Apologies were given for Miss Q being left on a plastic sheet overnight. This is unacceptable and has been discussed at the ward staff meeting. Work is in progress across the Trust focussing on improving the quality of clinical documentation to ensure legible and meaningful notes occur for all patients by all disciplines. We have purchased a name stamp for all nursing staff which, for registered staff, includes their Nursing and Midwifery Council registration number. This has encouraged staff to confirm their signature by stamping the notes rather than printing their name and status alongside their signature. This system is already in place for medical staff.

2. Pain Killers

Miss Q was concerned that no-one seemed to check her pain levels post operatively and she had to ask to be taken off some of her painkillers because she was feeling “sick and giddy”. She stated that she mentioned to staff on several occasions that she thought this was due to the Codeine Phosphate she was taking, but it remained on her drug chart and continued to be offered to her on a daily basis. After a few days, Miss Q started to decline this medication and felt a lot better.

Investigation Outcome
A pain assessment score was completed for Miss Q on the first evening post-operation, but thereafter it was not recorded. Miss Q was prescribed different kinds of analgesia on a regular basis and on an “as required” basis post operatively.

Action and Learning
New pain assessment charts are being piloted within the some of the surgical wards and, if successful, then the ultimate aim will be to introduce these new pain assessment charts to all wards and to ensure that they are completed for each patient. Meanwhile the Ward Sister has raised this issue at the ward staff meeting. Staff have been asked to ensure the pain assessments are completed every time the observations are done, and when analgesia is given to assess the effectiveness of this and report any issues from the patients. Staff have also been reminded of the importance of documenting their assessments and actions.

3. Osteoporosis Treatment

Miss Q was concerned she was not started on any osteoporosis treatment whilst she was an inpatient.

Investigation Outcome
A fractured neck of femur care pathway has been in place for over a year and includes a recommendation for doctors to consider commencing appropriate drug treatment for osteoporosis management. Osteoporosis treatment was not prescribed during Miss Q’s admission.

Action and Learning
Learning from this complaint regarding osteoporosis treatment within the fractured neck of femur pathway has been fed back to Miss Q’s orthopaedic consultant, who has in turn fed this back to his junior medical staff.

4. Discharge

Miss Q was very anxious about going home and felt that the whole discharge experience could have been much better. She was taken to the discharge lounge at approximately 11.30am and discharged in the late afternoon/early evening, when her niece had offered to collect her earlier in the day. When Miss Q arrived home, she had to negotiate some steps – she was very anxious about this as she had only practiced this once or twice whilst an inpatient. The Occupational Therapy equipment did not arrive until the day after discharge so things like getting on and off the

toilet were difficult. There was no intermediate care or therapy arranged on discharge and a domiciliary physiotherapist only arrived several months later.

Investigation Outcome

An ambulance was arranged to transport Miss Q home on discharge, rather than accepting her niece's offer to transport her home earlier in the day, was to ensure the crew were available to assist Miss Q to navigate the steps into her home. Occupational Therapy completed an initial interview with Miss Q 5 days prior to her discharge and various assessments were completed - including transfer, mobility and kitchen assessments. A detailed conversation regarding existing equipment at home also took place and new equipment needs were identified for discharge. The Occupational Therapy technician delivered a perching stool and free standing toilet frame on the afternoon of Miss Q's discharge. Having done this the technician returned to BRI and met with Miss Q on the ward to discuss the equipment drop and to inform her that her armchair could not be raised and that the recommendation was that she used a dinning chair – at the time Miss Q appeared happy to follow this advice. We apologise that Miss Q's expectations regarding the domiciliary physiotherapy service were not met.

5. **Consultant**

Miss Q and her niece have stated that they did try to raise their concerns when they attended the Trauma & Orthopaedic Clinic but felt that the consultant brushed their concerns aside, telling them not to worry as she was "alright now".

Investigation Outcome

We apologise for the response from the consultant when Miss Q and her niece tried to raise their concerns.

Action and Learning

The consultant has reflected on this complaint. A productive out-patients project had been set up to help to address patient experience and system productivity in outpatients. This will include workshops for staff illustrated by examples of when patients' experiences of out-patients have not been good, based on complaints received.

Miss Q has been contacted and is happy for the Trust to use her experience as a patient story to be fed back to the Board and hopes that it will be a useful learning tool.

1.2 QUALITY DASHBOARD

		ID	Title	Green Threshold	Year To Date	Monthly Totals												Quarterly Totals			
						Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Q2	Q3	Q4	Q1
Patient Safety	Infection Control	PS-A1	MRSA Pre-Op Elective Screenings	100%	100.0%	99.1%	96.2%	98.1%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.8%	100.0%	100.0%	100.0%
		PS-A2	MRSA Emergency Screenings	90%	92.4%	59.2%	59.7%	60.5%	62.4%	59.9%	79.9%	80.6%	90.4%	92.0%	91.7%	91.5%	93.3%	60.9%	72.2%	91.3%	92.4%
		PS-A3	Hand Hygiene Audit Compliance	95%		95%	96%	98%	96%	96%	97%	95%	96%	96%	97%	97%	95%				
		PS-A4	Antibiotic Compliance	95%		74%	76%	73%	67%	71%	73%	79%	77%	80%	76%	81%	78%				
		PS-A5	Matron's Checklist	95%		95%	94%	93%	94%	95%	96%	94%	95%	95%	94%	95%	93%				
		PS-A6	Cleanliness Monitoring - Overall Score	95%		96%	97%	97%	97%	93%	96%	96%	96%	95%	95%	95%	96%				
		PS-A7	Cleanliness Monitoring - Very High Risk Areas	95%		97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%				
		PS-A8	Cleanliness Monitoring - High Risk Areas	95%		96%	96%	96%	97%	97%	97%	99%	97%	96%	96%	96%	96%				
		PS-A9	Number of GRE Bacteraemias	<=2		1	0	0	1	2	0	0	3	1	1			1	2	5	
		PS-A10	Infection Control - C.Diff Infections Against National Trajectory	<Traj.	12	12	12	3	12	7	8	3	7	7	7	1	11	27	18	21	12
		PS-A11	MSSA Cases Against Trajectory	<Traj.	5											3	2				5
	Incidents	PS-B1	Serious Untoward Incidents (SUIs)		7	9	9	6	4	8	11	6	6	9	6	2	5	19	25	21	7
		PS-B2	Serious Untoward Incidents Reported Within 48 Hours	80% (Q3)	86%											50%	100%				86%
		PS-B3	Percentage of SUI Investigations Completed Within National Timescales	80% (Q3)																	
		PS-B4	Total Never Events	0	1	0	1	0	0	0	0	0	0	0	0	1	0	1	0	0	1
	Falls	PS-C1	Number of Inpatient Falls Per 1,000 Beddays	<5.6	4.13	3.09	3.13	3.28	3.85	4.23	4.60	4.24	5.16	4.88	5.44	4.13		3.42	4.35	5.17	4.13
		PS-C2	Repeat Inpatient Falls																		
		PS-C3	Number of Inpatient Falls - Patients Aged 65 And Over		78	58	56	54	67	82	90	86	99	90	117	78		177	258	306	78
		PS-C4	Number of Inpatient Falls - Patients Aged Over 65 With Cognitive Impairment		32								28	35	59	32				122	32
	Pressure Ulcers	PS-D1	Total Pressure Ulcer Incidence per 10,000 Bed Days	6.51	7.16	4.26	5.49	8.51	5.97	10.30	10.31	5.06	7.06	9.84	9.84	7.16		6.51	8.46	8.89	7.16
		PS-D2	Percentage of Hospital Acquired Pressure Ulcers Not Graded	0%	0.0%	45.5%	28.6%	5.9%	6.7%	4.3%	3.8%	0.0%	0.0%	4.2%	14.8%	0.0%		13.0%	3.2%	7.1%	0.0%
		PS-D3	Number of Hospital Acquired Grade 2 Pressure Ulcers		16	4	9	15	12	17	24	13	17	21	19	16		36	54	57	16
		PS-D4	Number of Hospital Acquired Grade 3 Pressure Ulcers	<1	2	2	1	1	1	3	1	0	2	2	3	2		3	4	7	2
		PS-D5	Number of Hospital Acquired Grade 4 Pressure Ulcers	<1	0	0	0	0	1	2	0	0	0	0	1	0		1	2	1	0
	Venous Thrombo-embolism (VTE)	PS-E1	Adult Inpatients who Received a VTE Risk Assessment	90%	94.7%	63.1%	59.1%	69.2%	67.7%	59.2%	75.8%	69.3%	82.4%	84.4%	91.6%	94.2%	95.1%	66.2%	68.2%	86.8%	94.7%
		PS-E2	Percentage of Adult Inpatients who Received Thrombo-prophylaxis																		
	Nutrition	PS-F1	Patients with Nutritional Screening Within 24 Hours	80%		66.6%			72.2%			76.6%			76.1%			72.2%	76.6%	76.1%	
	Safety	PS-G1	WHO Surgical Checklist Compliance	95%	98.6%	81.9%	95.6%	97.4%	97.9%	97.1%	98.4%	97.8%	97.7%	98.7%	98.0%	98.6%		97.0%	97.8%	98.1%	98.6%
		PS-G2	Reduction in Medication Errors	<4.06%		1.64%	2.20%	2.17%	3.15%	2.42%	1.92%	3.39%	3.73%	5.10%	5.93%			2.58%	2.60%	4.86%	
	Leadership	PS-H1	Number of Executive Director Patient Safety Walk-arounds	>=6	18	4	5	9	4	6	5	7	5	5	5	7	11	18	18	15	18
		PS-H4	Percentage of Non-Estates Actions Completed Within 2 Months	80%	100%		100%	100%	75%	82%	71%	29%	100%	80%	67%	100%	100%	90%	62%	75%	100%

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		ID	Title	Green Threshold	Year To Date	Monthly Totals											Quarterly Totals			
						Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Q2	Q3	Q4	Q1
Clinical Effectiveness	Mortality	CE-A1	Hospital Standardised Mortality Ratio (HSMR)	<=80		76.6	67.2	81.9	75.3	77.3	68.6	79.5	98.1	68.8	65.5			75.0	75.2	77.4	
	NICE Guidance	CE-B1	New Technology Appraisal Implemenation Plans Agreed In 3 Months	90%		100%			75%			75%			75%			75%	75%	75%	
		CE-B2	Assessed Clinical Guidelines	90%		100%			50%			75%			100%			50%	75%	100%	
		CE-B3	Assessed Clinical Guidelines: All Recommendations Compliant	90%		88%			96%			94%			91%			96%	94%	91%	
		CE-B4	Assessed Clinical Guidelines: Priority Recommendations Compliant	90%		67%			87%			84%			91%			87%	84%	91%	
	Length of Stay	CE-C1	Average Length Of Stay - Elective	<=3.64	3.86	3.60	3.52	3.93	3.63	3.86	3.42	4.00	3.52	3.75	3.66	4.34	3.40	3.69	3.76	3.64	3.86
		CE-C2	Average Length Of Stay - Emergency	<=5.07	5.29	5.55	5.12	5.61	5.05	4.86	5.12	5.28	5.15	5.52	5.33	5.31	5.27	5.26	5.09	5.33	5.29
	Learning Disability	CE-D1	Risk Assessment of Patients with Known Learning Disability within 48 Hours of Hos	75%	93.8%	87.5%	88.9%	95.5%	100.0%	100.0%	83.3%	100.0%	77.8%	85.7%	87.5%	87.5%	100.0%	95.0%	96.2%	83.3%	93.8%
	Readmissions	CE-E1	Emergency Readmissions Within 30 Days	<6.4%																	
Patient Experience	Single Sex Accom.	PE-A1	Breaches of the Same Sex Accommodation Requirements	0	23	0	0	0	10	53	10	29	4	22	39	5	18	10	92	65	23
	Patient Experience	PE-B1	Patient Survey - Overall CQUIN Score	73.0		74.3	72.4	74.1	73.4	75.2	76.4	75.2	72.2	73.8	75.5	74					
		PE-B2	Monthly Patient Survey - Confidence and Trust	95		88	85	87	86	88	88	88	86	87	88	88					
		PE-B3	Monthly Patient Survey - Communication	85		72	70	74	71	72	74	73	71	73	75	72					
		PE-B4	Monthly Patient Survey - Cleanliness	95		91	90	90	90	89	90	91	89	90	91	91					
		PE-B5	Monthly Patient Survey - Involvement in Care	80		74	71	74	73	73	75	72	70	70	72	71					
	Complaints/Compliments	PE-C1	Number of Patient Complaints	<=120	221	122	140	115	127	130	110	92	152	156	170	107	114	382	332	478	221
		PE-C2	Percentage of Complaints Regarding Patient Care	<40%	16.7%	25.4%	32.1%	11.3%	23.6%	19.2%	19.1%	29.3%	13.8%	24.4%	12.4%	15.9%	17.5%	23.0%	22.0%	16.7%	16.7%
		PE-C3	Percentage of Complaints Resolved Within Timeframe (Formal Compalints)	98%	91.0%	92.7%	93.2%	95.9%	100.0%	89.4%	93.4%	95.5%	100.0%	98.7%	98.4%	88.9%	92.2%	96.6%	92.4%	99.1%	91.0%
		PE-C4	Number of Complainants Disatisfied with Response	<=5	7	0	1	2	6	7	8	5	4	6	9	3	4	9	20	19	7
		PE-C5	Number of Compliments		682	450	1084	598	807	446	716	573	788	741	436	295	387	2489	1735	1965	682

1.3 SUMMARY

The quality dashboard for 2011/1 2 has been reviewed and will be updated. The aim of this review was to remove or refine metrics which had proved not to be as useful as anticipated, and to develop others, introducing new ones which are in line with our quality objectives, CQUINs for 2011/12 and the NHS Outcomes Framework. The Quality Metric Guide provided to Board members will be updated once this is finalised. It has been clarified that the timescales for completing serious incident investigations as set out within the National Framework for Reporting and Learning from Serious Incidents and included in commissioning contracts will apply to incidents which occurred after 1st April 2011. Therefore reporting against this metric will trigger in June when the first incident investigations deadlines are reached.

The Board's attention is drawn to a key change in metrics in this month's Quality dashboard:

i. There has been a significant increase in the number of *Clostridium difficile* cases against the national trajectory in May 2011. A detailed exception report has been provided in relation to this.

A summary of the Trust's performance against quality metrics is shown below.

Achieving set threshold (21)	**Thresholds not met or no change on previous Month (3)**
- MRSA (Meticillin Resistant *Staphylococcus Aureus*) screening – elective - MRSA screening – emergency - Hand Hygiene Audit - Cleanliness monitoring overall Trust score - Cleanliness monitoring very high risk areas - Cleanliness monitoring high risk areas - Glycopeptide Resistant Enterococci (GRE) Bacteraemias - MSSA (Meticillin Sensitive *Staphylococcus Aureus*) cases against trajectory. - Serious Incidents reported with 48 hours - Never Events - In-patient falls incidence per 1,000 bed days - Percentage of hospital acquired pressure ulcers not graded at all - Number of hospital acquired grade 4 pressure ulcers	- Matrons checklist (*C. difficile* dashboard) - Reduction in average emergency length of stay - Percentage of complaints resolved within agreed timescale

QUALITY

- Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment - Number of executive director patient safety walk rounds - Percentage of all actions completed with 2 months of patient safety walk round - Hospital Standardised Mortality Ratio - Reduction in average elective length of stay overall - Total number of complaints - Number of complainants dissatisfied with the response - % Complaints regarding clinical care	
 **Quality metrics not achieved or requiring attention (7)**	 **Quality metrics with thresholds not yet finalised or which are being reported quarterly (9)**
- Antibiotic prescribing compliance - *Clostridium difficile* cases against national trajectory - Total pressure ulcer incidence per 10,000 bed days - Number of hospital acquired grade 2 pressure ulcers - Number of hospital acquired grade 3 pressure ulcers - Reduction in medication errors - Number of breaches of the single sex accommodation standard	**Data not available** - Percentage adult in-patients who received thrombo-prophylaxis - 30 day emergency re-admissions - WHO surgical safety check list compliance in theatres **Metrics where measures for 2011/12 do not yet apply** - Serious Incident investigations completed with national timescales **Metrics where changes in measurement require new thresholds to be set** - Falls in in-patients over 65 - Falls in patients with cognitive impairment **Metrics where data capture is being developed** - Repeat in-patient falls **Metrics for information** - Number of serious incidents - Number of compliments

QUALITY

1.3.1 Summary of Performance Against Clinical Quality Indicator (CQUIN) Quality Dashboard Metrics

Please note 2011/12 CQUIN details are still being finalised within contract negotiations therefore, for the purpose of this report, performance is therefore compared to 2010/11 measures.

- Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment. Performance of 95.1% against the required figure of 90%.
- Reduction in elective length of stay. A decrease on previous month's figure to 3.4 days against a target of 3.64 days.
- Reduction in emergency length of stay. A slight decrease on previous month's figure to 5.27 days against target of 5.07 days.
- Patient Experience scores relating to the discharge survey. Confirmed patient experience index score for April 74 against target of 73.
- Reduction in medication errors: latest figure for March is 5.93% against a target of 4.06%. The aim is to reduce the percentage of incidents causing harm classified as moderate or greater by 20%.

1.4 CHANGES IN THE PERIOD

Performance against the following indicators changed significantly compared with the last reported month:

- Antibiotic prescribing compliance, a decrease ↓ from 81% in April, to 78% in May.
- Percentage of serious incidents reported with the 48 hour timescale up ↑ from 50% in April to 100% in May.
- Number of *Clostridium difficile* infections against the national trajectory, an ↑ increase from 1 in April to 11 in May.
- Pressure Ulcer incidence per 10,000 bed days down ↓ from 9.84 in March to 7.16 in April.
- Percentage of hospital acquired pressure ulcers not graded, a decrease ↓ from 14.8% to 0 in May.
- Same sex accommodation breaches up ↑ from 5 in April to 18 in May.

1.5 EXCEPTION REPORTS

Exception reports are provided for seven (7) indicators in total. This includes six (6) which are red rated and one (1)* which has been of continued interest to the Board.

1. Antibiotic prescribing compliance
2. *Clostridium difficile* infections against national trajectory.
3. Total pressure ulcer incidence per 10,000 bed days
4. Number of hospital acquired grade 2 pressure ulcers*
5. Number of hospital acquired grade 3 pressure ulcers
6. Reduction in medication errors
7. Number of breaches of the single sex accommodation standard

QUALITY

Q1. EXCEPTION REPORT: Antibiotic Prescribing Compliance	RESPONSIBLE DIRECTOR: Medical Director

Description of how the standard is measured:

Antibiotic compliance measures the compliance with the three elements of the antibiotic prescribing bundle (i.e. prescription in line with policy, indication stated and course length stated).

Performance in the period, including reasons for the exception:

The overall percentage fell slightly in April to 78%. Compliance rose in Specialised Services to 82%, but fell slightly in the other divisions: Medicine – 75%, Surgery - 76%, Woman's and Children's - 74%. Compliance failures remain predominantly in recording the indication for the prescription and the course length.

Recovery plan, including expected date performance will be restored:

The recovery plan detailed in last month's report continues

- An extra 5 minutes will be added to all junior doctor induction to cover anti-infective prescribing starting in August.
- The anti-infective compliance figures will be displayed in obstetrics and gynaecology as a trial to see if this has an impact on anti-infective prescribing
- We are still reviewing the possibility of a 'test' for doctors on anti-infective prescribing, although this does not appear to be possible in the short term.
- A formal education process for pharmacists and nurses on antibiotic prescribing will also be reviewed.
- Each speciality already receives a report on their antibiotic prescribing monthly. A rolling program of meeting with each speciality will be implemented to discuss their performance and what their action plan is to improve compliance – this should encourage specialities and divisions in taking responsibility in their antibiotic prescribing performance – this should start in the next month.

It is expected that the antibiotic prescribing compliance will make small improvements over the next couple of months then show further increases in August and September.

QUALITY

Q2. EXCEPTION REPORT: *Clostridium difficile* infections against national trajectory	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

The number of *Clostridium difficile* cases for patients in hospital for more than 3 days. The national reduction objective set centrally is 64 cases in year (32% reduction on 2010/11 outturn figure). Financial penalties are not linked to the national target but occur if a ceiling of 96 cases is breached in 2011/12.

Performance in the period, including reasons for the exception:

There were eleven Trust apportioned cases of *Clostridium difficile* in May 2011 and three cases that are not apportioned to target but were in patients linked to the Trust. The latter cases are important as although they are not included in official figure they give an indication of the overall burden of *Clostridium difficile* in an area. The breakdown of cases by location is as follows.

Division	Target	Number of target Cases	Number of non-target linked cases	Location of patients	Comments
Medicine	3	5	1	24 11 25 10 4	 Recent discharge from Ward 14
Surgery Head and Neck	2	2		6 x 2	
Specialised Services	0	3	1	51 53 62 61	Known previous positive patient Recent discharge from Ward 12
Women and Children	1	1	1	Bone Marrow Transplant Unit Oncology Day Beds	

The Divisions of Medicine and Specialised Services exceeded their monthly target in May. However, only Specialised Services Division has exceeded their cumulative trajectory to date. The eleven cases in May follows a month of excellent performance with *Clostridium difficile* in which only one target and one linked case were reported in April 2011. The cumulative cases from April to May 2011 is twelve target cases and is one under the

cumulative central target trajectory for year to date.

All cases of *Clostridium difficile* infections are investigated using a modified root cause analysis process by the Infection Control Team. Investigation of the cases in May has identified the following areas for practice improvement focus:

- Completion of Bristol Stool Charts
- Completion of risk assessment when patients have diarrhoea
- Correct specimen testing

Recovery plan, including expected date performance will be restored:

Weekly operational meetings have been reinstated to review new and existing cases and implement prevention measures; these are chaired by the Chief Nurse or Deputy Chief Nurse.

A recovery plan has been developed in consultation with Divisional staff and its implementation commenced. The plan is drawn from the national guidelines for prevention of *Clostridium difficile* and the five elements of the Trust's FLUSH *Clostridium difficile* prevention bundle:

- **F**ollow antibiotic guidelines
- **L**ocation of patients with *Clostridium difficile* and diarrhoea in isolation
- **U**se and remove protective clothing correctly
- **S**potlessly clean environment and equipment
- **H**and washing with soap and water

The following actions were immediately implemented:

- Making the Bristol Stool Chart and risk assessment form available to order as opposed to copying
- Amending the ICE specimen ordering system to prompt staff in correct specimen sending
- Monitoring achievement of the target time for isolation of patients with diarrhoea. This is an internally agreed target of four hours from the time that a patient is identified as needing isolation to the time that the patient is placed in a single room.
- Identification of specific bed spaces on wards for placement of patients with diarrhoea who cannot be isolated for clinical reasons
- Monitoring of practice, including isolation, completion of the Bristol Stool Chart and the Matrons checklist increased from monthly to weekly
- Increased awareness amongst facilities staff of bed space and isolation room cleaning procedures
- Trust-wide message to staff re-iterating the hand hygiene policy and hand washing for patients with diarrhoea
- Daily checks of soap, paper towel and alcohol hand gel availability in wards by Housekeepers

QUALITY

The following actions are being implemented in June 2011:

- Development of more robust systems for identifying patients who require isolation precautions for diarrhoea on main wards
- Modification of the infection control risk assessment form completed on admission to include identification of patients known to previously be positive for *Clostridium difficile*
- Introduction of a formal remedial meeting and action plan to address areas where cleanliness monitoring shows results below 90%
- Implementation of a plan to reduce the proportion of antibiotics that are administered by the intravenous route
- Detailed laboratory analysis of April and May samples to identify specific strains that may be contributing to the increased and linked cases

Actions planned from July 2011 onwards are:

- Additional training for Housekeepers enabling them to act as infection prevention champions
- Modifications to the current *Clostridium difficile* testing system to remove false negative tests
- Further actions to reduce inappropriate prescribing of antibiotics
- Divisional performance will be included in the quarter performance reviews commencing quarter one in July 2011

Delivery of the plan is being monitored and managed through the weekly infection control operational meeting and through exception reporting to the Service Delivery Group fortnightly.

QUALITY

Q3-Q5. EXCEPTION REPORT:	**RESPONSIBLE DIRECTOR: Chief Nurse**
• **Pressure ulcer incidence** • **Number of hospital acquired grade 2 pressure ulcers** • **Number of hospital acquired grade 3 pressure ulcers**	

Description of how the standard is measured:

Pressure Ulcers identified at nursing/medical assessment are graded 1-4 (Grade 1 being red discolouration, Grade 2 being a break or partial loss of skin, Grade 3 being tissue damage through the superficial layers, Grade 4 involving the most serious tissue damage). Pressure Ulcers are reported as patient safety incidents and their reduction remains a CQUIN for 2011/12.

Performance in the period, including reasons for the exception:

The overall rate of pressure ulcers reduced from 9.84 per 10,000 bed days in March 2011 to 7.16 per 10,000 bed days in April 2011. All reported pressure ulcers were graded into the appropriate categories in April 2011.

There were two patients with category three pressure ulcers reported in April 2011. Both patients were on a medical ward when the pressure ulcer was reported. However, both patients had also been cared for in the Intensive Care Unit during their admission. Both of these patients were immediately visited by a member the Chief Nurse or a member of her Senior Nursing Team to provide supportive review of the case. Root cause analysis of these incidents has been carried out.

One patient suffered a sore on their nose associated with the use of a ventilation mask to support their breathing. Actions that will be taken to prevent future occurrences include sourcing a silicone gel to protect the face when external ventilation masks are used and altering documentation to confirm correct fitting of mask and assessment of skin condition.

The other patient suffered a sore on their heel. This patient's mobility was compromised and risk of pressure ulcers increased due to a long-term musculo-skeletal condition. Actions that will be taken to prevent future occurrences include modifying the electronic documentation system used in the Intensive Care Unit to include pictures of pressure ulcer categories and prompting reporting. The unit tissue viability link nurse is undertaking further education and awareness sessions for all staff focusing on monitoring, assessment and clear documentation.

Recovery plan, including expected date performance will be restored:

- A programme of rapid improvement is being undertaken, modified from work undertaken in York and Southampton hospitals. A learning visit to Southampton is scheduled for 20th June 2011.
- Divisions will be focusing reporting and prevention on category 1 pressure ulcers to prevent these developing into category two skin damage.
- Education of staff continues through the tissue viability link nurses and the pressure ulcer champions.

QUALITY

- The pressure ulcer risk assessment form and associated care planning documentation are being modified as a result of incident feedback.
- An internal audit of the prevalence of pressure ulcers will be carried out in July 2011

QUALITY

Q6. EXCEPTION REPORT: Reduction in medication errors	RESPONSIBLE DIRECTOR: Medical Director

Description of how the standard is measured:

The aim is to reduce the percentage of medication incidents causing harm classified as moderate or greater by 20% (2010/11 compared to baseline 2009/10), i.e. to 4.06% or less, compared to the baseline measure of 5.07%.

Performance in the period, including reasons for the exception:

Latest figure for March is 5.93%, with Q4 average of 4.86% and the annual average of 3.35%. Assigning actual level of harm is somewhat subjective, and awareness within clinical areas of either the Trust or National Patient Safety Agency definitions is limited. The validation of the levels of harm in February and March was felt not sufficiently robust.

Recovery plan, including expected date performance will be restored:

Monthly medication review meeting with Divisional safety leads to sign off risk rating now minuted. Improvement seen in April 2011 (2.1%) and May 2011 (awaiting confirmation provisional figure 2.7%). Safeguard descriptors of level of harm to change week commencing 20th June to reflect Trust risk policy.

QUALITY

Q7. EXCEPTION REPORT: Same Sex Accommodation	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the standard is measured:

Patients in all hospital wards must not share sleeping accommodation and sanitary facilities with members of the opposite sex unless their clinical need takes priority.

Performance in the period, including reasons for the exception:

Measurement against this standard commenced in April 2010. Since September 2010 the Trust has seen a rise in emergency admissions and in order to maintain patient flow and avoid clinical risk some patients have been nursed in mixed sex bays for periods of time.

In May there were 18 breaches of single sex compliance. Eleven (11) occurred on the Medical Assessment Unit (MAU); three (3) of these were due to capacity and 8 were attributable to a major water leak in the Old Building which prevented admissions into any of the wards. All of these were for duration of 8 hours or less. There were 7 breaches in Surgery. Four (4) were in the Surgical and Trauma Assessment Unit (STAU) and due to lack of capacity; they lasted for 12 hours. The other 3 were on ward 41 in the Bristol Eye Hospital and were caused by lack of capacity complicated by a patient requiring isolation due to a severe allergy. These breaches lasted for 2 hours 15 minutes.

The breaches of the single sex accommodation standard within the BRI occurred on three separate days. On one of the days there was a major water leak. On a further day levels of emergency admissions into the BRI were exceptionally high (i.e. above the 95th percentile level of emergency admissions in 2008/09 – which has been agreed with the Primary Care Trust (PCT) as being an exceptional level of operational pressure).

Recovery plan, including expected date performance will be restored:

The Medical Division is extending the Medical Assessment Unit (MAU) as of the 1st August, by moving to ward 17. This will increase MAU by around 50%, and increase flexibility in the bed resource within the BRI.

