University Hospitals Bristol NHS
NHS Foundation Trust

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

| *Item* | *Sponsor* | *Page* |
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| **1. Chairman's Introduction and Apologies**<br>To **note** apologies for absence received. | Chairman | |
| **2. Declarations of Interest**<br>In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda. | Chairman | |
| **3. Minutes**<br>To consider the Minutes of a Joint Public Trust Board and Membership Council meeting dated Thursday 25 August 2011 for **approval**. | Chairman | 1 |
| **4. Matters Arising**<br>To review the status of matters arising from previous meetings of the Trust Board of Directors. | Chairman | 22 |
| **5. Chief Executive's Report**<br>To receive this report by the Chief Executive, including the activities of the Trust Management Executive to **note**. | Chief Executive | 23 |
| *Quality, Performance and Compliance* | | |
| **6. Summary Quality and Performance Report**<br>To receive the standing Summary Quality and Performance Report to **note**.<br>a. Overview – Director of Strategic Development<br>b. Quality – Medical Director and Chief Nurse<br>c. Workforce – Director of Workforce & Organisational Development<br>d. Access – Chief Operating Officer | Executive Leads | 26<br><br><br><br>29<br>49<br>81<br>89 |
| **7. Histopathology Action Plan Update**<br>To receive this quarterly report by the Chief Executive to **note**. | Chief Executive | 99 |
| **8. Safeguarding Annual Report**<br>To receive this report by the Chief Nurse to **note**. | Chief Nurse | 117 |
| **9. Security Annual Report**<br>To receive this report by the Chief Operating Officer to **note.** | Chief Operating Officer | 140 |
| *Finance and Governance* | | |
| **10. Committee Chairs' Reports**<br>To receive reports on the activities of Board Committees by their respective Chairs and consider any recommendations to **note**. | Committee Chairs | 148 |

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| a. Audit Committee dated 12 September 2011<br>b. Finance Committee dated 21 September 2011, including the Finance Report<br>c. Quality and Outcomes Committee dated 27 September 2011 | | |
| *Strategy and Business Planning* | | |
| **11. Bristol Haematology and Oncology Centre (BHOC) Business Case Development**<br>To receive this report by the Director of Strategic Development and consider the recommendations for **approval**. | Director of Strategic Development | 165 |
| **12. Partnership Programme Board Terms of Reference**<br>To receive this report by the Trust Secretary and consider the recommendations for **approval**. | Chairman | 184 |
| **13. Partnership Programme Board Report**<br>To receive this report by the Chief Executive to **note**. | Chief Executive | 193 |
| *Monitor Reports* | | |
| **14. Results of Q1 Monitor Assessment of NHS Foundation Trusts Compliance**<br>To receive this report by the Chief Executive to note. | Chief Executive | 194 |
| *Risk* | | |
| **15. Corporate Risk Register**<br>To receive this report by the Chief Executive to **note**. | Chief Executive | 196 |
| *Information and Other* | | |
| **16. Any Other Business**<br>To consider any other relevant matters not on the Agenda. | Chairman | |
| **17. Date of Next Meetings**<br>Public Meeting of the Trust Board of Directors, Wednesday 26 October 2011 from 10:30 – 13:30 in Tutorial Room 4 of the Education Centre, Upper Maudlin Street, Bristol, BS2 8AE. | Chairman | |

University Hospitals Bristol NHS
NHS Foundation Trust

# Minutes of a Joint Public Board and Membership Council Meeting, held on 25 August 2011 at 10:30 in Lecture Theatre 1, 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
- Selby Knox – Non-executive Director
- Kelvin Blake – Non-Executive Director
- James Rimmer, Chief Operating Officer
- Robert Woolley – Chief Executive
- Steve Aumayer – Director of Workforce and Organisational Development
- Paul Mapson – Director of Finance
- Deborah Lee – Director of Strategic Development
- Alison Moon – Chief Nurse
- Sean O'Kelly – Medical Director

## Membership Council Members Present

- Anne Ford – Public Governor, North Somerset
- Ken Booth – Public Governor, Bristol
- Sue Silvey – Public Governor, Bristol
- Alex Bunn – Staff Governor – Non-Clinical Healthcare
- Pauline Beddoes – Public Governor – South Gloucestershire
- Mary Hodges – Public Governor – South Gloucestershire
- Neil Auty – Patient Governor – Tertiary & Governor Representative
- Mo Schiller – Public Governor, Bristol
- Sylvia Townsend – Appointed Governor – Bristol City Council
- Chris Payne – Appointed Governor – South Gloucestershire Primary Care Trust
- Jeanette Jones – Partnership Governor, Joint Union Committee
- Maggie Mickshik – Partnership Governor – Voluntary Group
- Clive Hamilton – Public Governor, North Somerset
- John Steeds – Patient Governor – Local
- Florene Jordan – Staff Governor – Nursing and Midwifery
- Suzanne Green – Patient Governor – Tertiary
- Jacob Butterly – Patient Governor – Local
- Peter Holt – Patient Governor – Local
- Sian Evans – Public Governor – Bristol
- Lorna Watson – Patient Governor, carers of under 16 years
- Wendy Gregory – Patient Governor, carers of 16 years and over
- Garry Williams – Patient Governor, carers of 16 years and over
- Belinda Cox – Staff Governor – Nursing and Midwifery
- Jan Dykes – Staff Governor – Non-clinical Healthcare
- Phil Quirk – Staff Governor – Other Clinical Healthcare Professions
- Louise Newall – Staff Governor – Medical and Dental

## Others Present or In Attendance

- Christine Perry – Director of Infection Prevention and Control
- Fiona Reid – Head of External Relations
- Victoria Church – Management Assistant to the Trust Secretary
- Vicki Mathias – Bristol Evening Post
- Three Foundation Trust Members
- Maria Fox – Membership Manager
- Debbie Marx – Membership Administrator

| *Item* | *Action* |
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| **1. Chairman's Introduction and Apologies**<br>The Chairman noted apologies from Lisa Gardner, Non-executive Director & Chair of the Finance Committee, John Moore, Non-executive Director & Chair of the Audit Committee and Charlie Helps, Trust Secretary. | |
| **2. Declarations of Interest**<br>In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Board Meeting Agenda.<br>No declarations of interest were made. | |
| **3. Minutes**<br>The Board considered the Minutes of the previous meeting held on 28 June 2011 and resolved to **approve** these as an accurate record of matters transacted. | |
| **4. Matters Arising**<br>All items on the Board Schedule of Matters Arising were noted as complete as reflected in the Schedule of Matters Arising. | |
| **5. Chief Executive's Report**<br>The Board received and considered a report by the Chief Executive which included the activities of the Trust Management Executive to **note**. The report included:<br>• The NHS Litigation Authority (NHSLA) had accredited the Trust at Clinical Negligence Scheme for Trusts (CNST) Level 2. Robert explained that as the Trust increased its level of accreditation, insurance premiums decreased. This demonstrated the Trust's commitment to increasing quality whilst reducing costs. At the Risk Management Group meeting on 18 August 2011, it was agreed to continue working towards accreditation at Level 3 within two years.<br>• The Trust and the University of Bristol have received £11.5 million of funding for two biomedical research units. The Trust already has a renewed research unit in the Bristol Heart Institute and the new research unit would look at factors of lifestyle and obesity.<br>• John Savage congratulated the Trust for securing this funding. Selby Knox added his endorsement, emphasising the importance of research units in ultimately contributing to good patient care. Paul May added that this news would have a positive impact on the morale of Trust staff.<br>*There being no further questions or discussion, the Board resolved to* ***note*** *the Chief Executive's Report.* | |
| *Board: Quality, Performance and Compliance* | |
| **6. Summary Quality and Performance Report**<br>The Board received and considered this report by members of the Trust Executive to **note**. | |

### a. Overview

The Director of Strategic Development, Deborah Lee, introduced the Performance Report and noted positive improvements in patient experience and efficiency. However, there was deterioration in finances due to the Cash Releasing Efficiency Savings targets not being achieved. Deborah also reported an 'Amber-Red' outcome for the Monitor Compliance Framework, saying that the Trust would have gained a 'Green' rating had there not been improvements to be made in the Care Quality Commission outcome for nutrition.

### b. Quality

The Chief Nurse, Alison Moon, presented the Quality element of the Summary Quality and Performance Report, the main points of relevance were:

- The Commissioning for Quality and Innovation (CQUIN) indicators were on-track for achievement, but pressure ulcers still fell short of expectations. A decline in numbers of pressure ulcers had been reported, as detailed in the report, but there was still a focus on 'zero-tolerance'. A rapid-spread programme to disseminate best practice was currently underway across the Trust and was due for review at the Quality and Outcomes Committee meeting on 20 December.
- Mixed-Sex Accommodation breaches (Q7 Exception Report) had decreased recently, which was attributed to changes made in the Medical Assessment Unit (MAU) from 01 August. Alison was optimistic that there would be no further breaches after this date, other than in exceptional circumstances.
- Referring to the Q2-Q4 Exception Reports, the number of complaints was noted. Divisions were required to complete thorough and timely investigations. However, there had been instances when complaints had not been sufficiently reviewed and the complainant had raised further issues in addition to the original complaint.
- The Medical Director, Sean O'Kelly referred specifically to the decrease in Antibiotic Prescribing Compliance shown in the Q1 Exception Report from 84% in June, to 80% in July. Action was being taken to train new doctors to fully complete the antibiotic section of the new drug chart. It was also noted that the Joint Pharmacy and Microbiology ward rounds were taking place to facilitate learning and this raised optimism that the level would be achieved.
- A downward trend was reported with regard to the World Health Organization (WHO) Surgical Safety Checklist standard (Q5 Exception Report), and as a result, the Trust had revised the reporting format from mid-May 2011. The importance of full completion of forms had been reinforced to staff, along with the revisions to reporting.

Discussion commenced following the Chief Nurse's presentation of the Quality Report, and included the following:

- Referring to the Performance Overview graph, John Steeds (Governor) requested clarification on the management of the monthly trajectory of Clostridium Difficile. The Director of Infection Prevention and Control,

Christine Perry, confirmed that it was derived from national and locally-set targets. Methicillin-Sensitive Staphylococcus Aureus (MSSA) was a local target for 25% reduction this year, but the overall figure was an accumulation of targets.

- Garry Williams (Governor) requested a definition of 'Access', as he felt there could be confusion around the use of the word. James Rimmer responded that it largely defined the timeliness of patient care.
- Garry Williams asked how many patients pursued redress of their complaints beyond the Trust. Alison Moon responded that this information was given in the Trust Annual Report and that very few complainants took external action or contacted the Ombudsman. There was a preference to reconcile inside the Trust. Paul Mapson said that negligence claims were low.
- Following a request for assurance from Paul May around 'Exception Report Q6 – Stroke care – percentage receiving brain imaging within an hour', Sean O'Kelly confirmed that the meeting between the stroke clinical team and emergency department staff to discuss Recognition of Stroke in the Emergency Room (ROSIER) had taken place. He also confirmed that the performance of the standard had improved recently, but there were still challenges around scanning patients within one hour of arrival, and the reasons were felt to be 'multi-factorial'. Sean assured the Board that the performance would increase and he would report back at a future date. He also clarified to Paul May that the scanner and operational team ran a 24-hour service and approximately 50% of stroke patients were suitable for thrombolysis within an hour. Others would be scanned within 24-hours. Deborah Lee added that CT (Computed tomography) scans were the first diagnostic on the pathway. It was also noted that North Bristol NHS Trust provided stroke care out-of-hours. Alison Moon and Sean O'Kelly were meeting with the Stroke Group on 26 August 2011.
- Referring to Complaints, Alison Moon reported wider learning across the Trust. She chaired the Patient Experience Group with representatives from governors, LINKS, and a complaints manager. A newsletter for staff regarding patient experiences and outcomes was currently in development and would be for distribution across the Trust.
- Clive Hamilton (Governor) asked who decided to move patients to mixed or single-sex wards. It was confirmed that this was the responsibility of senior site managers. Alison said that the mind-set across the NHS was to drive-out mixed-sex accommodation. At University Hospitals Bristol NHS Foundation Trust there were very few exceptions for mixed-sex accommodation and these were always based on clinical need. Alison stressed that in all cases where mixed-sex accommodation was unavoidable, that standards of privacy and dignity were always upheld.
- Referring to '1.6 Supporting Information' and second 'Recent Complaint', Iain Fairbairn questioned why the patient did not undergo an internal examination, and why there seemed to be no review with the clinician. Sean O'Kelly had investigated this and Iain Fairbairn was "absolutely assured" that this had been fully investigated and learning had been achieved by the clinicians involved.
- Clive Hamilton requested assurance that processes towards the

achievement of 'zero-tolerance' were in-place for pressure ulcers and complaints, and how staff tackled the issues. Alison Moon explained that these were the main priority and focus for Ward Sisters and their nursing staff and the care they gave had the biggest impact in achieving the standards. Alison explained that Grade 2 ulcers and below were reviewed on the same day they were found and the patient received appropriate treatment. She reviewed Grade 3 and 4 ulcers personally, before applying the same system. If persistent failings were noted, leadership would be questioned and given special attention. Following a request for detail by Emma Woollett, Alison confirmed that it was possible for an ulcer to be a Grade 3 from the outset.

### Patient Experience

The Patient Experience Report related to a patient who had to wait over a month for the results of an urgent CT scan.

The learning and action taken as a result of the complaint was as follows:

- Completed radiology examinations were no longer assigned to a specific radiologist to report on, and were instead assigned to a Work Space, where radiologists specialising in the appropriate work area could access them. The result of the change ensured that if a radiologist was absent or had a reporting backlog, others in the group could pick up the work. Staff in the department were reminded of the importance of good 'housekeeping' of the system.

Members of the Board questioned if the Trust reacted fast enough to the scan being 'lost in the system' and Sean O'Kelly clarified that there was a possibility that the scan was in a queue of reports, or investigations yet to be reported, and that the system had not been fit-for-purpose. He confirmed that it had since been updated and re-designed, to avoid this occurring again. John Savage added that losing tests results and scans was unacceptable and questioned the outcome of this complaint had the results contained 'bad news'.

### c. Workforce

The Director of Workforce and Organisational Development, Steve Aumayer, introduced the Workforce element of the Summary Quality and Performance report.

Steve reported that since the last meeting of the Trust Board of Directors, he and Paul Mapson had completed work on Whole time Equivalents and the red-line increase from March to July was the result of the work completed and the main issue was around pay-savings in the Trust. Steve was pleased to report that the Mutually Agreed Resignation Scheme (MARS) had been worthwhile, and potentially saved the Trust circa £800k recurrently.

The Trust was still not achieving its 'stretch' targets for sickness absence, although progress was being made. It was a high target to achieve and equated to a saving of £700k per year.

Appraisal rates were noted as challenging, but with the help of the Divisions, it was predicted that 80% compliance would soon be achieved and exceeded. A complicated 'best-practice' process remained in-place, but a new performance management process was being launched in October, which was expected to aid compliance. The new process focused on quality and added greater value.

Decreases in attendance at Infection Control Statutory and Mandatory Training had been reported, and it was felt this was due to the rotation of medical staff. A recovery in attendance figures was expected to be reported at the next Public Trust Board meeting.

The drop in fire safety compliance is as a result of the requirement moving from 2 yearly to annual updates. A full recovery plan is in place to achieve the annual standard within 12 months. In the meantime, progress against the trajectory will be reported as well as absolute compliance with the annual plan.

### d. Access

The Chief Operating Officer, James Rimmer, introduced the Access element of the Summary Quality and Performance Report.

James informed the Board that the reported Access Standards were largely related to the Monitor Compliance Framework. He reported good performance in emergency waits and noted that plans were being prepared for winter. There were challenges for Cancer Pathways, as shown in the A1 Exception Report, and the 62-Day Cancer Standard was failed in June. There was also concern around the 62-day Cancer Screening Pathway, but James reported that there was a new team working on revising the focus around them.

The plan was being reviewed for the A2 Exception Report - Last Minute Cancelled Operations. The Divisions are to be assigned greater accountability for the cancellation of operations and will assume responsibility for escalation and sign-off.

Breastfeeding rates in the Trust were below last year's overall performance, but improvement was noted for June.

Discussion commenced following the Chief Operating Officer's presentation of the Access Report, and included the following:

- Wendy Gregory (Governor) raised concerns about late scheduling at St Michael's Hospital and James confirmed that occasionally there were scheduling problems there due to emergencies, but that he did not have specific details to-hand in this regard.
- Emma Woollett and Kelvin Blake asked if there was any link between problems around Urology and Last Minute Cancelled Operations. James responded that Urology had a wider pathway issue but, as a general rule, cancelled operations were disruptive and always a last resort.
- Following a request for further clarity by Mo Schiller (Governor), James said that there was also a focus on not cancelling operations more than once per patient. Wendy Gregory expressed concern that the figure was still high and James responded that any last minute cancellations were based on clinical priorities and were not necessarily due to equipment or other failures and that clinical necessity and patient choice issues were taken into account for re-booking. Wendy went on to ask about the access to a cancer nurse in the working-week and James responded that the access was good and the Trust had just appointed a new leadership team and full-time cancer nurse. Alison Moon added that Clinical Nurse Specialists supported patients with cancer and she would be very happy to discuss this with Wendy in more detail.