1.6 SUPPORTING INFORMATION

1.6.1 Quality Achievements – Division of Diagnostics and Therapies

Physiotherapy

We are implementing changes to the operational hours for musculo-skeletal physiotherapy services to patients as a result of patients' responses to a questionnaire sent last year. We are also implementing a successfully piloted patient self-referral system a for musculo-skeletal physiotherapy to all GP surgeries for which we are a preferred provider. In addition, the Division is planning the implementation of a telephone management service for ankle fracture patients, thereby reducing the length of stay in hospital for these patients. Efficiency improvements have also been made in our administration systems.

Physiotherapy Rehabilitation

We have reduced our waiting lists to zero for neurology physiotherapy outpatients and the waiting list for rehabilitation physiotherapy in the William Lloyd Day Unit is now minimal. We have also consolidated our physiotherapy and occupational therapy notes to avoid repeated assessment questions for patients. For neurology inpatients we have created a clinical specialist post to improve services for these patients. The neurology physiotherapy out-patients service were awarded the Divisional Excellence award for their response to a local patient survey which included re-engineering their appointments system to provide late appointments to increase patient choice and create an additional two slots for patients system without incurring additional costs.

Radiotherapy/Medical Physics

We have introduced a new protocol to reduce the number of treatment fractions required for high dose rate prostate brachytherapy treatment, meaning less hospital visits for patients. We have also commissioned virtual simulation on a new big bore CT scanner which will enable 3D breast treatment planning in radiotherapy physics. This will enable application of more accurate radiotherapy to tumours whilst sparing more of the healthy breast tissue.

1.6.2 Examples of Learning from Recent Complaints

Summary of Complaint

A six year old patient was brought to the Accident & Emergency Department at the Bristol Royal Hospital for Children by his parents with a blue bumpy rash on his toes and the child was also unable to weight bear. The parents were told that the injury on their child's foot was a bruise and that an x-ray was not needed. The patient was brought back the Accident & Emergency Department twenty four hours later, at which point an x-ray was carried out and it was discovered that he had a broken tibia. The patient was put in a full leg cast for six weeks.

Actions Taken

- Apologies given that the fracture was not picked up during the original admission.
- The patient was originally seen by a relatively junior doctor. The consultant in charge has discussed the situation with the doctor concerned and additional training has been provided on the diagnosis and investigation of un-displaced fractures.

Summary of Complaint

A patient arrived at the Bristol Royal Infirmary for her surgery at 12 noon. She was triaged and prepared by staff who were waiting for the consultant to arrive. At 2.30pm, the patient was informed that consultant was on leave that week and that staff had not been aware of this. Staff were unable to find another doctor who could cover the consultant's list and the patient was therefore sent home with no new date for her surgery – she was told she would be contacted with a new date within 28 days.

Actions Taken

- It was identified that an error had been made by the booking staff as the consultant had notified them of his leave dates with the required notice.
- As a "double check", a new process has now been implemented so that consultants are sent details of their lists two weeks in advance, to avoid a recurrence of this situation
- The patient's surgery was rescheduled for two weeks later.

QUALITY

Summary of Complaint

A patient was admitted to Bristol Royal Infirmary with a fractured knee. She suffers from Alzheimer's Disease and has had previous hospital admissions, when her family have had problems in respect of her care. The patient's daughter was concerned that issues previously experienced would arise again. The specific concerns raised by the patient's daughter were:-

- The patient's walking stick, purse, teeth and hearing aids appeared to be missing and ward staff were unable to find these items or the property list that had been completed.
- The patient had a leg ulcer on admission – this had been managed at home for the preceding nine weeks. At the time of the complaint, the ulcer was not dressed and was rubbing against the frame that had been fitted on the patient's leg.
- The patient's family were concerned that staff were not aware of the patient's support needs and that the patient was not receiving the care and treatment required for someone with Alzheimer's. The family felt that staff always appeared to be too busy to understand the patient's individual care needs.

Actions Taken

The Patient Support & Complaints Team met with the patient's family, provided emotional support and liaised with the nurse in charge in respect of the issues raised.

- Ward staff completed a new property list for the patient's daughter to review and sign on her next visit.
- The leg ulcer was discussed with the nurse in charge and the appropriate dressing was applied.
- One-to-one nursing care was arranged for the patient by bringing in additional bank staff to sit with the patient.
- A further meeting was arranged between the patient's family and the Ward Sister. At this meeting, all of the concerns raised were fully discussed and a review of the care package and progress of the patient was undertaken.

WORKFORCE

2.1 SUMMARY

The Trust has selected a range of key workforce indicators. Targets for appraisal and bank and agency usage were achieved in May 2011. The indicators which are below target this month are sickness absence, workforce numbers and workforce costs.

 **Achieving (2)**	 **Underachieving (0)**
- Appraisal compliance - *compared with target* - Bank and agency Usage - *compared with 2010/11*	
 **Failing (3)**	 **Not reported/scored (1)**
- Sickness absence - *compared with target* - Workforce numbers – *compared with budget* - Workforce costs – *compared with budget*	- Turnover *(no target)*

2.2 EXCEPTION REPORTS

Exception reports are provided for the red-rated indicators, which in May 2011 were as follows:

1) Sickness absence – red rated against Divisional targets
2) Workforce numbers – red rated against Trust budgeted numbers
3) Workforce costs – red rated against Trust budgeted costs

WORKFORCE

W1. EXCEPTION REPORT: Sickness compliance	RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development

Description of how the standard is measured: Sickness absence figures are shown as percentage of available fte (full time equivalent) absent

Performance in the period, including reasons for the exception:

Absence has increased from 3.7% in April to 3.8% in May. All Divisions are above monthly target, except Estates and Facilities. In Estates and Facilities, there has been a reduction from 4.7% to 4.5% this month.

	UH Bristol	Diagnostic and Therapies	Medicine	Specialised Services	Surgery Head and Neck	Women and Children	Trust Services (exc Estates and Facilities)	Estates and Facilities
Absence May 2010	3.8%	2.6%	4.6%	3.3%	3.8%	3.6%	2.8%	6.0%
Target May 2011	3.1%	2.5%	3.3%	3.3%	2.8%	3.1%	3.2%	4.6%
Absence May 2011	3.8%	3.0%	4.0%	3.8%	3.5%	4.0%	3.4%	4.5%
Cumulative absence May 2011	3.7%	2.8%	4.1%	3.6%	3.6%	4.2%	3.4%	4.6%

Recovery plan, including expected date performance will be restored:

Divisions are working with Employee Services to give support on managing sickness absence, being offered the opportunity to meet with Employee Services to discuss, with a specific focus on the worst performing areas in relation to long term sickness. Employee Services are working with Occupational Health to ensure that their focus is to get staff back to work as soon as possible. They are also ensuring that the Supporting Attendance policy is being applied robustly and consistently, and have discussed with staff side. Human Resources are doing a research project with the University of West of England to look at areas of good and poor attendance, to see what can be learnt and improve practice.

Progress against recovery plan:

See above**.**

WORKFORCE

W2. EXCEPTION REPORT: Workforce Numbers	RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development

Description of how the standard is measured:

Workforce numbers in Full Time Equivalent (FTE) compared with budgeted establishment

Performance in the period, including reasons for the exception:

Workforce numbers for May 2011 are 197.4 FTE (2.8%) above budget (including bank and agency usage).

DIVISION	Budgeted staff	Staff in post	Bank/agency	Total staff	FTE Variance	% variance
Trust Services (exc Estates & Facilities)	650.4	681.8	22.6	704.4	54.0	8.3%
Estates & Facilities	756.9	699.8	56.2	756.0	-0.9	-0.1%
Diagnostics And Therapies	933.7	913.9	23.1	937.0	3.3	0.3%
Medicine	1087.4	1009.1	125.9	1135.0	47.6	4.4%
Specialised Services	741.3	742.8	42.7	785.5	44.2	6.0%
Surgery Head And Neck	1549.6	1502.2	70.4	1572.6	23.0	1.5%
Women's And Children's	1416.5	1370.3	72.4	1442.7	26.2	1.9%
Total (including adjustments)	7135.8	6919.9	413.3	7333.2	197.4	2.8%

Reasons include:

Medicine:

- Ongoing use of bank & agency to support unfunded high care patients (ITU step down), primarily on Ward 10
- High maternity leave (particularly in A&E)
- Norovirus in April, continuing impact into May

Specialised Services:

For Trust Services excluding Estates and Facilities, some budgets have not yet had FTE allocated, particularly in the Research and Development area.

WORKFORCE

Recovery plan, including expected date performance will be restored:

Medicine

- Plans to minimise use of Ward 10 as ITU step-down with consultants support as agreed at May Divisional Board (from July)
- Closure of 12 beds on Ward 22/ 20 in advance of CRES plan (closed in May) – impact on bank and agency expected next month (from June)
- Letter to all Ward Managers regarding a bank and agency quota sent from Divisional Management at end of May – impact expected in next month's figures (from June).

Specialised Services

- Appointment of specialist nurse practitioners to reduce dependence on junior doctors and reduce costs (overlap in costs of four more months).
- Planned appointment of cardiac surgeon to increase activity/income and reduce premium payments.
- Regular scrutiny of pay budgets with budget holders in control costs.

Progress against recovery plan:

Expectation of recovery plan to impact by July 2011.

WORKFORCE

W3. EXCEPTION REPORT: Workforce Costs	RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development

Description of how the standard is measured:

Workforce costs compared with targets set by Division for 2011/12

Performance in the period, including reasons for the exception:

All Divisions except Facilities and Estates are over budget on pay costs. The reasons are as per W2 above. In addition, budgetary adjustments have been made but savings not yet achieved in respect of pay costs for CRES.

	Diagnostic and Therapies	Medicine	Specialised Services	Surgery Head and Neck	Trust Services (exc Facilities and Estates)	Facilities and Estates	Women's And Children's
	£ '000	£ '000	£ '000	£ '000	£ '000	£ '000	£ '000
Workforce Costs	£3,078	£3,686	£3,159	£5,657	£375	£1,530	£5,730
Budgeted Costs	£2,998	£3,635	£3,066	£5,245	£294	£1,532	£5,526

Recovery plan, including expected date performance will be restored:

Recovery plan as per W2 above.

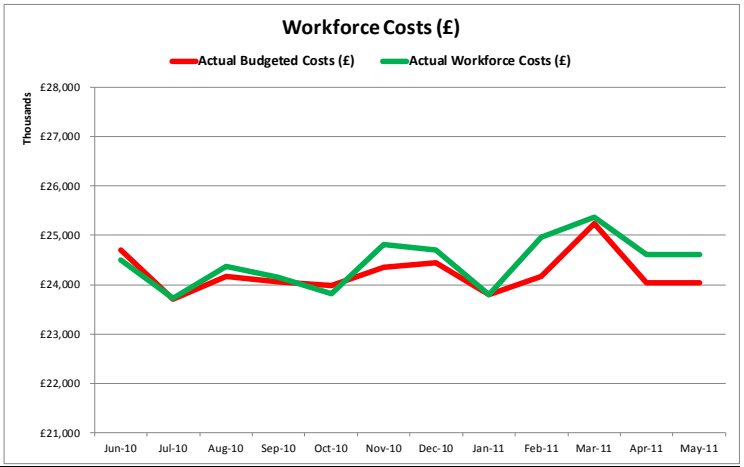
Progress against recovery plan:

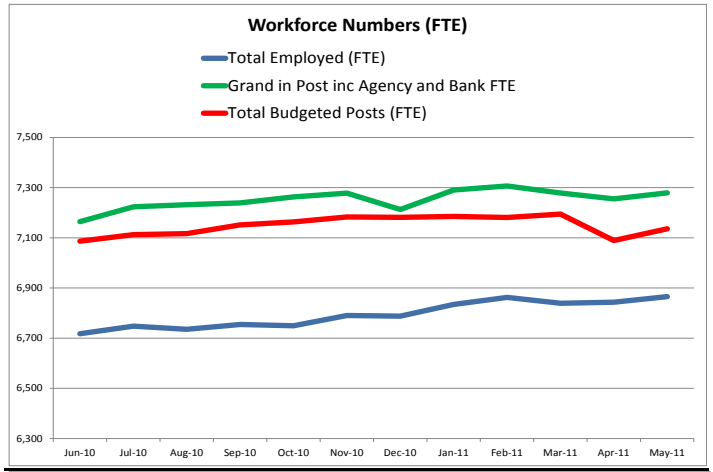
Expectation of recovery plan to impact by July 2011.

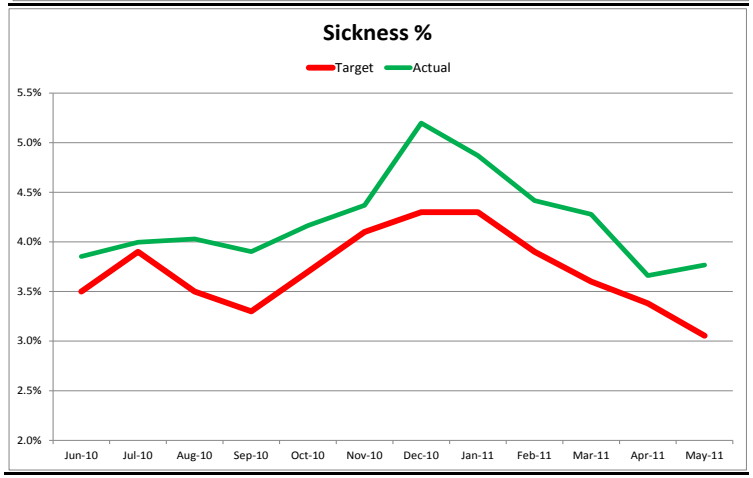
2.3 SUPPORTING INFORMATION

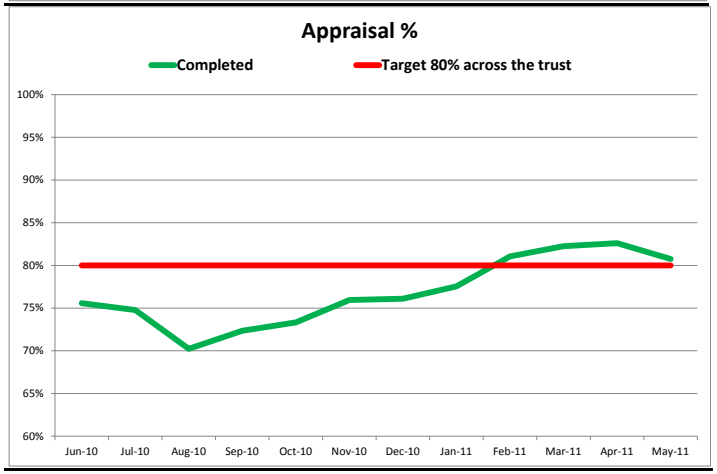
This report provides an outline of the Trust's position against key workforce standards for the month of May 2011 and year to date performance for 2011/12.

2.3.1 Summary







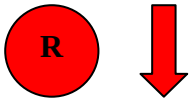
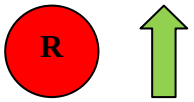
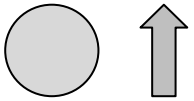
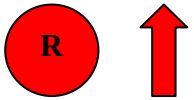


WORKFORCE

2.3.2 Changes in the period

Performance is monitored against workforce costs, workforce numbers, bank and agency usage, turnover, sickness and appraisal numbers. Indicators on a rolling reporting programme are: Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (July 2011), Statutory and mandatory training (August 2011) European Working Time Directive (EWTD) (September 2011).

The following dashboard shows key workforce information indicators RAG (Red, Amber, Green) rated. Red rated indicators are outside tolerance limits and exception reports are provided for these.

Indicator	RAG Rating[1]	Commentary	Notes
Workforce Costs		Workforce costs in this report represent an average of April and May to reduce the impact of year end accounting processes. Workforce costs reduced by 2.9% in April and May compared with March, and the budgeted costs reduced by 4.7% in the same period. May`s costs were 4.1% above the budgeted workforce costs.	See exception reports
Workforce Numbers		Workforce numbers increased by 0.4% compared with April 2011, 2.8% above the budgeted workforce numbers. This compares with April 2011 when workforce numbers were 2.3% above budget.	See exception reports
Turnover		Rolling voluntary turnover increased by 0.6% to 8.9%.	
Sickness		Sickness increased by 0.1 percentage points compared with April 2011 across the Trust, 0.7 percentage points above the monthly target for 2011/12.	See exception reports
Bank/Agency		Bank and agency increased by 1.3 fte compared with April 2011, but is 0.1% below the usage for May 2010.	See supporting information
Appraisal		Appraisal rates reduced by 2.8 percentage points to 80.8% compared with April 2011.	See supporting information

Note: RAG (Red, Amber, Green) rating reflects whether the indicator has achieved the target. The direction of the arrow shows the change from last month. The colour of the arrow reflects whether actual this month is better in relation to the target (green) or further from the target than last month (red). Please note that sickness targets are set by Divisions.

2.3.3 Monthly forecast and overview

Measure	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	May 11 Forecast
Budgeted Posts (FTE)	7045.0	7086.4	7112.6	7116.8	7151.5	7163.5	7183.0	7181.6	7185.2	7181.2	7194.6	7089.0	7135.8	
Total Employed (FTE)	6747.9	6718.0	6748.0	6735.4	6754.4	6749.7	6790.7	6788.0	6834.7	6862.4	6839.4	6843.2	6919.9	
Sickness Rate (%)	3.8%	3.9%	4.0%	4.0%	3.9%	4.2%	4.4%	5.2%	4.8%	4.4%	4.3%	3.7%	3.8%	3.1%
Agency (FTE) Admin & Clerical	9.6	11.3	8.8	6.0	6.9	9.0	7.3	5.2	6.2	6.8	9.4	7.0	4.3	10.1
Agency (FTE) Ancillary Staff	28.0	29.3	38.2	40.9	48.2	52.4	43.1	41.7	28.5	32.1	35.2	31.1	34.7	29.2
Agency (FTE) Nursing & Midwifery	12.7	13.1	17.0	12.1	13.4	12.7	8.0	8.4	14.0	6.9	10.0	17.5	12.3	12.1
Bank (FTE) Admin & Clerical	80.5	94.4	99.7	92.5	92.6	85.6	84.3	78.9	81.5	80.1	89.1	73.6	73.0	79.6
Bank (FTE) Ancillary Staff	24.9	25.7	29.9	29.6	26.0	27.7	25.0	23.9	23.4	20.6	25.5	20.3	20.5	27.9
Bank (FTE) Nursing & Midwifery	220.4	235.4	250.5	261.8	249.6	263.0	245.9	212.9	239.8	214.8	232.4	231.5	233.1	221.5
Overtime	66.92	74.15	64.72	74.83	64.71	63.37	74.78	50.80	57.32	65.97	72.10	61.61	63.61	63.60
Appraisal (%)	75.8%	75.6%	74.8%	70.2%	72.4%	73.3%	75.9%	76.1%	77.6%	81.1%	82.3%	82.6%	80.8%	80.0%
Rolling Average Turnover (%)	15.4%	15.3%	15.8%	15.9%	15.4%	15.8%	15.6%	15.4%	15.3%	15.3%	15.4%	15.0%	14.8%	
Rolling Average Voluntary Turnover (%)	9.1%	9.0%	9.7%	9.4%	9.6%	9.9%	9.6%	9.6%	9.5%	9.2%	9.3%	9.1%	8.9%	
Vacancy Rate (%)	3.4%	4.4%	4.8%	1.9%	4.8%	4.6%	5.2%	4.4%	4.0%	3.2%	3.4%	2.7%	2.8%	
Bank Nursing & Midwifery % unfilled	2.0%	1.8%	2.0%	2.6%	1.8%	1.4%	1.0%	1.8%	1.6%	0.9%	0.9%	0.7%	0.2%	
Bank Nursing & Midwifery Unfilled Shifts	97	84	87	131	82	71	40	71	71	36	39	35	17	

Notes

- 'Turnover' measures the number of leavers expressed as a percentage of the average number of staff in post in the defined period. 'Vacancy' measures the number of vacant posts as a percentage of the budgeted establishment. The Sickness Rate is expressed as a percentage of total whole time equivalent (FTE) staff in post

ACCESS STANDARDS

3.1 SUMMARY

The following section provides a summary of the Trust's performance against key national access standards at the **end of May 2011**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 1)***, and/or the ***year to date***. The standards include those used in Monitor's Compliance Framework, as well as key standards included within the NHS Operating Framework and NHS Constitution. The Trust is currently achieving fourteen (14), under-achieving none (0) and failing four (4) of these access standards.

Achieving (14)	**Underachieving (0)**
- 31-day diagnosis to treatment cancer standard - *first* - 31-day diagnosis to treatment cancer standard – *all subsequent treatments* - 62-day referral to treatment cancer standard – *Screening referred* - 2-week wait urgent GP referral cancer standard - Symptomatic breast patients (cancer not initially suspected) 2-week wait - Referral to Treatment Time for admitted patients (95th percentile) - Referral to Treatment Time for non-admitted patients (95th percentile) - Genito-Urinary Medicine (GUM) 48-hour access - Stroke care standard – patients spending 90% of their time on a designated stroke unit - A&E Time to Treatment - A&E Left without being seen rate - A&E Unplanned re-attendance - A&E Maximum waiting time (4-hours) - Access to healthcare for patients with learning disabilities	
Failing (4)	**Not reported/scored (1)**
- A&E Time to Initial Assessment (ambulance arrivals) (95th percentile) - 62-day referral to treatment cancer standard – *GP referred* - Infant health – breastfeeding rate - Last-minute cancelled operations / 28-day readmission	- Reperfusion times (call to balloon time of 150 minutes) – *April's data is not yet finalised.*

Please note: the position shown above for the cancer standards includes the draft performance figures for May. Performance for these standards is reported by all trusts in the country two months in arrears. ***Indicators are shown as being failed where <u>both</u> the year-to-date and quarterly performance is below the required standard.*** *The Rapid Access Chest Pain Clinic standard, and the Infant Health: mothers not smoking, are no longer being reported nationally, and have been removed from the above report.*

3.2 ACCESS DASHBOARD

Access Standards - dashboard

		Thresholds		2010/11	2011/12												Quarterly Performance 2011/12			
	Target	Green	Red	to date	To Date	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Q1	Q2	Q3	Q4
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	88%	95.2%	96.0%	94.8%	96.2%	97.0%	96.4%	95.7%	95.9%	94.6%	91.9%	96.8%	96.9%	96.0%		96.0%			
	Cancer - Symptomatic Breast (cancer not suspected) in Under 2 Weeks	93%	88%	78.1%	100.0%	82.8%	91.9%	93.5%	97.1%	95.5%	90.9%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%			
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	93%	98.3%	97.3%	98.1%	98.4%	100.0%	99.1%	99.0%	100.0%	96.1%	96.0%	97.8%	98.0%	97.3%		97.3%			
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	93%	98.9%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%		99.0%			
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	89%	100.0%	98.2%	94.0%	93.2%	94.7%	97.7%	96.9%	95.7%	91.7%	92.3%	93.0%	98.0%	98.2%		98.2%			
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	89%	Not applicable	100.0%								99.2%	100.0%	99.5%	100.0%		100.0%			
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	80%	85.0%	86.1%	86.9%	97.6%	91.0%	79.9%	82.7%	89.9%	90.0%	79.3%	85.7%	91.2%	86.1%		86.1%			
	Cancer 62 Day Referral To Treatment (Screenings)	90%	85%	87.0%	96.8%	90.5%	100.0%	95.8%	92.3%	93.8%	81.5%	100.0%	94.4%	70.8%	87.5%	96.8%		96.8%			
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	100.0%	100.0%	100.0%	97.3%	97.6%	91.8%	81.0%	96.8%	92.5%	97.9%	100.0%	100.0%	100.0%		100.0%			
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	80%	92.1%	92.7%	94.9%	93.3%	92.8%	93.4%	93.0%	92.6%	93.4%	94.0%	92.7%	91.5%	93.0%	92.4%	92.7%			
	Referral To Treatment Non Admitted Under 18 Weeks	95%	85%	97.8%	98.4%	98.6%	98.8%	98.7%	98.5%	98.2%	98.5%	98.6%	98.4%	98.0%	98.0%	98.1%	98.7%	98.4%			
	Referral to treatment time admitted patients (95th percentile - weeks)	23	23	Not applicable	21.6											21.3	21.6	21.6			
	Referral to treatment time non-admitted patients (95th percentile - weeks)	18.3	18.3	Not applicable	13.6											13.6	13.7	13.6			
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	96.5%	97.9%	98.0%	98.3%	97.8%	96.1%	95.4%	95.9%	90.8%	89.5%	90.8%	94.2%	97.0%	98.8%	97.9%			
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	Not applicable	43											90	65	71			
	A&E Time to treatment decision (median) - in minutes	60	60	Not applicable	24											24	20	21			
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	Not applicable	2.1%											2.1%	1.6%	1.8%			
	A&E Left without being seen	5%	5%	Not applicable	1.6%											1.6%	0.8%	1.2%			
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	1.11%	0.96%	1.10%	0.95%	1.08%	0.74%	0.90%	1.78%	1.69%	2.21%	1.44%	1.69%	0.97%	0.94%	0.96%			
	28 Day Readmissions	95%	85%	97.1%	93.2%	96.4%	90.2%	90.6%	94.9%	95.3%	96.1%	88.2%	80.5%	91.1%	82.9%	94.1%	91.5%	93.2%			
	GUM Offer Of Appointment Within 48 Hours	98%	95%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%			
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	Not applicable	Not applicable	91.7%	100.0%	100.0%	92.3%	100.0%	100.0%	93.8%	84.2%	75.0%	88.0%						
	Infant Health - Mothers Initiating Breastfeeding	76.3%	76.3%	75.6%	73.5%	77.1%	76.3%	77.9%	76.3%	76.9%	74.3%	77.9%	75.5%	75.1%	77.1%	72.3%	74.7%	73.5%			
	Stroke Care - percentage of patients spending at least 90% of their time on a designated stroke unit	80%	65%	69.9%	83.8%	81.0%	76.3%	89.3%	77.6%	78.0%	90.0%	89.8%	82.1%	62.9%	80.6%	81.4%	86.5%	83.8%			

Please note:
Where the threshold for achieving the standard has changed between years, the latest threshold for 2011/12 has been applied in the Red, Amber, Green ratings
The Rapid Access Chest Pain standard and the Infant Health: mothers not smoking have now been withdrawn from national reporting.
The standard for Primary PCI 150 Call to Balloon Time now only applies to direct admissions - threshold to be confirmed

3.3. CHANGES IN THE PERIOD

Performance against the following national standards changed significantly compared with the last reported period:

- Emergency access maximum 4-hour wait ↑ (up 97.0% in April to 98.8% in May) – *please note the figures quoted now exclude Walk in Centre attendances*
- Last-minute cancellations ↓ (down from 0.97% in April to 0.94% in May)
- 28-day readmissions following cancellations of surgery ↓ (down from 94.1% in April to 91.5% in May)
- 62-day referral to treatment cancer standard - screening ↑ (up 87.5% in March to 96.8% in May)

Please note the above summary is based upon the final reported position and does not include the draft May performance for the cancer standards.

3.4 EXCEPTION REPORTS

Exception reports are provided for the four (4) RED rated performance indicators.

1) A&E Time to Initial Assessment within 15 minutes (ambulance arrivals) (95th percentile) – target comes into effect July 2011
2) 62-day cancer: referral to treatment for GP referrals
3) Last-minute cancelled operations / 28-day readmission
4) Infant Health: Breastfeeding rates

Please note that details of the progress made with implementing the Patient Flow plan can be found in the Supporting Information section at the end of this report. This plan supports the sustained achievement of the A&E maximum waiting time of 4 hours.

ACCESS STANDARDS

A1. EXCEPTION REPORT: A&E Time to Initial Assessment within 15 minutes (95th percentile)	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The time from arrival in the Emergency Department through to the time at which an initial assessment of the patient's condition is started. This assessment should include physiological assessment, including pain scoring.

The standard is only applied to ambulance arrivals. At least 95% of patients should have a time to initial assessment of less than or equal to 15 minutes. The standard is reported in minutes (i.e. the maximum wait for 95% of patients).

Please note: amendments were made to the April figures previously reported to the Trust Board, following confirmation from the national guidance that records with missing assessment times are to be excluded from the reported figures. However, there is a data completeness requirement for at least 95% or all ambulance arrivals to have assessment times recorded.

Monitor measurement period: Quarterly, commencing from quarter 2 2011/12

Performance during the period, including reasons for exception:

Performance is currently being shadow monitored as this standard comes into effect on the 1st July 2011.

In May, 76% of ambulance arrivals had an initial assessment within 15 minutes of arrival in the Trust's Emergency Departments. This is against a target of 95% from the 1st July. At the end of May performance was 91% against the 15-minute standard.

In May 95% of patients had an initial assessment time within 65 minutes, which is a significant improvement on the previous month.

Data completeness has been significantly below the required 95% standard. This was in part due to the process of data capture, but also due the initial assessment time being carried-out when the clinical management plan was started in some cases (e.g. patients requiring resuscitation). This meant a treatment time had been recorded, but an initial assessment time was missing. Where the initial assessment time is missing, treatment times are now used as the assessment time. In addition, where a patient re-attends the Emergency Department the mode of arrival from the previous attendance is carried through and cannot be amended by the Emergency Department staff. If the previous attendance is an ambulance arrival, some patients will be showing as having arrived by ambulance and needing an initial assessment within 15 minutes, when they arrived by another means and an initial assessment including physiological measurement, wasn't necessary.

Recovery plan, including expected date performance will be restored:

The following actions are being taken to achieve the required standard and improve data completeness (*please note: actions completed in previous months have been removed from the following list*):

ACCESS STANDARDS

- Each Emergency Department to review the process put in place for both carrying-out initial assessment within 15 minutes, and implement changes to achieve the required standard by the end of May (Action complete)
- Each Emergency Department to review the process by which the information that is written on patients' A&E cards is being entered on to PAS, to ensure the data is both accurate and complete (Action complete)
- BRI Emergency Department to roster additional staff to ensure 15 minute assessments are carried-out (Action complete); electronic time stamps are to be purchased and used to make sure assessment times are captured and recorded on the Patient Administration System (mid June)
- Information Team to finalise options for the validation and amendment of records where un-planned attendances are inappropriately picking up an ambulance being the mode of arrival from the previous attendance (underway)

Progress against the recovery plan:

During the last week in May performance was 91% against the 95% standard, with data completeness being above the required 95%.

Each Department remains confident it can meet the required standard in time for this target coming into effect in quarter 2.

ACCESS STANDARDS

A2. EXCEPTION REPORT: 62-day referral to treatment for GP referred patients	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients with confirmed cancers treated within 62 days of referral, as a percentage all cancer patients treated during the period under that standard. There are separate targets for GP, screening and consultant referred patients.

Monitor measurement period: Quarterly, as part of a combined 62-day cancer standards (weighted 1.0)

Performance during the period, including reasons for exceptions:

The 85% standard for GP referred patients has been achieved for four consecutive quarters. **April's** performance was above the 85% standard, with the breach reasons being as follows:

- 59 out of 68.5 (86.1%) patients were treated within 62 days during **April** (in accountability terms – with shared patients counting as 0.5) against the 85% standard
- There were 9.5 breaches of the 62-day standard (in accountability terms):
    - 2.0 x late referral to the Trust by another provider (i.e. two late referrals, each counting as 0.5 for each trust)
    - 2.0 x delays for diagnostic tests requiring an admission (gynaecology and upper gastrointestinal pathway)
    - 1.5 x clinically complex cases, requiring unplanned additional diagnostic tests/staging
    - 1.5 x patient choice to delay diagnostics
    - 1 x theatre cancellation due to theatre over-run; could not be re-scheduled within target
    - 0.5 x delay in an outpatient appointment being able to be scheduled
    - 0.5 x multiple reasons including both diagnostic delay and medical problems
    - 0.5 x medical problems

58% of the breaches in the month were outside of the Trust's control (late referrals, patient choice, clinically complex). This is higher than in previous months and may in part reflect the impact of bank holidays on available capacity at other providers. This leaves 42% of breaches that were potentially predictable and avoidable. The improvement plan is focusing on ways of limiting any avoidable breaches that are due to such internal pathway delays. This includes reducing delays to diagnostic tests and outpatient appointments, which remains a leading cause of breaches of standard.

Performance is now expected to dip in June, based on the current bookings for treatment. Action is currently being taken to try to ensure the 85% standard is achieved for the quarter as a whole. Further analysis of June breaches has identified the main causes of the breaches are as follows:

- Late tertiary referrals from other providers (which appear to be related to a lack of capacity over the bank holiday period)

ACCESS STANDARDS

- High number of complex urology cases needing surgery with one particular surgeon
- Delays to the start of pathways over the April and May bank holiday periods
- Delays in the booking of surgical treatment, partly due to escalation processes not always working, but also capacity constraints
- Recent delays to some diagnostic tests (vetting stage)

Recovery plan, including expected date performance will be restored:

The actions being taken to ensure continued quarterly achievement of the 62-day standard for GP (and screening) referred patients are detailed below. *Please note: actions completed in previous months have been removed from the following list*:

- A new standard of a maximum 5 day wait for follow-up outpatient appointments for patients on cancer pathways will be implemented by Divisions (phase 2 - end July) - Audit MDT outcomes undertaken to confirm escalation policy in place for waits of over 5 days; whilst the recent spot check confirmed escalation was happening, this will continue to be closely monitored given the delays identified for pathways started earlier in the quarter
- A maximum 10 day wait from MDT/outpatient clinic request to reporting of diagnostic test results, will be implemented for all radiology investigations – new booking guidance is being developed and implemented, to ensure patients are booked within 7 days (for the scan) to allow 3 days for reporting; changes will be made to the waiting list report to facilitate the management of booking; an escalation process will also be established (July)
- Direct booking of 2-week wait appointments to be established in Choose & Book, to reduce delays at the start of a patient's pathway - (Further delay as South Gloucestershire PCT Professional Executive Committee has NOT supported the pilot scheme). This action will be closed pending next steps being agreed
- Reduce wait for first outpatient appointment, aiming to book within 7 days of receipt through direct booking via Choose & Book (end June) – implementation delayed due to delay in Choose & Book roll-out; but escalation in place for key problematic first appointments (e.g. urology prostate clinic), so this action will be closed pending further developments
- Tertiary referral times to be shared with the local cancer network at the Network Provider Group (end January) – Network Provider Group re-scheduled to May – (Action complete); Discussion held at Provider Group, further work to be undertaken by the network to map the cross network referral flows and impact of late referrals across network
- Reduce delays for specific diagnostic tests (including CT colonography and TRUSS biopsies) (end June); underway - Division of Diagnostics & Therapies identifying actions to reduce wait for high breach risk investigations (commencing with CT colonography)
- Prepare and implement an action plan to mitigate the risks of delays to diagnostic scanning with PET scanning transferring to another provider (Action plan completed)
- Undertake review of June breaches of standard (Action complete – see previous section)
- Undertake a consultation on Cancer Services Management within the Trust, and the proposal to move operational management of cancer services into one of the Clinical Divisions (Action complete) – it has been agreed that the operational elements of Cancer Services will be moved to the Division of Surgery, Head & Neck.

ACCESS STANDARDS

- Appoint a Performance & Operations Manager to jointly manage the Cancer Fast-Track Office, Multi Disciplinary Team Co-ordinators and Bristol Royal Infirmary Waiting List Office, under the management of the Division of Surgery, Head & Neck (end September) – this post will replace the existing post of Performance & Operations Manager for the Cancer Fast Track Office and will help to improve the co-ordination of the booking of dates for admission for diagnostics and surgical treatment
- Develop an action plan for meeting high demand for specialist urology work (Action complete – plans have been developed with North Bristol Trust, with NBT planning to provide capacity for these operations as part of the cross-city working arrangements for this specialty)

Progress against the recovery plan:

The 62-day GP referred standard was achieved in April. Performance was confirmed as 86.1%% against the 85% standard. The draft figures for May are just below the 85% standard. Performance has deteriorated in June, and further action is being taken to try to achieve the 85% for the quarter as a whole.

ACCESS STANDARDS

A3. EXCEPTION REPORT: Last-minute cancelled operations / 28-day re-admission	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

1) The number of patients whose operation was cancelled at last minute for non clinical reasons, as a percentage of all admissions.
2) The number of patients re-booked within 28 days of a last-minute cancellation, as a percentage of all last-minute cancellations

This standard remains part of the NHS Constitution.

Department of Health measurement period: Annual, with quarterly submissions.

Monitor measurement period: Not applicable

Performance during the period, including reasons for exception:

The last-minute cancelled operations standard is not being achieved on a monthly basis. There were 49 last-minute cancellations of surgery in May (0.94 % of operations). The main reasons for these cancellations were as follows:

Of the 49 cancellations:

- 33% of cancellations (16 cancellations) resulted from a lack of theatre time *(which usually result from delays in identifying beds prior to cases being operated upon*)
- 6% of cancellations (3 cancellations) resulted from a ward bed not being available to admit the patient to
- 33% (16 cancellations) were due to another patient being prioritised, such as an emergency or cancer patient needing to take priority over the patient that had been scheduled
- 16% (6 cancellations) were due to a booking error, with 5 of the 6 incorrect bookings being made for a Trauma & Orthopaedics theatre list

91.5% of patients were re-admitted within 28 days of the cancellation of surgery at last-minute in May, which represents a deterioration on the previous month's position of 94.1%. Performance is currently just below the 95% national standard.

Recovery plan, including expected date performance will be restored:

The following actions continue to be taken to reduce last-minute cancellations (*please note: actions completed in previous months have been removed from the following list*):

- Programme of work on Theatre Lists starting on Time is continuing; overall there has been a 20% increase in the percentage of all theatre sessions starting on time over the last year; the BRI, which has most of the last-minute cancellations, is now starting 70% of its lists on time, compared with 33% in April 2010 – this will help to address cancellations that are due to lack of theatre time.

ACCESS STANDARDS

- Phase 1 of the Productive Theatre is in the process of being completed, with final actions being taken to establish theatre list booking rules and procedure times, to improve the booking of theatre lists (September) this will help to address cancellations that are due to lack of theatre time and also booking errors
- Phase 2 of the Productive Theatre is underway, including focus on actions to improve the scheduling of theatre lists, finalising theatre lists the day before and establishing the process for escalating any theatre list changes (December)
- Implementation of the Optimising Use of Beds work-steam – with the aim of balancing bed capacity and demand for beds (ongoing)
- Continued focus on reducing over 14 day length of stays, through the agreed escalation process (ongoing)
- Following a review of the causes of last-minute cancellations, Divisions to prepare actions plans based upon the identified opportunities for reducing cancellations (Action complete); these plans will be monitored at the fortnightly Service Delivery Group
- Weekly performance being escalated to the Chief Operating Officer where levels of cancellations are above the Division's control totals (ongoing)
- Patient Flow action plan to be implemented, aimed at reducing emergency admissions into the inpatient bed-base, reducing delayed discharges and overall length of stay (see Supporting Information section for an update).
- Investigate the booking errors within Trauma & Orthopaedics (July)

It is expected that the 0.8% standard will be achieved by the end of quarter 2, if the current improvement in bed-related cancellations

Progress against the recovery plan:

The number of last minute cancellations for the year to date is half that of the monthly average between November 2010 and March 2011. However, the 0.8% standard is still not quite being achieved. As reported last month, April and May are usually better months for last-minute cancellations though, due to the easing of winter pressures, although this wasn't the case in 2010/11. So it will not be clear for a few months if these lower levels of cancellations can be sustained with the actions that have been taken.

ACCESS STANDARDS

A4. EXCEPTION REPORT: Infant health: mothers breast feeding rates	**RESPONSIBLE DIRECTOR:** Chief Operating Officer

Description of how the target is measured:

The number of mothers breast feeding as a percentage of the total number of mothers that gave birth during the period.

NHS Operating Framework: Quarterly submissions

Monitor measurement period: Not applicable

Performance during the period, including reasons for exception:

Breastfeeding rates are below last year's levels, for reasons not well understood. May's performance was though within the range of monthly figures seen last year.

The percentage of mothers breastfeeding has not improved over the last two years, and remains below the local stretch target set by the Primary Care Trust of 80%. However, it has been acknowledged that achievement of this standard largely relates to patients choice and so the Trust's ability to influence breast feeding rates is to a certain extent limited.

Recovery plan, including expected date performance will be restored:

- Breast feeding rates continue to be reported to St Michael's staff each month to raise profile of breastfeeding rates and the importance of encouraging mothers to initiate breastfeeding wherever possible.

Progress against recovery plan:

To be reported next month

3.5 SUPPORTING INFORMATION

3.5.1 Patient Flow Programme

Below is the programme of work that has been developed to improve patient flow and enable the 95% 4-hour standard and the new care standards to be achieved in 2011/12.

PROGRAMME

Purpose of the Programme
• To improve all aspects of patient flow in the Trust thereby ensuring patients do not spend any more time in hospital than is absolutely necessary, doing so has a negative impact on their health and wellbeing • To improve the Trust's performance against national A&E standards • The programme is divided into 3 workstreams; front door, patient flow and patient discharges
Overall status
AMBER – The programme of work is largely on track. More work is required on the ambulatory care service which will help prevent admissions. Trust performance for the A&E 4 hour standard currently stands at 98.9% for the month of June (up to 19th).
Key Risks/ Issues
Risks and Mitigation • Staff are not aware of the programme of work and the changes /expectations require – The communications plan has been supported by the Trust Management Executive backed up by presentation for cascade through divisions about what the benefits will be in return for changes in practice/behaviour. ECIST (Emergency Care Intensive Support Team) has also recommended that the Trust develop a group of clinical champions for this work. This has also been supported by the Trust Management Executive. • Clinical engagement with the programme of work is imperative to be successful- This will be covered partly by the communications plan but also by setting out expectations for clinicians in relation to flow and supporting champions to help drive change • Working between speciality and DGH (District General Hospital) sides of the Trust could be more effective –staff from across the Trust are involved in the programme of work

ACCESS STANDARDS

WORKSTREAM – A - Front door

Purpose of the workstream
To review the strategy for the 'front door' of the Trust, ensuring that each element is used effectively and efficiently To improve the systems and processes used at the front door – specifically around ensuring the Trust can meet the new care indicators and that there is appropriate specialist input and referral to Emergency Department in a timely manner
Overall status
AMBER – The workstream is largely on track but the decision on specialist input to ED requires agreement across the Trust and this is taking some time.
Key Achievements since last report
A third and final workshop has been run looking at the Trust's strategy for its front door and in particular the role of that ambulatory care can make. The 10 Ambulatory Care Pathways have been reviewed which will reduce the number of emergency admissions to the Trust Based on the discussions at the three workshops the front door model has been written up for sign off at the Emergency Access Steering Group in June.
Key Risks/ Issues
Issues and Mitigation **Red Issues** • Expectations of how the physician, surgical and specialist medical teams interface with the Emergency Department (ED) need to be spelt out, particularly in relation to protocols for input to ED and the use of ED for referrals between specialisms. This has been set out in professional standards which now need to be agreed and implemented. **Amber issues** • The ambulatory care service needs to deliver 10 care pathways – being taken forward by the Transformation Team. Currently there is no separate location for an ambulatory care unit and therefore the pathways will need to be delivered in existing settings rather than in a single unit **Risks and Mitigation** **Amber** • Projects to not deliver results in discharges or reductions in 4 hour breaches – a dashboard has been put in place to monitor performance

ACCESS STANDARDS

- Actions do not support the Trust meet the new care quality indicators – this is being built into the work programme

Decisions required

- A decision is required on how fast each of the 10 ambulatory care pathways can be implemented given the lack of a separate location. This decision sits with the Medical Division.

Next Steps

- Sign off Front Door Model at Emergency Access Steering Group in June.
- Review operational model for Medical Assessment Unit prior to move 1st August 2011
- Agree implementation of professional standards for the Emergency Department - July
- Continue to develop ambulatory care pathways– June/ July

Key Milestones

Front Door Model Developed

Sign up to the proposed ambulatory care pathways

ACCESS STANDARDS

WORKSTREAM – B - Patient Flow

Purpose of the workstream
To improve the systems and processes which enable patients to move through the Trust effectively and efficiency
Overall status
GREEN
Key Achievements since last report
• Approval has been given to develop an Operations Centre from at which all capacity issues will be identified and action plans discussed and implemented. This will be in place from 1st July. • The Acting Chief Operating Officer and new Medical Director gave a presentation to the Hospital Medical Committee in June • A communications plan has been developed and approved using a fictional character 'Flo' to ensure a consistent message to all staff on the importance of patient flow. • A new flow process which clarifies roles and responsibilities and identifies discharges the day before they are due to happen has been developed and will be implemented in June. • A comprehensive escalation process for managing capacity has been developed and divisions are replicating escalation plans for their own services • Internal transfer protocol has been developed and is currently being piloted by Medicine Division where the wards "pull" patients to appropriate beds.
Key Risks/ Issues
Issues and Mitigation **Red** • "Expected" patients are still going through ED – this will be addressed by the larger Medical Assessment Unit in place from 1st August **Risks and Mitigation** **Amber** • There is a lack of clarity on who does what relating to flow – this is being addressed through workshops and through the communications plan and new system

ACCESS STANDARDS

Green

- There is no operations centre in the Trust but now approval has been given, this should be fully operational by 1st July..
- Restarting of programme of works relating to developing professional standards for sick speciality and complex pathway patients – a date has been set in the plan to review this work

Decisions required

Final sign off of corporate and divisional escalation plans

Next Steps

- Winter workshop planned for 5th July 2011
- Operations centre to be set up and new capacity meetings implemented – July
- Sign off of Trust and divisional escalation plans – July

Key Milestones

Timescale / Key Milestones

- Operations centre set up by July
- Launch of new escalation plans with divisional flex capacity identified – July

ACCESS STANDARDS

WORKSTREAM – C - Patient Discharges

Purpose of the workstream
To improve the number and timeliness of safe, appropriate patient discharges from the Trust
Overall status
AMBER - the projects are largely on track however a clear way forward on the discharge lounge is required
Key Achievements since last report
• Key performance indicators for discharges are now in place and being monitored through a Trust dashboard • The teleconference with all partners to unblock 'red' patients is now taking place twice per week • The protocol for escalating patients with a long length of stay is being implemented, a script has been developed for sign off at the Emergency Access Setting Group on 21st June. Patients with a length of stay over 28 days have started to be escalated to the Medical Director. • A single management function to improve discharges across the Trust is being piloted – this role will support wards expedite discharges and help improve relationships with external agencies/ partners • Following on from the external partner workshop on 19th May, a joint exercise with NHS Bristol colleagues of mapping existing work processes from internal hospital discharge team, social work, mental health referrals and continuing health is being undertaken for review at a follow-up workshop on 1st July 2011. • Improvements have been made to patient transport services with a Trust vehicle being used and a 'sweeper' vehicle has been made available from GWAS (Great Western Ambulance Service)
Key Risks/ Issues
Issues and Mitigation **Red** • The Trust needs to identify an appropriate area for a Discharge Lounge and ensure it is not used inappropriately • The approach to the new "E Discharge" process is preventing earlier discharges as it is linked to pharmacy making up prescriptions on discharge – more work is required to ensure junior doctors start writing the summary on admission and continue to write the summary during the patient stay rather than leaving it to the day of discharge - to be discussed with the new Medical Director **Risks and Mitigation**

ACCESS STANDARDS

Amber

- The length of stay escalation process does not deliver expected reductions in patients over 14 days – this will be monitored through a dashboard produced weekly

Decisions required

The Emergency Access Group and the Trust Service Delivery Group need to get agreement on the long term solution for the discharge lounge and how we will prevent inappropriate use.

Next Steps

- Implement divisional key performance indicators for review at Emergency Access Steering Group, which will help monitor compliance with the length of stay escalation process.
- A long term solution is required for single management of patient discharges in the Trust
- There will be further development of the process with 'red**,** amber, green' patient list as the Trust gets feedback from partners

Key Milestones

Timescale / Key Milestones

Draft work programme developed with external partners for review and further development on 1st July

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Trust Board Meeting, to be held on 28 June 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Histopathology Action Plan Update - Item 7

Purpose

To brief the Board on progress against the Trust's action plan in response to the Independent Inquiry into its Pathology Services published December 2010.

Abstract

Version 13 of the action plan dated 10 June 2011 is provided for the purpose of updating the Board on progress being made. The plan has been simplified in response to comments received. A number of pieces of work have been completed since the Board received its last progress report in March 2011; therefore no exceptions are reported to the Board this month.

UH Bristol's governors have set up a sub-group of their Quality Group which meets quarterly to receive updates on progress against the Trust's action plan in response to the Independent Inquiry into its pathology services and also provides a forum for questions and discussion on this matter, their comments have been included as an appendix to this paper.

Monitoring of the action plan is as follows:

- An internal histopathology group meets fortnightly to drive the actions forward.
- Monthly meetings take place with NHS Bristol and North Bristol NHS Trust.
- Progress is reported quarterly to the Trust Management Executive, the Clinical Quality Group, the Quality and Outcomes Committee, the Trust Board, UH Bristol Governor Sub-Group, Bristol Health Overview and Scrutiny Committee and the Care Quality Commission.

Recommendations

The Board is recommended to **note** the report.

Executive Report Sponsor or Other Author

Alison Moon, Chief Nurse. Author - Anne Reader, Assistant Director of Governance and Risk Management.

Appendices

Appendix A – Governors' comments on progress against the University Hospitals Bristol NHS Foundation Trust Histopathology Action Plan.

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	15 June 2011	27 June 2011			Clinical Quality Group - 14 July 2011

University Hospitals Bristol NHS
NHS Foundation Trust

Recommendations from Histopathology Inquiry – Action Plan

Ref No	Actions	Timescale	Responsible person	Progress	Complete
Section 1 Section Lead: Rob Pitcher	**Overarching recommendation A: A single Histopathology Service should be established for Bristol with the potential to be one of the leading service and academic centres.**				
1.1	Appoint Clinical Lead for Cellular Pathology	30 June 11	Jane Luker/ Chris Burton	Complete. Clinical Lead in post as of 3 May 11.	√
1.2	Develop Service Structure and Proposition for integrated cellular pathology service	See comment	Rob Pitcher	These issues are being considered as part of the Pathology Services Review being led by NHS Bristol Meanwhile, a governance structure is being put in place, the Bristol Cellular Pathology Forum. Its purpose is to provide: a) A monthly formal business meeting with agenda and minutes that will report to agreed structures at both NBT and UHB. b) A series of workshops to enable discussions on particular issues that concern the staff working in cellular pathology and the users of our service.	

Ref No	Actions	Timescale	Responsible person	Progress	Complete
				The purpose of these workshops will be to determine common ways of working. The outcome will be codified in procedures and policies to be approved at the formal meeting. c) Educational activities including case discussion, audit presentations, research, feedback from external educational activities etc. The forum is jointly sponsored by UHB and NBT and will take place twice a month starting on the 20 June and alternating between the BRI and Southmead sites. Invitees include: Consultants in Cellular Pathology, Senior scientific staff in Cellular Pathology, Trainees in Cellular Pathology (for educational activities) Clinical Director of Diagnostics and Therapies Directorate at NBT, Head of Division of Diagnostics and Therapies at UHB.	

Ref No	Actions	Timescale	Responsible person	Progress	Complete
1.3	**Short term** Consultants should work across both sites when necessary to provide the optimum service to patients.	31 Mar 11	Jane Luker/ Chris Burton	Agreed and implemented where appropriate. Cross site working in place for haemato-malignancy, Head and Neck, Lung and Her 2 Breast pathology. Further work underway to develop greater cross site working in line with planned service reconfiguration.	√
1.4	Put in place honorary contracts for cellular pathologists with reciprocal trust.	31 Mar 11	Philippa Finch/ Tracy Smallwood	Honorary contracts issued to pathologists to be signed and returned by 17 Jun 11.	√
1.5	All new cellular pathology appointments to be joint	31 Dec 10	Jane Luker/ Chris Burton	Agreed. March 11: Two new adult pathologists appointed on 50:50 contracts	√
1.6	Clarify roles and responsibilities of Heads of Division, Lead Doctor and Specialty Lead	31 Dec 10	Robert Woolley	Complete. Communications to relevant staff and revised job descriptions completed.	√

Ref No	Actions	Timescale	Responsible person	Progress	Complete
1.7	Review consultant staffing levels in accordance with the Royal College of Pathologists' "Guidelines on staffing and workload for histopathology and cytopathology departments" (2nd edition) June 2005, and, if necessary, adjusted to ensure they are sufficient for a safe, timely and reliable service.	31 Aug 11	Rob Pitcher	Data collection and analysis has commenced across both Trusts. The latter is made more complex by the knowledge that there will be revised guidelines on workload from the Royal College of Pathologists. The consultants are being interviewed during June and July to review all aspects of their current work including EQA participation and audit activity. There are two strands to this work which will be synthesised during August into a medical staffing plan.	
1.8	Identify areas of urgent staffing need and produce action plan	31 May 11	Rob Pitcher	Complete. Necessary measures in place to manage current workload, including outsourcing.	√
1.9	Identify short term and longer term location plan for department.	31 Oct 11	Rob Pitcher	The Inquiry recommended that the service should for the time being remain on two sites. The longer term plan is subject to the outcome of the Pathology Services Review. See actions for 1.2.	
1.10	Develop process to ensure service changes are fully supported by Histopathology	31 Oct 11	Rob Pitcher	The Bristol Cellular Pathology Forum described is part of developing the wider team ethos and will include discussions with clinical teams on issues such as service reconfiguration, standards etc.	

Ref No	Actions	Timescale	Responsible person	Progress	Complete
Section 2 Section Lead: Mark Callaway	**The MDTs in both Trusts should be reviewed to promote collaboration.**				
2.1	Complete MDT reviews	31 May 11 Complete reviews	Mark Callaway/ Chris Burton/Rob Pitcher	UH Bristol MDT review for pathology completed. NBT review will be completed for their June Board.	√
2.2	Agree a plan for ongoing development of joint MDT	31 Jul 211	Mark Callaway/ Chris Burton/Rob Pitcher	Joint approach and action to be taken forward.	
	Agree joint approach UH Bristol/NBT	30 June 11			
	Exec sign off in both Trusts	31 Jul 211			
2.3	Ensure slides are available at MDTs.	30 Mar 11	Lis Kutt	Complete. The MDT outcome records indicate where a patient referred in from another Trust is deferred to the next meeting if their slides are not yet available from the referring trust.	√
2.4	Agree and implement process to ensure patients are aware that a diagnosis given pre MDT may be refined at the MDT meeting.	30 May 11	Teresa Levy/ Dany Wells	Cross Trust leaflet finalised and being piloted.	√
Section 3 Section Lead: Rob Pitcher	**Quality Assurance** For information: The Royal College of Pathologists is working on a set of Key Performance Indicators for pathology.				

Ref No	Actions	Timescale	Responsible person	Progress	Complete
3.1	Agree audit programme 2011/12 for Histopathology	30 April 11	Lis Kutt	Complete and shared with NBT. 5 audits are planned: • An audit of the double reporting protocol (starting August) • An audit of reporting systems (start date to be confirmed). • Review of supplementary reports after multi-disciplinary team meeting (starting August) • High grade serous carcinoma of endometrium-network audit (starting August) • Correlation of breast tumour grading between core biopsies and resection specimens in a screened population (starting July)	√
3.2	Develop joint audit plan across both Trusts	30 June 11	Rob Pitcher	This is on track for completion by the end of June.	
3.3	Ensure current involvement in all appropriate EQAs and CPD to develop specialisation	31 Mar 11	Lis Kutt	UHB EQA involvement identified. All specialist pathologists have an appropriate EQA programme.	√
3.4	Develop full joint EQA and CPD programmes	31 Aug 11	Rob Pitcher	The consultants are being interviewed during June and July to review all aspects of their current work including EQA participation and audit activity.	

Ref No	Actions	Timescale	Responsible person	Progress	Complete
Section 4 Section Lead: Lis Kutt	**Upgrade Histopathology Department**				
4.1	Upgrade work to be completed	31 Jul 11	Sven Howkins	Work commenced 23 May 11 and is on track for completion by end July.	
Section 5 Section Lead: Rob Pitcher	**Double Reporting** For information: There is a current Royal College of Pathologists document in existence about double-reporting. The College Histopathology Specialist Advisory Committee is meeting in June 11 and will be asked to comment on whether further work is required.				
5.1	Agree and implement a revised joint double reporting protocol	31 May 11	Rob Pitcher	Complete. Protocol has been finalised and disseminate.	√
Section 6 Section Lead: Rob Pitcher	**Overarching Recommendation E: Raising Concerns about diagnostics** **Any concerns about the standard of pathology reporting should be thoroughly, rapidly and, where appropriate, independently investigated and the results made available to all those involved.** **Concerns should be dealt with at the lowest possible level and not escalated unnecessarily.** **The pathologist(s) involved should be consulted directly.**				
6.1	Agree and implement a revised raising concerns protocol	31 May 11	Rob Pitcher	Complete. Protocol has been finalised and disseminated.	√
Section 7. Section Lead Sarah Pinch	**Overarching recommendation F: Whistleblowing** **The Department of Health should review advice on whistleblowing to ensure that local policies include clear guidance on raising concerns about the work of a pathologist or any other clinician who works for a different Trust from the Trust employing the person raising the concern.**				
7.1	Strengthen UHB Whistleblowing policy	31 May 11	Sarah Pinch	Complete. Policy agreed and confidential staff helpline in place.	√

Ref No	Actions	Timescale	Responsible person	Progress	Complete
Section 8 Section Lead: Sarah Pinch	**Overarching recommendation G: Media Relationships.** **Relationships with the media should be proactive with an emphasis on openness, honesty and the involvement of senior managers and clinicians** **Relationships with the media should reinforce positive relationships with patients. Service change should be explained including the Chief Executive**				
8.1	The Trust Board will approve the revised communications strategy and plan in light of the report's recommendations	30 June 11	Sarah Pinch	The Communications Strategy will go to the Board in June 2011.	
8.2	The Trust's media protocols will be revised in light of the report's recommendations and will include consultation with relevant staff groups. The revised protocol will then be reissued to all staff. The protocol will be included in the revised communications strategy.	31 Mar 11	Sarah Pinch	Complete. Revised media protocols approved 13 April 11.	√
8.3	The Trust's website is currently being redeveloped and will deliver a more responsive, interactive up-to-date tool for Trust communications, direct to patients, staff, FT members and the media.	30 June 11	Sarah Pinch	The new website is being launched at the end of June 2011.	
Section 9 UHB Section Lead: Lis Kutt	**Overarching recommendation H: Paediatric and Perinatal Pathology** **Paediatric and perinatal pathology should be valued and supported by managers, pathologists and other clinicians.** **The minimum level of staffing should be one paediatric pathologist, one perinatal pathologist and one pathologist trained in both paediatric and perinatal pathology.**				
9.1	Recruit and permanently appoint to proposed staffing levels demonstrating full commitment to the service	31 Jul 11	Lis Kutt/ Rob Pitcher	Interviews held Feb 2011. No appointment made. Further interviews to be held 23 Jun 11. Interim outsourcing provision in place.	
9.2	CEO to write to Southampton and Oxford to seek opportunities for joint working in principle	31 Dec 10	Robert Woolley	Complete. Positive responses received from Southampton CEO and Oxford MD.	√

Ref No	Actions	Timescale	Responsible person	Progress	Complete
9.3	Establish joint working arrangement	31 Jul 11	Sean O'Kelly	Initial approaches being followed up. UH B Medical Director has a meeting with Oxford on 16 Jun 11 and meeting is being arranged with Southampton.	
Section 10 Section Lead: Alison Moon	**Overarching recommendation I: Patients and Histopathology** For information: The Royal College of Pathologists has an active programme to inform the public about histopathology. Next year is designated National Pathology Year.				
10.1	Implement PPI strategy – Year 1 (Inpatient feedback systems)	31 Mar 11	Alison Moon	Complete. Inpatient feedback mechanisms in place and providing timely information on the quality of patients' experiences, the results of which are being acted upon within the Trust.	√
10.2	Implement PPI strategy – Year 2 (Expansion of Year 1 approach into Outpatients – pending identification of funding)	31 Mar 12	Alison Moon	Year 2 funding obtained.	
10.3	Devise and delivery four UH Bristol patient focus groups to explore current awareness and future involvement in the on-going development of histopathology at UH Bristol	30 Apr 11	Tony Watkin \ Lis Kutt	Complete. The report from the focus groups has been finalised and will be shared with the Pathology Services Review.	√
10.4	Develop proactive and constructive working relations with new 'Local Healthwatch', including its proposed responsibilities for patient advocacy (detail has yet to be announced by the DH).	DH expects HW to be "up and running by 2012"	Tony Watkin	Awaiting publication of DH plans.	