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| • James clarified to Neil Auty (Governor Representative) and Emma Woollett that equipment breakdowns affected operating lists and the primary reasons for these breakdowns were accidental damage and general machinery failure, which he would outline in more detail at the September Public Trust Board Meeting. John Savage added that the report gave no statistics on the levels of breakdowns and James said that the national target was 0.8% and the Trust came close, but was not yet achieving this. After a query from Iain Fairbairn, Robert Woolley confirmed that it was hard to generalise if the Trust carried back-up equipment, in case of failure, as it was a complex issue.<br>• Clive Hamilton informed the Board that equipment was found to be missing during a Peer Review. James confirmed the Trust's procedure that the Divisions re-issued missing equipment. Robert Woolley added that there had been problems tracking equipment, but items were now barcoded and asset-managed and logged at libraries in the Trust.<br>• James confirmed to Anne Ford (Governor) that tighter scheduling was needed to avoid double-booking operating theatres.<br>*There being no further questions or discussions, the Board resolved to **note** the Summary Quality and Performance Report.* | Chief Operating Officer |
| **7. Dignity and Nutrition Inspection Programme Care Quality Commission Report**<br>The Board received and considered this report by the Chief Nurse to **note**.<br>Alison Moon informed the Board that the Care Quality Commission recently inspected the Trust for its Dignity and Nutrition Programme and the purpose of the report was to brief the Board on the findings of the inspection, including the Trust's agreed recovery plan in relation to the non-compliant 'Outcome 5 – Meeting Nutritional Needs'.<br>Some improvements had been noted since the Care Quality Commission's visit in October, but changes had not been implemented swiftly enough to allay their concerns, so a 12-week recovery programme had been established. Alison described the key actions given in the report, and her expectation that the Trust will achieve compliance by the end of September 2011.<br>Discussion commenced following the Chief Nurse's presentation of the Dignity and Nutrition Programme Care Quality Commission Report, and included the following:<br>• Paul May informed the Board that the Quality and Outcomes Committee had reviewed the action plan at their meeting on 23 August. He commented that the plan was brief and simple, yet hopefully effective with good timescales. The Committee should receive the results of the recovery plan at the meeting on 25 November, but would be looking for sustainability in the future.<br>• The Care Quality Commission had expressed dissatisfaction that some members of staff were not spending enough time with patients at mealtimes, and in reference to this, Iain Fairbairn and Garry Williams requested more detail. Alison Moon said that a strategy was being produced into how the Trust recruited and trained its volunteers to assist patients, and also confirmed that occupational therapists and other staff helped with 'feeding'. Alison | |

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| named Redcliffe ward in the Bristol General Hospital as a particular exemplar of good standards.<br>• Robert Woolley concluded that there was an urgent need for the Trust to ensure improvement in nutrition.<br>*There being no further questions or discussions, the Board resolved to **note** the Dignity and Nutrition Inspection Programme Final Care Quality Commission Report.* | |
| **8. Infection Control Annual Report and**<br>**9. Infection Control Quarterly Report**<br>*(Items 8 and 9 were discussed together)*<br>The Board received and considered these reports by the Chief Nurse to **note**.<br>Alison Moon said the reports demonstrated how seriously the Trust took Infection Control and compliance to the 'Hygiene Code' (Code of Practice for the Prevention and Control of Health Care Associated Infections). She thanked the Director of Infection Prevention and Control, Christine Perry, for her enthusiasm and commitment in achieving full compliance with the Code.<br>Christine Perry briefed the Board on the progress made in Infection Control, saying that her team spent significant time at Infection Control Meetings discussing decontamination for the Quarterly Report, which was more operational than clinical. As a result of the work around decontamination, the Trust had developed robust leadership, and as such, significant activity was underway to target norovirus, for which the Service Development Group would receive a report in December. Christine also reported that her team were working on a table-top review with the Primary Care Trust in preparation for potential norovirus instances during the forthcoming winter months.<br>Discussion included:<br>• Paul May thanked Christine and her team for the report, but requested clarification about matrons' training. Christine confirmed that a plan was in-place for widespread training for all matrons throughout the year. Following a query from Iain Fairbairn, Alison Moon confirmed that there was clear national guidance on the role of a matron being visible and accessible in a clinical leadership role and that we were working on how we can strengthen this here at UH Bristol.<br>• Clive Hamilton questioned a 'contradiction' contained within the report describing how two members of staff were found to have tuberculosis, despite the Trust screening programme. Christine Perry acknowledged the conflict within the report, but assured Clive that robust processes were in-place with Occupational Health. With reference to the two staff mentioned, one staff member worked in a non-clinical capacity, so would not have been screened. The second staff member would have been screened, but there was a possibility that the tuberculosis was not active at the point of screening (the test only found active tuberculosis, which could take up to five years to develop). The Trust was assessing changing the tests for greater accuracy.<br>• Following a query by Alex Bunn (Governor), Steve Aumayer confirmed that agency staff were screened and immunised, adding that the Trust also | |

sought to re-screen staff who were known to have spent time in high-risk countries, but this was a challenging task.

- John Steed (Governor) asked who was responsible for cleaning headphones and television sets in the Trust, as during a stay in hospital he noted that they were not cleaned. Jan Dykes said that the television installation company was responsible for the cleaning of the television sets. James Rimmer would be meeting with the company shortly.
- John Steeds asked for an update on the Methicillin Resistant Staphylococcus Aureus (MRSA) objectives. Christine confirmed that plans had been in-place for two months.
- Garry Williams asked about the dangers of infection in public areas of the hospitals, and about the quality of our laundry cleaning services. Christine confirmed that there was signage around the hospitals to deter people from entering the premises if unwell, plus a robust plan for winter colds and flu and a vaccination programme for Trust staff. The plan included an education event for members. Alison Moon would look into the take-up of immunisations by staff.
- Regarding laundry services, James Rimmer confirmed that the current laundry contract was due to expire at the end of November 2011, when a new laundry provider would commence.
- Following a question by Mo Schiller, Christine responded that a review of hand gel was currently underway, taking safety and locations into account. The Trust was also assessing the use of a new gel with a built-in 'gag-reflex trigger', to deter people from consuming it.
- John Savage requested that all signage relating to the previous alcohol gel locations be removed in the interim.

*There being no further questions or discussions, the Board resolved to **note** the Infection Control Annual Report and the Infection Control Quarterly Report.*

## 10. Health and Safety Annual Report

The Board received and considered this report by the Director of Workforce and Organisational Development to **note**.

Steve Aumayer informed the Board that the report summarised all the main Health and Safety issues for 2010/2011 in the Trust, including Manual Handling.

Steve drew the Board's particular attention to Table 1 on page 67, which showed a significant reduction in the total number of incidents in the Trust. Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents had increased by 20% due to increased reporting and most reports were due to staff having up to four days absent from work, requiring a 'RIDDOR'. The nature of these incidents was closely monitored.

Chart 4 on page 71 showed a significant increase in Health and Safety incidents caused by non-medical equipment, and this was felt to be due to changes in reporting and awareness, attributable to the online tool.

Discussion included:

- Iain Fairbairn noted that the majority of incidents were around manual-handling and wanted to know what was in place to mitigate risk in the design of the new building. Deborah Lee said this was identified and discussed at the Risk Management Group, but there was a need for improved 'read-across' to the capital planning process. Alison Moon added that the availability and deployment of equipment for use when moving or lifting bariatric patients was under review.
- Following a question by Sylvia Townsend, Steve Aumayer responded that there were no specific details included regarding the review of legionella, but that the Health and Safety Executive was pleased with the progress noted during their visit. Robert Woolley confirmed that no incidences of legionella had been reported at the Trust.
- Neil Auty requested further clarity on the incidences of both violence and aggression in the Trust and Steve Aumayer responded that the figures included 'verbal' abuse, and every occurrence was investigated to see if it could have been avoidable. Neil expressed concern at the level of violence and abuse in the Trust and the impact this might have on staff morale. Steve said he would provide a more detailed analysis Governors prior to the next Board meeting.
- Alison Moon added that there had been a cultural shift in the NHS from 20 or 30 years ago, when staff 'tolerated' abuse, and nowadays there were supported routes to criminal conviction for people who committed violent or abusive acts. Steve mentioned that many incidences of violence and abuse were directed at estates and ancillary staff.

*There being no further questions or discussions, the Board resolved to **note** the Health and Safety Annual Report.*

## 11. Information Governance Annual Report

The Board received and considered this report by the Medical Director to **note**.

Sean O'Kelly said that the report highlighted compliance with the requirements of Version 7 of the Information Governance Toolkit and the Trust's self-assessment of compliance with Version 8. These assessments showed that progress was needed in three indicators, which were:

1. Information Governance training,
2. Confidentiality audits,
3. Pseudonymisation.

The report outlined plans designed to secure this improvement, and also highlighted the increase in Freedom of Information requests received by the Trust. It also gave details concerning Information Governance incidents. No incidents categorised as 'Serious Information Governance Incidents' were reported during the year. Sean clarified that when the Trust shared information with other parties, patients' details were always removed.

Discussion included:

- Garry Williams (Governor) referred the Board to page 80 of the report, asking if the Trust ever refused Freedom of Information requests. Robert Woolley confirmed that if any of the statutory Exemptions applied, the Trust

would apply them in accordance with the Act.

- Following a question from John Steeds (Governor), Paul Mapson clarified that the Trust had adopted a new category titled 'Documentation – Misfiled' and there was no comparative data for the previous year.
- Sean O'Kelly responded to Emma Woollett's query about the number of Information Governance Incidents for 2010-2011, saying that he did not think it was a significant number. Paul May added that 'Breaches of Patient Confidentiality' gave the Trust a "level of worry" and Sean gave assurances that the Trust invested vigour and control into securing patient confidentiality.

*There being no further questions or discussions, the Board resolved to **note** the Information Governance Annual Report.*

## 12. Board Assurance Framework Report

The Board received and considered this report by the Director of Strategic Development to **note**. It was noted that the report included and subsumed the previous Strategic, Corporate and Compliance Objectives Status Report.

Deborah Lee explained that the purpose of the report was to provide the Board with the quarterly update on progress against the Trust's objectives at the end of Quarter 1, and to provide associated assurance of the control of any associated risks to delivery.

This was a 'combined' report which had received input from the Audit Committee during its development. The Trust was declaring one high risk (Serial Number 1.4) which was the need for increased recruitment of patients into National Institute for Health Research (NIHR) trials. Three other risks were 'Red-rated', but had been de-escalated due to controls being put in-place.

Discussion included:

- Referring to Objective 1.4, John Steeds asked for reasoning behind the delays in giving honorary contracts to research staff. Robert Woolley responded that it was entirely a process issue.

*There being no further questions or discussions, the Board resolved to **note** the Board Assurance Framework Report (including Strategic, Corporate and Compliance Objectives Status Report).*

*Board: Finance and Governance*

## 13. 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 22 August 2011, including the Finance Report

Emma Woollett (Vice Chair in Lisa Gardner's absence) reported on the main issues discussed at the Finance Committee meeting held on Monday 22 August 2011:

1. The Trust had delivered a surplus of £1.078m for the first four months of 2011/12, which was in-line with the Annual Plan at this stage in the year. It

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| was noted that the significant feature for the July position continued to be achievement of the Cash Releasing Efficiency Savings programme.<br><br>2. The Finance Committee received a progress report on Cash Releasing Efficiency Savings from the Chief Operating Officer and the forecast savings for the year currently totalled £21.067m or 79% of the 2011/12 target of £26.635m. Actual Cash Releasing Efficiency Savings achieved for April to July totalled £4.603m, which was equivalent to slippage of £2.406m when compared with the Plan for the period of £7.009m. Additionally, the reported position also reflected the prudent view that progress against the plan should be monitored on the basis that savings would be delivered evenly throughout the year, which would result in a further adverse variance of £1.869m, giving a total adverse variance on the Cash Releasing Efficiency Savings programme of £4.275m.<br><br>3. The Finance Committee received an update on action taken / progress made since the previous meeting. There was agreement that medium term Workforce Plans were essential and needed to inform and influence Cash Releasing Efficiency Savings Plans. It was noted that a significant proportion of the Cash Releasing Efficiency Savings achieved in 2011/12 were of a non-recurring nature and that there was a need for a higher proportion of sustainable, recurring savings. A comprehensive review of all Cash Releasing Efficiency Savings schemes is to be completed and reported to the September meeting of the Finance Committee. This was seen as a pivotal moment in assessing the impact of the Trust delivering its Financial Plan for the year and the requirement for remedial action for 2011/12 and beyond.<br><br>4. The other principal item of business was the consideration of the Bristol Haematology and Oncology Centre Outline Business Case. The Committee recognised the importance of this proposal for Oncology and Bone Marrow Transplant (BMT) services and that consideration and approval of the Full Business Case by the Trust Board in November was on the critical path for the Centralisation of Specialist Paediatrics scheme. The Director of Strategic Development agreed to oversee the further work required by clinicians and managers in the Specialised Services Division, which should see a strengthening of the proposal with regards to the Bone Marrow Transplant service, bed numbers and the planned replacement of linear accelerators. The Committee agreed to authorise the further proposed expenditure on fees (£675k) to develop the Full Business Case, but was unable to approve the Outline Business case given the current shortfalls in capital funding and revenue costs being greater than that deemed affordable in the Long Term Financial Plan. The Committee noted that there was an expectation that the financial issues would be addressed and a more compelling business case prepared.<br><br>Discussion included the following:<br><br>• Iain Fairbairn said that the Bristol Haematology and Oncology Outline Business Case had not been approved by the Finance Committee and Robert Woolley added that the Finance Committee decided to proceed with design work but bring the Business Case back later in the year. The Trust had its own capital expenditure policy and was at liberty to vary the policy as it chose. Emma Woollett said that despite the Finance Committee not approving, the Board still could. Iain Fairbairn responded that the Board | |

needed to look across the whole city (of Bristol), to which Robert agreed, saying that the two Bristol Trusts were reviewing the strategic context of cancer care across the city. John Savage added that Non-executive Directors had an important role in pushing forward a Strategic Review.

- A number of governors requested clarification about staff vacancies in the Finance Department. Paul Mapson confirmed that there were no new staff, but there had been a restructure and two senior staff members were now working on the Cash Releasing Efficiency Savings programme.
- Robert Woolley clarified that 'WCLRN' in the report, was an acronym for 'Weston Comprehensive Local Research Network'.
- Robert Woolley explained that the Trust was doing well in its funded clinical trials, although more time and energy was required to explain the procedure of entering clinical trials to patients. There was a suggestion that it could be explained in a letter, and special Research Nurses could discuss with patients.

### b. Quality and Outcomes Committee dated 23 August 2011

The Chair of the Committee, Paul May, reported on the main issues discussed at the Quality and Outcomes Committee meeting held on Tuesday 23 August 2011:

1. **Serious Incident (breast misdiagnosis)**

The Quality and Outcomes Committee gave assurance that the Serious Incident practices had been reviewed and were effective, specifically with regard to the formal process of the reporting and follow-up procedures, which included the following key issues:

- It was essential that Incidents were reported promptly to the Patient Safety Team and Executive Directors.
- There were formal definitions regarding the grading of incidents, with an emphasis to 'grade-up', rather than down, if there was uncertainty about the severity of an incident.
- The investigations were carried out by the new corporate Patient Safety Group and the Division where the breach occurred;
- The Committee was reassured by the thorough processes of completing Root Cause Analyses.
- The Executive Directors would be regularly notified of progress and outcomes of actions resulting from the review of the Incident;
- The Committee would monitor the frequency and seriousness of incidents to identify issues requiring further investigation and action;
- Being alert to absences of reporting was also an important consideration and robust plans were in place to monitor these.

In addition, the Committee had noted that:

- The style of reporting a 'catastrophic' incident was being reviewed for the future.
- The training and culture of staff within the Divisions were important factors in the reporting of Serious Incidents.
- A review of Multi-Disciplinary Teams would be on the Committee

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| Agenda for 25 October meeting.<br>• There are clear and unequivocal processes, frameworks and guidance for reviews in-place, which were effective, providing the action plans were robust and timely.<br>• A detailed Serious Incident investigation into a breast screening misdiagnosis demonstrated how the system worked and further information would be submitted to the Committee regarding the review of the Cancer Multi-disciplinary process.<br>2. **Histopathology Action Plan**<br>• It was noted that the plan in the Committee pack was not current and the latest version would be circulated.<br>• The Histopathology Core Meeting occurred on a fortnightly basis.<br>• The Committee was pleased to note the conciseness of the plan and of the description of actions taking place within the service.<br>• Examples were given of actions being taken by both Trusts to ensure that the Partnership Agreement was being implemented as widely as possible.<br>• The Committee agreed that the new Joint Clinical Lead should be supported by both Trust Medical Directors in his role. The wider Primary Care Trust-led Pathology Services review process had been difficult for the staff involved, so progress was reported as "patchy on occasions".<br>The Committee had resolved to keep the plan under review.<br>3. **Nutrition**<br>The Care Quality Commission Dignity and Nutrition inspection raised some concerns. A detailed 12-week action plan around Nutrition was being developed and a fortnightly audit taking place.<br>The Committee had agreed that the report was of a high quality and ensured improved outcomes for patients. A further report of the internal audit review in September would be discussed at the meeting of the Committee on 25 November.<br>*There being no further questions or discussions, the Board resolved to **note** the Committee Chairs' Reports.* | |
| **14. Partnership Programme Board Report**<br>The Board received and considered this verbal report by the Chief Executive to **note**.<br>Robert Woolley explained that the purpose of the Trust's partnership with North Bristol NHS Trust was to oversee work under agreement at three to four meetings annually.<br>The Partnership Programme Board had adopted its revised Terms of Reference and focussed on overseeing the programme of work between the Trusts around Breast, Ear, Nose and Throat and Urology Centralisation and the probable centralisation of Trauma services. Robert also reported that a wider review of Pathology services was underway and there was a need to undertake acute service work for commissioning plans in Bristol and review what other services might change. No decision had been made regarding the potential sharing of back-office services. | |

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| Robert will undertake to continue reporting to the Board following each meeting of the Partnership Programme Board.<br>*There being no further questions or discussions, the Board resolved to **note** the Partnership Programme Board Report.* | |
| *Board: Strategy and Business Planning* | |
| **15. Future of the Audit Commission's Trust Practice**<br>The Board received and considered this report by the Chief Executive to **note**.<br>Robert Woolley gave notice to the Board that the Audit Commission had formally advised the Trust of timescales for the winding-up of their practice, with a requirement to approve the appointment of new Auditors for the 2012-2013 financial year.<br>*There being no further questions or discussions, the Board resolved to **note** the Future if the Audit Commission's Trust Practice.* | |
| **16. Monitor Feedback on the Annual Plan**<br>The Board received and considered this report by the Chief Executive to **note**.<br>Robert Woolley explained that the Trust had submitted its Annual Plan to Monitor whose response was that Monitor was sufficiently assured and would therefore not be undertaking a further review.<br>In the Annual Plan, the Trust had highlighted risks around Clostridium Difficile and the Maximum Wait Time in Accident and Emergency, which was in the Compliance Framework for the financial year.<br>Monitor had changed the scoring criteria after submission of the Annual Plan and, as a consequence, the Trust's 'Amber-Green' risk rating for governance was changed to 'Amber-Red'.<br>Robert assured the Board that the Trust was completely focussed on delivering standards throughout the year.<br>*There being no further questions or discussions, the Board resolved to **note** the Monitor Feedback on the Annual Plan.* | |
| **17. Academic Health Science Centre Update**<br>The Board received and considered this verbal report by the Chief Executive to **note**.<br>Robert Woolley said that following agreement in principle to establish an Academic Health Science Centre in Bristol, the Board needed to examine the processes and consider the funding, measuring processes and responsibilities involved.<br>Robert explained the need for appointing key posts to the Joint Health Science collaboration and the intention that there would be an agreement by Christmas. The collaboration would be in place from April 2012 and a Chair and Director appointed.<br>There were presently five official Academic Health Science Centres in Britain, including three in London, and Robert believed one in Bristol would be "hugely positive". The Leadership Group planned more work, but Robert | |

assured the Board that it would be kept abreast of any decisions. Related Corporate Objectives were reported in the Board Assurance Framework, with action plans.