Ref No	Actions	Timescale	Responsible person	Progress	Complete
10.5	Agree process to promptly inform patients of diagnostic errors	31 Jan 11	Jane Luker	Complete. Staff Support and Being Open Policy 2009 is already in place. An update is underway which will make link to diagnostic errors more explicit.	√
10.6	Explore options for providing service users with information about the purpose of role and multi-disciplinary cancer teams and team meetings.	31 Mar 11	Teresa Levy	Cross Trust leaflet finalised and being piloted.	√
10.7	Where a patient's care is going to be discussed at a multidisciplinary team meeting, patients should not be given information contained in histopathology reports until the reports have been considered by the multidisciplinary team.		The Trusts have agreed that implementing this recommendation could lead to a delay in patients being given information concerning their diagnosis and could put clinicians in the position of having to withhold important information from patients. The Trusts' ability to run one-stop clinics would also be compromised. Instead the Trusts propose that patients should be given information appropriate to their care, with an explanation of the diagnostic and treatment decision process by the Multidisciplinary Team.		N/A
Section 11 Section Lead: Rob Pitcher	**Training**				
11.1	Trainees should have supervised involvement in the full range of specimens, including the most complex cases, in accordance with their seniority	Nov 10	Lis Kutt	Complete.	√
11.2	Training plans to be adjusted to provide access to all levels of case	30 Nov 10	Lis Kutt	Complete.	√

Ref No	Actions	Timescale	Responsible person	Progress	Complete
Section 12 Section Lead: Steve Aumayer	**Overarching recommendation L: The histopathologists should be given whatever support they need to face the aftermath of this Inquiry including skilled facilitation.**				
12.1	Develop detailed organisational development plan to support the move towards an integrated cellular pathology service	31 Aug 11	Steve Aumayer/ Rob Pitcher	Linked to action 1.2. Future team development activities are under discussion (meeting with the HR Directors of both Trusts booked for 19 Jul 11).	
12.2	Provide Counselling and Occupational Health support to affected staff	31 Dec 10	Steve Aumayer	Complete. Some staff have accessed this	√
12.3	Provide facilitation and mediation	As required	Lis Kutt	No staff member has requested support to date. Externally facilitated event took place in Jan 11 with NBT.	√
12.4	Support to assist in development of single service	On-going.	Lis Kutt/ Rob Pitcher	Future team development activities are under discussion (meeting with the HR Directors of both Trusts booked 19 Jul 11.)	
Section 13 Section Lead: Rob Pitcher	**Overarching recommendation J: Specialist Pathology**				

Ref No	Actions	Timescale	Responsible person	Progress	Complete
13.1	The Royal College of Pathologists should review its guidance on specialist histopathology with the intention of making it more explicit where possible.		RCPAth	Rob Pitcher has met informally with the President of the Royal College of Pathologists. There is a current Royal College of Pathologists document in existence and the College Histopathology Specialist Advisory Committee have been asked to comment on whether further work is required.	
13.2	There should be at least two specialist histopathologists in each subspecialist area to allow proper review and to provide cover for meetings and periods of leave.			Linked to section 1.2.	
Section 14 Section Lead: Rob Pitcher	**Pathology reports**				
14.1	Review style of reporting and implement any changes if deemed appropriate	To be agreed	Rob Pitcher	The Bristol Cellular Pathology Forum has topics already identified to be built into its work programme. These topics for discussion, debate and development into policy and procedure include pathology reporting.	

Appendix 1

Governors comments on UH Bristol's Histopathology Action Plan

09 May 2011

The governors have set up a sub-group of their Quality Group which meets quarterly to receive updates on progress against the Trust's action plan in response to the Independent Inquiry into its pathology services and also provides a forum for questions and discussion on this matter. The group originally comprised five governors, including the Lead Governor.

Version 9 of the Trust's action plan was the current version in place for the May meeting of the group. The governors felt the action plan reflected lessons learned from the Inquiry and embraced the developing relationship with North Bristol's Pathology Services

Each element of the action plan was discussed in detail.

Key points of discussion included:

1. Dr Rob Pitcher has now taken up this post and the joint Clinical Lead for Cellular Pathology across the city and will dedicate his time 50:50 between UH Bristol and North Bristol with the remit to ensure the provision of the highest standard of service from histopathology. Dr Pitcher was already in touch with the President of the Royal College Pathology to discuss their planned developments and how this would support developing the service in Bristol. Dr Pitcher will be invited to join future sub-group meetings.

2. Alison Moon advised that Executive Directors had all been required to sign an amendment to their contract obliging them to share concerns they may have immediately with the Trust Board, which was in direct response to one of the criticisms from within the Inquiry.

3. The Trust now has a policy which requires that slides must be reviewed by a histopathologist with EQA (External Quality Assurance) accreditation and results are made available at weekly multidisciplinary meetings (MDT). If however, the MDT is not quorate or there has been no EQA histopathologist's input then the patient's case will be held over to the next week. The governors asked to be briefed on a monthly basis on the frequency of such events. The governors sought reassurance that this would not cause divergence from the patient's cancer pathway and were informed that this would be an uncommon occurrence.

4. For patients who are transferred from other trusts to UH Bristol, their slides are re-reviewed by the UH Bristol histopathology team. This is time consuming, but is considered essential to ensure that clinicians at UH Bristol treat patients against a standard histopathology interpretation.

5. The governors noted a delay in the production of a generic patient leaflet covering the histopathology service, this needs urgent action.

6. It was also noted that there had been a delay in the implementation of double reporting protocol as this had required further revision following Dr Pitcher's appointment.

7. The current vacancy of Paediatric and Perinatal Pathology was noted and a recruitment plan and interim arrangements are in place. As a result of the adverse publicity both the recent and past, it is now very difficult to recruit to histopathology posts in Bristol which has impacted on staff morale. The governors asked Liz Kutt to advise her histopathology team of the vote taken by governors at their last Membership Council meeting that they would not support a further public enquiry following the Independent Inquiry. Neil Auty offered to meet the team to show the support of the governors. The governors recognised the difficulties faced by the department and will investigate how they can further provide support

The governors who attended this sub-group have recommended to their governor colleagues that they accept the actions being taken by the Trust in response to the Independent Inquiry and that they continue to provide input to the actions of the trust in this matter.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Trust Board Meeting, to be held on 28 June 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Quality Strategy - Item 8
Purpose
To report to the Board on revisions to the Trust's Quality Strategy.
Abstract
The Trust's original Quality Strategy was written by Dr Jonathan Sheffield (then Medical Director) and approved by the Board in March 2010. A planned review of the Quality Strategy has recently been undertaken, resulting in the revised document attached here, which is brought to the Board for approval. Key changes to the Quality Strategy include: - Inclusion of explicit links with other Trust strategies - Clear commitments relating to patient safety, patient experience and clinical effectiveness and outcomes, which mirror those reported in the Annual Quality Report - Recognition of what 'quality' means to patients - Acknowledgement of the challenges of delivering quality improvement in the face of financial challenges - A delivery framework based on annual self-assessment by Divisions, linked to the development of annual Operating Plans, monitored through the Divisional Review process.
Recommendations
The Board is recommended to **approve** the Quality Strategy.
Executive Report Sponsor or Other Author
Alison Moon, Chief Nurse & Dr Sean O'Kelly, Medical Director. Author: Chris Swonnell, Assistant Director for Audit and Assurance.
Appendices
List your appendices, including your Report in the following format: • Appendix A – Quality Strategy (draft)

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	15 June 2011	27 June 2011			

University Hospitals Bristol NHS
NHS Foundation Trust

University Hospitals Bristol NHS Foundation Trust

Quality Strategy 2011-2014

Chairman's introduction

I am delighted to be able to add a few words to welcome this new iteration of the Trust's Quality Strategy. There can be no argument that our mission is to deliver services of the highest quality. Clinical effectiveness and outcomes must never be compromised. Every opportunity must be taken to improve the built environment in which these are delivered. Above all, patients must be kept safe and have the experience of being properly cared for. It is the nature of this "caring" that is on the one hand so blindingly obvious but on the other so very difficult to fully describe and uniformly quantify.

It is the greatest calling to care for others and the concept goes far beyond the practical and technical repair of our damaged, hurting and frail fellow citizens. All of us need to strive to ensure that in our professional dealings with patients and their friends and loved ones we transmit the clear signs of our compassion; we must act out our caring to the very depth of the meaning with consistency and unending commitment.

If this is to be expected of the whole workforce then all of our staff must also expect and receive the greatest expression of care for them by the organisation. This is embedded in our statement of values and it needs constant and meaningful reaffirmation. And, to be fully effective, the concept must embrace our care for each other as we go about our varied and challenging tasks in dealing with over 500,000 patients every year. It is a staggering mission. The Trust Board believes this, is grateful for the attributes and achievements of all our employees, and will strive to ensure wholeness in the strategy for quality.

John Savage, Chairman

Part 1 – Why have a Quality Strategy?

1.1 The purpose this strategy

Quality is one of five strategic enabling strategies within the Trust's overall Integrated Business Plan and Long Term Financial Model (see Appendix). "Quality at the heart of what we do" is also one of four Strategic Themes underpinning the Trust's five year Clinical Services Strategy (2010-2015). This means that, as we formulate strategic plans to ensure that our three core businesses - clinical services; research and innovation; and teaching and learning – not only survive but thrive through challenging economic times, we will also maintain a clear focus on quality improvement. The Clinical Services Strategy makes the following commitment:

> "[We will] ensure that our services are consistently safe, deliver outcomes that match the best in Europe and offer an experience that is perceived by our patients and staff to be the best it possibly could be"[1]

Furthermore, Quality is also one of six enabling themes underpinning the Trust's Teaching and Learning Strategy (2011-2015):

> "We employ more than 7,000 staff, operate across eight hospital sites, and throughout the community, and intend to be recognised for the excellence of the outcomes we achieve for patients and most notably the quality of their experience whilst under our care"[2]

The purpose of the **Quality Strategy** is therefore to articulate our ambition to be a leader in healthcare quality, both within the NHS and internationally. We want our patients to receive the best possible treatment, delivered with care and compassion. We will achieve this by implementing our shared values – respecting everyone, working together, embracing change and recognising success – and by learning – from what our patients and staff tell us; from external review; from internal peer review and audit; and from the implementation of evidence-based treatment and care derived from high-class research.

1.2 Developing a strategy for Quality

The NHS Next Stage Review[3] made it clear that quality should be at the heart of everything the NHS does. The Health and Social Care Act 2008 in turn established a statutory framework for quality, underpinned by a range of key quality and risk standards (registration Outcomes).

At the same time, the consequences of NHS trusts failing to focus on quality have been evident for all to see:

> "Where staff have not been encouraged to focus on high quality care for their patients and have not been supported to be open and learn from mistakes, patients have borne the brunt of those failings. Where providers and commissioners have failed to listen to and proactively engage with patients and the public, patients have

[1] UH Bristol Clinical Services Strategy 2010-2015, p10
[2] UH Bristol Teaching and Learning Strategy 2011-2015, p5
[3] *High quality care for all,* Professor the Lord Darzi of Denham, June 2008

> borne the brunt of these failings. Where the ambitions of both individuals and organisations have taken precedence over a focus on quality, patients have borne the brunt of those failings. Where the system has failed to share information on risk and work collaboratively to rectify problems, patients have borne the brunt of those failings. To create a self-improving and responsible NHS, we need to aim for a culture of open and honest cooperation. This means individuals and organisations being open and honest about the quality of care being provided to patients and the whole system working collaboratively to address concerns and raise standards."

National Quality Board – *Review of Early Warning Systems in the NHS*, February 2010

In summary, there have been too many avoidable adverse incidents in NHS trusts and too little learning from them.

1.3 The Board's challenge

The Health Foundation urges Boards to "develop a corporately agreed quality strategy with output goals that are reported on a regular basis, underpinned by a collective understanding of how you think change can be stimulated and embedded"[4], and proposes a simple model for an organisational quality strategy[5]:

- Define goals which will improve quality (and do this with service users)
- Set measures for improvement
- Identify responsibility for implementation
- Explain how progress will be monitored and reported
- Say how success will be recognised and celebrated

This Quality Strategy adopts the Health Foundation's model and includes:

- A working definition of quality
- An explanation of how the Quality Strategy supports and reflects the Trust's Values
- Board Quality Governance arrangements
- The Trust's high-level quality ambitions for the next three years, as reflected in the Trust's organisational objectives
- Detailed quality objectives for 2010/11 determined by the Trust's Clinical Divisions

1.4 The Board's response and commitment

This Quality Strategy has been developed by the Board through a consultation process which has included managers and clinicians in its corporate services and clinical Divisions, Governors and Local Involvement Networks. The intention from the outset has been to produce a document which is simple in structure and clear in purpose and which re-affirms the Trust's commitment to excellence, to learning and to making our services better for patients. We also wanted to set some specific and measurable ambitions for quality for which Clinical Divisions will be held to account.

Lord Darzi has emphasised that "we can only be sure to improve what we can actually measure"[6]: we will develop measures for the things that matter to our patients.

[4] The Health Foundation, *Quality Improvement Made Simple*, p38
[5] p31
[6] *High quality care for all,* p49

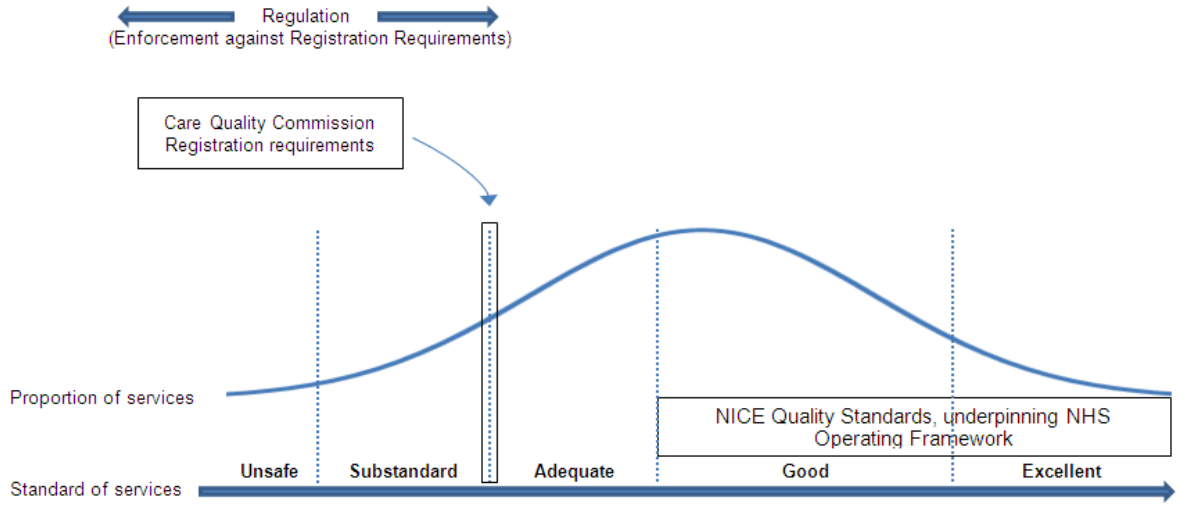
This document updates the Trust's first Quality Strategy, approved by the Board in March 2010. Since this time, much has happened, so that we are building on strong foundations. For example:

- The Board approved the Trust's third annual Quality Report (Account) in April 2011, setting out its achievements and immediate plans for quality
- The Dr Foster Hospital Guide (2010) once again confirmed the Trust as having one of the lowest Hospital Standardised Mortality Ratios in the NHS
- The Trust has introduced a comprehensive approach to measuring and learning from patient experience in inpatient services, which is currently in the process of being extended into outpatient areas
- The Board has confirmed new quality governance arrangements which will ensure appropriate levels of scrutiny and accountability as we move forward
- Each month, the Board now receives a quality report which includes a patient story and patient experience indicators derived from our monthly inpatient survey
- A user group with patient representation has influenced the design of the Trust's new web site

1.5 The scope of Quality – a working definition

Although there is no universally accepted definition of 'quality' in healthcare, quality in its broadest sense may be described as "the degree of excellence in healthcare". So, for example, whilst this strategy supports compliance with the Care Quality Commission's registration standards (Outcomes), quality is about more than this: the CQC standards describe minimum acceptable practice, not necessarily *excellence*. Figure 1, reproduced courtesy of the National Institute for Health and Clinical Excellence, demonstrates this point. The Trust is currently registered with the CQC without conditions, i.e. we are already somewhere to the right of the CQC mark on the graph; however our ambition is to be amongst trusts at the leading edge of quality (i.e. at the far right hand edge of the curve).

Figure 1.



The Trust has chosen to adopt the model of quality proposed by Lord Darzi[7], defining quality in terms of whether patients are safe, whether their treatment achieves the best possible clinical outcome for each individual, and whether people are treated with humanity.

The table below explains sets out our commitment to patients, based on these core dimensions of quality.

Dimension of quality	Our commitment
Safety	We will focus on avoiding and preventing avoidable harm to patients from the care, treatment and support that is intended to help them. There should be no avoidable deaths as a consequence of healthcare.
Effectiveness / Outcomes	We will ensure that the each patient receives the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome.
Experience	All our patients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support. We want all our patients to have a positive experience of healthcare.

The Trust accepts that these commitments represent a journey: the challenge will be to learn, be open and develop skills, systems and the commitment of all our workforce.

1.6 Understanding what quality means to patients

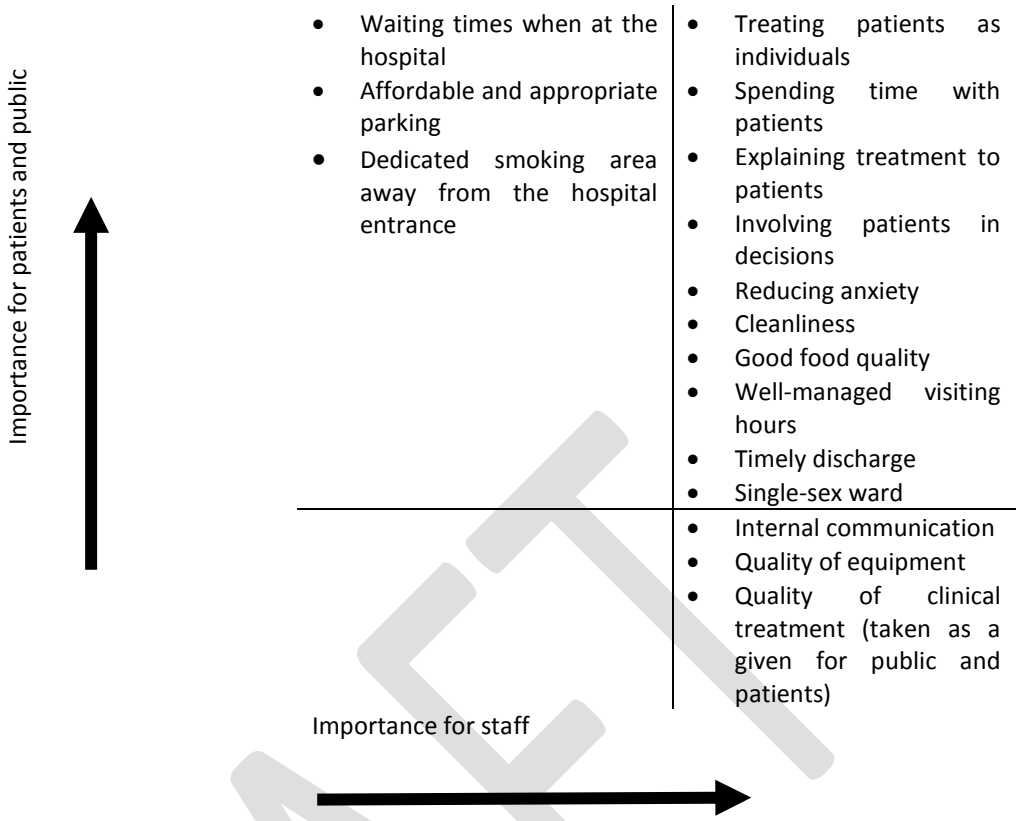
In July 2010, Ipsos MORI published *Perceptions of quality of NHS secondary care.* The findings of this significant piece of research in NHS West Midlands revealed how patients think about quality, and how they expect excellent care to be delivered:

> "The way [patients and the public] think about quality in a hospital environment is *different* to how they think about quality in other parts of their lives, due to the emotional impact of being in a hospital and associated feelings of vulnerability. This means they had much higher expectations of the care they should receive and things that might go unnoticed in other situations (e.g. someone smiling at them) took on a greater significance"[8]

Figure 2, reproduced from the Ipsos MORI report, compares the things that govern perceptions of quality for patients and the public, with the things that influence staff opinion. The research demonstrates how patients and the public tend to take clinical outcomes and clinical effectiveness as read: perceptions of quality are instead influenced by issues relating to access and safety, but are overwhelmingly determined by patient experience. This is why understanding, and responding to, patient experience must be a prominent feature of our strategy for quality.

[7] *High quality care for all,* Professor the Lord Darzi of Denham, June 2008
[8] Ipsos MORI, *Perceptions of quality in NHS secondary care: a research report for NHS West Midlands*, p2

Figure 2.



This view is supported by the Health Foundation:

> "Patients may define quality differently from clinicians and managers. What [patients] view as 'the problem' or value within a system may be surprising. So, boards need to question how patient involvement is being embedded in their organisation's quality improvement programmes."[9]

1.7 Patient and carer satisfaction

We already know from our own local analysis of national patient survey data that there are four key factors which influence patients' overall satisfaction with the care they have received:

- The extent to which patients have confidence and trust in the staff who care for them
- Cleanliness of the hospital environment
- Quality of communication between staff and patients and those who care for them
- The extent to which patients are involved in decisions about their care ('nothing about me without me')

As we go forward, we are also committed to working with carers to understand what matters most to them and develop our services in ways which reflect this.

[9] The Health Foundation, *Quality Improvement made simple*, p27

1.8 Quality at what price?

The Ipsos MORI research referred to in section 1.6 also reveals that patients and the public "sometimes feel that financial resources and government targets are more important to senior management, than quality". This strategy seeks to address this perception, placing quality firmly at the heart of the Board's and Trust's business. Providing a quality service need not involve increasing costs: sometimes it's the small things that matter to patients. Indeed, quality may go hand-in-hand with cost efficiencies, as the following quotations demonstrate:

> "When some say *'we cannot afford higher quality at this time'* they overlook the fact that low quality, so often the result of inappropriate behaviours and attitudes, can actually cost more."[10]

> "…continuing with poor or sub-optimal care results in unnecessary costs. Longer stays for patients with a healthcare-acquired infection... add to hospital costs. Improving care and hygiene standards will reduce costs per case, and can boost productivity such as throughput of patients per bed."[11]

In 2011, the Trust has introduced a requirement that Cash Releasing Efficiency Savings (CRES) plans must demonstrate that their implementation will not compromise clinical quality and that appropriate consultation has taken place with clinical teams. When CRES plans are submitted, managers are required to use a quality impact assessment tool to describe any anticipated impact on patient safety, patient experience and clinical effectiveness and outcomes.

The Trust will also continue to participate in the CQUIN (Commissioning for Quality and Innovation) scheme, working in partnership with our commissioners to use financial incentives to mutual benefit to support achievement of many of our quality ambitions.

[10] Northern Ireland Department of Health, Social Services and Public Policy, *A ten year quality strategy for health and social care in Northern Ireland*, January 2011, p4
[11] The Health Foundation, *Quality Improvement Made Simple*, p44

Part 2 – Developing a framework for excellence

2.1 The Board framework for Quality Governance

The Board's aspiration is for the Trust to deliver services of the highest order. In order to achieve this, the Board is committed to implementing a quality system founded on the following principles:

- Identifying the 'things that matter' in partnership with patients, those who care for them, and those who represent them
- Ensuring that quality objectives are identified through analysis of relevant data from a range of available sources: objectives which are stretching and measurable
- Moving from measurement of inputs to measurement of outcomes
- Using risk management to achieve quality improvement
- Putting systems in place which deliver reliable data in which the Board can place confidence
- Monitoring the Trust's quality performance in relation to its peers and/or agreed audit 'families'
- Developing comprehensive ward and department level quality dashboards and corporate learning
- Avoiding duplication: a single dashboard of indicators will be developed to meet internal reporting requirements and to provide assurance to commissioners and the Board
- Aligning existing internal assurance systems, e.g. clinical audit, internal audit, to support assurance of delivery of quality improvement
- Ensuring required standards are achieved
- Investigating and recommending action on any substandard performance
- Identifying, sharing and ensuring delivery of best-practice
- Planning and driving continuous improvement

Responsibility for delivering such a system does not rest with a single designated Executive Director, but rather with each member of the Executive team.

2.2 Setting patient-centred goals

Ipsos MORI's research identifies a number of areas which providers should focus on to improve perceptions of quality amongst patients and the public:

- Maximising the amount of time staff have available to spend with patients – for example, via the Productive Ward programme[12]
- Improving the focus on person-centred care
- Improving the Trust's ability to obtain honest feedback about its services, and to demonstrate how this is acted upon
- Improving information available to patients about quality of services
- Improving the visibility of Trust leadership at ward level – e.g. through Board 'walk-abouts'
- Improving patients' perceptions of feeling involved and in control of their care

The Board welcomes these challenges and will seek evidence of progress in these areas alongside, and as part of, delivery of the specific annual corporate quality objectives set out in Part 3.

[12] We would also include the Productive Theatre programme in this category, providing key links between quality and efficiency

Part 3 – Delivery of Quality Improvement

3.1 Corporate quality objectives 2011-2014

"Quality at the heart of what we do" is a one of the themes underpinning the Trust's corporate objectives for 2011-14. Within the corporate objectives, the Trust has set a number of measurable quality objectives. In a number of cases, these objectives set out an aspiration to improve quality relative to other NHS providers, underlining the Trust's desire to be the 'provider of choice'.

Part 3 of the strategy focuses on our ambitions for the three core dimensions of quality: safety, experience and effectiveness/outcomes.

3.2 Patient Safety

Our overarching ambition for patient safety is to eliminate unintended harm to patients and be recognised nationally for the safety of the services we offer. In adult services, our work in patient safety is focused around the various work streams of the South West Quality and Patient Safety Improvement Programme. These include:

- Executive leadership patient safety walk-rounds.
- Use of the General Ward Observation Chart and development of a medical Early Warning System to more promptly identify deteriorating patients.
- Medicines Management, including specific emphasis on the management of high risk drugs with a priority continuing in anticoagulation management and expanding the work to include better control of insulin in diabetic inpatients.
- Peri-operative Care including, for example, ensuring the patient's body temperature is within normal limits throughout the operation.
- Intensive Care, focused on the monitoring of care bundles, for example: monitoring a range of actions with the aim of reducing complications associated with the use of ventilators, and applying them with reliability in order to deliver improved outcomes.

The Trust will also ensure a continuing focus on patient safety in paediatric services through participation in the Leadership in Patient Safety Programme which has previously been successful in the development of paediatric safety management in Sheffield Children's Hospital. We will also continue to respond positively to national guidance about patient safety, e.g. National Patient Safety Agency publications.

By 2013/14, our aim is to implement all key changes relating to the NHS South West Quality and Patient Safety Improvement Programme across all work streams, with at least 50% penetration into other applicable patient populations and areas. Our goal is also to achieve zero 'Never' events for each year of the strategy. The following table sets out some specific milestones along the way:

Annual Milestones for Patient Safety		
2011/12	**2012/13**	**2013/14**
• We will achieve sustained improvement (three months without sliding backwards) in process and outcome measures for pilot populations in all five work streams of the NHS South West Quality and Patient Safety Improvement Programme. • We will also achieve spread - including testing, training, communication, etc - of all key changes beyond the pilot populations of the same Programme. • We will focus specifically on seeking improvements in hospital acquired thrombosis (VTE), medication errors, inpatient falls and pressure ulcer prevention and management. Success criteria will be defined via the CQUIN framework. • We will fully implement the agreed action plan following the Inquiry into Histopathology services.	• The spread of all key changes relating to the NHS South West Quality and Patient Safety Improvement Programme will be achieved in one to three (breadth) work streams with at least 50% penetration (depth) into other applicable patient populations and areas	• The spread of all key changes relating to the NHS South West Quality and Patient Safety Improvement Programme will have been achieved in all (breadth) work streams with at least 50% penetration (depth) into other applicable patient populations and areas

3.3 Patient Experience

Our overarching ambition for patient experience is to be recognised by our patients and their families for the consistently high quality of the care they receive whilst in our care.

In 2010/11, the Trust introduced a comprehensive system for gathering, and responding to, patient feedback about inpatient services. The Trust has introduced:

- A monthly post-discharge postal survey, received by the vast majority of discharged inpatients
- Targeted 'deep dive' surveys using hand-held electronic devices addressing specific themes, e.g. staff-patient communication; humanity of care; etc – these surveys have engaged staff, volunteers and Governors
- Comment cards on all wards as a quality improvement tool for wards

Patient Experience Action Plans have been developed by each Division in response to feedback from the systems described above. These are 'live' documents, monitored by Divisional Boards and Governance/Quality groups.

Every month, the Board now receives a 'patient story' as part of the quality report: this enables the Board to reflect on an individual patient's experience of our services, and to challenge whether and how the organisation has learned lessons.

For 2011/12 and beyond, the Trust is committed to continuing this work in inpatients settings and to rolling out adapted versions of these methodologies in outpatient services. In doing so, we will build upon previous and on-going work conducted by our Governors in outpatient areas. The postal surveys will be the main vehicles for monitoring progress with patient experience objectives.

By 2013/14, our aim is to achieve a Top 5 ranking amongst peer trusts for at least 50% of patient experience measures in National Inpatient Survey (2013). The following table sets out some specific milestones along the way:

Annual Milestones for Patient Experience		
2011/12	**2012/13**	**2013/14**
• We will extend our patient experience strategy to include Outpatients and carers, learn from feedback and improve scores in measures of satisfaction. • We will achieve measurable reductions in patient-reported noise at night* • We will ensure that patients who need assistance at mealtimes receive this* • We will review the provision of ward-based patient information ensuring that this meets our patients' needs • We will develop customer care training for staff in response to what our patients tell us matters to them	• We will place a particular focus on the experience of children, patients in End of Life care (reflecting NHS Outcomes Framework priorities), and A&E patients (with a view to improving our scores for at least 50% of measures in the 2012 National A&E Patient Survey, when compared to the previous survey in 2008).	• We will place a particular focus on the experience of patients who use our maternity services (with a view to improving our scores for at least 50% of measures in the 2013 National Maternity Survey, when compared to the previous survey in 2010).

* specific objectives reflected in the Trust's CQUIN scheme for 2011/12

3.4 Clinical Effectiveness/Outcomes

Our overarching ambition for clinical effectiveness/outcomes is to be recognised for the excellent clinical outcomes we achieve for our patients across all areas of service.

In 2011, the Trust has implemented a new Executive-led 'Quality Intelligence Group', responsible for tracking and instigating investigation of any reported concerns about clinical outcomes, e.g. mortality, re-admissions, misadventures, complications. As we go forward, the Trust will continue to use clinical audit as a bedrock of assuring and improving the clinical effectiveness of services; we will also maintain our focus on responding positively to findings from national audits and confidential enquiries; furthermore we will seek to develop to the use of Patient Reported Outcome Measures (PROMs) throughout the period covered by this strategy. The Trust is also committed to developing the use of clinical case-note review as a tool for improving both clinical effectiveness and patient safety, and specifically the Quality in Care tool as a measure of assurance of care at ward level.

By 2013/14, our aim is to achieve clinical outcomes that are consistently in the upper quartile of comparable Trusts' performance, including a relevant measure of hospital mortality. The table below sets out some specific milestones along the way:

Annual Milestones for Clinical Effectiveness/Outcomes		
2011/12	**2012/13**	**2013/14**
• We will maintain our Dr Foster "Lower than expected mortality" status for HSMRs and Mortality in high-risk conditions. The Trust will implement a new Quality Intelligence Group to ensure early detection of and response to statistical outliers, supported by strengthened M&M review in Divisions. • In line with the NHS Outcomes Framework, the Trust will seek to achieve year-on-year improvements in one year survival rates for colorectal, breast and lung cancer. Actions will include: review of respiratory MDT by Division of Medicine to improve outcomes for lung cancer patients; on-going focus on patient access times; implementation of the policy is *Improving Outcomes: a Strategy for Cancer* (DH, January 2011) • We will achieve improved Dr Foster ratings (measured by comparison with peer trusts) in at least 5 out of 7 stroke-related indicators. The Division of Medicine will create a dedicated stroke unit on the BRI site to improve outcomes • We will implement the action plan resulting from a local gap analysis of the NICE Quality Standard for Dementia, and agreed standards of dementia care developed by the South West Expert Reference Group. • We will increase the proportion of spontaneous vaginal births. Will we do this by actively promoting home births and vaginal delivery after C Section; ensuring 1-1 care in labour; introducing staff study for normal births	• We will maintain our focus on cancer and stroke care and outcomes • We will achieve upper quartile ratings for 50% of measures linked to the NHS Outcomes Framework (to be defined by the NHS Commissioning Board during 2011/12).	• We will maintain our focus on cancer and stroke care and outcomes • We will achieve upper quartile ratings for 60% of measures linked to the NHS Outcomes Framework (to be defined by the NHS Commissioning Board during 2011/12).

3.5 The role of Divisions

For each year of Quality Strategy, through the annual planning process, each Division will be expected to develop a set of local quality ambitions. These will reflect:

- The Trust's overarching goals for quality
- How the Division will contribute to achievement of the Trust's corporate quality objectives for the year in question
- Other local priorities for quality identified by the Division

From 2012/13 onward, local ambitions will also need to be balanced with a focus on national priority themes set out in the *NHS Outcomes Framework*.

Divisional quality objectives will be identified through self-assessment which Heads of Division will be expected to lead, reporting their findings and conclusions to the Board Quality and Outcomes Committee. The process of agreeing, implementing and monitoring Divisional quality objectives is set out in the figure on page 13 which adopts the themes of "**assess**", "**improve**" and "**assure**". Divisional Boards will be expected to adapt and develop their quality dashboards to monitor progress against their annual quality objectives. Progress towards achieving quality ambitions will be monitored through the Divisional Review process.


Assess
•Annual Divisional self-assessment based on available quality data including: patient stories, feedback and complaints; clinical audit evidence; compliance with NICE guidance, NHSLA standards, CQC Outcomes and NCEPOD recommendations; PROMs data
•Taking account of: high-level Trust Quality Objectives for 2011-2014; NHS Outcomes Framework; CQUIN priorities and contract specifications; Clinical Services Strategy
•Working with: Board, Governors, commissioners, other Divisions
•Supported by: corporate Governance Team
•Resulting in: Divisional quality ambitions which are measurable, stretching and achievable
•Common themes informing: choice of trust-wide annual quality objectives in Quality Accounts
•Process open to: independent scrutiny through peer review and internal audit
Improve
•Divisions tasked with delivery
•Working in partnership with corporate services
•Awareness and management of risks to non-achievement
•Integration with Transformation workstreams
•Supporting achievement of CQUINs, and compliance with CQC registration and NHSLA standards compliance.
Assure
•Monthly quality reports to Divisional boards, aligned to Divisional quality objectives
•Utilising local clinical audit
•Progress monitored by Executives via Divisional Review process
•Progress monitored by Trust Board through the Quality and Outcomes Committee
•Key outcomes of care published in annual Quality Report (Account), with web-based progress reports available during the year
•Open to scrutiny from external audit, CQC, NHSLA, Monitor and the public

3.6 Learning from experience

In the words of Professor Aidan Halligan, then England's Deputy Chief Medical Officer, "To err is human, to cover up is unforgiveable, *to fail to learn is inexcusable*."[13] Through a range of existing policies and initiatives, the Trust is already focused on learning from experience - both good and bad - from incidents, claims, complaints, patient and staff feedback. For example, the Complaints and Concerns Policy explains how patient complaints will be used not only for individual and team learning, but also within Divisions, across work streams for operational groups, between Divisions and throughout the organisation.

As part of developing a strategy for quality, the Trust is recommitting itself to the concept of being 'an organisation with a memory' and as such, there is a natural synergy with its mission for Teaching and Learning, which is:

> "To develop a culture of life-long learning across all staff groups within the Trust where Teaching and Learning is aligned with the Trust Values and Strategies and synonymous with quality, cost, performance, and the delivery of excellent patient care."

In 2011, the Trust has agreed a comprehensive Teaching and Learning Strategy which sets out the Trust's ambitions for developing and maintaining a competent, trained and motivated workforce: ambitions which are also essential to achieving the goals set out in the Quality Strategy. The Teaching and Learning Strategy also makes a commitment to "develop transformational Leadership competencies to embrace the Trust Values, to drive our performance, and to deliver high quality patient care"[14].

A specific aspiration of the Quality Strategy is that, by 2013/14, every member of staff will have at least one quality-related personal objective identified through the annual appraisal process.

3.7 How does this strategy relate to the Trust's mission and values?

The Trust's stated mission is "To provide patient care, education and research of the highest quality". This strategy therefore supports the Trust's mission by defining what 'quality' means and offering a framework for raising standards.

The Trust's Values were published in 2010 following extensive consultation: staff, patients, members and Governors gave feedback about what mattered to them, what they expected of their employer, their colleagues, the people who care for them, and themselves. The Values are a guide for all staff about what is important and how we behave.

The table on page 16 sets out the Trust's four key Values and explains how they are reflected in the Quality Strategy.

[13] Sir Liam Donaldson was speaking at the launch of the World Alliance for Patient Safety in Washington DC on 27 October 2004

[14] Teaching and Learning Strategy p8

Values	What this means for the Quality Strategy	Organisational fit
Respecting everyone	In the context of the Quality Strategy, this means respect for all the people who use our services, their carers and families, and for all staff involved in service delivery.	Begins with each member of staff
Working together	The Trust's quality ambitions will only be achieved through working together: collaboration between healthcare professionals, managers, patients and the people who care for them. This may involve other agencies and our local communities.	Involves working as a team
Embracing change	Improving quality means embracing change: doing a thing better, or doing a better thing, but either way, making things better for patients	Requires change in corporate culture
Recognising success	The Trust will develop a culture of 'measuring the things that matter' in such a way that the Board can be confident about the messages it receives about quality, and therefore recognise, credit and celebrate improvement.	

Part 4 – Quality outcomes aspirations

4.1 What implementation of this strategy will mean

This strategy reflects the commitment of the Board to improving quality. Implementing the strategy will be challenging and will require the engagement of all staff from 'ward to board' – everyone will need to be involved. But if we succeed, this is what it will mean:

Delivering quality services for patients – enhancing our reputation

- The patient's experience will be integral to the Trust's approach to Quality
- A commitment to ensuring that patients receive the right treatment, at the right time, in the right place
- Transparent and open communication of information about quality of care
- All patients will :
    - be treated as individuals
    - be involved in their own care
    - be treated with respect and dignity
    - be kept fully informed
    - have their individual needs taken into account
    - have their concerns addressed
    - be treated/cared for in a safe environment, and taking into account best practice

Turning values into staff behaviours

- All staff will work in a safe environment
- When things go well, information will be shared so others can learn from it.
- When things have not gone well, the focus will be on learning lessons and improving quality for the future

A commitment to change for the Trust and its partner organisations

- Quality will be at the heart of planning and performance management, with quality related objectives in every business plan, each year.

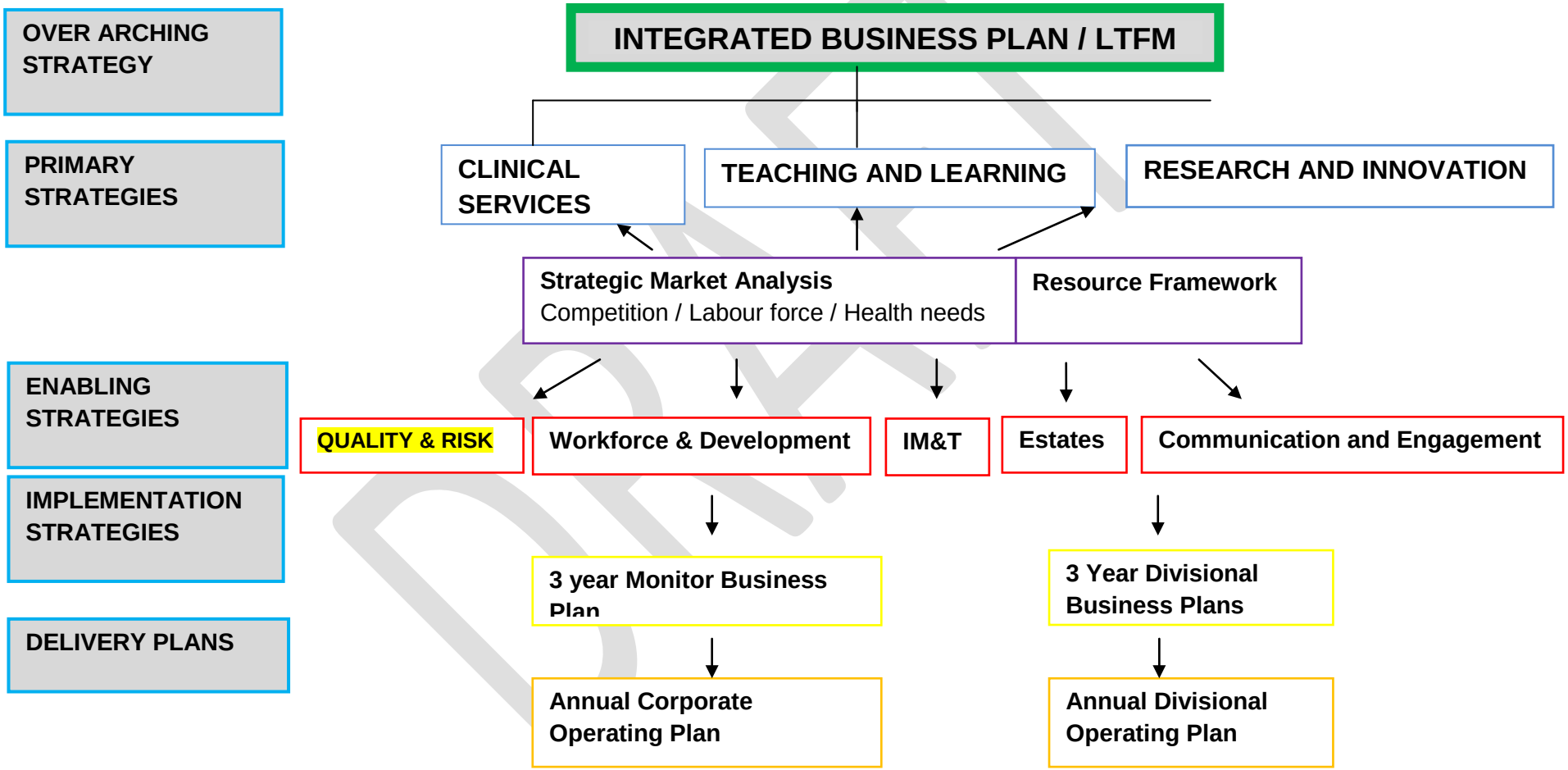
4.2 Monitoring and measuring success

Implementation of this strategy, and the achievement of corporate objectives for quality, will be closely allied to the Trust's Transformation agenda and monitored by the Quality and Outcomes Committee of the Board, the Executive-led Clinical Quality Group, and by Divisions. Measurable in-year milestones will be agreed as part of this process.

Whilst there are many specific goals set out in this strategy, the ultimately test of 'success' will be when every patient who has been in our care can tell a story of how our clinical interventions have made a difference to their health and quality of life, and how they have been treated as an individual, with respect and with compassion.

Appendix

University Hospitals Bristol NHS Foundation Trust – Strategy overview



University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Trust Board Meeting, to be held on 28 June 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Report of the Finance Director – Item 9a
Purpose
To report to the Board on the Trust's financial position and on related financial matters that require the Board's attention.
Abstract
The summary financial statement reports an income and expenditure surplus of £0.180m for the first two months of 2011/12. The report shows that the Trust's financial position is in line with the forecast given in the Annual Plan. However, there is concern about the delivery of cash releasing efficiency savings to date and for the year as a whole.
Recommendations
To **note** the financial position at 31May 2011.
Executive Report Sponsor or Other Author
Sponsor – Paul Mapson, Finance Director. Author – Paul Tanner, Head of Finance.
Appendices
• Appendix 1 – Summary Income and Expenditure Statement • Appendix 2 – Divisional Income and Expenditure Statement • Appendix 3 – Analysis of pay expenditure • Appendix 4 – Executive Summary • Appendix 5 – Financial Risk Matrix • Appendix 6 – Financial Risk Ratings

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	16 June 2011		21 June 2011		

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £0.180m for the first two months of 2011/12. This is in line with the proportion of the forecast made in the recent Annual Plan submission to Monitor i.e. a surplus of £0.258m for the June quarter.

The key issues for this month's report are as follows:

- Central reserves in excess of £39.4m have been allocated to management budgets across the Trust. Further details are given in section 2 below.

- Activity and income for March 2011 has now been assessed as being higher than that previously forecast and included in the Trust's 2010/11 Accounts. The benefit this 'over performance' has been reflected in the reported position to 31 May. The net gain for Divisional services is £0.61m with a further £0.2m being credited to the Trust's Strategic Reserves in line with established practice.

- Progress against the Cash Releasing Efficiency Savings programme is a cause for concern. The May report reflects an adverse variance of £1.83m on the CRES programme. Actual savings of £2.118m represents slippage in excess of £1m when compared with planned savings for the first two months of £3.151m. However planned savings assume a pick up in the rate of savings to be achieved over the later part of the year. To counter the risk that the CRES programme poses in having a disproportionate volume of savings phased in this way the CRES target to date has been reprofiled to reflect the position based on savings targets being phased evenly over the year. The effect of this adjustment is to bring into account a further £0.806m of non achieved CRES in the May report. This will require careful monitoring throughout the year. The delivery of actual savings against the CRES programme will allow for the unwinding of this phasing adjustment as we progress through the year.

- The Trust has operated within the SLA (national trajectory) ceiling for the number of cases of C Difficile (maximum of 64 for the year). The threshold for financial penalties applies when the number of cases is two or more greater than last year's outturn of 94 i.e. a fine would be incurred for the 96th and c9 subsequent cases to a maximum payable of £3m. No fine is payable on performance to 31 May.

- The Trust has an opportunity to earn additional non recurring income for the delivery of CQUINs targets. At this stage no income has been assumed to accrue to the Trust.

2. The main Budget changes in May include the following:-

	£'000
NICE funding to Divisions	20,405
Contracts transfer (funding Trust budgets to meet cost of delivering planned changes in activity agreed under 2011/12 SLAs).	12,123
Operating Plan Support – non recurring funding to Surgery, Head and Neck (£2m); Specialised Services (£0.75m) and Women's & Children's (£0.5m)	3,250
Pay Award funding	975
Avon Breast Screening Unit	776
Additional Incremental Drift funding	550
Internal Cost pressures funding	546
Changes in Employers National Insurance costs	435
Acute Physicians	250
Newborn Screening	111

3. Income

Activity was lower than plan in April, leading to an underperformance of £0.18m. A significant item to note within this value is that PbR excluded drugs and devices / NICE treatments were £0.64m lower than plan. In addition, the Trust has had to absorb the adverse impact of the emergency marginal tariff reduction of £0.37m. Other SLA Contract Penalties / Fines / Rewards total £0.01m.

A more detailed report will be presented to the Finance Committee (agenda item 5.2) at the June meeting.

4. Expenditure

In total, Clinical Divisions are shown as overspent by £1.249m for the two month period to 31st May. The position for each Division is summarised below:

Clinical Division	Variance to 31st May Favourable / (Adverse)	Memorandum CRES Variance to 31st May
	£'000	£'000
Diagnostic and Therapies	(102)	(216)
Medicine	(152)	(171)
Specialised Services	(553)	(419)
Surgery, Head and Neck	(59)	(551)
Women's and Children's	(383)	(257)
Totals	**(1,249)**	**(1,614)**

It can be seen from the above that the adverse variance on the CRES programme is the major factor for three of the clinical divisions. Specialised Services, has similar challenges in achieving its CRES programme and, in addition, the delivery of planned activity for cardiac services. The Women's and Children's Division position reflects non achievement of CRES, staffing levels higher than funded establishments and some 'one-off' items of expenditure.

There are similar issues which require resolution for Facilities and Estates and Trust HQ Services.

A more detailed report will be presented to the Finance Committee (agenda item 5.3) at the June meeting.

5. Financial Risk Rating

The Trust's overall financial risk rating, based on results to 31 May is 3. The actual value for each of the 5 metrics is given in the table below together with the bandings for each metric.

Metric	31st May 2011 Metric Result	Metric Score	Weighted Average Score	Weighting %	Rating categories 5	4	3	2	1
EBITDA									
Margin	6.0%	3	0.75	25	11	9	**5**	1	<1
Plan achieved	101%	5	0.50	10	**100**	85	70	50	<50
Return on Capital Employed	3.3%	3	0.60	20	6	5	**3**	-2	<-2
I&E surplus margin	0.38%	2	0.40	20	3	**2**	1	**-2**	<-2
Liquidity ratio (days)	38.9	4	1.00	25	60	**25**	15	10	<10
			3.25						

Overall Financial Risk Rating	**3**

The Trust is operating well within the 4 metrics specified in the Prudential Borrowing Limit.

6. Capital Programme

A summary of actual income and expenditure for the two months to 31st May is given in the table below.

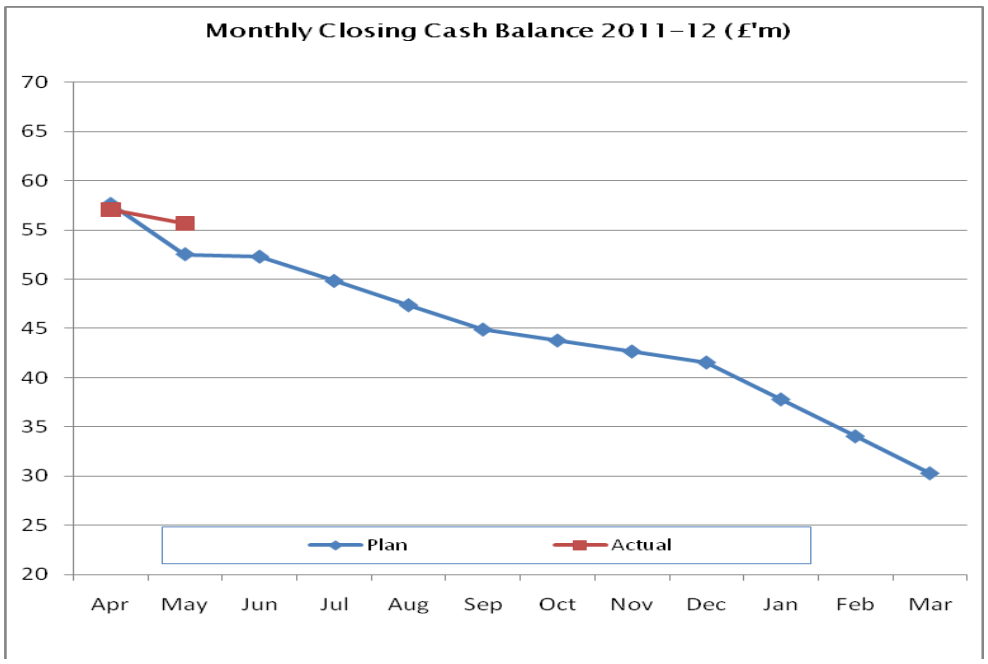
Plan for Year		**2 Months Ended 31st May 2011**		
		Plan	**Actual**	**Variance**
£'000		£'000	£'000	£'000
	Sources of Funding			
1.3	Donations	-	-	-
16.8	Retained Depreciation	2.8	2.8	0.1
1.5	Sale of Property	0.1	0.1	-
24.4	Cash balances	1.3	1.2	-
44.0	**Total Funding**	**4.2**	**4.1**	**0.1**
	Expenditure			
(20.0)	Strategic Schemes	(2.3)	(2.3)	-
(6.1)	Medical Equipment	(0.1)	(0.1)	-
(4.9)	Information Technology	(0.1)	(0.1)	-
(2.7)	Roll Over Schemes	(0.1)	(0.1)	-
(4.6)	Refurbishments	(0.9)	(0.7)	0.2
(10.3)	Operational / Other	(0.7)	(0.8)	(0.1)
4.6	Anticipated Slippage	-	-	-
44.0	**Total Expenditure**	**(4.2)**	**(4.1)**	**0.1**

Planned expenditure for the year is £44.015m. This includes slippage on schemes carried over from 2010/11. A recent review indicates that capital expenditure for the year will be higher than planned, by up to £3.7m. This reflects better than previously advised progress on the BRI Redevelopment and Centralisation of Paediatrics schemes i.e. slippage is much lower than assumed and is a cash flow timing issue rather than one of scheme overspending. The projected expenditure on these schemes will be reviewed following the formal signing of contracts (c September 2011).

7. Statement of Financial Position (Balance Sheet) and Cashflow

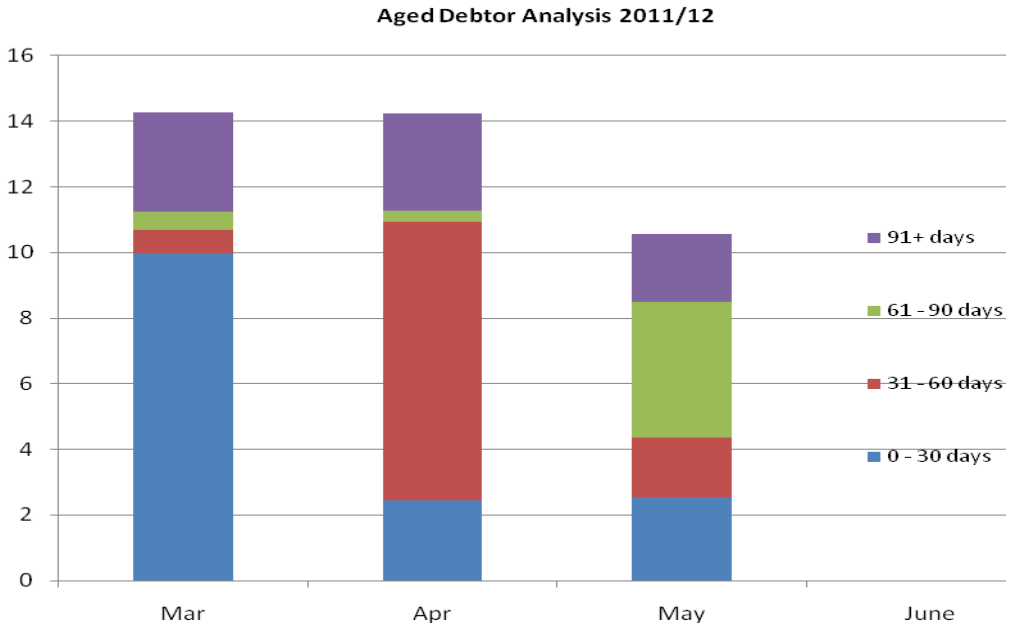
Cash

The Trust held a cash balance of £55.667m as at 31st May. This represents a decrease of £1.424m in the month. The cash position is marginally ahead of the forecast used in the Annual Plan. The graph, shown below, sets out the current assessment on the cash balance to March 2012.



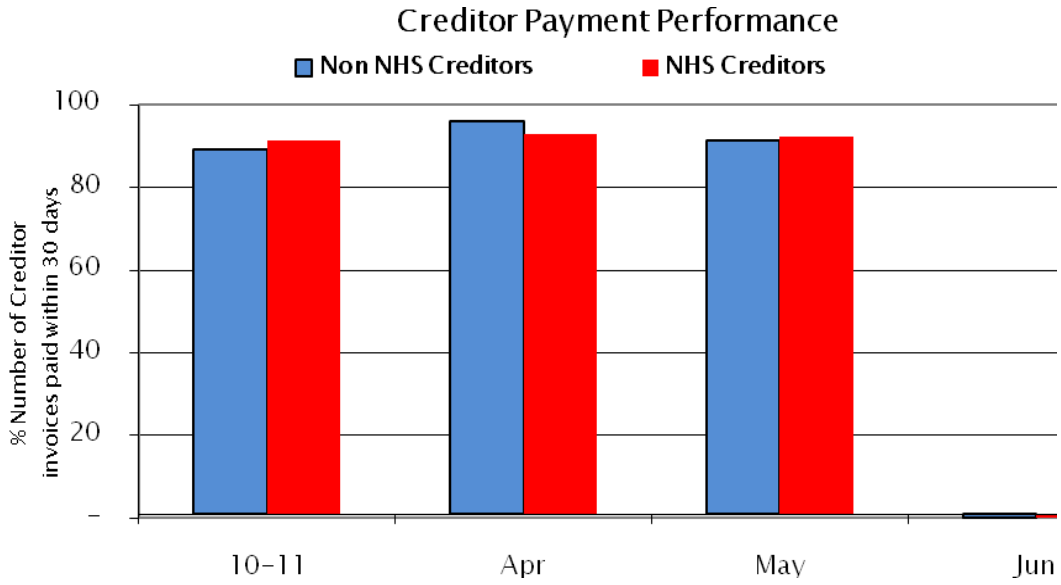
Debtors

The total value of invoiced debtors has decreased by £3.662m during May to a closing balance of £10.575m. The amount owing is equivalent to 9.7 debtor days.