Discussion included:

- Garry Williams questioned the function of the Institute of Child Health, with regard to the Health Science Centre and asked if there might be conflicts with the Royal Colleges. Robert responded that the Trust would look to incorporate the function of the Institute within the identified health partnership, and that there were no conflicts with Royal Colleges, only positives. The Trust already collaborated with the University of Bristol, which would add further benefit to the proposal.
- Following a question by Paul May, Robert confirmed that research funding played a substantial role in the sustainability of funding and further work would be completed with regard to this.

*There being no further questions or discussions, the Board resolved to **note** the Academic Health Science Centre Update.*

## 18. Quarter 1 Capital Projects Status Report

The Board received and considered this report sponsored by the Director of Strategic Development to **note**.

Deborah Lee updated the Board on the current status of major on-going development projects within the Trust.

The Status Report in Appendix A outlined the current status of the Bristol Royal Infirmary Redevelopment and Centralisation of Specialist Paediatrics Project. It provided an update on other associated key schemes, which included the Welcome Centre, site-wide generators and the Bristol Haematology and Oncology Centre Business Cases, all of which had a material effect on the delivery of the major projects.

It was noted that the major projects already had approved Business Cases, full planning permission and funding in-place.

*There being no further questions or discussions, the Board resolved to **note** the Quarter 1 Capital Projects Status Report.*

## 19. Generator Business Case

The Board received and considered this report by the Director of Strategic Development and considered the recommendations for **approval**.

Deborah Lee explained that in-line with the Trust's Standing Financial Instructions, the Business Case was presented to the Board for the development of a site-wide emergency generator scheme, to seek the Board's approval to proceed with Option 2 (attached at Appendix A), namely: the Central High Voltage Generator solution, which was noted to be affordable in the overall indicative capital programme.

The Business Case concluded that Option 2 was a significantly superior technical solution that addressed the target 100% emergency cover requirement and provided an element of future-proofing for future site developments. It was possible the emergency generator could be installed with minimum disruption to existing services and potentially provide revenue

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| benefits for the Trust by supplying energy back to the 'grid'.<br>Deborah explained that the recent major incident led the Trust to look at solutions to address risks and development requirements and as a result of this, the Trust had been able to accommodate a more expensive solution, as a result of the raised profile and priority.<br>Deborah pointed out the high clinical risks which would be mitigated by the introduction of the proposed generator scheme, including the 'biggest risk of compromising patient care'.<br>Discussion included:<br>• Following a question by Garry Williams, Deborah Lee confirmed that the Trust had a 'green plan' in place regarding energy consumption and any new developments were informed by best-practice and credentials for the scheme. Paul Mapson clarified that the generator was for emergency back-up only.<br>*There being no further questions or discussions, the Board resolved to **approve** Option 2 as outlined in the recommendations of the Generator Business Case.* | |
| **20. Bristol Haematology and Oncology Centre Outline Business Case**<br>The Chairman confirmed that, for the reasons outlined in the Finance Committee Chair's Report, consideration of this Business Case has been deferred. | |
| *Board: Information and Other* | |
| **21. Any Other Business**<br>No items of other business were discussed. | |
| *Membership Council* | |
| **22. Chairman's Introduction and Apologies**<br>The Chairman welcomed the governors, in particular the new governors. He noted the apologies from governors.<br>*It was confirmed that those present made up a quorum of the Membership Council.* | |
| **23. Declarations of Interest**<br>In accordance with the Trust's Constitution, all members present are required to declare any conflicts of interest with items on the Membership Council Meeting Agenda.<br>*No declarations of interest were made.* | |
| **24. Minutes**<br>*The Membership Council considered the minutes of the previous meeting and resolved to **approve** them as an accurate record of matters transacted.* | |
| **25. Matters Arising**<br>The Membership Council considered the Schedule of Matters Arising. The | |

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| status of each item for action arising from previous meetings was confirmed.<br>*The Council resolved to **update** the Membership Council Meeting Schedule of Matters Arising accordingly.* | |
| **26. Governors' Report**<br>The Membership Council received and considered the Governors' Report from Neil Auty. In addition to the report, Neil highlighted that governors' had been invited by the Trust to take part in the hospital ward peer reviews. A number of governors have completed the peer reviews and considered them to be useful and valuable. Ken Booth, Public Governor, added that he had taken part in a peer review and he was very impressed with staff and quality. Neil thanked Alison Moon for this opportunity.<br>Alison thanked the governors for taking part in the peer reviews.<br>*There being no further questions, the Membership Council resolved to **note** the Governors' Report.* | |
| *Membership Council: Quality, Performance and Compliance* | |
| **27. Quality Working Group Report**<br>Mary Hodges, the Chair of the Quality Working Group, presented the Quality Working Group Report, and the minutes from the last meeting. She thanked Paul May, Non-executive Director, for attending the meeting on 22 August, and for briefing the group on the role, functions and activities of the Quality and Outcomes Committee.<br>Mary raised that the group suggested a governors' seminar on claims and settlements. Robert Woolley said he would speak to the Trust Secretary who manages the Trust's legal services.<br>*There were no further comments from the Governors. The Membership Council resolved to **note** the report.* | Chief Executive |
| *Membership Council: Corporate Governance* | |
| **28. Nominations and Appointments Committee Report**<br>John Savage presented the paper, including an extract from Minutes of the meeting and the basis of the Committee's recommendations for the reappointment of two Non-executive Directors. The Membership Council was satisfied with the process followed and the recommendations made by the Nominations and Appointments Committee. There being no further questions, the Membership Council resolved to:<br>a) **Approve** the reappointment of Paul May as Non-executive Director for a second, three year, term of office commencing 01 November 2011 and ending 31 October 2014.<br>b) **Approve** the reappointment of Kelvin Blake as Non-executive Director for a second, three year, term of office commencing 01 November 2011 and ending on 31 October 2014. | |
| **29. Membership Working Group Report**<br>Suzanne Green, Chair of the Membership Working Group, presented the Membership Working Group Report and Minutes of the last meeting. | |

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| Suzanne stated that the Terms of Reference had been compiled and finalised by the Membership Working Group and were presented to the Membership Council to note.<br>*There were no further comments from the Governors. The Membership Council resolved to **note** the report and Terms of Reference.* | |
| *Membership Council: Strategy and Business Planning* | |
| **30. Strategy Working Group Report**<br>Anne Ford, Chair of the Strategy Working Group, presented the Strategy Working Group Report and Minutes of the last meeting. Anne highlighted the following items:<br>a) Information talks have taken place at the Strategy Working Group meetings. These included Garry Higgins, Programme Lead for Pathology, on the Pathology Review and Andy Headdon, Strategic Development Programme Director, on the Bristol Royal Infirmary & Centralisation of Specialist Paediatrics projects.<br>b) A governors' visit to the Medical Simulation Centre had been arranged by Steve Aumayer, which the governors had found very informative. Steve explained that a business case to improve its utilisation was in the development phase.<br>*There were no further comments from the governors. The Membership Council resolved to **note** the report.* | |
| *Membership Council: Information and Other* | |
| **31. Any Other Business**<br>a) **Staff Engagement:** Ken Booth will present a paper on Staff Engagement at the Governors' Meeting with Alison Moon and Steve Aumayer on 13 October 2011.<br>b) **Sponsored sky dive:** Anne Ford commented that she was completing a sponsored sky dive on 03 September for Ovarian Cancer Research. Any sponsors would be welcome.<br>c) **Children receiving palliative care:** Maggie Mickshik informed the group of work currently being undertaken involving children receiving palliative care and their families. Maggie asked if the Trust was aware that this work was going on. Alison Moon replied that she was not aware and that she would discuss it at the next Patient Experience Group meeting.<br>d) **Child Protection:** Maggie Mickshik asked about the Trust's policy to help staff identify if a child was "under child protection". Alison Moon explained that it was the responsibility of staff to find out if a child was on a protection plan, but she would look into this further. Paul Mapson reported that the Trust was looking into an electronic system that would link in with Bristol City Council.<br>e) **Mental Health:** Pauline Beddoes updated the group on Mental Health facilities. Pauline had spoken to Dr Lucy Griffin regarding the out-of-hours service at weekends, and the analysis was: | |

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| • There were 1,165 records of attendance for self-harm between 20 September 2010 and 03 July 2011.<br>• On average 28.4 people attended per week.<br>• Out of the 1,165 records, 321 of attendances occurred between 09:00 and 17:00, which was 27.5% of the total.<br>• 349 out of 1,165 attendances occurred at the weekend. 85 occurred between 09:00 to 17:00. When only looking at attendances at the weekend, this proportion decreased slightly to 24.4% (85/349).<br>Alison Moon reported that statistics suggest people self-harm during the out-of-hours period. Key indicators for the level of service expected from the Mental Health Trust would be agreed in the next couple of months, but in the meantime, the Crisis Response line was available for staff.<br>f) **Wait times for pharmacy at the Oncology Unit:** Pauline Beddoes mentioned the wait times for Pharmacy at the Oncology Unit. She explained that bloods that were marked urgent take two hours to be reported, and a prescription was then needed by a doctor, which could take up to a further four hours. Alison agreed to look into this matter.<br>g) **When a patient is the Trust's responsibility:** Wendy asked when a patient was the Trust's responsibility and when they are not. Inpatients were looked after but Wendy's concerns were with someone in Outpatients, who may get lost within the system if a patient was referred on to another department and was not officially under anyone's care. Paul Mapson verified that it was Trust policy that each patient was booked onto the hospital system as 'Inpatient' or 'Outpatient'. Robert Woolley offered to look into certain cases if given the details.<br>h) **Televisions:** Sue Silvey raised the problem of some televisions (which include telephones) not working. For some isolated patients, a telephone was a lifeline. James Rimmer has a meeting on Friday 26th August with an external company who provide the television service and he would raise this issue with them.<br>i) **Smoking:** Sylvia Townsend asked what support was given to staff who smoked, in light of a recent 'complaint' regarding hospital staff smoking. Steve Aumayer said the Trust's policy was no smoking on-site. It was a disciplinary offence for staff to smoke wearing their uniforms and ID cards. Sue mentioned that she was happy with the action taken by the Trust.<br>j) **Car parking system:** Jacob Butterly mentioned a 'possible loophole' in the car parking system and that it was possible to swipe in and out without getting charged. Jan Dykes verified that all swipe actions were logged by the security system and were routinely checked. | Chief Nurse<br>Chief Executive<br>Chief Operating Officer |
| **32. Foundation Trust Members' Questions**<br>a) **Ward 53 in the Bristol Heart Institute:** A member told the group that he was recently admitted as an emergency to Ward 53 in the Bristol Heart Institute. He flagged several concerns and stated that although he was not criticising staff, he felt that the Trust needed more staff to deliver quality care. John Savage commented that this unfortunate experience was not common and that the Trust would take note of the points raised.<br>Alison informed the member of public that Comment Cards were used on all | |

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| wards, which gave patients the chance to write comments or suggestions. Robert stated that other patients may require a fat-free diet and Alison would liaise with relevant managers.<br>b) **Outpatient appointments:** A member asked for an update regarding outpatient appointments and how they were allocated. Robert Woolley confirmed that there was a Trust-wide outpatient review currently underway. The review was looking at all areas and how patients were booked, how clinics were scheduled, how staff were allocated to each clinic and how information flows between areas.<br>Alison commented that results from new outpatient surveys were fed into a patient information programme.<br>Anne Ford reported that over the last three years constituency meetings had seen an increase in patients' satisfaction with the Trust's services.<br>c) **Staff wearing uniforms:** A member mentioned seeing staff outside the hospital grounds wearing their uniforms. Alison clarified that the Uniform Policy stated that staff members could come to and from work in uniforms if the uniform was covered by a full-length coat. The Trust was aiming to provide all work areas with on-site changing facilities. The older sites were more difficult to provide for, but all new buildings would have changing facilities.<br>John Savage concluded by welcoming all governors' to public meetings of the Trust Board of Directors and confirmed that he would accommodate any questions the governors may have. | |
| **33. Date of Next Meeting**<br>**Annual Members Meeting**, Thursday 22 September 2011 from 18:00 to 20:00 in Lecture Theatre 1 of the Education Centre, Upper Maudlin Street, Bristol, BS2 8AE.<br>**Public Trust Board Meeting**, Wednesday 28 September 2011 from 10:30 to 13:30 in Lecture Theatre 1 of the Education Centre, Upper Maudlin Street, Bristol, BS2 8AE.<br>**Membership Council**, Wednesday 02 November 2011 from 13:00 to 15:00 in Lecture Theatre 1 of the 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 |
|---|---|---|---|---|---|---|---|
| 15 | 25/08/2011 | 6 | **Summary Quality and Performance Report (Access)** - James Rimmer to outline primary reasons for general machinery failure to the September Public Trust Board Meeting. | Chief Operating Officer | 28/09/2011 | | |

University Hospitals Bristol NHS
NHS Foundation Trust

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

| Item 05 - Chief Executive's Report |
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| **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 attached report summarises the key issues considered by the Trust Executive Group in the past month. |
| **Recommendations** |
| The Trust Board is recommended to **note** the key issues addressed by the Trust Management Executive in the past month and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board Agenda. |
| **Report Sponsor & Author** |
| Robert Woolley, Chief Executive |
| **Appendices** |
| • Appendix A – Trust Management Executive Report - 14 September 2011 |

**APPENDIX A**

# TRUST MANAGEMENT EXECUTIVE

# REPORT TO TRUST BOARD - SEPTEMBER 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 **agreed** to the circulation via intranet of the Trust-wide events calendar and the development of a mechanism for capturing, maintaining and circulating key corporate messages to inform communications planning throughout the year.

## 3. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** the removal by Monitor of an amber-red over-ride governance rating relating to concerns arising from the Independent Inquiry into Histopathology Services. It also **noted** that the Trust's current governance rating remained at amber-red because of non-compliance with Outcome 5 of the Care Quality Commission's essential standards. Action in hand to deliver the Trust-wide Nutrition plan and restore compliance by the end of September was **noted**.

Continued achievement of the total 4 hour wait time target was **noted**, alongside successful control of the incidence of healthcare acquired infections. However, given likely under-achievement of the 62 day cancer standard for Quarter 2, it was **agreed** that priority be given to reviewing cancer pathways to improve performance for the remainder of the year.

Given the challenging targets this year for reducing *Clostridium Difficile* infection rates, the Trust Management Executive **agreed**, subject to final financial assessment, to make an in-year investment in a new testing protocol which will reduce levels of false-positive results causing unnecessary inconvenience to patients.

Improvement in the delivery of safeguarding training was **noted**, giving a level of confidence about meeting internal targets by the planned date of 31 October.

Reports from subsidiary management groups were **noted**, which included the following items:

- preparation of an updated Norovirus management plan by 31 October
- continued development of plans for a new acute oncology service
- progress with the implementation of new Pharmacy Stock Control and Patient Administration Systems
- successful redesign of research project approval processes, reducing lead times to start-up by approximately 75%

- revised leadership and management arrangements for the Transforming Care programme, with Trust-wide leadership and staff development activities planned to launch in October

## 4. RISK, FINANCE AND GOVERNANCE

The Group received reports from the Director of Finance and from the Risk Management Group, **noting** the following issues in particular:

- financial pressures in Divisions requiring further investigation after the Month 5 position was published
- continuing focus on the improved reporting and management of risk at Divisional and corporate risk levels.

The Trust Management Executive **noted** the latest report of progress against the Histopathology Inquiry action plan and **agreed** that a target date for the creation of an integrated service should be set in consultation with North Bristol Trust.

Revised terms of reference for the following subsidiary management groups were **approved**, subject to minor amendments:

- Risk Management Group
- Service Delivery Group
- Clinical Quality Group.

The following reports were **approved** for submission to the Trust Board, subject to final proofing:

- Safeguarding annual report 2010/11
- Security annual report 2010/11

The Group **approved** a protocol, subject to certain clarifications, for the preparation and approval of Internal Audit investigation reports, which includes Trust Management Executive oversight of all future reports. The Group **agreed** that the draft reports presented at the meeting should be subject to further discussion with relevant Executive Directors.

The Trust Management Executive **noted** the current clear status of the log of serious concerns.

## 5. RECOMMENDATIONS

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

**Robert Woolley**
**Chief Executive**
14 September 2011

University Hospitals Bristol NHS
NHS Foundation Trust

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

| Item 06 – Summary Quality and Performance Report |
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| **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 recommended to **note** the current performance of the Trust and to ratify the actions being taken to improve performance. |
| **Report Sponsors** |
| • Health of the Organisation – Director of Strategic Development<br>• Quality – Chief Nurse & Medical Director<br>• Workforce – Director of Workforce & Organisational Development<br>• Access – Chief Operating Officer |
| **Other Authors** |
| Head of Performance Assurance / Deputy Director of Strategic Development<br>Assistant Director of Governance & Risk Management<br>Assistant Director of Workforce Planning |
| **Appendices** |
| • Appendix A – Summary Quality & Performance Report |

### Previous Meetings

| Executive Team | Trust Management Executive | Quality and Outcomes Committee | Finance Committee | Audit Committee | Other |
|---|---|---|---|---|---|
| N/A | N/A | 27 September 2011 | N/A | N/A | N/A |

University Hospitals Bristol NHS
NHS Foundation Trust

# SUMMARY QUALITY & PERFORMANCE REPORT

## September 2011

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## PERFORMANCE OVERVIEW

### SECTION A – Performance Overview

### Summary

Overall, the 'health' of the organisation remains similar to that of last month, with an increase in the number of GREEN rated indicators by one, and an increase in RED rated indicators by one. This net change includes the Number C. diff (*Clostridium difficile*) cases and Elective Length of Stay indicators going from GREEN to RED, and Single Sex Accommodation breaches and Patients Recruited into National Institute for Health Research (NIHR) Trials indicators going from a RED to a GREEN rating.