Creditor Payments

The Trust aims to pay at least 90% of undisputed invoices within 30 days. In May, the Trust achieved 92% and 91% compliance against the Better Payment Practice Code for NHS and Non NHS creditors.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Monthly analysis of pay expenditure 2011/12
Appendix 4 – Executive Summary
Appendix 5 – Financial Risk Matrix
Appendix 6 – Financial Risk Rating

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report May 2011 – Summary Income & Expenditure Statement

Approved Budget / Plan 2011/12	Heading		Position as at 31st May Plan	Actual	Variance Fav / (Adv)	Actual to 30th April
£'000			£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)					
395,367	From Activities		62,785	62,700	(85)	33,881
99,818	Other Operating Income		16,496	16,704	208	8,843
495,185	Sub totals income		**79,281**	**79,404**	**123**	**42,724**
	Expenditure					
(295,256)	Staffing		(49,779)	(51,005)	(1,226)	(26,038)
(145,020)	Supplies and services		(23,537)	(23,610)	(73)	(13,894)
(440,276)	Sub totals expenditure		**(73,316)**	**(74,615)**	**(1,299)**	**(39,932)**
(21,298)	**Reserves**	Reserves	(1,162)	–	1,162	–
(21,298)		Sub Total Reserves	**(1,162)**	–	1,162	–
33,610	**EBITDA**		**4,803**	**4,789**	**(14)**	**2,792**
6.79	**EBITDA Margin – %**			**6.03**		**6.53**
–	Profit / loss on asset disposals		–	–	–	–
(122)	Fixed asset impairments		(122)	(122)	–	(61)
(18,565)	Depreciation & Amortisation		(3,023)	(3,023)	0	(1,569)
173	Interest Receivable		29	48	19	14
(428)	Interest payable on loans & leases		(71)	(68)	3	(34)
(8,662)	PDC Dividend		(1,444)	(1,444)	–	(722)
6,006	**NET SURPLUS / (DEFICIT)**		**172**	**180**	**8**	**420**
1.21	**Net margin – %**			**0.23**		**0.98**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report May 2011 – Divisional Income & Expenditure Statement

Approved Budget / Plan 2011/12	Division	Total Net Expenditure / Income to Date	Position as at 31st May [Favourable / (Adverse)] Pay	Non Pay	Operating Income	Income from Activities	Total Variance to date	Memorandum CRES Variance to Date	Cumulative Variance to 30th April
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements								
389,699	Service Agreements	62,200	–	–	(50)	51	1	–	–
–	Overheads	246	–	–	–	246	246	–	–
39,827	NHSE Income	6,638	–	–	–	–	–	–	(6)
429,526	**Sub Total Service Agreements**	**69,084**	**–**	**–**	**(50)**	**297**	**247**	**–**	**(6)**
	Clinical Divisions								
(40,872)	Diagnostic & Therapies	(6,890)	(78)	(95)	(102)	173	(102)	(216)	(2)
(54,198)	Medicine	(9,593)	(90)	49	23	(134)	(152)	(171)	(124)
(65,517)	Specialised Services	(10,829)	(153)	63	(3)	(460)	(553)	(419)	(255)
(83,805)	Surgery Head & Neck	(14,083)	(279)	(127)	54	293	(59)	(551)	(419)
(81,158)	Women's & Children's	(14,371)	(232)	102	(21)	(232)	(383)	(257)	(193)
(325,550)	**Sub Totals (1)**	**(55,766)**	**(832)**	**(8)**	**(49)**	**(360)**	**(1,249)**	**(1,614)**	**(993)**
	Corporate Services								
98	Analytical Review	98	–	–	–	–	–	–	133
(649)	Trust Wide Accruals	(649)	–	–	–	–	–	–	–
(1,799)	Central Services	(338)	(18)	(24)	–	–	(42)	(21)	(22)
(56)	Community	(4)	–	5	–	–	5	(1)	3
(6,139)	Trust HQ	(1,089)	14	(100)	22	–	(64)	(15)	(7)
(5,175)	Human Resources	(861)	17	(76)	60	–	1	2	1
(4,845)	Information Technology	(872)	24	(7)	(16)	–	1	(3)	–
(5,037)	Finance	(817)	28	–	(15)	–	13	(14)	(1)
(25,062)	Facilities & Estates	(3,896)	(1)	(70)	(7)	8	(70)	(97)	(31)
(9,702)	Misc Support Services	(1,435)	(27)	46	5	(30)	(6)	(67)	(20)
7,625	Research and Development	976	(247)	226	30	–	9	–	4
(25,991)	Capital Charges	(4,251)	–	–	–	–	–	–	–
(76,732)	**Sub Totals (2)**	**(13,138)**	**(210)**	**0**	**79**	**(22)**	**(153)**	**(216)**	**60**
(402,282)	**Sub Totals (1) and (2)**	**(68,904)**	**(1,042)**	**(8)**	**30**	**(382)**	**(1,402)**	**(1,830)**	**(933)**
–	**Skills for Health**	–	(184)	(43)	228	–	1	–	–
(402,282)	**Totals I & E**	**(68,904)**	**(1,226)**	**(51)**	**258**	**(382)**	**(1,401)**	**(1,830)**	**(933)**
	Reserves								
(21,238)	General	–	–	1,162	–	–	1,162	–	859
(21,238)	**Sub Total Reserves**	**–**	**–**	**1,162**	**–**	**–**	**1,162**	**–**	**859**
6,006	**TRUST TOTALS**	**180**	**(1,226)**	**1,111**	**208**	**(85)**	**8**	**(1,830)**	**(80)**

Appendix 3

Analysis of Pay Expenditure 2009/10, 2010/11 and 2011/12

Division		2009/10 Actual £'000	Quarter 1 £'000	Quarter 2 £'000	Quarter 3 £'000	Quarter 4 £'000	Totals 2010/11 to date £'000	2011/12 April £'000	2011/12 May £'000	Totals 2011/12 to date £'000	2009/10 Monthly Average £'000	2010/11 Monthly Average £'000
Women's and Children's	Pay budget	62,853	16,278	16,297	16,491	16,825	65,891	5,560	5,526	11,086	5,238	5,491
	Bank	1,946	466	518	546	546	2,076	119	165	284	162	173
	Agency	370	112	246	109	187	654	39	88	127	31	55
	Waiting List initiative	502	103	73	63	68	307	26	25	51	42	26
	Overtime	90	19	29	25	18	91	4	5	9	8	8
	Other pay	61,039	15,583	15,388	15,806	16,018	62,795	5,401	5,447	10,848	5,087	5,233
	Total Pay expenditure	63,947	16,283	16,254	16,549	16,837	65,923	5,589	5,730	11,319	5,329	5,494
	Variance Fav / (Adverse)	(1,094)	(5)	43	(58)	(12)	(32)	(29)	(204)	(233)	(91)	(3)
Medicine	Pay budget	40,756	10,529	10,273	10,381	10,562	41,745	3,391	3,635	7,026	3,396	3,479
	Bank	3,763	886	833	850	865	3,434	220	260	480	314	286
	Agency	521	156	127	97	179	559	30	62	92	43	47
	Waiting List initiative	361	65	115	94	41	315	9	10	19	30	26
	Overtime	48	21	13	20	15	69	4	6	10	4	6
	Other pay	37,314	9,655	9,602	9,792	9,834	38,883	3,262	3,253	6,515	3,110	3,240
	Total Pay expenditure	42,007	10,783	10,690	10,853	10,934	43,260	3,525	3,591	7,116	3,501	3,605
	Variance Fav / (Adverse)	(1,251)	(254)	(417)	(472)	(372)	(1,515)	(134)	44	(90)	(104)	(126)
Surgery Head and Neck	Pay budget	62,265	16,318	16,563	16,447	16,820	66,148	5,541	5,245	10,786	5,189	5,512
	Bank	2,592	532	521	544	503	2,100	119	127	246	216	175
	Agency	1,730	250	324	282	350	1,206	41	69	110	144	101
	Waiting List initiative	2,158	250	412	264	283	1,209	98	127	225	180	101
	Overtime	276	43	46	35	28	152	7	7	14	23	13
	Other pay	58,271	15,137	15,021	15,186	15,727	61,071	5,143	5,327	10,470	4,856	5,089
	Total Pay expenditure	65,027	16,212	16,324	16,311	16,891	65,738	5,408	5,657	11,065	5,419	5,478
	Variance Fav / (Adverse)	(2,762)	106	239	136	(71)	410	133	(412)	(279)	(230)	34
Specialised Services	Pay budget	32,323	8,577	8,137	8,450	8,626	33,790	2,669	3,066	5,735	2,694	2,816
	Bank	1,025	251	305	288	205	1,049	61	74	135	85	87
	Agency	363	13	47	135	459	654	(69)	230	161	30	55
	Waiting List initiative	587	146	98	168	125	537	51	42	93	49	45
	Overtime	119	5	3	7	5	20	2	0	2	10	2
	Other pay	30,949	8,134	7,818	8,083	8,255	32,290	2,684	2,813	5,497	2,579	2,691
	Total Pay expenditure	33,043	8,549	8,271	8,681	9,049	34,550	2,729	3,159	5,888	2,754	2,879
	Variance Fav / (Adverse)	(720)	28	(134)	(231)	(423)	(760)	(60)	(93)	(153)	(60)	(63)

Analysis of Pay Expenditure 2009/10, 2010/11 and 2011/12

Division		2009/10 Actual £'000	Quarter 1 £'000	Quarter 2 £'000	Quarter 3 £'000	Quarter 4 £'000	Totals 2010/11 to date £'000	2011/12 April £'000	2011/12 May £'000	Totals 2011/12 to date £'000	2009/10 Monthly Average £'000	2010/11 Monthly Average £'000
Diagnostic & Therapies	Pay budget	35,327	9,136	9,291	9,276	9,226	36,929	3,045	2,998	6,043	2,944	3,077
	Bank	537	123	141	136	144	544	46	50	96	45	45
	Agency	692	96	118	92	83	389	24	32	56	58	32
	Waiting List initiative	131	35	46	43	32	156	14	15	29	11	13
	Overtime	169	69	66	70	59	264	22	20	42	14	22
	Other pay	33,437	8,775	8,938	8,922	8,880	35,515	2,937	2,961	5,898	2,786	2,960
	Total Pay expenditure	34,966	9,098	9,309	9,263	9,198	36,868	3,043	3,078	6,121	2,914	3,072
	Variance Fav / (Adverse)	361	38	(18)	13	28	61	2	(80)	(78)	30	5
Facilities & Estates	Pay budget	17,714	4,545	4,672	4,693	4,796	18,706	1,398	1,532	2,930	1,476	1,559
	Bank	572	116	136	114	117	483	29	29	58	48	40
	Agency	1,295	293	316	352	339	1,300	128	105	233	108	108
	Waiting List initiative	19	3	1	2	1	7	1	1	2	2	1
	Overtime	1,187	291	303	267	299	1,160	79	95	174	99	97
	Other pay	14,934	3,823	3,820	3,944	4,004	15,591	1,164	1,300	2,464	1,245	1,299
	Total Pay expenditure	18,007	4,526	4,576	4,679	4,760	18,541	1,401	1,530	2,931	1,501	1,545
	Variance Fav / (Adverse)	(293)	19	96	14	36	165	(3)	2	(1)	(24)	14
Trust Services	Pay budget	26,181	6,651	6,694	7,052	6,366	26,763	4,191	472	4,663	2,182	2,230
	Bank	619	139	184	303	(17)	609	54	34	88	52	51
	Agency	196	63	49	36	61	209	13	(4)	9	16	17
	Waiting List initiative	3	5	1	0	1	7	1	1	2	0	1
	Overtime	88	33	24	24	27	108	8	6	14	7	9
	Other pay	25,114	6,511	6,555	6,637	6,384	26,087	4,244	514	4,758	2,093	2,174
	Total Pay expenditure	26,020	6,751	6,813	7,000	6,456	27,020	4,320	551	4,871	2,168	2,252
	Variance Fav / (Adverse)	161	(100)	(119)	52	(90)	(257)	(129)	(79)	(208)	13	(21)
Trust Total (excl Skills for Health)	Pay budget	277,419	72,034	71,927	72,790	73,221	289,972	25,795	22,474	48,269	23,118	24,164
	Bank	11,054	2,513	2,638	2,781	2,363	10,295	648	739	1,387	921	858
	Agency	5,167	983	1,227	1,103	1,658	4,971	206	582	788	431	414
	Waiting List initiative	3,761	607	746	634	551	2,538	200	221	421	313	212
	Overtime	1,977	481	484	448	451	1,864	126	139	265	165	155
	Other pay	261,058	67,618	67,142	68,209	69,102	272,071	24,835	21,615	46,450	21,755	22,686
	Total Pay expenditure	283,017	72,202	72,237	73,336	74,125	291,900	26,015	23,296	49,311	23,585	24,325
	Variance Fav / (Adverse)	(5,598)	(168)	(310)	(546)	(904)	(1,928)	(220)	(822)	(1,042)	(466)	(161)

NOTE: Other Pay includes all employer's oncosts.

University Hospitals Bristol NHS
NHS Foundation Trust

Appendix 4

Key Issue	RAG	Executive Summary	Table
Service Level Agreement Income and Activity	G	For the year to date contract income was £0.25m higher than plan, of which £0.81m relates to 2010/11. The reported position includes the impact of the emergency marginal tariff reduction which is valued at £0.37m. A&E Attendances at 10,303 are 1,127 higher than planned. The average number of daily attendances is 343. Emergency activity at 3,267 is 4.7% or 148 spells higher than planned. Non Elective activity at 1,335 is 5.6% or 71 spells higher than planned. Day case activity at 3,738 is 11.2% or 376 spells higher than planned. Elective activity at 1,083 is 0.3% or 4 spells lower than planned. New Outpatients activity at 9,598 is 1.3% or 127 attendances lower than planned. Follow up Outpatient activity at 23,108 is 0.9% or 198 attendances higher than planned. Outpatient Procedure activity at 1,739 is 5% or 91 attendances lower than planned. An income analysis by commissioner is shown at Table INC 2. Information on clinical activity by Division, specialty and patient type is provided in table INC 3.	INC 1
Income and Expenditure	G	The reported surplus for the first two months of 2011/12 is £0.180m. The EBITDA surplus of £4.789m equates to 101% of the Annual Plan target for the period. Total income to date £79,404m is £0.123m greater than planned..This includes £0.810m of residual over performance relating to 2010/11. The net underperformance against the 2011/12 contracts relates mainly to lower than planned activity on NICE and PbR exclusions where underperformance is offset by correspondingly lower costs. Expenditure at £74.615m is higher than planned by £1.299m, reflecting slippage to date on CRES plans. Financing costs are lower than plan by £21k.	I&E 1 I&E 2 I&E 3a I&E 3b
Cash Releasing Efficiency Savings	R	The 2011/12 CRES programme totals £16.854m. Actual savings achieved for April and May total £2.118m compared with a target for the period of £3.151m, a shortfall of £1.033m. The carried forward CRES total from 2010/11 totals £9.782m with actual CRES achievement to date of £1.005m being £159k less than Plan.	I&E 4a – 4b

Statement of Financial Position & Treasury Management	G	The cash balance on 31 May was £55.7m. The Trust remains on target to have cash balance at March 2012 of £30.3m in line with the Annual Plan. The balance on Invoiced Debtors has decreased by £3.7m in the month to £10.575m. The invoiced debtor balance equates to 9.7 debtor days. Creditors and accrual account balances total £60.93m although £10.8m relates to deferred income. Invoiced Creditors - payment performance for the year for Non NHS invoices and NHS invoices within 30 days was 91% and 92% respectively.	BS 1 BS 2 BS 3 BS 4 BS 5
Capital	G	Expenditure for the first two months of 2011/12 totals £4.053m - this is marginally less than profiled for the period. A recent review indicates that capital expenditure for the year will be higher than planned by up to £3.7m. This reflects better than previously assumed progress on the BRI Redevelopment and Centralisation of Paediatrics schemes i.e. slippage is much lower than advised and is a cash flow timing issue rather than one of scheme overspending. The projected expenditure on these schemes will be reviewed following the formal signing of contracts (c September 2011).	Capital 1 Capital 2 Capital 3
Financial Risk Rating	G	The Trust's overall financial risk rating using the results for the two months to 31 May 2011 has been calculated to be 3 (actual score 3.25). The Trust's ratings under the Prudential Borrowing Code are satisfactory with all ratios well within the Monitor thresholds.	
Private Patient Cap	G	Private patient income for the period is £0.276m or 0.44% of total patient related income. This is well below the Trust's Private Patient Cap of 1.1%.	

Appendix 5

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report May 2011 - Risk Matrix

Corporate Risk Register Ref.	Description of Risk	Risk if no action taken		Action to be taken to mitigate risk	Lead	Residual Risk		Progress / Completion
		Risk Score	Financial Value			Risk Score	Financial Value	
			£'m				£'m	
741	CRES Targets	High	10.0	Programme Steering Group established. Monthly Divisional reviews to ensure targets are met. Benefits tracked and all schemes risk assessed.	JO'C	Medium	4.0	Monthly reviews. Non recurring action if necessary.
1240	SLA Performance Fines	Medium	3.0	Infection Control plan implemented. Regular review of performance.	DL	Low	1.0	
	PCT Income challenges	Medium	4.0	Maintain reviews of data, minmise risk of bad debts	PM	Medium	2.0	Position being managed.
1623	Risk to UH Bristol of fraudulent activity.	Medium	-	Local Counter Fraud Service in place. Pro active counter fraud work. Reports to Audit Committee.	PM	Medium	-	
1082	Cost pressures - unforseen cost pressures greater than provision in Annual Plan	Medium	-	Monthly monitoring of financial performance. Divisional reviews by Executive Directors.	JO'C	Medium	-	
962	Delivery of Trust's Financial Strategy in changing national economic climate.	Medium	-	Long term financial model and in year monitoring of financial performance by Finance Committee and Trust Board.	PM	Medium	-	
1418	Breach of Private Patient Income Cap	Low	-	Monitoring and reporting to Finance Committee.	PM	Low	-	

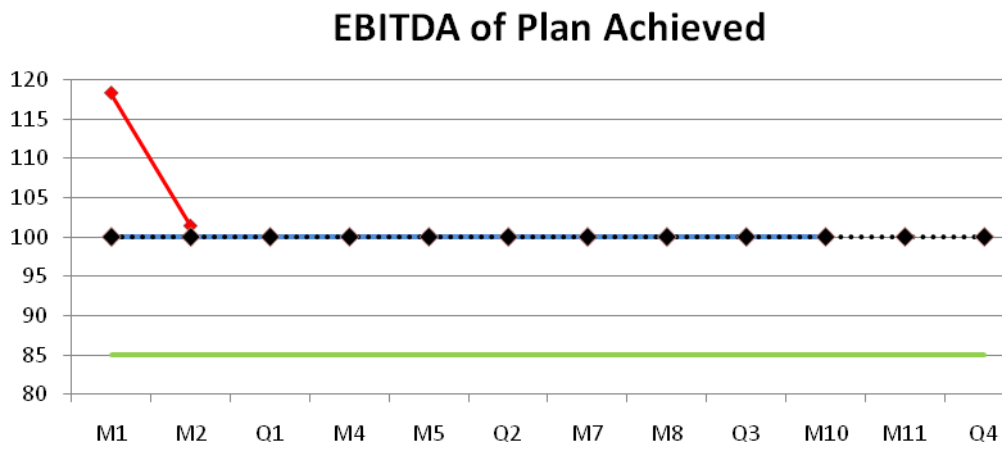
Financial Risk Ratings – May 2011 Performance

1. Financial Risk Rating

The Financial Risk Ratings provided in this month's report are based on Annual Plan forecasts for 2011/12.

The Compliance Framework 2011/12 has seen the introduction of a new metric 'Return on Capital Employed'. This replaces the 'Return on Assets' metric. The weighting of this item in the overall calculation of the financial risk rating is unchanged at 20%.

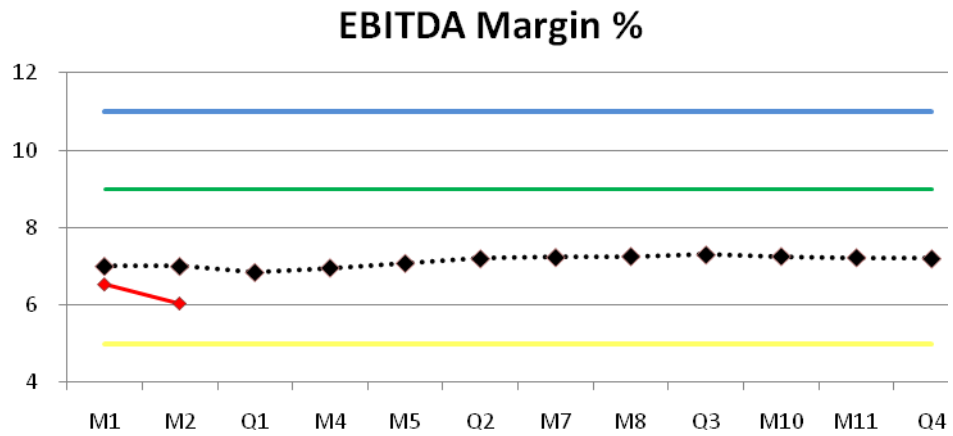
The following graphs will show performance against the 5 Financial Risk Rating metrics. The 2011/12 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for FRR 5 (blue line); FRR 4 (green line) and FRR 3 (yellow line). A comment for May performance is given beside each graph.

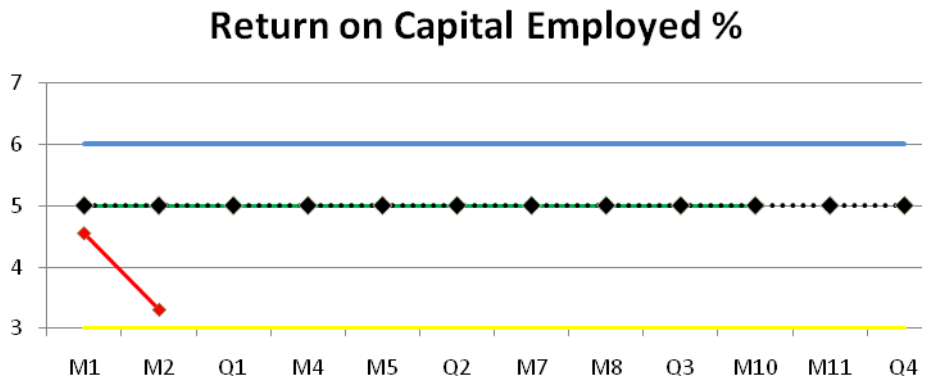


An EBITDA of £4.789m was achieved. This is in line with the plan to date of £4.722m.

EBITDA Achievement of 101% of Plan earns a metric score of 5.

The EBITDA Margin of 6.03% for May achieves a metric score of 3.

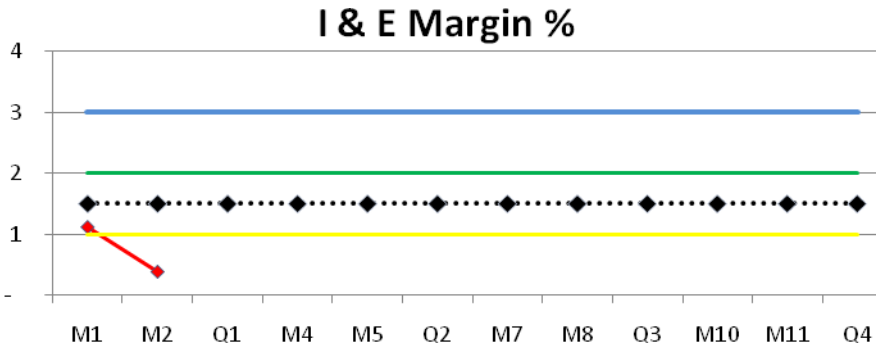


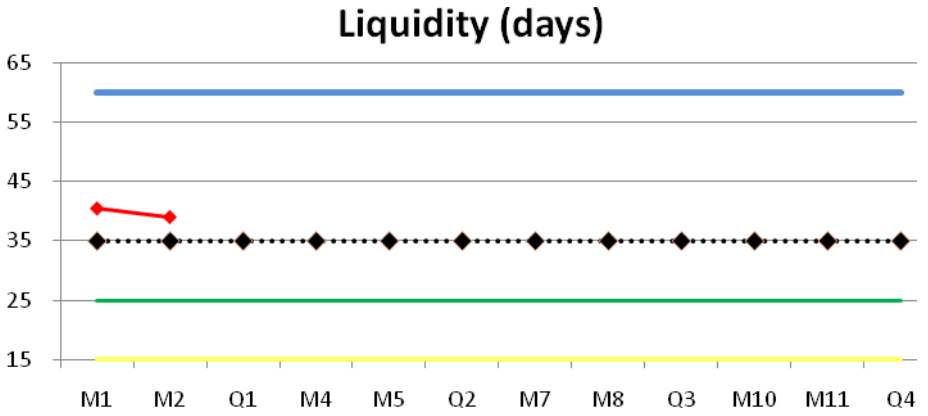


The Return on Capital Employed for the 2 months to 31st May is 3.3% and earns a metric score of 3.

2011/12 Annual Plan Income & Expenditure surplus margin is 0.2% for the first quarter.

The Income & Expenditure surplus margin for the 2 months to May is 0.38%, a metric score of 2.





2011/12 Annual Plan liquidity ratio is 38.7 days at Quarter 1.

The actual liquidity ratio for May is 38.9 days and above the band 4 minimum of 25 days.

The Trust's Financial Risk Rating is calculated by using a weighted average score to determine the overall rating. The weighted average score is 3.25. The Trust has therefore achieved a Financial Risk Rating of 3 for the two months to 31st May 2011.

2. Prudential Borrowing Limit

A summary of the Trust's performance for May 2011 is given in the table below.

Prudential Borrowing Limit Performance	Monitor Ratio Tier 1	31st May 2011
Minimum Dividend Cover	>1x	3.3x
Minimum Interest Cover	>3x	71x
Minimum Debt Service Cover	>2x	50x
Maximum Debt Service to Revenue	<2.5%	0.1%

It can be seen that Trust performance against all of these ratios is very good.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Trust Board Meeting, to be held on 28 June 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Communications Plan Summary Report – Item 10
Purpose
To brief the Board on the strategic communications plan for the Trust.
Abstract
The paper outlines the role and function of the communications team; the paper has been informed by a review of current research, within and outside the NHS and a review of the outcomes of the Loud & Clear research and details a future communications strategy for the Trust.
Recommendations
The Board is recommended to **note** the report.
Executive Report Sponsor or Other Author
Sponsor – Chief Executive, Author, Head of Communication.
Appendices
• Appendix A – A framework for describing communicating organisations: Prof A Gregory, Leeds Metropolitan University/Department of Health.

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
On-going	15 June 2011				

University Hospitals Bristol NHS
NHS Foundation Trust

Communications within University Hospitals Bristol NHS Foundation Trust
A strategic way forward

June 2011
Sarah Pinch
Head of Communications

With input from Fiona Reid, Head of External Relations and Steph Phillips, Communications Manager

1. Introduction

This paper provides an overview of the corporate communications function at University Hospitals Bristol NHS Foundation Trust (UH Bristol). It outlines the development and programmes of communications methods, tactics and progress against the objectives set out in the 2009 communications strategy.

The paper looks at the communications landscape for UH Bristol going forward, draws on research and best practice (internal and external to the organisation) and outlines the communications objectives and plans for the next twelve months.

It is recommended that monthly reports be reviewed by the Trust Management Executive Group and the board, with a detailed report presented into private board sessions on a quarterly basis.

2. The communications department

The Trust's communications department is responsible for the corporate communications function within the organisation and for providing advice and support to teams, divisions and individuals who request it.

By recruiting individuals to the team, since 2009, with a variety of communications backgrounds and a professional approach to their own development and knowledge, the Trust has a team that can deliver the appropriate and necessary level of communication output and support to every level of the organisation.

The team is headed up by a head of communications, who is supported by a head of external relations, press officer and assistant press officer; alongside a communications manager, web assistant, publications officer and communications project co-ordinator. The print manager is part of the communications team, managing the review of printing across the Trust, to support CRES plans and the management of the print room and THQ reception.

The communications team must continue work in such a way that ensures adequate support for the key organisational objectives and subsequent projects and work streams in the future, as detailed in section five.

The head of communications works closely with the chief executive, executive directors and the board; and is a member of the Trust Management Executive and attends all board meetings. The head of external relations or communications manager attend the Service

Delivery Group and the team sit on a variety of other groups and committees to ensure that communications issues are appropriately discussed and supported.

The head of communications is an active member of the Chartered Institute of Public Relations and as regional chair ensures that the team is up to date with developments in communications and marketing as well as maintaining a strong network across the NHS and outside of it. She has just been shortlisted for the inaugural CIPR and IOD Communications Director of the Year prize.