All three of the indicators of Being Accessible achieved a GREEN rating reflecting both the improved performance against the cancer standards at the end of the first quarter, and A&E 4-hour performance being above the local target of 98%. The position against three of the four Efficiency measures deteriorated in the month, although theatre productivity retained its GREEN rating. Both indicators of Research activities were GEEEN rated in the month, following the improvement in the numbers of patients recruited on to trials. Performance against all four indicators of Financial management improved, with three of the four measures being GREEN rated both in the month and year to date.

At the end of August the Trust was rated AMBER-RED against Monitor's Compliance Framework reflecting the Compliance Actions required to meet the Care Quality Commission's Nutrition standard and current performance against the Cancer Standards.

## 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) | 76.3 | 74.4 | N/A | Green: >= 74.4<br>Red: <72.4 | ↓ | Current month is July 2011. |
| A02 | Number of Patient Complaints | 123 | 151 | 633 | Green: <120<br>Red: >=135 | ↑ | |
| A03 | Same Sex Accommodation Breaches (Number of Patients Affected) | 3 | 0 | 48 | Green: 0<br>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 | 10 | Green: 0<br>Red: > 1 | ↓ | No RAG rating for YTD. Current month is July 2011. |
| B02 | Number of Inpatient Falls Per 1,000 Beddays | 4.89 | 5.16 | 4.86 | Green < 5.6<br>Red: >= 5.6 | ↑ | Current month is July 2011. |

### Keeping People Safe

| ID | Indicator | Previous | Current | YTD | Thresholds | Trend | Notes |
|---|---|---|---|---|---|---|---|
| C01 | Number of Serious Incidents (SIs) | 6 | 2 | 28 | | ↓ | |
| C02 | Number of C.Diff cases | 4 | 7 | 28 | Below Trajectory | ↑ | |

### Being Accessible

| ID | Indicator | Previous | Current | YTD | Thresholds | Trend | Notes |
|---|---|---|---|---|---|---|---|
| D01 | 18 Weeks Admitted Pathways | 91.8% | 91.3% | 92.2% | Green: >=90%<br>Red: <85% | ↓ | |
| D02 | Number of Cancer Standards Failed | 1 | 0 | 0 | Green: 0<br>Red: >=2 | ↓ | Previous is Quarter 4 2010/11. Current and YTD is Quarter 1 2011/12. |
| D03 | A&E 4 Hour Standard | 97.69% | 98.14% | 97.98% | Green: >=98%<br>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) | 65.5 | 87.0 | | Green: <80<br>Red: >=90 | ↑ | Previous and Current totals are March and April 2011. |
| E02 | 30 Day Emergency Readmissions | 332 | 294 | 1853 | Below 10/11 volumes | ↓ | Changed from last month, to now show absolute number of 30 Day Emergency Readmissions rather than a percentage. |

## Being Efficient

| ID | Indicator | Previous | Current | YTD | Thresholds | Trend | Notes |
|---|---|---|---|---|---|---|---|
| F01 | Elective Length of Stay Reduction | 3.19 | 4.01 | 3.71 | Green: <= 3.64<br>Red: >= 3.83 | ↑ | |
| F02 | Emergency Length of Stay Reduction | 5.01 | 5.21 | 5.14 | Green: <= 5.07<br>Red: >= 5.34 | ↑ | |
| F03 | Theatre Productivity - Percentage of Sessions Used | 92.1% | 95.5% | 94.9% | Green: >= 90%<br>Red: < 90% | ↑ | |
| F04 | Outpatient Follow-Up To New Ratio | 2.12 | 2.15 | 2.05 | Green: <2.03<br>Red: >=2.03 | ↑ | |

## Valuing Our Staff

| ID | Indicator | Previous | Current | YTD | Thresholds | Trend | Notes |
|---|---|---|---|---|---|---|---|
| G01 | Workforce Costs | 0.3% | 1.7% | 1.7% | above current month and ytd budget | ↑ | |
| G02 | Staff Sickness | 3.9% | 3.8% | 3.8% | See note | ↓ | Red: Above Forecast (over 0.7% of target) 0.5 percentage points above target = red 0.2–0.5 above target = amber on target or less = green |

## Promoting Research

| ID | Indicator | Previous | Current | YTD | Thresholds | Trend | Notes |
|---|---|---|---|---|---|---|---|
| H01 | NIHR Income (£000s) | £1,365 | £1,458 | £1,458 | Green:>Same Period Last Year<br>Red:<Same Period Last Year | | Previous is Apr-Jul cumulative total. Current (and YTD) is Apr-Aug cumulative total. Trend arrow is not applicable, as Current will always be higher than Previous. |
| H02 | Weighted Patients Recruited Into NIHR Trials | 1,657 | 1,631 | 6,564 | Green: > YTD Last Year<br>Red: < YTD Last Year | ↑ | Previous and Current are rolling 3 month totals Mar-May 2011 and Apr-Jun 2011 respectively). YTD is Apr-Jun 2011 |

# PERFORMANCE OVERVIEW

## Governing Well

| ID | Indicator | Previous | Current | YTD | Thresholds | Trend | Notes |
|---|---|---|---|---|---|---|---|
| J01 | Monitor Governance Risk Rating | 3 | 3 | N/A | Green: < 1<br>Red: > = 4 | ➡ | Previous is July, Current is August. This reflects the Care Quality Commission (CQC) Compliance Actions and current 62-day cancer standard performance. |

## Delivering Our Contracts

| ID | Indicator | Previous | Current | YTD | Thresholds | Trend | Notes |
|---|---|---|---|---|---|---|---|
| K01 | Financial Performance Against CQUINs (£millions) | | | £3.63 | Green: £2.75m (50%)<br>Red £0m | | No previous or current values, as this is the first month CQUINs achievement has been estimated. Forecast 11/12 rewards based on post month-end assessment. |
| K02 | Contract Penalties Incurred (£millions) | £1.15 | £2.88 | £2.88 | Green: Below Plan<br>Red: Above Plan | ⬆ | Previous is Apr to June 2011. Current and YTD is April to July 2011. |

## Managing Our Finance

| ID | Indicator | Previous | Current | YTD | Thresholds | Trend | Notes |
|---|---|---|---|---|---|---|---|
| L01 | Monitor Financial Risk Rating | 3 | 3 | 3 | Green: >3<br>Red: <3 | ➡ | For all four financial measures, Current is Current Year To Date so will be the same as the "YTD" column. |
| L02 | EBIDTA (Compared To Plan) | 96% | 107% | 103% | Green: 100%<br>Red: <95% | ⬆ | |
| L03 | CRES Achievement | 52% | 81% | 69% | Green: >=90%<br>Red: <75% | ⬆ | |
| L04 | Liquidity (in Days) | 38.5 | 38.3 | 38.3 | Green: 25+ days<br>Red: <=14 days | ⬇ | |

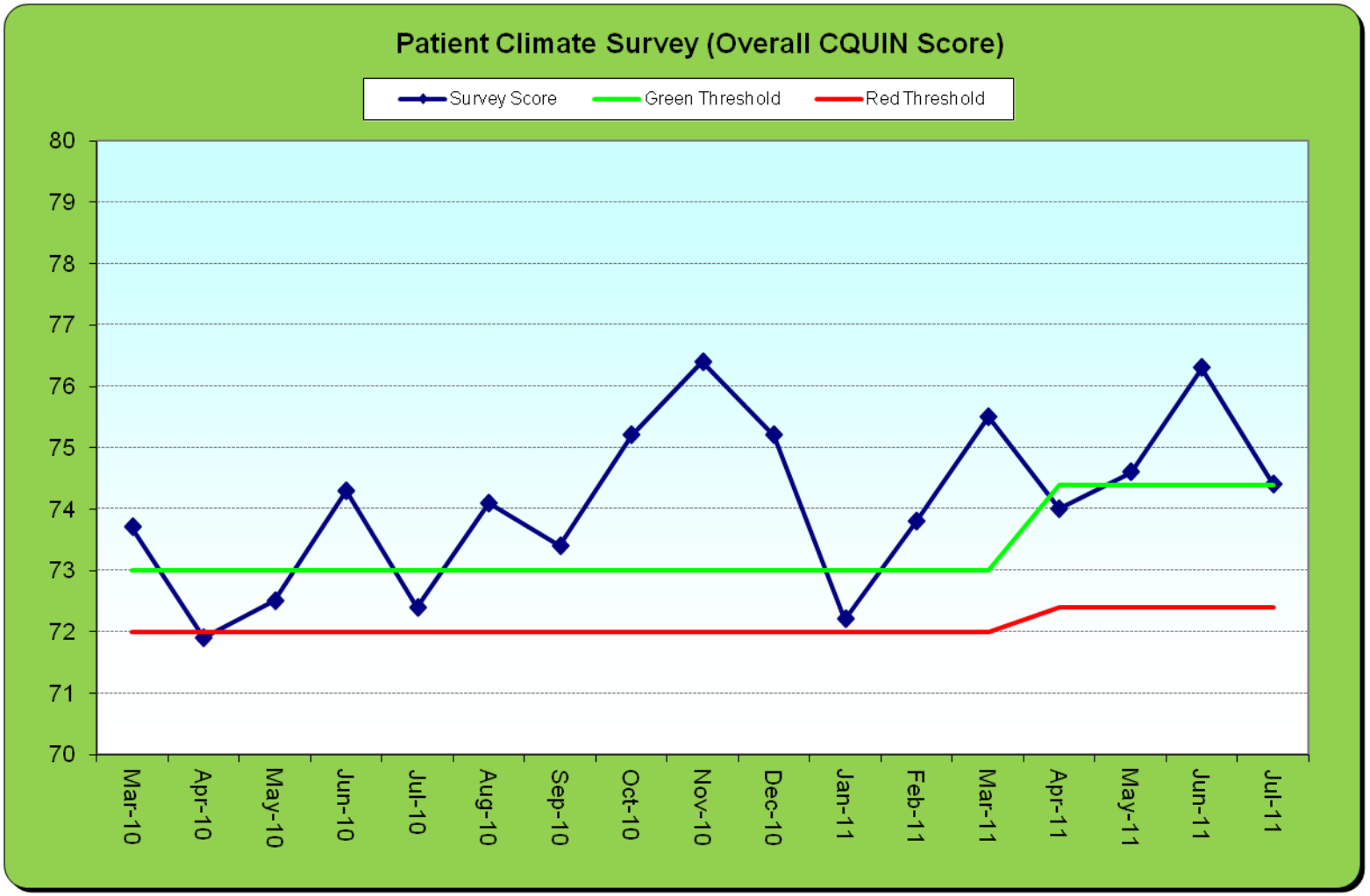
## Notes

Unless otherwise stated, Previous is July 2011 and Current is August 2011

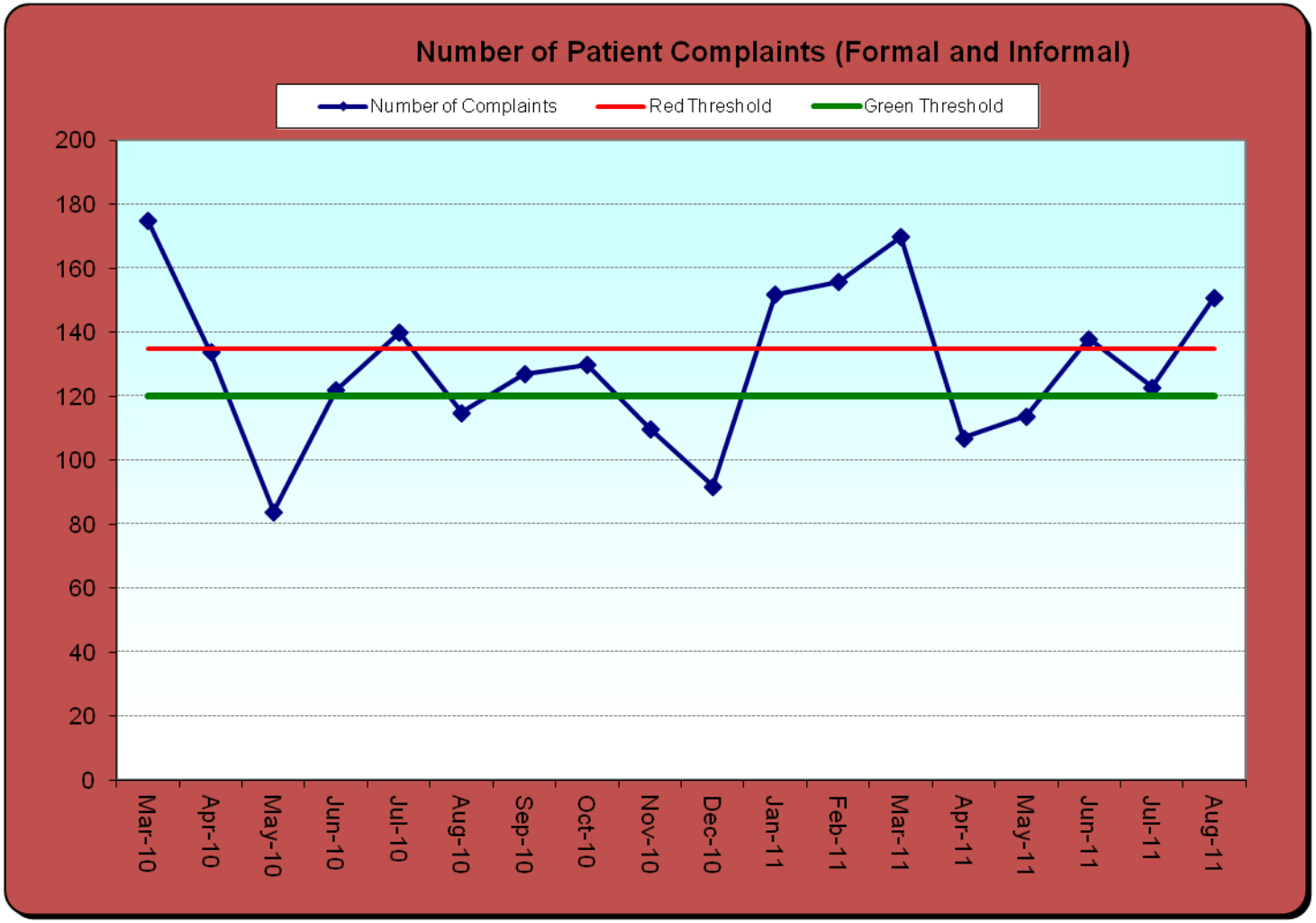
YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2011 up to and including the current month

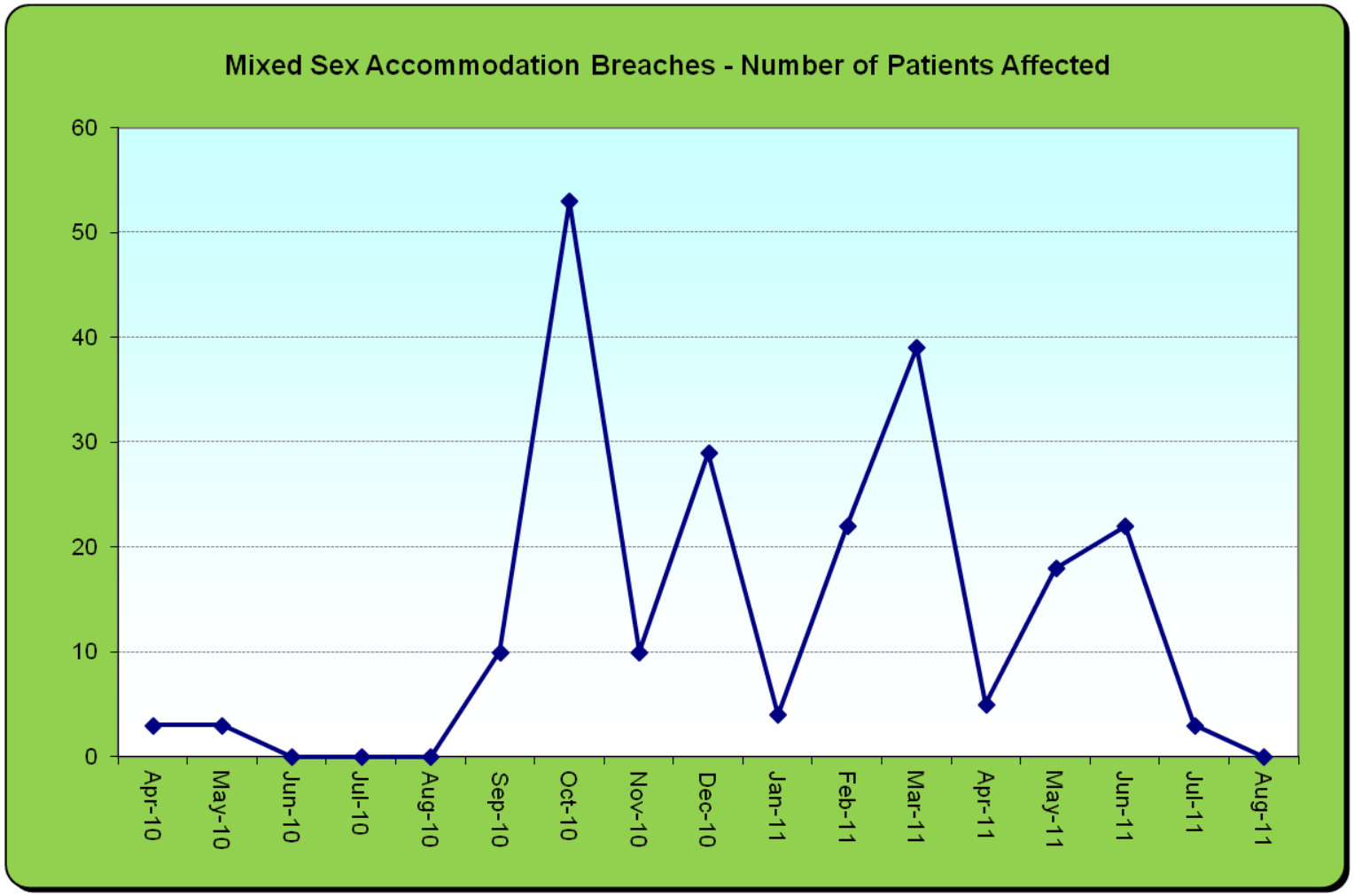
RAG (Red/Amber/Green) rating only applied to YTD where an agreed target number of cases/score exists for the year.

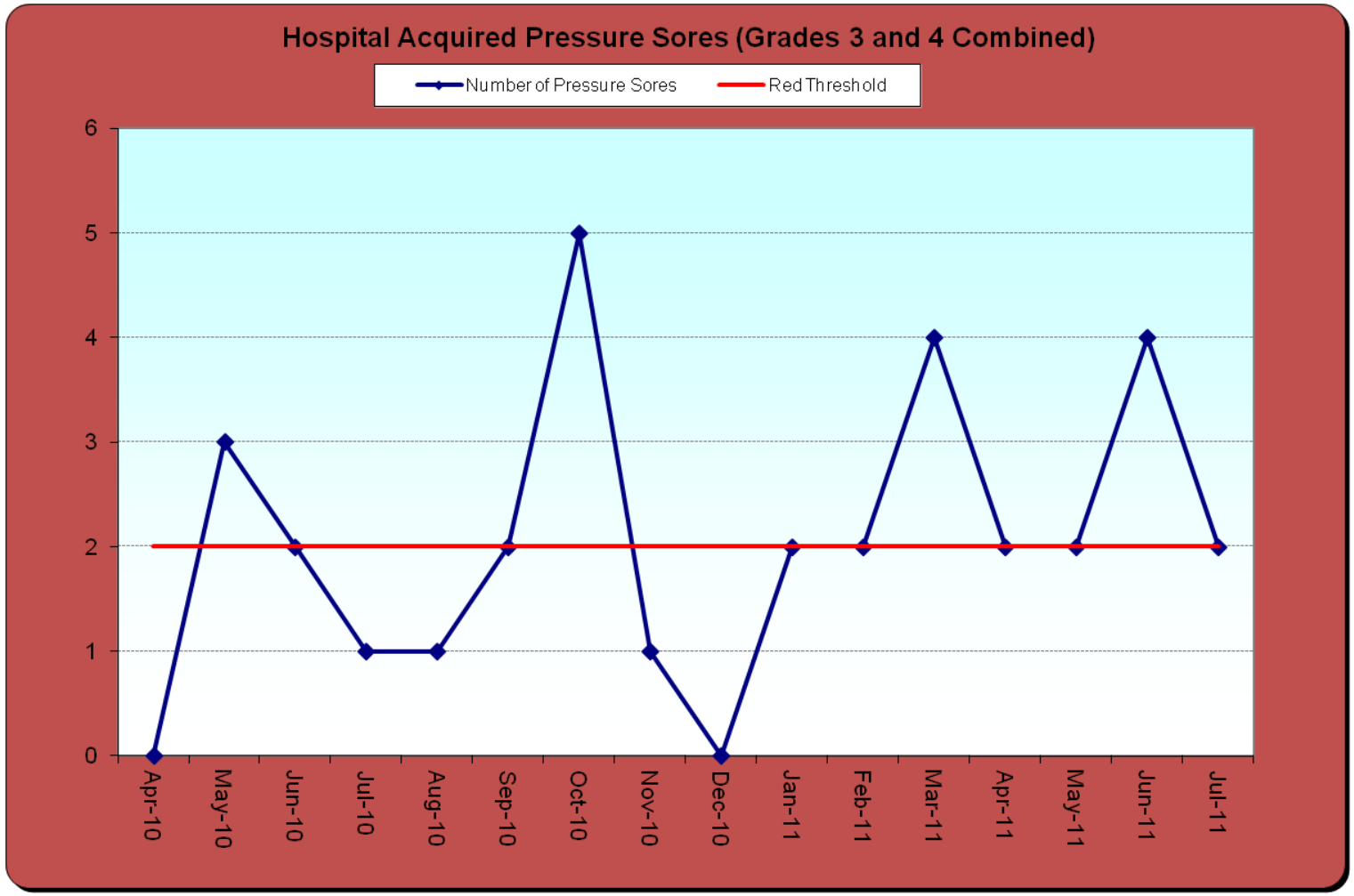
## PERFORMANCE OVERVIEW

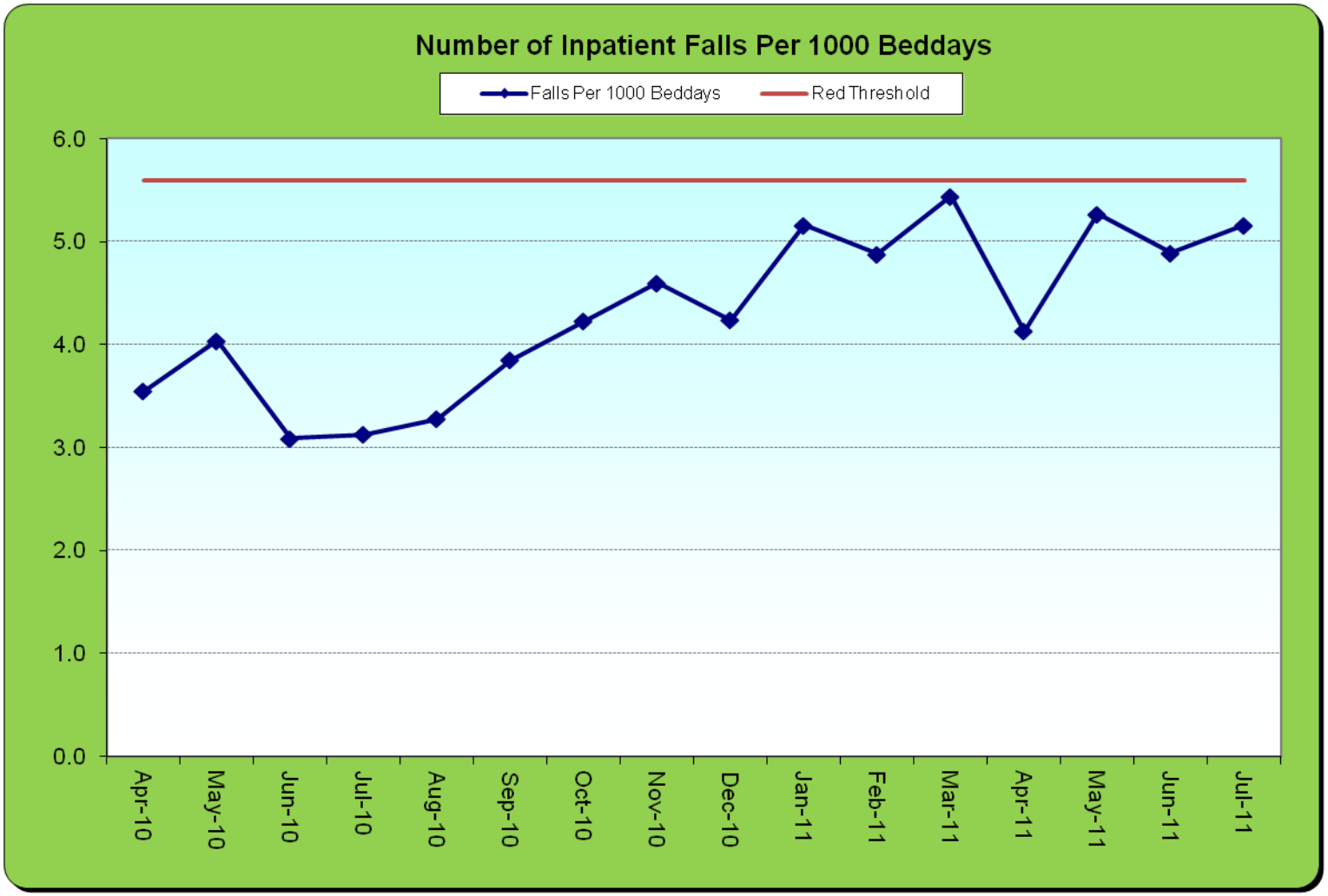


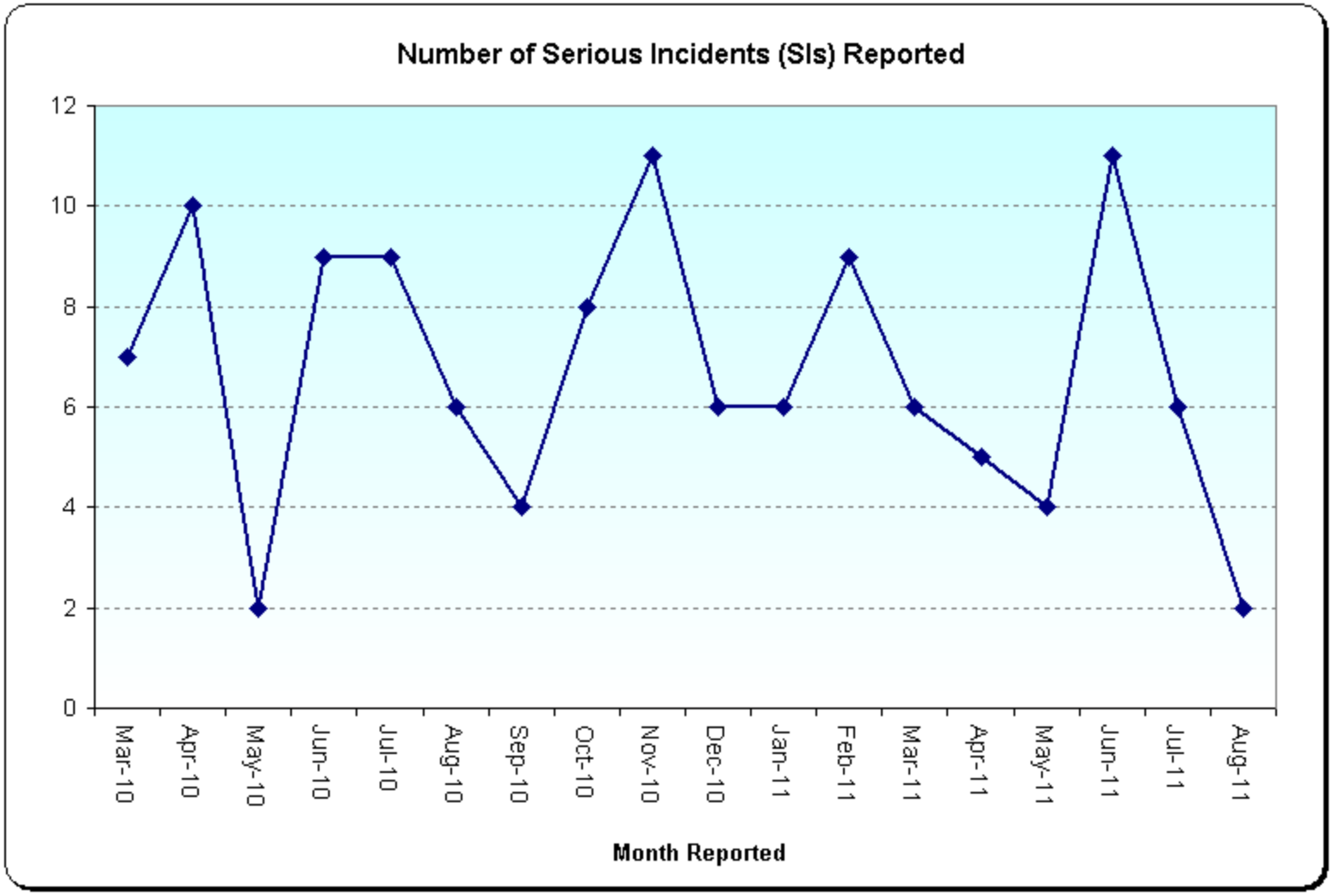
## PERFORMANCE OVERVIEW



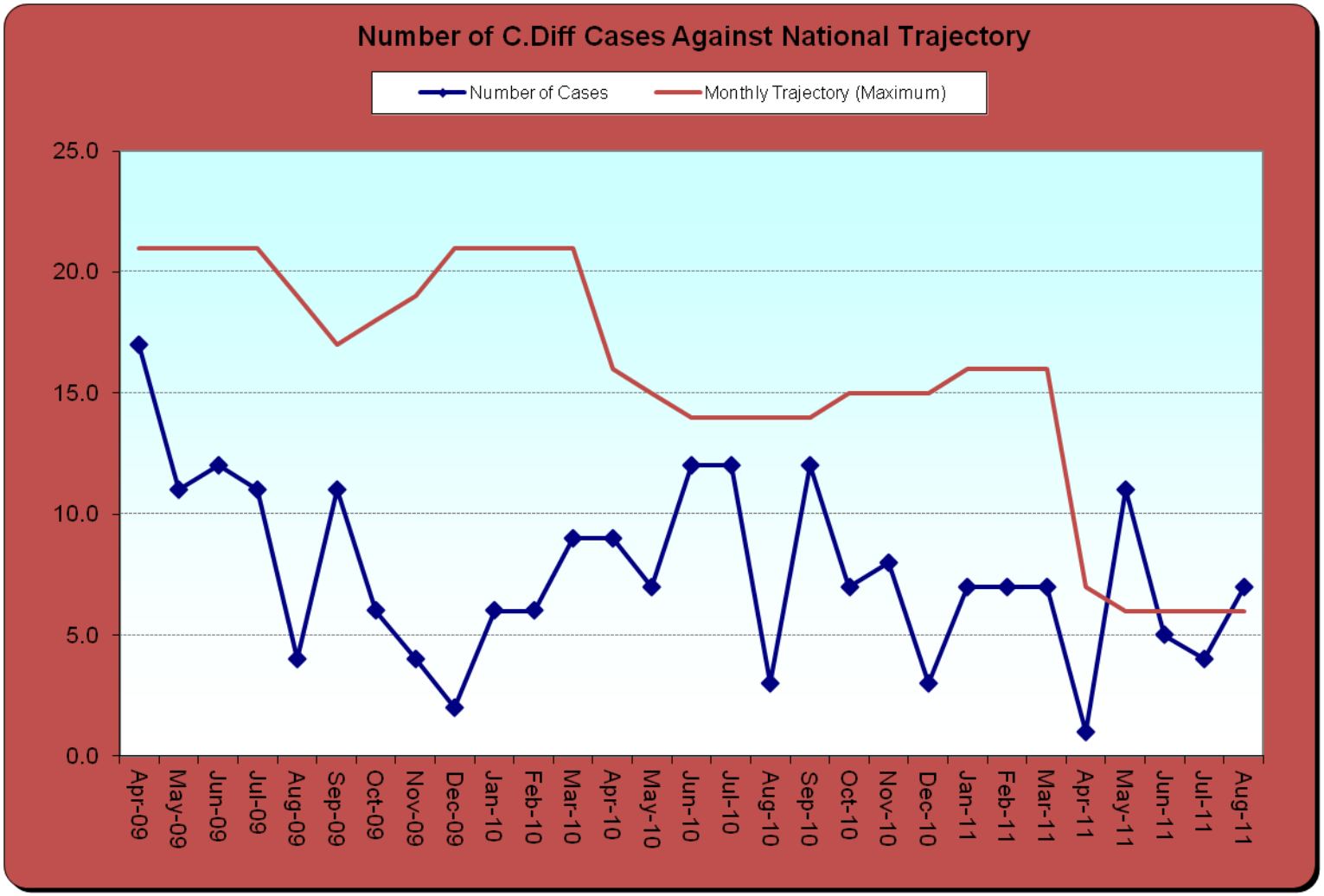

Mixed Sex Accommodation Breaches - Number of Patients Affected
60
50
40
30
20
10
0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11


Hospital Acquired Pressure Sores (Grades 3 and 4 Combined)
Number of Pressure Sores
Red Threshold
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
May-11
Jun-11
Jul-11

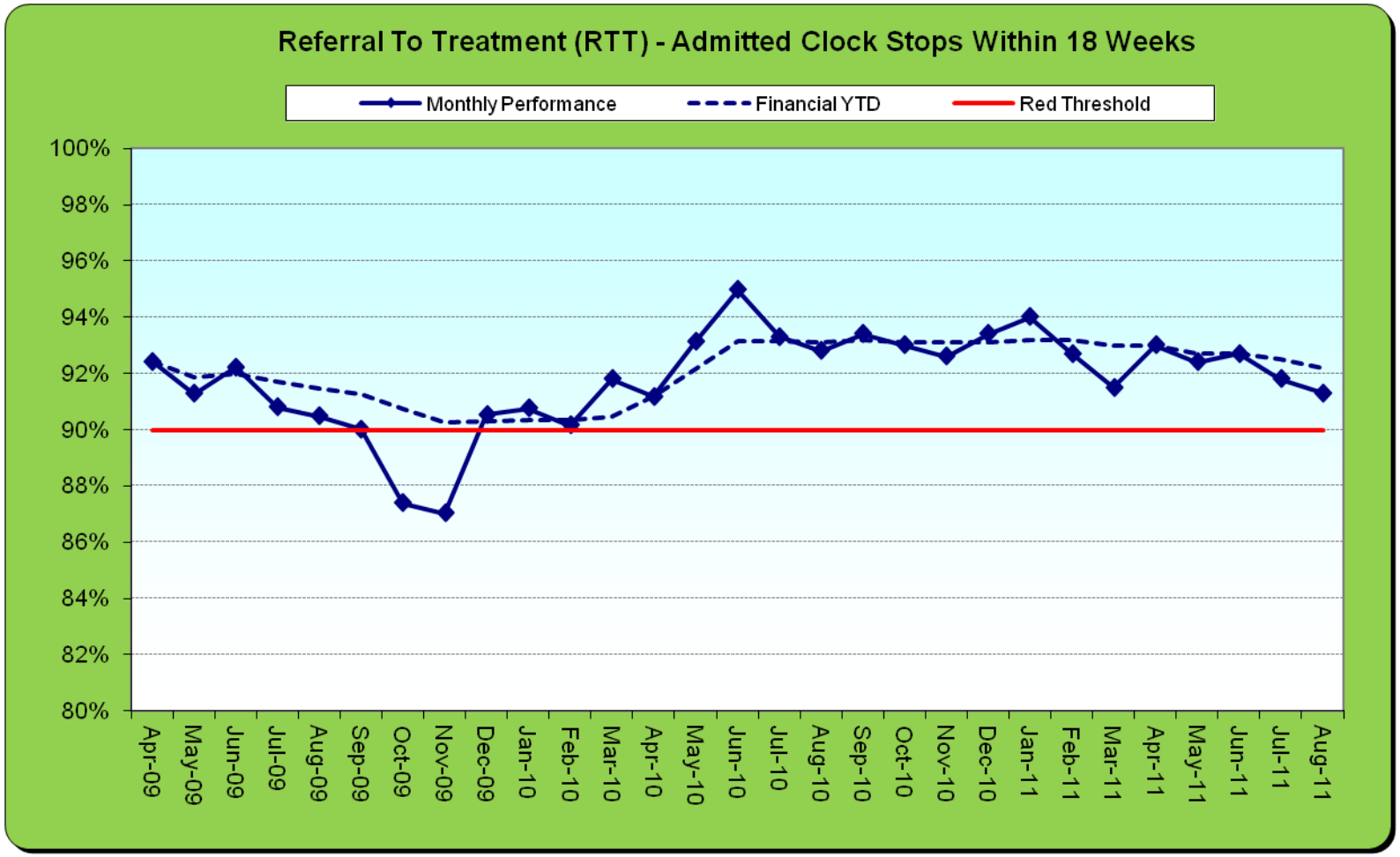

Number of Inpatient Falls Per 1000 Beddays
Falls Per 1000 Beddays
Red Threshold
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11