It is important to stress that every manager has responsibility to communicate to their staff, to ensure the Trust's values are upheld and that every patient, visitor or colleague is communicated with respect and in an appropriate way.

The communications department is hugely grateful to the Bristol Royal Infirmary League of Friends, Above & Beyond and the Grand Appeal for their ongoing support for communications projects, including the launch of the Trust's new values, the BEH 200th anniversary celebrations, the BRCH 10th anniversary birthday, the redevelopment of the Trust's website and staff reward and recognition programmes.

3. Research

In 2009 the Department of Health commissioned and subsequently published 'The Communicating Organisation', a research led guide for NHS organisations to establish excellence in communications practice.

Within the guide, Professor Anne Gregory outlined in 'What Good Looks Like: An evidence base (2009), Centre for Public Relations Studies, Leeds Met University' the following four key attributes for an organisation to effectively communicate:

- An excellent understanding of the brand
- Excellence in planning, managing and evaluating communications
- Leadership support for communication
- Communication as a core competency.

Prof Gregory goes on to encourage NHS organisations to apply the four attributes across four perspectives:

- Societal: how the NHS is perceived as a whole at national and local levels,
- Corporate: how communication operates within each organisation at the level of strategy setting,
- Service user and stakeholder: an understanding of how patients and the public experience the NHS locally,
- Functional: the way in which communication strategies and programmes are put into operation.

When these four attributes are mapped across a simple framework it provides a description of excellent communication. This can be seen in appendix 1.

This framework, along with KPIs associated with each work stream plan (as detailed in section six) will be used to measure the success and progress of the communications team's work.

Also in 2009, UH Bristol undertook its own research into communications and staff engagement across the Trust, through the Loud & Clear quantitative and qualitative research. This has been completed again between February and April 2011 and has provided useful insight into progress and clarity on the future priorities for communications within the organisation and the focus for the communications team.

In developing this plan, detailed analysis has been undertaken of the changing local and regional media landscape, as well as seeking insight into the national picture.

4. Introduction to strategic way forward

All communications activity will be underpinned by the Trust's commitment to be:

- Trustworthy
- Reliable
- Honest
- Fair
- Not to 'spin' or 'polish' the truth

The communications team will build on the successes of the last two years and seek to address future challenges through different ways of working. The team will establish a strategic approach to the communication of messages to staff. This approach will ensure that there is effective communication of key Trust messages and engagement all audiences, through the Trust values, in their role to deliver compassionate care through excellence.

Externally, the team will look to ensure all routes to market are explored and looking for new ways of communicating to patients and visitors, building on current successes but being open to new and innovative methods.

5. Over arching corporate objectives

Continue to work with our media partners locally, regionally and nationally to ensure UH Bristol positions itself as a trustworthy and notable commentator on health issues and is recognised as a successful organisation, through case studies of our staff and patients in relation to Research and Innovation, Teaching and Learning and patient care.

Continue to embrace all appropriate methods of communication, with staff, patients, members and the wider public to involve them in the strategic developments of the Trust.

Fully embed the Trust's values in everything we do and say and establish them as the behaviours that drive the way we do things around here.

Develop strong two-way communication routes with staff, ensuring staff have equitable access to information and develop a deeper understanding of their role in the delivery of the overall objectives of the Trust.

Strengthen our approach to marketing our services to both GPs and consultant referrers with a view to maintaining or growing market share in our target areas

The communications team will:

- Provide accurate and timely information to internal and external audiences, operating with integrity and honesty.
- Develop strong meaningful relationships with the divisions by keeping close regular contact; re-establish the link of a team member to divisions.
- Further develop professional skills in communications, project management, media relations, stakeholder management and event management.
- Take an active role in the communications profession, through networking and training opportunities, ensuring the Trust benefits from emerging methods of communications and knowledge and experience of best practice.

- Build strong relationships inside and outside the Trust.

6. Key work streams

The communications team will work in the way outlined above to support the delivery of the overarching objectives through the following key work streams. Each work stream is supported by its own detailed communications plan, with objectives, time lines, key messages and audience segmentation.

The overall communications plan will be reported back to the Trust Management Executive Group on a monthly basis, linked to Professor Gregory's framework and progress reported against the KPIs in each detailed work stream communications plan.

Work stream 1
Reputation management of the Trust

- Led by Chief Executive, this work stream encompasses leadership of the organisation and linked to the key messages for the three Trust's strategic and priorities. Methodology for communications will include stakeholder engagement, including improved use of the Trust's re-launched website and ongoing staff engagement and internal communications.
- Full plan to be worked up and agreed by the Executive Directors.

Work stream 2
Redevelopment of the Trust's estate

BUILDING A BETTER BRISTOL

An overall communications plan already agreed by communications steering group, the plan sets out our approach and then details the key messages and audiences for the BRI redevelopment and the extension to the BRCH and centralisation of paediatric services. A further piece of work will need to be done to support the BHOC redevelopment

These communication plans will be monitored by the communications steering group, and reports will be submitted to the BRI and CSP development boards. A report for information will also be given to the Stakeholder Reference Group.

Work stream 3
The closure of the Bristol General Hospital and the opening of South Bristol Community Hospital

A fully developed communications plan for the closure of the Bristol General Hospital (BGH) has been approved by the steering group and includes communication with BGH staff (audiences segmented by nursing staff, AHPs and estates/soft FM) the closure of the BGH including a memory project and the opening of the SBCH.

Further development is underway to ensure UH Bristol is fully involved in the opening of SBCH including branding and marketing new services, and communicating with patients.

In addition, divisions are in the process of identifying those staff who currently work across the BRI but will be moving to work, some or all of the time, at SBCH. This reworked paper will return to the SBCH steering group for approval.

Work stream 4
Fully embedding the Trust's values and engaging staff in the strategic direction of the trust and the delivery of excellence through patient care, research and innovation and teaching and learning.

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

A detailed action plan has been agreed by the board and TME. Further work continues as outlined within this plan, which will address employee engagement, internal communications, experiencing and living the values and will be linked to behaviours, appraisals, induction and training. The revised, more detailed plan will come back to TME in July and will be presented as a joint paper from the HR and Communications teams.

Work stream 5
Bringing the work of the Trust to life
This is a new work stream for the team and sits across all outputs and methods of communication, ensuring that new commissioners, current and future patients, potential employees, referring clinicians, the wider Bristol community, politicians, potential supports and investors understand and know about the life and work of the Trust. This work stream will require input across the organisation to ensure that the flow of information is adequate to support such a major communications plan. Following initial discussion with the communications team, an initial outline plan is brought back to TME for discussion at a leadership session.

Work stream 6
Key additional Trust projects
The communications team is managing the print review, through the appointment of a print manager. The role reports jointly to the Head of Communications and the Finance Director and is looking at all aspects of printing and print management. The role has to deliver significant CRES targets and is self funding.

There will also be other streams of work that arise within the year, which will require communications input and advice and this will be provided as and where necessary.

The Trust is conscious of national and regional designation for a number of specialities and the communications team will work with and support the commissioning and planning team, and each division, in their communications and marketing activity. This is already underway with Safe and Sustainable, the designation of paediatric cardiac services.

Appendix 1

Table – a framework for describing communicating organisations

Perspectives / Attributes	Societal perspective	Corporate perspective	Service user/stakeholder perspective	Functional perspective
Excellent understanding of the brand	The purpose, principles and values, set out in the NHS Constitution, are embodied in the NHS, supported by the public and define the national brand. The local brand is aligned to the national brand	The corporate strategy and brand are aligned. The board understands the value of relational and reputational capital	The brand is experienced through services and by engagement with stakeholders	The communications function understands the brand, effectively promotes and defends it and anticipates threats and risks to it
Excellence in planning, managing and evaluating communication	Communication plans and strategies take full account of the brand and follow best practice	Communication priorities and strategies inform, and are aligned to, the corporate strategy	Effective processes are in place to listen to service users and stakeholders, and to engage them in dialogue and action	There is effective implementation of programmes of action which promote services and the organisation, and respond to user and stakeholder needs
Leadership support for communication	Leaders understand the brand and model it in their behaviour	The role of communication is understood and supported by the organisation's leaders in the formulation of corporate strategy and in resource decisions	Leadership action is informed by customer and stakeholder insight	The communications function has direct access to the leadership
Communication as a core competency	The wider organisation understands the brand and models it in its behaviour	The communication perspective is embedded in the way that the management role is undertaken	Appropriate communication skills exist among staff involved in delivering services and stakeholder engagement	The communications function is appropriately located in the organisation with professionally competent staff in post

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Trust Board Meeting, to be held on 28 June 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Results of Q4 Monitor Assessment of NHS Foundation Trusts Compliance – Item 11
Purpose
To brief the Board on the assigned Monitor risk rating for quarter 4 of the 2010/2011 financial year.
Abstract
The report sets out governance and financial risk ratings assigned to the Trust by Monitor, the Foundation Trust regulator, following their review of performance in quarter 4 of the 2010/2011 financial year.
Recommendations
The Board is recommended to **note** the report.
Executive Report Sponsor or Other Author
Sponsor - Robert Woolley, Chief Executive.
Appendices
• Appendix A – Report to the Trust Board

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
13 June 2011					

APPENDIX A

Q4 2010/11 MONITORING OF NHS FOUNDATION TRUSTS

REPORT TO TRUST BOARD - JUNE 2011

1. INTRODUCTION

This report sets out governance and financial risk ratings assigned to the Trust by Monitor, the Foundation Trust regulator, following their review of performance in quarter 4 of the 2010/11 financial year.

2. ASSESSMENT

The assigned Monitor risk ratings are as follows:

Financial risk rating - 4;
Governance risk rating - AMBER-RED.

We are advised that the governance rating was assigned following consideration by Monitor's Executive Committee.

3. COMMENTARY

The executive summary overleaf shows the governance risk rating as amber-green, in line with the Trust's self-assessment in April, reflecting failure to meet the 62 day cancer wait for first treatment from consultant screening service referral and the 4 hour Accident and Emergency wait time target in quarter 4.

The amber-red governance risk rating reflects the Monitor Executive's regulatory concern following consideration of the issues identified in the Trust's Histopathology services, as highlighted in the 'Independent Inquiry into Histopathology Services Report', which was commissioned by the Trust and published in December 2010.

Monitor have advised that they will undertake a review to understand the basis for the Trust Board's assurance that matters highlighted within the Inquiry report are not indicative of wider governance concerns at the Trust and that the governance concerns within the Histopathology service itself have been addressed in a sustainable manner. Monitor will communicate its conclusions about any regulatory action required in due course.

4. RECOMMENDATIONS

The Board is recommended to note this report.

Robert Woolley
Chief Executive
15 June 2011

University Hospitals Bristol NHS FT
Q4 10/11 reporting executive summary

Monitor
Independent Regulator of NHS Foundation Trusts

Trust continue to implement actions to address concerns raised within a report commissioned by the Trust into its Histopathology Services, published in December 2010.

	Q1	Q2	Q3	Q4	Plan
FRR	3	4	4	4	4
Governance	AMBER-GREEN	GREEN	GREEN	AMBER-GREEN	AMBER-GREEN

Recommended action(s)

- Continue quarterly monitoring.

Liquidity

- At Q4 the FT had a liquidity rating of 4 (39.5 days).
- Cash at £53.0m is £22.2m over plan mainly reflecting capex slippage, EBITDA above plan and significant improvements in working capital management.
- The FT has a working capital facility of £37.5m which remains unutilised.

Prudential Long Term Borrowing limit £71.9m
Long Term Borrowing at Q4 was £6.3m

Financial Summary £m		Quarter Plan	Quarter Actual	Quarter Variance	YTD Plan	YTD Actual	YTD Variance	FY Plan
Revenue (Total)		123.3	122.9	(0.4)	494.3	506.6	12.3	494.3
Employee Expenses		(75.3)	(76.9)	(1.6)	(301.8)	(307.0)	(5.2)	(301.8)
Drugs		(8.7)	(12.0)	(3.3)	(34.8)	(41.1)	(6.3)	(34.8)
PFI operating expenses		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other costs		(30.5)	(21.7)	8.9	(122.0)	(116.7)	5.4	(122.0)
EBITDA		**8.7**	**12.4**	**3.6**	**35.7**	**41.8**	**6.1**	**35.7**
Depreciation and amortisation		(4.8)	(4.4)	0.4	(19.2)	(17.4)	1.8	(19.2)
Net interest		(0.1)	(0.0)	0.0	(0.3)	(0.1)	0.1	(0.3)
Other		(2.5)	(4.9)	(2.4)	(10.0)	(12.3)	(2.3)	(10.0)
Net Surplus / (Deficit)		**1.4**	**3.0**	**1.6**	**6.3**	**12.0**	**5.8**	**6.3**
EBITDA as % Income	%	7.1%	10.1%	3.0%	7.2%	8.3%	1.0%	7.2%
CIPs	£m	4.4	3.5	(0.9)	15.5	11.5	(4.0)	15.5
Net Surplus / (Deficit)		1.4	3.0	1.6	6.3	12.0	5.8	6.3
Change in working capital		(5.2)	14.5	19.7	(3.0)	12.2	15.1	(3.0)
Non cash I&E items		7.0	5.9	(1.1)	28.1	25.4	(2.8)	28.1
Cashflow from operations		**3.2**	**23.4**	**20.2**	**31.5**	**49.6**	**18.1**	**31.5**
Cashflow from investing activities		(8.6)	(10.2)	(1.6)	(29.3)	(25.4)	3.9	(29.3)
Cashflow before financing		**(5.4)**	**13.2**	**18.6**	**2.2**	**24.2**	**22.0**	**2.2**
Cashflow from financing activities		(4.5)	(4.5)	0.0	(12.6)	(12.4)	0.2	(12.6)
Net increase/(decrease) in cash		**(9.9)**	**8.8**	**18.6**	**(10.4)**	**11.8**	**22.2**	**(10.4)**
Cash at period end		**30.8**	**53.0**	22.2	**30.8**	**53.0**	22.2	**30.8**
Cash and Cash equivalents at PE		30.8	53.0	22.2	30.8	53.0	22.2	30.8

Financial

Key risks

- FRR of 4 (unrounded 4.3) delivered in line with plan.
- EBITDA margin notably ahead of plan in quarter and for the full year as a result of contribution from over-activity and 'other' income sources. This positive impact has been partly offset by CIP slippage of £4m for the full year.
- Financial risk indicators triggered :
  - Debtor days >90 days for more than 5% or outstanding debtors.
  - WCF agreement includes a non-standard default clause.
- Trust is planning a capital development (BRI & CSP) which meets the significant threshold (when combined) in the *Compliance Framework*.

Action /Resolution

- Continue quarterly monitoring.
- Trust's FY CIP delivery of £11.5m equates to 2.4% (vs. plan 3.0%) of operating costs.
- Debtor FRI - work is being undertaken to identify early disputed invoices and reduce debtor invoices >90 days.
- WCF FRI - level of risk considered low.

Non financial

- Declaration 2 signed.
- Trust failed the 62 day cancer wait for first treatment from consultant screening service referral (85.9% vs. target of 90%) and the 4 hour A&E wait target (94.2% vs. target of 95%).
- Histopathology concerns. The Trust commissioned a report into concerns associated with its Histopathology service. The Report was published in December 2010 and identified a number of failings at the Trust and the manner in which it sought to address concerns raised by external parties over a prolonged period of time.

- Continue quarterly monitoring.
- Trust attributes the cancer target failure to low number of patients.
- Trust attributes failure in quarter to significant outbreak of norovirus in January and February.
- The Trust has reported that it continues to implement its action plan to address the Report's recommendations and related governance matters . This action plan has been reviewed and is currently being monitored by the Care Quality Commission (CQC).
- Monitor is currently considering information and assurances provided by the Trust to assess whether the Histopathology concerns reflect wider governance concerns at the Trust.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Trust Board Meeting, to be held on 28 June 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Corporate Risk Register – Item 12

Purpose

To provide the Board with the updated Corporate Risk Register.

Abstract

The Corporate Risk Register contains the key risks to the delivery of the Trust's objectives identified from wide range of sources. The Chief Executive has chosen to exercise his overall risk management responsibilities through his executive team, each being responsible for their particular are of risk e.g. Finance Director for financial risk, Chief Nurse and Medical Director for clinical risk etc. Each risk is owned by an Executive Director who is responsible for overseeing the mitigating actions to reduce the risk. The executive Risk Management Group reviews the corporate risk register on a quarterly basis prior to its presentation to the Board.

Since the Corporate Risk Register was last presented to the Board in April 2011 the following key changes have been made:

Risks closed

Risk 1417: Risk of Non-compliance with Civil Contingencies Act has been closed following an internal audit which concluded that the Trust was compliant.

New risk added

Risk 1823: Funding for Multi-Professional Education and Training

Where risks have been reduced this is indicated on the risk register. The direction of travel indicated is in relation to each risk's status as presented to the April Board.

Recommendations

The Board is asked to **note** the Trust's key risks in its Corporate Risk Register.

Executive Report Sponsor or Other Author

Sponsor - Alison Moon, Chief Nurse. Author - Anne Reader, Assistant Director of Governance and Risk Management.

Appendices

Appendix A – Corporate Risk Register

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
					Risk Management Group, 19/05/2011

Corporate Risk Register

University Hospitals Bristol NHS
NHS Foundation Trust

Description	Source Of Risk	Risk Type	Date	Last Review Date	Next Review Date	Owner	Likelihood	Severity	Risk Rating	Effectiveness	Residual Risk Rate	Direction of travel	Controls In Place	Details	Independent Assuranc	Action Details	Progress	Target Date
Risk escalated from Division of Surgery Head and Neck Risk Register no: 1346 Risk to delivery of safe patient care due to demand for emergency admissions being consistently above bed capacity resulting in use of temporary, environmentally unsuitable and ill equipped areas to accommodate, treat and care for patients.	Incidents Or Near Misses	Improve Patient Safety	29/03/2011	01/06/2011	07/08/2011	Jim O'Connell	4 Likely	4 Major	4. Extreme	Low	Extreme		Performance Management	The escalation policy has been amended - patients who need to be admitted to avoid the 4hr A+E breach are now admitted into SAS [back of ward 6] - the next over flow area is DOSA [ward 99] where there are 5 inpatient beds. This change in policy will be reviewed regularly to ensure patient safety. March 2011- Ward 99 and DOSA/SAS are no longer being used - Ward 1A and Queens Day Unit are now being used routinely to cope with the increased demand on the BRI site - there was a control target set of 4 patients only in QDU at any one time - this target is continually being breached due to the demand. The nursing cover on ward 1a and QDU have been reviewed - there will be additional matron/senior nurse cover and increased support out of hours is now in place.	N/A	A co-ordinated implementation od Srandard Operating procedures for the management of outliers is being progressed. A recovery plan has been created covering the following: 1) Front Door 2) Patient flow 3) Discharges	Outlyers SOP now in place. Progress has been made with all three components of the plan. The number of patients with over 14 days LOS has reduced and outlying to QDU and IA is now a rare occurrence. More work needs to be done to move the plans sustainable for the winter	31/07/2011
													Service Redesign	1) Reduction of activity on QDU lists to manage flow. Gaps: Activity levels amended as A+E pressures occur, often late notice and carries the risk of increased cancellations(28 days), lack of theatre and treatment capacity resulted in extended waiting times, particularly pertenent to endoscopy 6 week target. This increases the likelihood of the Trusts profile being damaged on a local and national scale for the Bowel Cancer Screening Program. March 2011 - controls previously identified have been altered. 1) Reduction of activity on QDU lists to manage flow; Although this has occurred it has not been possible to manage the reduced flow in a rigorous manner Cancer Screening Program - Due to the late notice of increased numbers in QDU it has been difficult to amend lists to match the available capacity. In light of this the division has poor control over this risk.				
													Planning	A programme of work has been agreed by the Trust Management Executive in March 2011 to improve patient flow in the Trust with a view to stopping outlying in to QDU and Ia by 1st July 2011. The work programme aims to: Increase the number of discharges per day to manage take Increase the percentage of discharges by 12.30 each day to 80% (from 20% baseline) - this stops ED becoming blocked which has a knock on impact on decisions on oulying patients Reducing the number of patients who are 'medically fit' but still in acute care -thereby freeing up capacity Key completed elements of this work include: Implementing key performance indicators for divisions on flow - completed Daily review of all 'medically' fit patients who are still in acute care with PCT and other agencies - completed The remaining elements are identified in the action section. This work is also supported by the CRES programme of work focussing on reducing length of stay.				
Risk of harm to patients and visitors due to difficulty in maintaining the estate due to its age.	Strategic Decision Making	Invest In Estate And Patient Access/Environment	04/12/2009	01/06/2011	10/08/2011	Jim O'Connell	3 Possible	4 Major	3. High	Low	Extreme		Planning	Annual safety reviews on the following will be instituted from 01 2011: windows, fire training systems and evacuation, road approaches, legionella and water termperature, disabled access, security, asbestos, back up generation, lifts (not an exclusive list). Many reviews are 3 years old	Asbestos surveys undertaken independently as are lift maintenance surveys. Avon Fire service is undertaking a programme of visits with advisory notices resulting	Enforcement notice from HSE requiring action to comply. Internal audit report on Estates Maintenance received by Audit Assurance Committee.	Work to comply with enforcement notice at St Michael's Hospital complete. Action plan developed and being closely monitored.Detailed Actionplan on the maintenance audit being progressed	30/10/2011
													Benchmarked Best Practice	Occupational Health and Safety Standards Action in place, Eric and shape in use, back office benchmarking data available, condition surveys undertaken twice yearly, examples of good practice in carbon use and security but also poor practice in windows review and ongoing decontamination		Redevelopment plan for BRI/BRCH.	Full business case approved by the Board spring 2011. Enabling works underway.	31/03/2012
													Capital Programme	Investment in next four years concentrating on meetng fire and other statutory obligations but a a holding position as the Trust progresses its redevelopment plan for the BRI/BRCH. The redevelopment plan moves 50% of the Trust estate to a position of complaince with best etsates practice but still leaves a further agenda of investment to be managed using operational capital.				
													Capital Programme	Handrails on staircase in Old Building replaced for use by bariatric patients.				

Description	Source Of Risk	Risk Type	Date	Last Review Date	Next Review Date	Owner	Likelihood	Severity	Risk Rating	Effectiveness	Residual Risk Rate	Direction of travel	Controls In Place	Details	Independent Assuranc	Action Details	Progress	Target Date
It has been identified from an incident review and internal audit report that there is a risk of staff not completing full occupational health clearance and vaccination as well as low awareness of the risk of staff developing communicable infections, including Tuberculosis, after they have been given health screening clearance	Incidents Or Near Misses	Improve Patient Safety	19/04/2011	03/06/2011	01/09/2011	Stephen Aumayer	3 Possible	4 Major	3. High	Low	Extreme		Recruitment And Retention	All staff are required to complete an occupational health questionnaire before commencing employment. This is screened by Occupational Health for signs of infectious disease. Staff are then employted and are expected to complete their vaccination history and programme as appropriate through visits to Occupational Health Department	N/A	Review of Occupational Health screening for TB.	Underway	31/07/2011
													Designated Accountability	Letter to line managers sent April 2011 remiding of their responsibilities regarding staff fitness to work				

Description	Source Of Risk	Risk Type	Date	Last Review Date	Next Review Date	Owner	Likelihood	Severity	Risk Rating	Effectiveness	Residual Risk Rate	Direction of travel	Controls In Place	Details	Independent Assuranc	Action Details	Progress	Target Date
Risk of sub-optimal outcomes for adult patients with congenital heart disease (GUCH) not receiving timely review, diagnostics and intervention due to lack of capacity to meet increased demand. GUCH is not a typical service in that discharge levels are very low due to the lifelong nature of the conditions suffered. Therefore every month approximately 40-45 patients are added to the total patient population, all of who need to be reviewed. Associated risk of failure to meet waiting times, reduction in patient experience and loss of service to other areas. Escalated from Specialised Services Risk Register: risk no 1046.	Incidents Or Near Misses	Improve Patient Safety	06/01/2011	01/06/2011	30/08/2011	Jim O'Connell	3 Possible	4 Major	3. High	Low	Extreme	→	Monitoring Board/Commitee	Division monitoring monthly via GUCH Management Committee. Quarterly reports to specialist commissioners	N/A	Locum appointed for 9 months. Increased consultant outpatient clinics at Children's Hospital. Implementation of nurse led clinic.	Completed	28/02/2011
													Planning	Capactity modelling undertaken and backlog action plan in place. Target to clear backlog by Dec 2011.		Revised prioritisation process for new and follow up GUCH patients to ensure those needing to be seen as a priority are flagged in future	Completed	31/03/2011
													Service Redesign	Completion of current review of service 29/01/2011 Weekly performance reporting on OP waiting lists. Clinical validation of patients overdue to be seen. Discharge to local spoke hospital where possible. Escalation process for patient led review.:		Implementation of UH Bristol spoke service involving trained speciality doctor and nurse specialist.	Underway	31/08/2011
													Performance Management	Review of job plans to be undertaken before end of May 2011 Weekly performance reporting on OP waiting lists. Monthly risk management of backlog to be undertaken as follows: 1)Pull spread sheet of patients who do not have a date for a follow up to be run on last working day of the month. 2)All patients on list reviewed by designated GUCH consultant - consultants rotate in a monthly basis.		Training and skills development to reduce specialist consultant input to maternity clinics	Date to be confirmed.	/ /
													Workforce Management	Locum Consultant appointed for 9 months, commenced in February 2011. Specialist nurse hours increased.		Guch clincis are only to be cancelled with Head of Division agreement	Completed	24/05/2011
Risk of damage to the Trust's reputation to deliver high quality and effective care.	Individual Or Group Concern	Enhance Trust's Positive Reputation	20/04/2011	10/06/2011	08/09/2011	Robert Woolley	4 Likely	3 Moderate	3. High	Medium	High	→	Audit - External To Trust	Claims that mistakes made by histopathology. Independent Inquiry concluded. Action plan shared with Overview and Scrutinty and regulators.	Independent Inquiry concluded that the Trust's histopathology services were safe but made recommendations to improve services focussing on partnership working with North Bristol Trust.	Action plan in response to recommendations from the Independent Inquiry approved by the Trust board.	Immediate actions completed February 2011. Short term actions on track for completion June 2011. Some actions dependent on NHS Bristol led pathology services review outcome.	31/10/2011
													Monitoring Board/Commitee	Histopathology Core Group Chaired by Chief Nurse				
													Planning	Detailed and robust action plan from the Independent Inquiry being implemented.				
													Partnership Working	Partnership working with North Bristol Trust and commissioners on furture development of histopathology services in Bristol.				
													Designated Accountability	Joint Clinical Lead for Histopatholgy appointed. Took up post in May 2011.				

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Vulnerable children or adults may not be fully protected from harm due to gaps in the Trust's safeguarding arrangements, and are currently non- compliant with the Care Quality Commission Outcome 7 due to: 1. A system of multiple sets of note for one child remains in the Trust resulting in non compliance with information sharing requirements of CQC Safeguarding Children Review 2. Insufficient compliance with mandatory Safeguarding Children and Adult Training. 3. insufficient staff knowledge of Restraint / clinical holding procedures and techniques	Performance Monitoring	Improve Patient Safety	21/08/2009	15/05/2011	10/08/2011	Alison Moon	2 Unlikely	5 Catastrophic	3. High	Medium	High		Monitoring Board/Commitee	Non- compliance with Care Quality Commission Outcome 7 (Safeguarding) declared due to poor compliance with staff safeguarding training (Adults and Children) Detailed action plan draw up reported quarterly to Safeguarding Adult and Children Steering Group and Care Quality Commission Committee. Quarterly reports to the Board re CQC outcome 7 Safeguarding, following declaration of non-compliance with this outcome.	2010 Ofsted report into Trust's Child Protection arrangements.	Comprehensive and detailed action plan in place. Monitored by Safeguarding Steering Group and reported to Clinical Quality Group and Trust Board.	1. A short life working group was convened to review and re-audit the current multiple notes situation, mitigating actions have been introduced and the situation will continues to be monitored by the Child Protection Operational Group within the Women's and Children's Division. Further guidance is awaited from NHS Bristol on the implementation plan for Care Plus. Following on from this a briefing paper will be submitted to TOG early next year. 2. Training - a robust action plan continues to be implemented and compliance figures are monitored	31/10/2011
													Training	Additional training provision for both Adult and children training Training Compliance Figures produced weekly by safeguarding Adult and Children's Teams, figures monitored weekly by Divisional Leads (all Divisions). Training Compliance figures monitored Monthly by Service Delivery Group		Bid for further resource made for 2010/11	Admin support in place. Second supervisor recruited.	31/12/2010
													Designated Accountability	External multi- agency monitoring of Trust safeguarding activity occurs through Adult and Children Local Safeguarding Boards and through the Bristol / S.Glos Commissioners.		Implementation of Care Plus 4 action plan in 2011/12. Briefing update paper to be presented to Trust Board June 2011	Underway.	31/03/2012
													Workforce Management	Safeguarding Teams are in place to support staff as well as polices and procedure for both Adult and Children.		Full training recovery plan in place, agreed at Trust Operational Board target set to achieve compliance with all safeguarding training by 31st October 2011		31/10/2011
Risk of harm to patients due to acquisition of pressure ulcers. Trust pressure ulcer incidence twice that expected in comparison to a nationally populated database.	External Audit Reports	Improve Patient Safety	22/12/2010	03/06/2011	01/09/2011	Alison Moon	3 Possible	5 Catastrophic	4. Extreme	High	High		Local Policy In Force	Policy for the prevention and management of pressure ulcers	Pressure Ulcer external audits bi-annually. External prevalence audit Feb 2011 showed reduced pressure ulcer incidence from 2010 figures but prevalence remains above national average.	Repeat external prevalence audit every 6 months and internal prevalence audit every 6 months in between external audit	Prevalence audit repeated Feb 2011. Result reported to Board May 2011. Repeat internal audit in August 2011.	31/08/2011
													Audit - External To Trust	Audit of pressure ulcers carried out annually by Huntleigh Arjo bi-annually		Rapid improvement plan agreed by Clinical Risk Assurance Committee and being implemented September 2010 to March 2011. Plan extended following result of prevalence audit Feb 2011.	Monitored by Clinical Quality group monthly.	31/03/2011
													Equipment	Availablilty of electric profiling beds to prevent pressure ulcers. At present this represents only 50% of bed stock				
													Equipment	Availabiity of pressure relieving mattresses				
													Local Policy In Force	Pressure ulcer prevention protocols.				
Changes in the external environment jeopardise achievment of the Trust's strategic aims	Economy Changes	Partnership Working For Service Redesign	05/04/2011	08/06/2011	06/09/2011	Deborah Lee	3 Possible	3 Moderate	3. High	Medium	High		Planning	Commissioner service design proposals now all captured in health system QIPP programme. Trust is increasingly well enaged with QIPP programme and is currnetly aligning system QIPP to individual divisions to ensure more robust operational involvement in service re-design. Current QIPP programme focus now well aligned with Trusts strategic direction.	N/A	Annual business planning process.	Business planning for 2011/12 underway.	31/05/2011

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Risk to delivery of excellent services and foundation trust authorisation arising from substantial activity changes in commissioned activity resulting in failure to meet the 95% 4-hour access target.	Regulatory Compliance	National And Locally Contracted Service Standards	09/09/2010	01/06/2011	30/08/2011	Jim O'Connell	3 Possible	4 Major	3. High	High	Moderate		Monitoring Board/Commitee	Emergency Access Steering Group meets monthly as a multi-agency group to agree actions and monitor progress against plan. Action plan is routinely reviewed by this group. Action plan also reviewed weekly at the Emergency Access Planning Group. Daily data is circulated and all breaches assessed and investigated.	DH IST team review, EASG is multi agency, repots also to BNSSG and Healthy Futures Board	Creation of 3 projects covering front door, patient flow and discharges. Regular monitoring of deliverable via EASG.	Medical short stay ward opened 07/10/09. 2 wte physician posts appointed, remaining post out to advert for second time. Twicw daily patient flow meetings in place. Agreement to cease using inappropriate clinical areas for outlying from 30/06/2011. Expanded MAU from 01/08/2011.	01/08/2011
													Monitoring Board/Commitee	Twice daily patient flow meetings held and activity across the wards and the health economy discussed and reviewed.	DH IST team	Increase in Medical Assessment beds and Observation beds.	PCT now engaged with planning to reduce demand in 2010/11. IMAS have undertaken a review of management of 4 hour processes. Peak activity analysed locally, awaiting PCT response. All acute physician posts now recruited to. MAU now split across two wards.	30/11/2009
													Monitoring Board/Commitee	Routine review and reports provided to the Trust Operational Group/Trust Executive Group and Trust Board.	DH IST	Comprehensive and detailed 4 hour action plan in place being reviewed frequently in conjuction with Monitor		31/03/2011
													Monitoring Board/Commitee	Action plan also reviewed fortnightly at the Emergency Access Steering Group. Daily data is circulated and all breaches assessed and investigated.	DH IST	Clinical focus to be placed on ward rounds on Monday mornings. CEO to write to all consultants advising them of importance of focussing attention on this target. All outliers to be reviewed daily to ensure patients are in the appropriate clinical area.		01/02/2010
													Performance Management	New performance metrics that map to the patient journey and move Trust towards measuring performance within ED rather than at 4 hours	DH IST			31/07/2011
													Service Redesign	Length of stay, delayed discharge and outlier reduction	DH IST			
													Service Redesign	Winter plan - plan to escalate additional capacity to meet forecast surges over winter. Also links to additional funding this winter for rehabilitaiton and reenablement to prevent readmisisns and accelerate discharge	DH IST			
													Service Redesign	New pathways for expected patients through use of Ambulatory Care centre reducing quantum of activity to ED	DoH Ambulatory care model, DoH IST recommendation following their review, PCT part of project group as external stakeholder			
													Planning	Programme of work to increase patient flow underway to improve the timliness of care and sustain achievemnt of the 95% 4 hour wait target.				
Failure to meet Cancer Targets, specifically 2-week, 31-day and 62-day target.	Performance Monitoring	National And Locally Contracted Service Standards	20/04/2009	01/06/2011	30/08/2011	Jim O'Connell	3 Possible	4 Major	3. High	High	Moderate		Monitoring Board/Commitee	Weekly meetings held with all Divisions to review cancer patient tracking. Performance reviewed every two weeks at the Trust Operational Group and at the Trust Management Executive. Monthly reports submitted to the Trust Board with full plan review on a regular basis.	N/A	Cancer Action plan in place and reviewed routinely at the weekly meeting. The cancer action team manage every referral that comes into the Trust. Weekly breach analysis to identify cause of breaches.Fortnightly meetings with Surgery, Head and Neck Division to review identified problems with surgical capacity.	Additional theatre sessions in place to meet breaches. Improved communications between services. 2 week, 31 day and 62 day referral to treatment met. 62 day GP screening not met.	31/03/2012
													Service Redesign	Choose and book - implemeted for 14 day breast and seen performance improve to 98%. needs to be sustained for Q4 at this level or better				
													Service Redesign	Additional ITU capacity - identified as cause of several key 62 day cancellations and addressed through additional capital investment in 2010 on interim basis and 2011 on semi permanent basis				
Norovirus outbreaks which will introduce significant risk to the achievement of the 4hour target and elective targets	Performance Monitoring	Reduce Incidence Of Healthcare Acquired Infections	10/03/2011	03/06/2011	01/09/2011	Alison Moon	4 Likely	3 Moderate	3. High	Medium	High		Partnership Working	Review of 07/08 outbreaks across health economy to manage future more effectively and collectively	Norovirus Outbreak report by Health Protection Agency Jan-April 2011	Review of bed capacity daily. High level campaigns to inform service users of risks and their need to engage in reduction infection spread. National picture of epidemiology monitored closely. Patients isolated immediately and ward closed where necessary.	Ongoing	Ongoing
													Local Policy In Force	Outbreak Policy		Recommendations from HPA report presented to Clinical Quality Group and will be presented to the Service Delivery Group		To be agreed
													Planning	08/09 Norovirus Outbreak Plan for Trust 10/11 Norovirus outbkreak plan amended following review of adequacy of controls				
													Documentation -Trust Paperwork	Norovirus risk assessment on admission				
													Audit - External To Trust	Review of 2011/12 Norovirus outbreak by Health Protection Agency. Review undertaken. Report expected June 2011				
Non compliance with European Working Time Directive	Regulatory Compliance	Enable Staff To Deliver To The Best Of Their Abilities	10/02/2011	06/06/2011	04/09/2011	Stephen Aumayer	3 Possible	4 Major	3. High	High	Moderate		Planning	Monitoring of rota's, monthly reports to Strategic Health Authority and project steering group, divisional action plans for non compliant rotas. Divisions continue to review implementation plans following monitoring and to investigate reasons behind doctors working in excess of official start and finish times. Monitoring of plans to achieve compliance in derogated areas by August 2011.	N/A	Currently five non compliant rota's. SHA have advised derogated rotats to be compliant by August 2011. Plans in place for all. Only 1 rota now outstanding.	Derogation agreed for 5 rotas, ENT first teir, anaesthesia first and second tier, cardiothoracic first and second tier. Divisions continue to review implementation plans. New contracts and standard operating procedures for new doctors.Participation in SHA recruitment continues. Recent monitoring of junior doctors shows a small number work longer than required. Action plans in place for all areas.	31/07/2011

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Risk of compromised patient outcomes due to failure to meet cancelled operations national standard.	Performance Monitoring	Improving Quality And Effectiveness	20/04/2009	01/06/2011	30/08/2011	Jim O'Connell	4 Likely	3 Moderate	3. High	High	Moderate	→	Local Policy In Force	Twice daily patient flow meetings supporting proactive management of cancellations with review of all elective admissions on a daily basis. Weekly operational meetings to validate cancellations and review action plan.	Links with Kaiser permanente forged in the summer but need to be made routine	Reported to Board via exception reporting in the Performance Report	Reported to Board via exception reporting in the Performance Report	31/03/2012
													Service Redesign	Productive theatre initiative successfulyl brigns on additional controls over theatre utlisation increaidng capacity and reducing cancllations	KM&T and Internal audit review of Transformaiton programme			
													Local Policy In Force	Protocol for use of intensive care between cardiac and surgical teams resulting in immediate reduction of cancllaations of cases due to shortage of bed Protocol agreed with medical director for priority use of ITU beds and embedded from 23/12/2010				
													Service Redesign	Additional ITU capacity planed for 2011 with interim capaity in 2010				
													Planning	Programme of work to improve patient flow in the Trust will reduce the risk of cancellations due to lack of beds. Paper presented to Service Development Group on cancelled ops and all divisions developing a plan to tackle.				
Inability to reduce length of stay and manage activity levels throughout the year resulting in breaches against national standards due to changes or delays to partner developments in the Bristol Health Services Plan which could lead to significant variance in patient flows and capacity requirements from projections (includes but not exclusively development of South Bristol Community Hospital and closure of acute services at Frenchay Hospital.)	Service Provision Changes Potential or actual	Partnership Working For Service Redesign	20/08/2010	01/06/2011	30/08/2011	Jim O'Connell	3 Possible	3 Moderate	3. High	Medium	High	→	Partnership Working	Participation in South Bristol Community Hospital Stakeholder Board.		Prioritise Trust objectives for internal capital programme.	Reclassify once financial close achieved for North Bristol Trust PFI and South Bristol Community Hospital LIFT.	Ongoing
													Planning	Capacity planning. Bed model has been developed which feeds into clinical strategy, BRI development and annual OPPs for Divisions. It is based on external and internal benchmarking and targets the Trust to deliver upper qaurtle performance in 75% of what we do by 2016/2017. Length of stay is already reducing in line with this plan. Business case on length of stay being developed with clear action plan as part of the CRES programme of work.	DH IST, KM&T, CHKS	Contingency plans identified alongside Outline Business Case for Bristol Royal Infirmary redevelopment.	Transformation Programme Board established. PMO to be launched by 31 March 2011	01/04/2012
													Service Redesign	Board rounds, enhanced recovery, day of admission initiatives, imporved day surgery rates, accelrated discharge, TTAs, access topathology, order comms, review of ED rota, review of medical model of care for general medicine take	DH IST, CHKS, KM&T	Making Our Hospitals Better Programme to redesign services independent of external developments.		31/03/2011
Cash Releasing Efficiency Savings Plans underachieve and impact on trust annual and planned outturn.	Annual Planning Process	Deliver Agreed Cash Releasing	08/12/2010	01/06/2011	30/08/2011	Jim O'Connell	4 Likely	3 Moderate	3. High	High	Moderate	→	Performance Management	Monthly Divisional CRES reviews, Monthly Divisional Performance reviews , Quarterly reviews, Monthly review by CRES Programme Steering Group, Monthly review by Finance Committee, monthly updated at a glance reports	Internal audit review 2010 KM&T external review 2010 AUHUK external benchmarking of CRES CHKS benchmarking re CRES areas	CRES plans to be monitored at divisional perfomance reviews and recovery actions will be put in place if required.	Divisions currently going through the TME sign off process for 2011/12 operational plans. 2 Divisions already signed off. Corporate CRES workstream plans being developed to merge any gaps	31/05/2011
														Benefits tracking systems - all schemes are tracked based on actual savings to specific budget line and this is monthly reviewed and end of year forecast risk assessed	KM&T assurance, Internal audit report	Set up Transformation Board, Programme Steering Group, PMO and formal benefits tracking systems	Transformaton Board launched in January 2011, PSG launched in January 2010, virtual PMO launched in July 2010, formal PMO to be set up using KM&T as facilitators in March 2011. benefits tracking in palce from May 2010 and audited in November 2010	31/03/2011
														Divisional control of vacancies and procurement monitored at monthly performance meetings. Those Divisions who have challenges meeting the target are given additional external and internal support to assist in managing the recovery.	Byrnes Freeman, AUKUH benchmarking	Set up workstream governance arrangements including SROs, PIDs and resource plans, key deliverables defined and finance and transformation support in place	SROs identified, key deliverables identified. Workstreams to be re-launched on 15th February	31/03/2011
														Regular Reporting to the Finance Committee and Trust Board	KM&T	Benchmarking and external review. identification of evidence to provoide pointers for where savings can be delivered and assurance of the cost benefits of change	Benchmarking sources identified and first CRES monthly workshop run in January 2011. External reviews of outpatients, logistics, urgent care undertaken in 2010-2011.	31/03/2011
Patient privacy and dignity is compromised due to patients having to share sleeping and bathroom facilities with those of other genders. Also risk of incurring financial penalties in commissioning contracts.	Performance Monitoring	Improving Quality And Effectiveness	03/06/2011	03/06/2011	01/09/2011	Alison Moon	3 Possible	2 Minor	2. Moderate	Medium	Moderate	↓	Environment	Planned development work on wards, to enable single-sex compliance, completed on time. Breaches of standard occurring when bed capacity tight. Clear hierarchy of priorities agreed, placing emphasis on clinical risk, following by achievement of the 4-hour waiting times standard. Breaches of standard reporting to be agreed with the PCT, although currently logged/reported on internally via the daily patient flow meetings, as they occur.	N/A	Business case formulated and plans in place to complete ward reconfigurations in the division of medicine to provide a larger Medical Admissions Unit.	Business case approved, work to be completd by 01/08/2011.	01/08/2011
													Environment	Fixed screens in place in adult emergency department from May 1st 2011.				

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Failure to reduce the Incidence of Health Care Acquired Infection, specifically Clostridium Difficile and MRSA. May 2011 - new targets for reduction of MSSA and E. coli bacteraemias added in 2011/12	Performance Monitoring	Reduce Incidence Of Healthcare Acquired Infections	10/05/2011	03/06/2011	01/09/2011	Alison Moon	3 Possible	3 Moderate	3. High	High	Moderate		Performance Management	Weekly meetings to review actions against outturn. Guidance on priortisation for isolation. Daily review of clostridium difficile numbers and movement of patients. Review of performance against plan at Trust Operational Group meeting, Trust Executive Group Meeting and Trust Board. Action plan delivery monitored and developed at the Trust Infection Control Committee. Trust-wide approach to increasing the number of single rooms. MRSA elective screening in place to meet national expectations. MRSA emergency screening being implemented in advance of December 2010.	N/A	Comprehensive action plan in place to prevent and control Healthcare Acquired Infections monitored by Infection Control Committee. Monthly performance monitoring by the Board of a range of infection control metrics. Quarterly comprehensive infection control report to the Board.	Reported directly to the Trust Board	31/03/2012
													Capital Programme	Increase in single roomas across the Trust as part of the BRI redevelopment from 11% to 33%				
													Audit -Trust Origin	Matron and ward monitoring for C diff dashboard monthly				
													Audit -Trust Origin	Saving lives/High Impact Intervention programme to reduce bacteraemias with audit of practice monthly				
													Documentation -Trust Paperwork	Admission risk assessment form				
													Local Policy In Force	Policies in place for MRSA and C diff prevention and management				
													Monitoring Board/Commitee	Infection control committee monitor progress quartlerly				
													Monitoring Board/Commitee	Trust Board monitor C diff and MRSA performance monthly				
													Training	Infection control induction and update training with compliance over 90%				
													Information Technology	Use of identification by yellow dot on clinical information systems				
													Planning	Recovery plan to address exceeding target for C difficile in May 2011				
The Trust's Financial Strategy may not be deliverable in the likely national economic climate	Economy Changes	Remain Financially Sustainable	11/05/2011	10/06/2011	08/09/2011	Paul Mapson	2 Unlikely	3 Moderate	2. Moderate	Medium	Moderate			Update of Integrated Business Plan on a regular basis	Monitor	Annual review of key assumptions - reporting to Finance Committee and Trust Board.	Annual Plan 2011/12-2013/14 produced in May 2011.	Ongoing
													Monitoring Board/Commitee	Financial Monitoring through Finance Committee and Trust Board.				
													Planning	Monitor Downside Plan showing impactproduced Sept 2009 and submitted to Monitor.				

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Lack of controlled assurance for all staff groups for mandatory training, induction.	Performance Monitoring	Improve Patient Safety	10/02/2011	06/06/2011	04/09/2011	Stephen Aumayer	3 Possible	3 Moderate	3. High	High	Moderate	→	Training	Continuous training carried out as per risk management training plan. Annual training needs analysis in place and training prospectus developed	N/A	Corporate Induction/Nursing Assistant Induction reviewed to cover all mandatory training in first week of employment. Clinical staff programme extended to 3 days and non clinical to 2 days. Annual review of training needs analysis in progress. Non attendance charge protocol agreed at Trust executive Group and implemented for induction and update training from January 2011. A passport system is to be introduced throughout the Bristol, North Somerset and South Glos Trusts except for Great Western Ambulance Trust and to also include Avon and Wiltshire Partnership.	Many elements of statutory and mandatory training are progressing well currently running at 80%+ range. Non attendance is the lowest it has been at 17% on centralised programmes. The areas not achieving so well have high level action plans in place. A new software programme has been implemented since Jan 2010 which allows recall of individuals to attend refreshers as per training standards. This will become self service in the future with departmental managers being able to take direct responsibility for maintaining the compliance of their staff. Induction review is being undertaken which includes work to improve alignment with S & M training as an extension of the induction process.	Ongoing
																Procurement of At Learning system underway.		
																Plans in place to charge all departments for non-attendance at statutory and mandatory training courses.		
																A pan-avon skills passport is being developed to make skills transferable between organisations		
																Passport prepared and going for approval.	Passport approved	30/04/2011
Non compliance with Equalities Legislation	Regulatory Compliance	Embed Equality And Diversity Into Trust Business	06/06/2011	06/06/2011	04/09/2011	Stephen Aumayer	3 Possible	3 Moderate	3. High	High	Moderate	→	Governance - All Types	Trust required to assess all functions, policies and services	N/A	Training in place. New Equality Delivery System (EDS) makes new changes to the provision of EIAS. Trust guidance will be change as a result although Divisions still expected to provide EIAs on their services, functions, policies to prioritise completion of assessment (including consultation and involvement with external partnerships where appropriate). Training needs analysis to be completed by end of March 2011 with critical need to be linked in with Teaching and Learning Strategy to ensure all E&D training requirements are met. New EDS requirements not fully clear, but action plan will be put in place as soon as clarity gained.	Approach to E & D refreshed to put more emphasis on meeting legislative requirements. Full time E & D Manager in post to ensure E & D training requirements are met and to support divisions in conducting Equality Impact Assessments. Significantly more resource in place in this area. Not all areas reviewing their services when changing to assess equalities impact as yet. Process regarding policy update/approval will manage ongoing risk. Board paper on E&D presented in May 2011	31/07/2011
													Training	External training provided June 2009.				
													Funding	Funding obtained for E & D Manager for 12 months				
														All new policies and policies for review have an Equality Impact assessment.				
													Monitoring Board/Commitee	Twice monthly monitoring at the SDG and the TME Group meeting. Reported monthly to the Trust Board and reviewed at monthly performance monitoring meetings.		Improved capacity management by the Surgical Division, including roll out of protected bed base to additional specialties. Imprvement management of elective lists and utilisation of theatre time. Review of all elective admission on a daily basis. Surgical theatre user group review theatre slot availability monthly to improve efficiencies.	Theatre related cancellations significantly reduced as part of productive theatres work. Ring fenced surgical beds proposals from 30/06/2011 will also improve performance in this area. Performance has improved significantly in recent weeks but more work needs to be done to achieve the target	30/06/2011
Risk to timely completion of CSP capital development due to delay in transfering out Adult BMT Services which sits on critcal path for the scheme	Captial And Service Developmen	Redevelop BRI And Centralisation of Specialist Paediatrics	05/04/2011	08/06/2011	06/09/2011	Deborah Lee	2 Unlikely	4 Major	3. High	High	Moderate	→	Planning	Adult BMT transfer now removed from immediate CSP critical path.	N/A	Action to remove Adult BMT transfer from CSP critcal path resulting reduction in risk. Business case for alternative scheme underway for conisderation at August Board.		01/09/2011

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Adult in-patients could develop venous thrombo-emboli and come to harm if not risk assessed and appropriate thrombo-prophylaxis prescribed.	NICE Guidance	Improve Patient Safety	20/04/2011	02/06/2011	31/08/2011	Sean O'Kelly	2 Unlikely	4 Major	3. High	High	Moderate	→	Documentation -Trust Paperwork	Risk Assessment tools avaiable for completion.Risk assessment tool to be integral to new prescription chart.	N/A	Improved data capture using a manual census methodology. Longer term plans to capture the data electronically via Trust's IT systems.	90% target achieved April 2011. Needs sustaining and embedding.	31/03/2011
													Workforce Management	Each Division has elected a clinical champion for VTE.		Programme of systematic audits of thrombo prophylaxis compliance commenced May 2011.		01/09/2011
													Training	The Department of Health on line VTE tool has been circulated throughout UHBristol to all Doctors, Registered Nurses and Pharmacists. VTE is included in Doctor's Induction and the Foundation programme.				
													Information Technology	Data needs to be collected on the % of patients being risk assessed.				
													Funding	VTE project nurse now in post.				
													Training	VTE week May 2011 used to raise awareness amongst staff and patients of the importance or risk assessment and prevention.				
Delays in finidng an affordable and acceptable service solution to the relocation of adult BMT services from the Children's Hospital to BHOC is now a risk to delviery of the CSP programme timeline.	Captial And Service Developmen	Partnership Working For Service Redesign	06/01/2011	13/06/2011	11/09/2011	Deborah Lee	2 Unlikely	4 Major	3. High	High	Moderate	→	Capital Programme	Outline Business Case being developed as part of wider scheme to mitigate this risk.	N/A	Develop OBC that is affordable and supports CSP critical timeline	On track - Board approval August 2011	01/09/2011
Human error in the temporary process of copying of electronic discharge summary information into the Clinical Document Service (CDS) from ICE, results in incorrect information being sent to GPs.	Complaints	Improve Clinical Information Systems	24/03/2011	10/06/2011	08/09/2011	Sean O'Kelly	2 Unlikely	4 Major	3. High	High	2. Moderate	↓	Performance Management	The supervisor for the discharge typing team is now checking check a random sample of500 letters a week, to pick-up and correct errors being made in the discharge summaries. This covers around a third of all discharge summaries loaded on to CDS.	N/A	Purchase and implement an interface between ICE and CDS to remove the manual element of getting discharge summaries into CDS format.	Interface purchased and development work to commence w/c 13th June; work to be undertaken by Web Team during the week, with testing of the interface w/c 20th June. New automated system to be launched w/c 27th June, assuming interface is fully operational and no further enhancements are required.	11/07/2011
													Audit -Trust Origin	500 letters were reviewed, with 2 letters having found to have contained information about two different patients.		Use bank staff to check an additional 500 letters a week.		18/04/2011
Risk that Strategic Development Programme Projects (includes Bristol Royal Infirmary redevelopment, air ambulance landing facility and centralisation of specialist paediatrics) are not completed to time and budget and delivery of identified benefits is jeopardised.	Captial And Service Development Projects	Redevelop BRI And Centralisation of Specialist Paediatrics	05/04/2011	08/06/2011	06/09/2011	Deborah Lee	2 Unlikely	4 Major	2. Moderate	High	Low	→	Governance - All Types	Robust programme management and programme governance structure in place.	N/A	Contigency measures for the continued delivery of the Centralisation of Specialist Paediatrics scheme are currently being developed.	Reported directly to the Trust Board	2014
													Local Policy In Force	Capital investment policy in place following Monitor guidelines		Major Risk to CSP Programme (transfer of Adult BMT) now removed from clinical pathwway with resulting reduction in level of risk. Loan funding secured - Monitor Due Diligence underway and proceeding positively.		
													Monitoring Board/Commitee	Programme and project status and risk reporting to Trust Board				
													Audit - External To Trust	External risk assessment by Regulator				
													Designated Accountability	Weekly oversight by Sernior Responsible Officer				
													Governance - All Types	Active risk management of all project components, including project specific risk registers				
													Planning	Development of contingency proposals for scheme delays, including retention of specialist paediatrics at NBT for a period				
													Funding	Active discussion with private lenders in train Exploration of alternatives to private lending being explored				
Cost Pressures - unforeseen cost pressures i.e. 0.5% over allowance in long term financial plan.	Performance Monitoring	Remain Financially Sustainable	11/05/2011	10/06/2011	08/09/2011	Paul Mapson	2 Unlikely	3 Moderate	2. Moderate	High	Low	↓	Local Policy In Force	Non recurring impact to be managed by alternative measures	N/A	Annual review for inclusion in each years' Resources Book - report to Finance Committee and Trust Board.	Ongoing.	Ongoing
													Local Policy In Force	Recurring impact to be managed by increasing savings plans and / or reprioritise strategic commitments				

Description	Source Of Risk	Risk Type	Date	Last Review Date	Next Review Date	Owner	Likelihood	Severity	Risk Rating	Effectiveness	Residual Risk Rate	Direction of travel	Controls In Place	Details	Independent Assuranc	Action Details	Progress	Target Date
National contract mandates financial penalties on under-performance against key indicators presenting a financial risk to the Trust.	Annual Planning Process	Remain Financially Sustainable	20/03/2008	10/06/2011	08/09/2011	Paul Mapson	3 Possible	2 Minor	2. Moderate	High	Low	↓	Local Policy In Force	Operational plans (especially infection control plan) : delivery of key targets by year end	N/A	Robust performance management in year. Prioritise service redesign initiatives to key performance issues.	Ongoing	Ongoing
													Performance Management	Corporate and divisional performance management framework.		2010/11 Monitor financial exposure in-year.		
													Performance Management	Transformation programme.		Reports routinely to the Finance Committee as part of the finance report. Continually reassessed. Provision made in 2010/11 budget.		
Risk that patient safety is compromised due to failure to comply with revised Care Quality Commission Standards on decontamination	Regulatory Compliance	Improve Patient Safety	12/09/2010	08/06/2011	06/09/2011	Alison Moon	2 Unlikely	3 Moderate	2. Moderate	High	Low	→	Monitoring Board/Commitee	Review at Trust Infection Control Committee. Decontamination Committee to report to the Trust Audit and Assurance Committee.	Internal audit on decontamination underway.	Comprehensive and detailed action plan in place being monitored by Decontamination Committee, Infection Control Committee and Trust Board.	Full briefing paper to Audit and Assurance Committee in March 2010, all outstanding actions from April 2009 achieved. Recommendations of specific internal audit report on outlying dental practices and endoscpy units actioned. Decontamination Committee action plan revised and actions underway for 2011.	31/03/2011
													Capital Programme	Capital programme in place to install RO water for endoscopy and clean steam for Sterile Services Department. Options being considered for longer term CSSD rebuild or replacement.		Review 'stock take' of trust wide local practices underway- to report by March 2011 to ensure all risks mitigated.		31/03/2011
													Performance Management	Key performance indicator dashboard in place and monitored monthly		RO plants scheduled to be installed in HeygrovesTheatres and the BHI by September 2011.		01/09/2011
													Local Policy In Force	Decontamination policy in place		Project to address clean steam situation underway.		31/10/2011
													Audit - External To Trust	Authorising Engineer (Decontamination) annual audit report		Internal audit on decontamination underway.		31/07/2011
													Local Policy In Force	Policy for water testing and acting on results				
													Audit - External To Trust					
Risk to University Hospitals Bristol of fraudulent activity within Divisions. There are two types of fraud risk that could affect the Trust. 1. High number of low value cases such as working whilst sick, time sheet fraud, expenses fraud etc. 2. High value small number of cases such as purchasing, contract or corruption.	External Investigations	Remain Financially Sustainable	03/03/2010	10/06/2011	08/09/2011	Paul Mapson	2 Unlikely	3 Moderate	2. Moderate	High	Low	↓	Monitoring Board/Commitee	Reports to Audit and Assurance Committee	N/A	Regular detailed review with Director of Finance.	Ongoing.	Ongoing
													Documentation -Trust Paperwork	CounterFraud and Speaking Out Policies				
													Designated Accountability	Local Counterfraud Service				
													Audit -Trust Origin	Proactive Councterfraud work				
Funding for Multi-Professional Eduction and Training	Economy Changes	Remain Financially Sustainable	14/06/2011	14/06/2011	12/09/2011	Paul Mapson	3 Possible	2 Minor	2. Moderate	High	Low	New Risk	Funding	Provision in long term financial model	N/A	Annual assessment for inclusion in Long Term Financial Model and Resources Book.		01/04/2012
Risk of breaching private patient cap.	Regulatory Compliance	Remain Financially Sustainable	11/05/2011	10/06/2011	08/09/2011	Paul Mapson	1 Rare	2 Minor	1. Low	Medium	Low	↓	Performance Management	Board and Finance committee receive regular reports on private patient income against cap.	External Auditors opinion on Annual Accounts.	Continue to monitor private patient income through Finance Committee.	Ongoing	Ongoing