Number of Serious Incidents (SIs) Reported
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
Jun-11
Jul-11
Aug-11
Month Reported

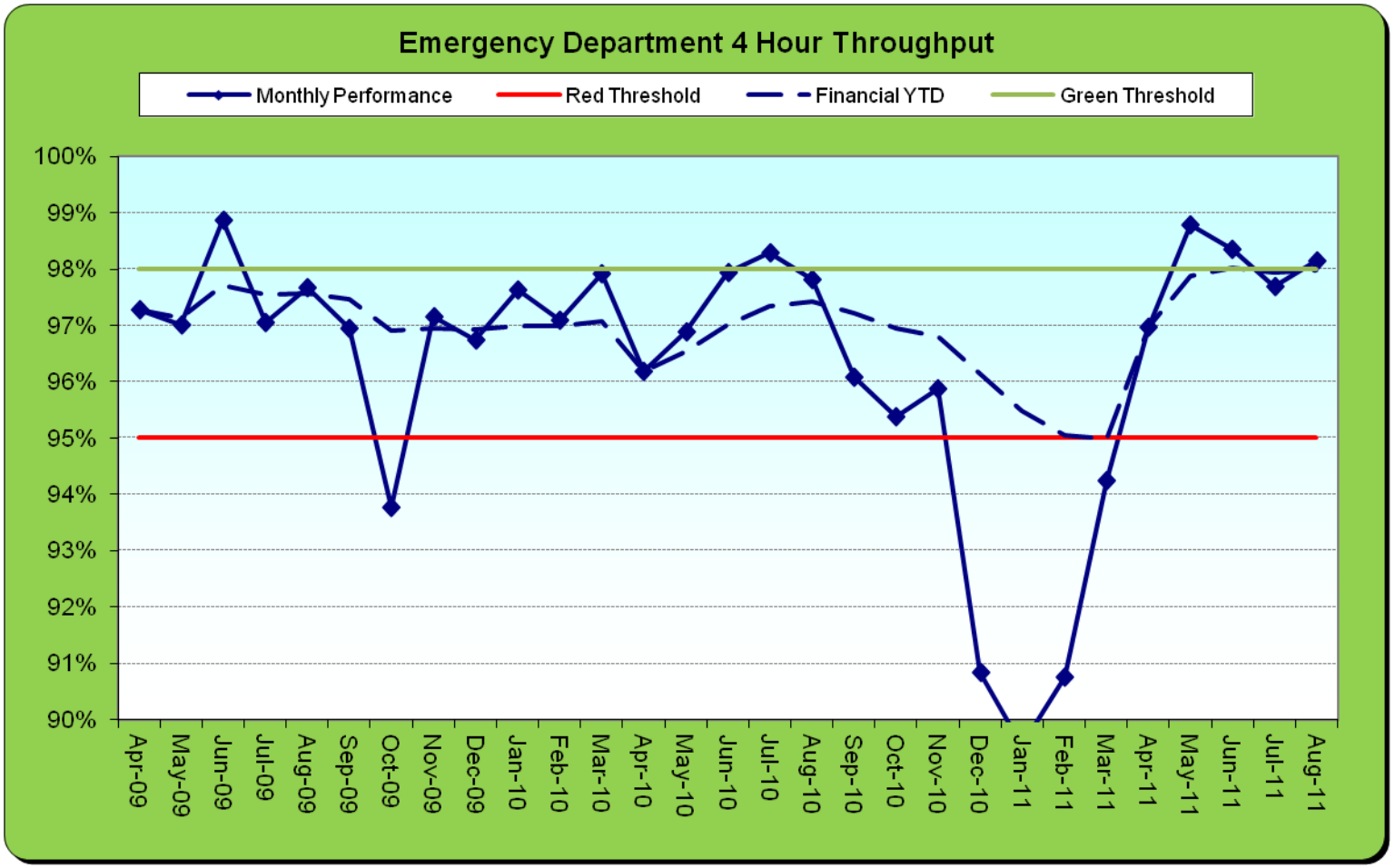
## PERFORMANCE OVERVIEW

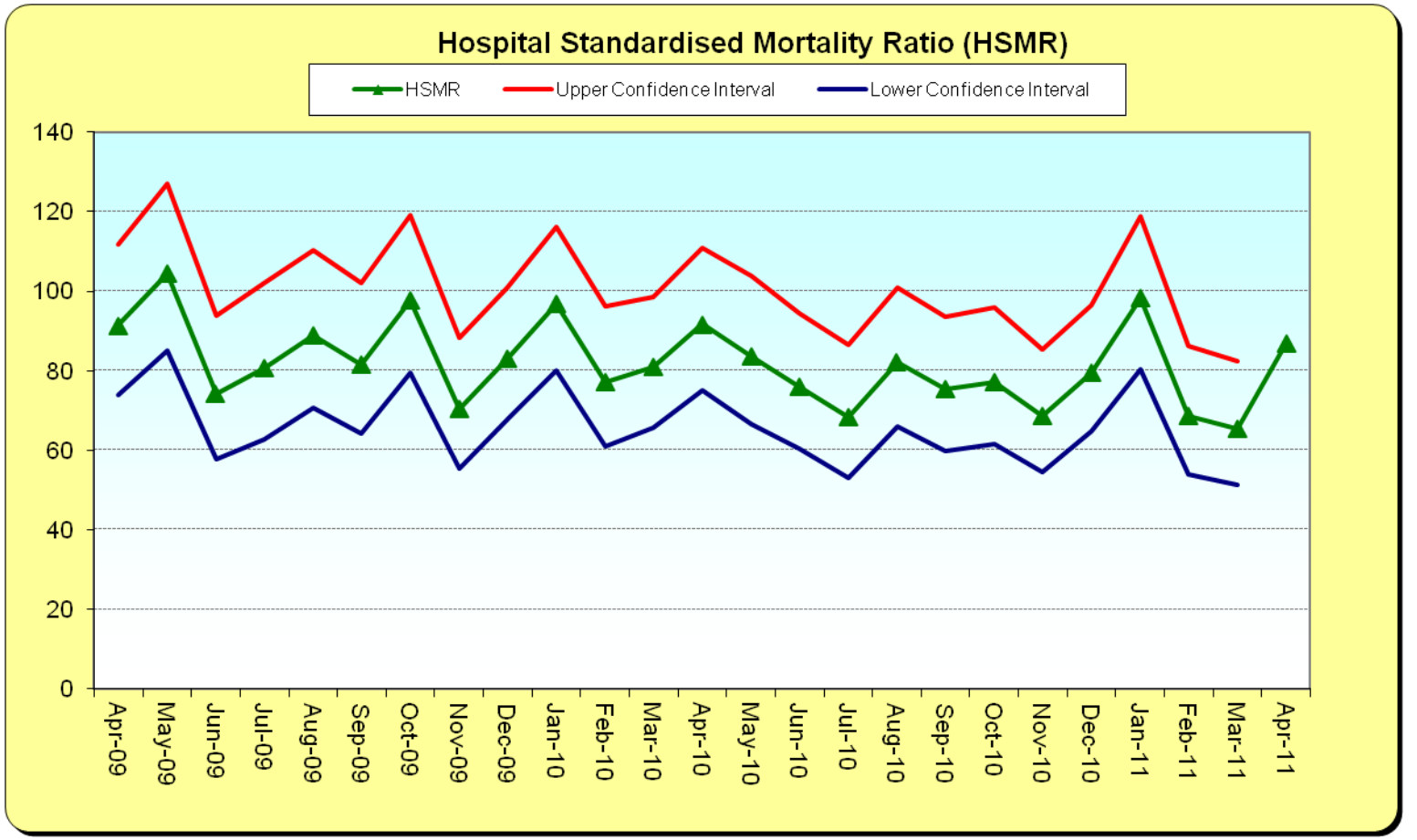


## PERFORMANCE OVERVIEW

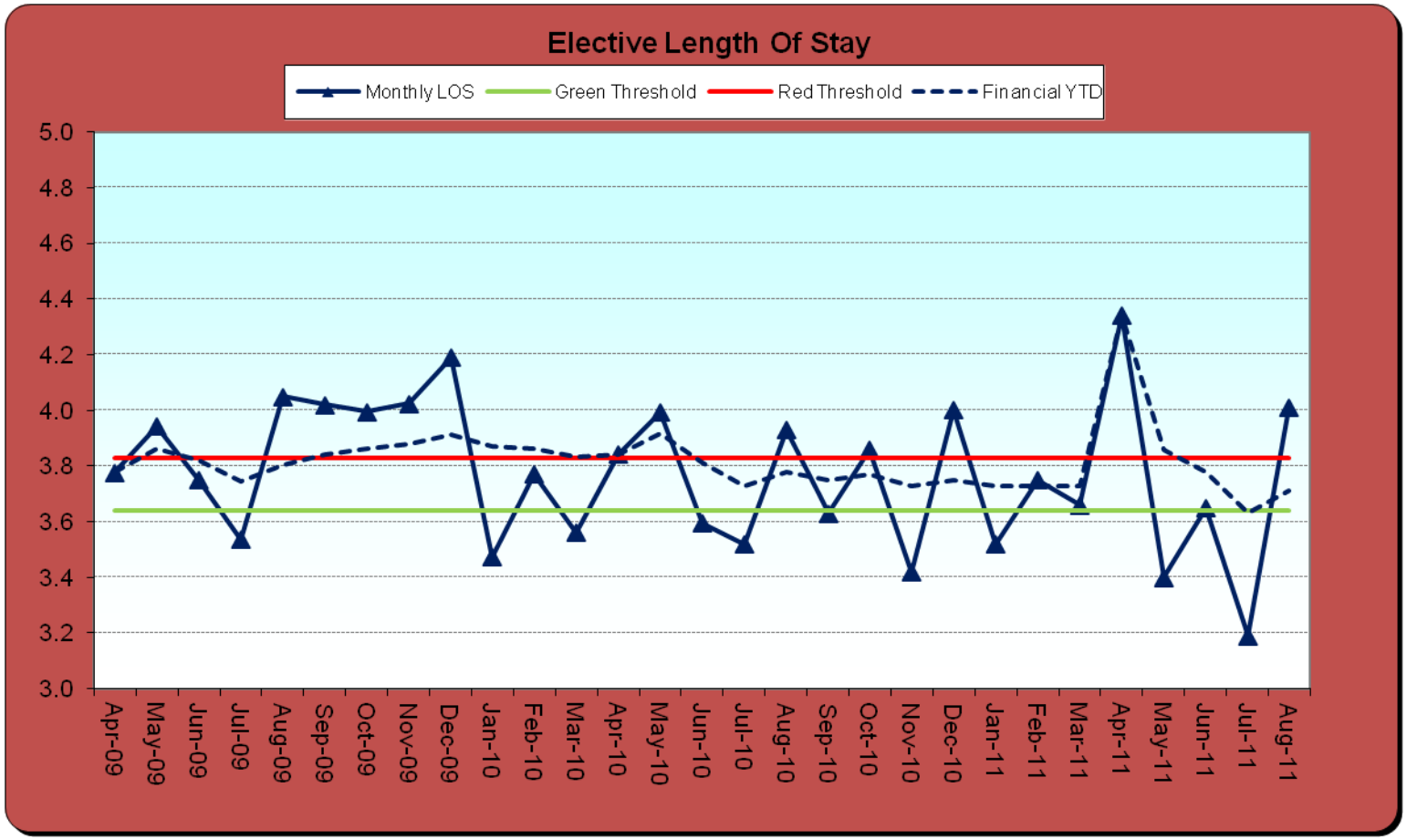


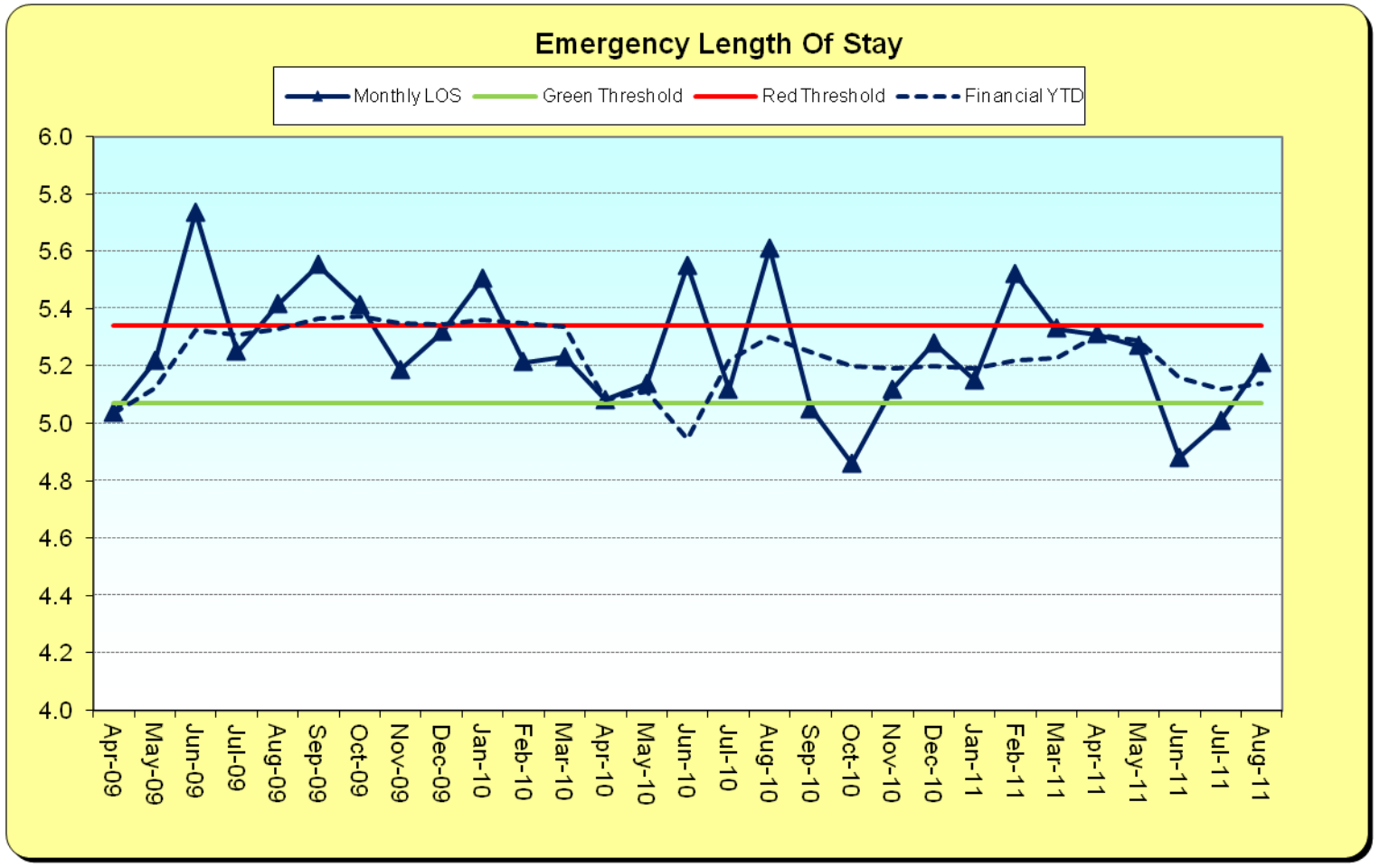
## PERFORMANCE OVERVIEW



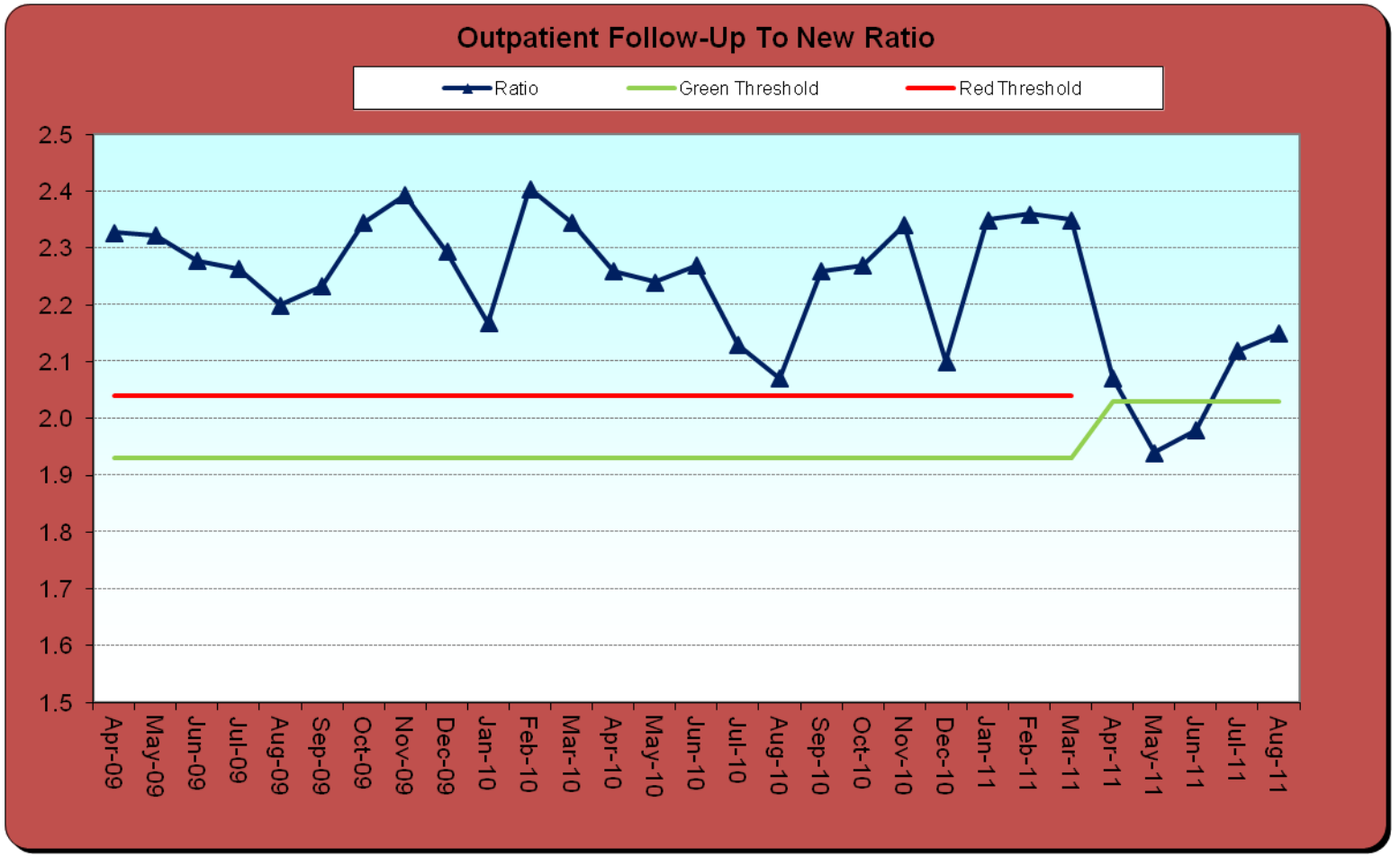

Hospital Standardised Mortality Ratio (HSMR)
HSMR
Upper Confidence Interval
Lower Confidence Interval
140
120
100
80
60
40
20
0
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11

## PERFORMANCE OVERVIEW




Emergency Length Of Stay
Monthly LOS
Green Threshold
Red Threshold
Financial YTD
6.0
5.8
5.6
5.4
5.2
5.0
4.8
4.6
4.4
4.2
4.0
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
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11

## PERFORMANCE OVERVIEW




***Please note:*** *The change in the follow-up to new ratio in April 2011 reflects the changing definition of this indicator as part of the 2011/12 contract*

## PERFORMANCE OVERVIEW

### Organisational Health Barometer – exceptions summary table

| Indicator in exception | Exception Report | Additional information |
|---|---|---|
| Number of Patient Complaints | In Quality section of this report | |
| Incidence of Hospital Acquired Pressure Sores | In Quality section of this report | |
| Number of C. diff cases | In Quality section of this report | |
| Elective Length of Stay | In Quality section of this report | |
| Outpatient Flow-up to New Ratio | See additional information | Analysis is being undertaken by Divisions to understand the change in this ratio following achievement of the contract limiter target up to the beginning of July. This is being reviewed at the Trust's Commissioning & Planning Group on a monthly basis. |
| Contract penalties | Finance Report | |

## SECTION C – Monitor's Compliance Framework

At the end of August 2011 the Trust is on track to achieve all of the targets in Monitor's Compliance Framework during quarter 2, with the exception of the one listed below. An exception report has been provided in the Access section of this report. Please note this assessment is based upon the draft position against the cancer standards for August.

- 62-day referral to treatment cancer standard for GP and Screening referred patients (weighting 1.0)

The Trust also has Care Quality Commission (CQC) Compliance Actions relating to the Nutrition standard, as detailed in the Nutrition Plan which the Board received last month. The CQC Compliance Actions have a weighting of 2.0 on Monitor's Compliance Framework, which gives the Trust a total score of 3.0 and an AMBER-RED Governance Risk Rating. This is the second highest risk rating out of four.

However, Monitor has confirmed that the CQC Compliance Actions will no longer be considered outstanding if the Trust completes the Nutrition Plan in full at the end of September as planned. If the scores relating to the Compliance Actions no longer apply, the Trust will achieve an AMBER-GREEN rating at the end of Quarter 2.

*Please see the Monitor dashboard on the following page, for details of current forecast for quarter 2 2011/12.*

# PERFORMANCE OVERVIEW

## Monitor's Compliance Framework - dashboard

| | Number | Target | Weighting | Target threshold | Year To Date | Q3 10/11 | Q4 10/11 | Q1 11/12 | Q2 to date* | Q2 Forecast | Notes | Current Q2 Governance rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Monitor Compliance Framework | 1 | Infection Control - C.Diff Infections Against Trajectory | 1.0 | < or = trajectory | 28 | ✓ | ✓ | ✓ | 11 | ✓ | Trajectory: Q1 19; Q2 17; Q3 13; Q4 15 | Achieved |
| | 2 | Infection Control - MRSA Bloodstream Cases Against Trajectory | 1.0 | < or = trajectory | 1 | ✓ | ✓ | ✓ | 0 | ✓ | Trajectory: Q1 1; Q2 2; Q3 1; Q4 2 | Achieved |
| | 3a | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug) | 1.0 | 98% | 99.8% | ✓ | ✓ | ✓ | 100.0% | ✓ | | Achieved |
| | 3b | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) | | 94% | 98.1% | ✓ | ✓ | ✓ | 95.4% | ✓ | | |
| | 3c | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) | | 94% | 99.7% | ✓ | ✓ | ✓ | 99.7% | ✓ | | |
| | 4a | Cancer 62 Day Referral To Treatment (Urgent GP Referral) | 1.0 | 85.0% | 84.9% | ✓ | ✓ | ✓ | 84.7% | ✗ | 62-day screening standard forecast not to be achieved; see exception report | Not currently achieved (1.0) |
| | 4b | Cancer 62 Day Referral To Treatment (Screenings) | | 90.0% | 93.4% | ✓ | ✗ | ✓ | 84.5% | ✗ | | |
| | 5 | Referral to treatment time for admitted patients (95th percentile) - in weeks | 1.0 | 23 | Achieved each month | Achieved 90% standard each month | | Achieved each month | 22 | Achieved each month | | Achieved |
| | 6 | Referral to treatment time for non-admitted patients (95th percentile) - in weeks | 1.0 | 18 | Achieved each month | Achieved 95% standard each month | | Achieved each month | 15 | Achieved each month | | Achieved |
| | 7 | Cancer - 31 Day Diagnosis To Treatment (First Treatments) | 0.5 | 96% | 97.0% | ✓ | ✓ | ✓ | 97.9% | ✓ | | Achieved |
| | 8a | Cancer - Urgent Referrals Seen In Under 2 Weeks | 0.5 | 93% | 95.4% | ✓ | ✓ | ✓ | 95.7% | ✓ | | Achieved |
| | 8b | Cancer - Symptomatic Breast in Under 2 Weeks | | 93% | 98.7% | ✓ | ✓ | ✓ | 97.4% | ✓ | | |
| | 9 | A&E Total time in A&E 4 hours (95th percentile) | 1.0 | 5% | 98.0% | ✓ | ✓ | ✓ | 97.9% | ✓ | | Achieved |
| | 10 | Stroke indicators - to be confirmed | 0.5 | To be confirmed (TBC) | Not applicable | To be confirmed | | | | 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 |
| | | CQC standards or over-rides applied | Varies | Agreed standards met | CQC Compliance actions | Not applicable | Hisopathology inquiry over-ride | CQC Compliance actions | CQC Compliance actions | Actions completed | Nutrition plan currently being implemented for sign-off at the end of the quarter. | Not currently achieved (2.0) |
| | | | | | rating | GREEN | AMBER-RED | AMBER-RED | AMBER-RED | AMBER-GREEN | | 3.0 |
| | | | | | | | | | | | | AMBER-RED |

**Please note:** If the same 1.0 weighted indicator is failed in three successive quarters, an automatic RED rating is applied. In Q4 2010/11 an AMBER-RED over-ride was applied to the Trust's declared governance rating, reflecting Monitor's current review of the histopathology inquiry findings.

*** Q2 cancer figures are based upon confirmed July figures and draft figures for August 2011.**

**Please note**: Monitor notified the Trust in August that changes had been made to the Compliance Framework. The changes were to remove four of the five A&E Clinical Quality Indicators, leaving the A&E 4-hour visit time. The target for the 4-hour standard remains 95%.

# QUALITY

## 1.1 PATIENT EXPERIENCE

Mr T was aged 53 when he was admitted as an emergency with shortness of breath. He was diagnosed with lung cancer, complicated by brain metastases (secondary tumours). Just prior to discharge from the ward he met with the UH Bristol Lung Cancer Clinical Nurse Specialist who provided support and advice. Mr T then experienced epileptic seizures due to brain metastases and he was transferred to another Trust where he underwent neurosurgery. His wife tried to get support from the brain cancer Clinical Nurse Specialist at this Trust but was told that because her husband's primary cancer was in his lung this was not possible. She was not able to be supported by the other Trust's Lung Cancer Clinical Nurse Specialist as his primary care was being provided by UH Bristol. Mr T was then transferred back to UH Bristol for the remainder of his care. Mr T was then listed for surgery to remove his lung tumour, however this was cancelled as a further scan showed that his cancer had spread. This was a devastating time for Mr T and his wife who had been prepared for surgery and had expected a reasonable outcome. Mrs T had expected the Lung Cancer Clinical Nurse Specialist to contact her at this point and felt abandoned when this did not happen. Although Mrs T had telephoned the Lung Cancer Clinical Nurse Specialist many times in the past she did not feel able to do so at this time. The main concern for Mrs T was the support available for her and her husband from the Clinical Nurse Specialist at a critical time in his illness and also the lack of continuity of support during his care at other hospitals.

Following her husband's death Mrs T formally complained about the level of support she and her husband had received, and a meeting took place with the Lead Cancer Nurse and the Head of Nursing for the Division. As a result the following actions were agreed:

- The Lung Cancer Clinical Nurse Specialist will clarify the level of support the service can provide at the first meeting with patients and families.
- The Lead Cancer Nurse has taken this complaint forward with her counterpart in the other Trust to review the support for patients whose pathways cross both Trusts.
- The Lung Cancer Clinical Nurse Specialist now discusses all cases with the consultant prior to clinic so that they can try to be available at key points in the treatment plan, such as when results of tests are received.
- A separate nurse led clinic has been set up for patients who want face to face support, rather than by telephone.

## 1.2 QUALITY DASHBOARD

| | | ID | Title | Green Threshold | Year To Date | Monthly Totals | | | | | | | | | | | | Quarterly Totals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Sep-10 | Oct-10 | Nov-10 | Dec-10 | Jan-11 | Feb-11 | Mar-11 | Apr-11 | May-11 | Jun-11 | Jul-11 | Aug-11 | Q3 | Q4 | Q1 | Q2 |
| Patient Safety | Infection Control | PS-A1 | MRSA Pre-Op Elective Screenings | 100% | 100.0% | 99.4% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | | PS-A2 | MRSA Emergency Screenings | 90% | 92.6% | 62.4% | 59.9% | 79.9% | 80.6% | 90.4% | 92.0% | 91.7% | 91.5% | 93.3% | 92.5% | 92.7% | 93.1% | 72.2% | 91.3% | 92.4% | 92.9% |
| | | PS-A3 | Hand Hygiene Audit Compliance | 95% | 97.8% | 96.2% | 95.7% | 97.1% | 95.3% | 96.1% | 96.0% | 97.3% | 97.8% | 95.0% | 98.3% | 99.1% | 98.8% | 96.1% | 96.4% | 97.0% | 98.9% |
| | | PS-A4 | Antibiotic Compliance | 95% | 79.8% | 67.4% | 70.6% | 72.8% | 78.6% | 77.5% | 79.4% | 76.5% | 81.5% | 78.4% | 84.1% | 80.1% | 76.3% | 73.2% | 77.7% | 81.4% | 77.7% |
| | | PS-A5 | Matron's Checklist | 95% | 93.9% | 94.0% | 94.8% | 94.5% | 94.4% | 94.8% | 94.8% | 93.7% | 94.8% | 93.1% | 93.7% | 94.2% | 93.8% | 94.6% | 94.4% | 93.8% | 94.0% |
| | | PS-A6 | Cleanliness Monitoring - Overall Score | 95% | | 97% | 93% | 96% | 96% | 96% | 95% | 95% | 95% | 96% | 96% | 95% | 95% | | | | |
| | | PS-A7 | Cleanliness Monitoring - Very High Risk Areas | 95% | | 97% | 97% | 97% | 97% | 97% | 97% | 97% | 97% | 97% | 97% | 97% | 96% | | | | |
| | | PS-A8 | Cleanliness Monitoring - High Risk Areas | 95% | | 97% | 97% | 97% | 99% | 97% | 96% | 96% | 96% | 96% | 96% | 96% | 97% | | | | |
| | | PS-A9 | Number of GRE Bacteraemias | <=2 | 1 | 1 | 2 | 0 | 0 | 3 | 1 | 1 | 1 | 0 | 0 | 0 | | 2 | 5 | 1 | 0 |
| | | PS-A10 | Infection Control - C.Diff Infections Against National Trajectory | <Traj. | 28 | 12 | 7 | 8 | 3 | 7 | 7 | 7 | 1 | 11 | 5 | 4 | 7 | 18 | 21 | 17 | 11 |
| | | PS-A11 | MSSA Cases Against Trajectory | <Traj. | 17 | | | | | | | | 3 | 2 | 4 | 0 | 8 | | | 9 | 8 |
| | Incidents | PS-B1 | Number of Serious Incidents (SIs) Reported | | 28 | 4 | 8 | 11 | 6 | 6 | 9 | 6 | 5 | 4 | 11 | 6 | 2 | 25 | 21 | 20 | 8 |
| | | PS-B2 | Serious Incidents Reported Within 48 Hours | 80% (Q3) | 86% | | | | | | | | 60% | 100% | 91% | 83% | 100% | | | 85% | 88% |
| | | PS-B3 | Percentage of Serious Incident (SI) Investigations Completed Within Timescale | 80% (Q3) | 100% | | | | | | | | | | 100% | 100% | 100% | | | 100% | 100% |
| | | PS-B4 | Total Never Events | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| | | PS-B5 | Total Number of Patient Safety Incidents Reported | | 2885 | 658 | 762 | 768 | 704 | 862 | 748 | 860 | 645 | 790 | 740 | 710 | | 2234 | 2470 | 2175 | 710 |
| | Falls | PS-C1 | Number of Inpatient Falls Per 1,000 Beddays | <5.6 | 4.86 | 3.85 | 4.23 | 4.60 | 4.24 | 5.16 | 4.88 | 5.44 | 4.13 | 5.27 | 4.89 | 5.16 | | 4.35 | 5.17 | 4.75 | 5.16 |
| | | PS-C2 | Repeat Inpatient Falls | | 25.4% | 14.7% | 11.8% | 16.7% | 21.7% | 21.2% | 26.9% | 20.0% | 31.9% | 15.4% | 31.8% | 21.7% | | | | | |
| | | PS-C3 | Number of Inpatient Falls - Patients Aged 65 And Over | | 370 | 67 | 82 | 90 | 86 | 99 | 90 | 117 | 78 | 104 | 93 | 95 | | 258 | 306 | 275 | 95 |
| | | PS-C4 | Number of Inpatient Falls - Patients With Cognitive Impairment | | 173 | | | | | 28 | 35 | 59 | 32 | 53 | 45 | 43 | | | 122 | 130 | 43 |
| | Pressure Ulcers | PS-D1 | Total Pressure Ulcer Incidence per 10,000 Bed Days | 6.51 | 12.31 | 5.97 | 10.30 | 10.31 | 5.06 | 7.06 | 9.84 | 9.84 | 7.16 | 14.15 | 14.37 | 13.61 | | 8.46 | 8.89 | 11.88 | 13.61 |
| | | PS-D2 | Percentage of Hospital Acquired Pressure Ulcers Not Graded | <5% | 0.0% | 6.7% | 4.3% | 3.8% | 0.0% | 0.0% | 4.2% | 14.8% | 0.0% | 0.0% | 0.0% | 0.0% | | 3.2% | 7.1% | 0.0% | 0.0% |
| | | PS-D3 | Number of Hospital Acquired Grade 2 Pressure Ulcers | <83 yr | 113 | 12 | 17 | 24 | 13 | 17 | 21 | 19 | 16 | 34 | 31 | 32 | | 54 | 57 | 81 | 32 |
| | | PS-D4 | Number of Hospital Acquired Grade 3 Pressure Ulcers | <1 | 10 | 1 | 3 | 1 | 0 | 2 | 2 | 3 | 2 | 2 | 4 | 2 | | 4 | 7 | 8 | 2 |
| | | PS-D5 | Number of Hospital Acquired Grade 4 Pressure Ulcers | <1 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | 2 | 1 | 0 | 0 |
| | Venous Thrombo-embolism (VTE) | PS-E1 | Adult Inpatients who Received a VTE Risk Assessment | 90% | 96.4% | 67.7% | 59.2% | 75.8% | 69.3% | 82.4% | 84.4% | 91.6% | 94.2% | 95.1% | 97.0% | 97.5% | 98.0% | 68.2% | 86.8% | 95.5% | 97.7% |
| | | PS-E2 | Percentage of Adult Inpatients who Received Thrombo-prophylaxis | 90% | 91.0% | | | | | | | | | | | 87.5% | 93.3% | | | | 91.0% |
| | Nutrition | PS-F1 | Patients who Received Fully Completed Nutritional Screening Within 24 Hours | 80% | 66.2% | 72.2% | | | 76.6% | | | 76.1% | | | 66.2% | | | 76.6% | 76.1% | 66.2% | |
| | Safety | PS-G1 | WHO Surgical Checklist Compliance | 98% | 93.0% | 97.9% | 97.1% | 98.4% | 97.8% | 97.7% | 98.7% | 98.0% | 98.6% | 92.6% | 90.2% | 87.3% | 96.8% | 97.8% | 98.1% | 93.5% | 92.2% |
| | | PS-G2 | Reduction in Medication Errors | <2.84% | 1.17% | 3.15% | 2.42% | 1.92% | 3.39% | 3.73% | 5.10% | 5.93% | 2.08% | 0.79% | 0.85% | | | 2.60% | 4.86% | 1.17% | |
| | Leadership | PS-H1 | Number of Executive Director Patient Safety Walk-arounds | >=6 | 38 | 4 | 6 | 5 | 7 | 5 | 5 | 5 | 7 | 11 | 9 | 6 | 5 | 18 | 15 | 27 | 11 |
| | | PS-H4 | Percentage of Non-Estates Actions Completed Within 2 Months | 80% | 88% | 75% | 82% | 71% | 29% | 100% | 80% | 67% | 100% | 100% | 77% | 95% | 75% | 62% | 75% | 89% | 87% |

# QUALITY

| | | ID | Title | Green Threshold | Year To Date | Monthly Totals | | | | | | | | | | | | Quarterly Totals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Sep-10 | Oct-10 | Nov-10 | Dec-10 | Jan-11 | Feb-11 | Mar-11 | Apr-11 | May-11 | Jun-11 | Jul-11 | Aug-11 | Q3 | Q4 | Q1 | Q2 |
| Clinical Effectiveness | Mortality | CE-A1 | Hospital Standardised Mortality Ratio (HSMR) | <=80 | | 75.3 | 77.3 | 68.6 | 79.5 | 98.1 | 68.8 | 65.5 | | | | | | 75.2 | 77.4 | | |
| | Length of Stay | CE-C1 | Average Length Of Stay - Elective | <=3.64 | 3.71 | 3.63 | 3.86 | 3.42 | 4.00 | 3.52 | 3.75 | 3.66 | 4.34 | 3.40 | 3.65 | 3.19 | 4.01 | 3.76 | 3.64 | 3.78 | 3.61 |
| | | CE-C2 | Average Length Of Stay - Emergency | <=5.07 | 5.14 | 5.05 | 4.86 | 5.12 | 5.28 | 5.15 | 5.52 | 5.33 | 5.31 | 5.27 | 4.88 | 5.01 | 5.21 | 5.09 | 5.33 | 5.16 | 5.11 |
| | Learning Disability | CE-D1 | Risk Assessment of Patients with Known Learning Disability within 48 Hours | 90% | 60.0% | | | | | | | | | | 60.0% | | | | | 60.0% | |
| | Readmissions | CE-E1 | Emergency Readmissions Within 30 Days | <412 mth | 1853 | | | | | | | | 431 | 402 | 394 | 332 | 294 | | | 1227 | 626 |
| | Maternity | CE-G1 | Percentage of Spontaneous Deliveries Compared to All Births | 64.4% | 63.76% | 61.86% | 66.13% | 65.02% | 59.63% | 64.67% | 62.34% | 65.04% | 63.83% | 65.01% | 63.53% | 64.88% | 61.22% | 63.58% | 64.05% | 64.13% | 63.20% |
| | Fracture NoF | CE-H1 | Fracture Neck of Femur Patients Treated Within 24 Hours | | 36.6% | 58.3% | 43.3% | 43.8% | 56.0% | 50.0% | 54.5% | 23.5% | 64.3% | 22.7% | 40.0% | 45.5% | 20.0% | 47.9% | 41.7% | 39.2% | 33.3% |
| | Stroke Care | CE-J1 | Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour | 50% | 28.8% | 35.9% | 22.9% | 26.8% | 32.5% | 20.0% | 30.0% | 39.4% | 25.7% | 23.1% | 25.0% | 42.9% | 28.6% | 27.6% | 29.5% | 24.7% | 34.9% |
| | | CE-J2 | Stroke Care: Percentage Spending 90%+ Time On Stroke Unit | 80% | 83.7% | 77.6% | 78.0% | 90.0% | 89.8% | 82.1% | 62.9% | 80.6% | 81.4% | 86.5% | 82.9% | 81.8% | 85.4% | 86.4% | 75.5% | 83.5% | 84.0% |
| | | CE-J3 | High Risk TIA Patients Starting Treatment Within 24 Hours | 60% | 61.04% | 62.50% | 60.00% | 81.25% | 63.16% | 78.95% | 52.38% | 74.07% | 70.00% | 75.00% | 42.86% | 50.00% | 63.16% | 67.27% | 68.66% | 63.04% | 58.06% |
| | Specialist Commissioning | CE-K1 | Percentage of Haemophilia Patients Undergoing Pharmocokinetic Study | | | | | | | | | | | | | | | | | | |
| | | CE-K2 | Lobectomy Patients - Median Length of Stay | <=5 days | 5 | | | | | | | | 5.5 | 5 | 6 | 5 | 4.5 | | | 5 | 5 |
| Patient Experience | Single Sex Accom. | PE-A1 | Same Sex Accommodation Breaches - Number of Patients | 0 | 48 | 10 | 53 | 10 | 29 | 4 | 22 | 39 | 5 | 18 | 22 | 3 | 0 | 92 | 65 | 45 | 3 |
| | Patient Experience | PE-B1 | Patient Survey - Overall CQUIN Score | 74.4 | | | | | | 72.2 | 73.8 | 75.5 | 74 | 74.6 | 76.3 | 74.4 | | | | 75 | 74.4 |
| | | PE-B2 | Monthly Patient Survey - Noise At Night | 81 | | | | | | | | | 83 | 83 | 81 | 82 | | | | 82 | 82 |
| | | PE-B3 | Monthly Patient Survey - Help To Eat Meals | 76 | | | | | | | | | 77 | 81 | 80 | 80 | | | | 79 | 80 |
| | | PE-B4 | Monthly Patient Survey - Patients Who Would Recommend The Trust | 92% | | | | | | | | | 96% | 96% | 96% | 97% | | | | 96% | 97% |
| | | PE-B5 | Monthly Patient Survey - Local Score | 83 | | | | | | | | | 87 | 87 | 89 | 86 | | | | 88 | 86 |
| | Complaints/Compliments | PE-C1 | Number of Patient Complaints | <=120 | 633 | 127 | 130 | 110 | 92 | 152 | 156 | 170 | 107 | 114 | 138 | 123 | 151 | 332 | 478 | 359 | 274 |
| | | PE-C3 | Percentage of Complaints Resolved Within Timeframe (Formal Compalints) | 98% | 92.0% | 100.0% | 89.4% | 93.4% | 95.5% | 100.0% | 98.7% | 98.4% | 88.9% | 92.2% | 89.5% | 97.4% | 92.7% | 92.4% | 99.1% | 90.4% | 94.7% |
| | | PE-C4 | Number of Complainants Disatisfied with Response | <=5 | 39 | 6 | 7 | 8 | 5 | 4 | 6 | 9 | 3 | 4 | 14 | 10 | 8 | 20 | 19 | 21 | 18 |

Please note: Following a clarification of reporting guidance, the Stroke Care TIA (Transient Ischaemic Attack) figures have been amended to exclude patients that have been admitted for their treatment. This brings reporting in line with the national definitions set-out in Vital Signs guidelines.

## 1.3 SUMMARY

The number of red rated metrics has increased this month to twelve from eight in the report received by the Board in August. Of note are the figures for *Clostridium difficile* and Meticillin sensitive *Staphylococcus aureus*, which are unusually both in exception this month. Further detail can be found in exception reports Q2 and Q3.

Reduction in the incidence of pressure ulcers remains a challenge. There is a greater awareness among front line staff to report pressure ulcers as incidents which is reflected in incident reporting trends. The launch of the "Being the Best" initiative earlier this month, which utilises a rapid improvement methodology, is expected to impact not only on the incidence of pressure ulcers, but also to support the on-going work to reduce harm from falls, and that to improve nutrition and infection prevention and control. This initiative is further described in exception reports Q4 to Q6 regarding pressure ulcers.

The metric relating to fracture neck of femur will be revised in subsequent months to include compliance with best practice tariff as a better measure of quality and outcomes for patients. This includes the patient receiving surgery within 36 hours and being seen by an Ortho-geriatrician within 72 hours.

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

|  **Achieving set threshold (27)** |  **Thresholds not met or no change on previous Month (5)** |
|---|---|
| - MRSA (Meticillin Resistant *Staphylococcus aureus*) screening – elective<br>- MRSA screening – emergency<br>- Hand Hygiene Audit<br>- Cleanliness monitoring overall Trust score<br>- Cleanliness monitoring very high risk areas<br>- Cleanliness monitoring high risk areas<br>- Glycopeptide Resistant Enterococci (GRE) Bacteraemias<br>- Serious Incidents reported with 48 hours<br>- Never Events<br>- Serious incident investigations completed within required timescales<br>- In-patient falls incidence per 1,000 bed days<br>- Percentage of hospital acquired pressure ulcers not graded at all<br>- Number of hospital acquired grade 4 pressure ulcers<br>- Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment | - Matrons checklist (*C. difficile* dashboard)<br>- WHO surgical checklist compliance<br>- Percentage of all actions completed with 2 months of patient safety walk round<br>- Reduction in average emergency length of stay overall<br>- Percentage of complaints resolved within agreed timescale |

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| | |
|---|---|
| - Percentage adult in-patients who received thrombo-prophylaxis<br>- Reduction in medication errors<br>- Hospital Standardised Mortality Ratio<br>- 30 day emergency re-admissions<br>- Stroke care: percentage spending 90% + time on a stroke unit<br>- High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours<br>- Lobectomy patients median length of stay<br>- Number of breaches of the single sex accommodation standard<br>- Patient experience overall CQUIN score<br>- Monthly patient survey: noise at night<br>- Monthly patient survey: help to eat meals<br>- Monthly patient survey: patients who would recommend the Trust<br>- Monthly patient survey local score | |
| **Quality metrics not achieved or requiring attention (12)** | **Quality metrics with thresholds not yet finalised or which are being reported quarterly (8)** |
| - *Clostridium difficile* cases against national trajectory<br>- MSSA (Meticillin Sensitive *Staphylococcus aureus*) cases against trajectory<br>- Antibiotic prescribing compliance<br>- Total pressure ulcer incidence per 10,000 bed days<br>- Number of hospital acquired grade 2 pressure ulcers<br>- Number of hospital acquired grade 3 pressure ulcers<br>- Number of executive director patient safety walk rounds<br>- Reduction in average elective length of stay<br>- Percentage of spontaneous deliveries compared to all births<br>- Stroke care: percentage receiving brain imaging within 1 hour<br>- Total number of complaints<br>- Number of complainants dissatisfied with the response | **Thresholds not yet applicable**<br>- Fractured neck of femur patients treated with 24 hours<br><br>**Quarterly metrics**<br>- Risk assessment of patients with known learning disability within 48 hours<br>- Patients who received fully completed nutritional screening within 24 hours<br><br>**Metrics for information**<br>- Number of serious incidents<br>- Total number of patient safety incidents reported<br>- Falls in in-patients over 65<br>- Falls in patients with cognitive impairment<br>- Repeat in-patient falls |

## QUALITY

### Summary of Performance against Clinical Quality Indicator (CQUIN) Quality Dashboard Metrics

The 2011/12 CQUIN details have been finalised. Those CQUINS whose baseline measurements are based on in year calculations are excluded from this list, but will be added in once the baseline is established.

- Percentage of adult inpatients who had a Venous Thrombo-Embolism (VTE) risk assessment. Performance of 98.0% in August against the monthly target of 90%.
- Spontaneous vaginal births. Performance of 61.22% in August against a target of 64.4%
- Patient Experience overall score relating to the discharge survey. Score for July 74.4 against target of 74.4.
- Patient Experience: reducing noise at night. Score for July 82 against target of 81.
- Patient Experience: assistance at mealtimes. Score for July 80 against a target of 76.
- Reduction in medication errors of 15% on 2010/11 outturn of 3.5%. Performance of 0.85% in June against a target of <2.84%.
- Reduction in median length of stay for adult patients undergoing a (lung) lobectomy from 6 days to 5 days. Performance of 4.5 days in August against a target of 5 days.
- Number of severe haemophilia patients on prophylaxis that have undergone pharmacokinetic testing (to better determine required clotting factor usage) against a baseline measure of 30 patients on 1st April 2011. The target figure is 70% =21 patients. The haemophilia team routinely see patients every 3-6 months and can only do these tests if the patients have not taken clotting factor over and above their prophylaxis dose. An ongoing performance figure is not helpful in this case because some patients will not have had their studies done either because they have yet to be routinely reviewed, or because they were not suitable to have their studies done at the time they were seen.

## 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 80.1% in July, to 76.3% in August.
- *Clostridium difficile* infections against national trajectory increased ↑ to 7 cases in August from 4 in July.
- Meticillin sensitive *Staphylococcus aureus* against trajectory, increased ↑ to 8 cases in August from 0 in July.
- Pressure Ulcer incidence per 10,000 bed days down slightly ↓ from 14.78 in June to 13.61 in July.
- Percentage of adult patients who received thrombo-prophylaxis ↑ from 87.5% in July to 93.3% in August.
- WHO Surgical Safety Checklist, an increase ↑ to 96.8% in July from 87.3% in July.
- Reduction in elective length of stay, an increase ↑ from 3.19 days in July to 4.01 in August.
- Stroke care brain imaging within an hour down ↓ from 42.9% in July to 28.6% in August.
- Percentage of spontaneous vaginal births, a decrease ↓ to 61.22% in August from 64.88% in July.
- Same sex accommodation breaches down ↓ from 3 in July to 0 in August.
- Number of complaints up ↑ from 123 in July to 151 in August

## 1.5 EXCEPTION REPORTS

Exception reports are provided for fifteen (15) indicators in total, twelve (12) which are red rated and a further three* (3) which are amber rated and have been of particular interest to the Board:

1. Antibiotic prescribing compliance
2. *Clostridium difficile* infections against national trajectory
3. Meticillin sensitive *Staphylococcus aureus* against trajectory
4. Total pressure ulcer incidence per 10,000 bed days
5. Number of hospital acquired grade 2 pressure ulcers
6. Number of hospital acquired grade 3 pressure ulcers
7. WHO Surgical Safety checklist*
8. Number of patient safety walk rounds
9. Percentage of non-estates actions completed with 2 months of walk round*
10. Reduction in elective length of stay
11. Percentage of spontaneous vaginal births
12. Stroke care: percentage receiving brain imaging with 1 hour
13. Number of complaints received

## QUALITY

14. Number of complaints resolved within timeframe*
15. Number of complainants dissatisfied with response

**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 dropped to 76% in August (from 81% in July). Compliance fell in Medicine (83%, down from 85% in July), fell hugely in surgery (58%, down from 82% in July), increased in Specialised Services (80%, up from 79% in July) and increased in Women and Children (76%, up from 71% in July). Fifty percent (50%) of compliance failures this month are writing a stop or review date on the antibiotic prescription, and 25% compliance failure in both prescribing according to guideline and including an indication on the drug chart.

The Division of surgery is the poorest performing division by some degree in August. Twenty-two percent (22% - 98) of antibiotic prescriptions checked in August were from Surgery, and of the 41 prescriptions not meeting compliance standards, 17 were not to guideline, 22 had no stop or review date and 13 had no indication. The unusual deviation from prescribing to guideline is difficult to explain since guidelines are widely available in the Trust and this deviation from prescribing according to guideline is not mirrored in other divisions.

**Recovery plan, including expected date performance will be restored:**

The recovery plan detailed in last month's report continues.

All new doctors to the Trust in August were given an induction in antimicrobial prescribing, including prescribing according to guideline, where to find the guidelines, writing an indication and a stop or review date on the prescription.

Joint microbiology and pharmacy rounds continue, and these rounds commenced in selected surgical wards in August. Following the results this month, the new round in Surgery will continue, with an emphasis placed on the poorest performing sub-divisions within Surgery.

August saw the implementation of the new drug chart which has specific boxes for indication and stop or review date to be written on the antibiotic prescription. The first full month results with the new chart will be available at the end of September so the impact of the new chart can be evaluated then.

The Heads of Division have been made aware of the reduced performance and have reinforced the requirements for antibiotic prescribing within their division.

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The Division of Surgery, Head & Neck has identified additional actions to improve performance:

- The Lead Doctor will meet again with all surgical trainees within next two weeks to further reinforce compliance requirement
- The Head of Division and Lead Doctor will request all consultant ward rounds specifically ask the question regarding individual patient compliance.
- The Head of Division and Lead Doctor will conduct weekly surgical ward rounds specifically looking at antibiotic prescribing compliance and to discuss this with trainee doctors immediately where omissions have occurred
- The Lead Doctor in conjunction with pharmacists will have discussions with trainee doctors to standardise all antibiotic prescriptions to five days with review at that time
- A “lead” trainee doctor will be identified with responsibility for antibiotic compliance and will be accountable for weekly surgical ward/patient review

**QUALITY**

| **Q2. EXCEPTION REPORT: *Clostridium difficile* cases against 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 for the Trust 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; this is the local target figure.

**Performance in the period, including reasons for the exception:**

There were seven Trust apportioned cases of *Clostridium difficile* in August 2011; one over the month target trajectory of six cases. The breakdown of cases by location is as follows.

| Division | Target | Number of target Cases | Location of patients |
|---|---|---|---|
| **Medicine** | 3 | 4 | Ward 7; Ward 11; Ward 23; Stroke Rehab Unit |
| **Surgery Head and Neck** | 1 | 0 | - |
| **Specialised Services** | 1 | 2 | Ward 51; Ward 61 |
| **Women and Children** | 1 | 1 | Ward 76 |

The target for quarter 2 is 17 cases, therefore, the quarter target is expected to be achieved.

The cumulative cases from April to August 2011 is 28 target cases and is three under the cumulative central target trajectory for year to date. Divisional performance against trajectory is outlined below.

| Division | Target | Number of target Cases | Performance to date |
|---|---|---|---|
| **Medicine** | 16 | 17 | +1 |
| **Surgery Head and Neck** | 7 | 3 | -4 |
| **Specialised Services** | 3 | 5 | +2 |
| **Women and Children** | 5 | 3 | -2 |

The current cumulative case figure of 28 is 35% lower than the cumulative number of cases for the same time period 2009/10 (43 cases).

All cases of CDI are investigated using a modified root cause analysis process by the infection control team. Investigation of the cases in August has identified the following areas for continued focus:

- Completion of risk assessment when patients have diarrhoea

**QUALITY**

- Correct specimen testing

**Recovery plan, including expected date performance will be restored:**

Current practice has been benchmarked against the best performing Trusts locally and nationally. One area of concern is the continued use of a one-stage testing method which has the potential to identify up to 1 in 5 cases as false positives. A two-stage test can be used to eliminate false positives. The Trust Management Executive (TME) Group supported in principle investment in two-stage testing at their September 2011 meeting. Following staff training and equipment validation it is expected that the two-stage testing will be operational by quarter four 2011/12.

Through weekly operational meetings and the Service Delivery Group Divisions have been asked to continue focus on the following preventative strategies:

- Correct assessment of the patient before specimen sending
- Addressing areas of the Matrons C diff checklist that are contributing to lower compliance figures

The current position and actions that Divisions are taking is included in Divisional Quarterly Performance reviews.

The position as at 14th September 2011 is one target case, supporting the expectation of achieving the quarter 2 target.

**QUALITY**

| **Q3. EXCEPTION REPORT: Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemias** | **RESPONSIBLE DIRECTOR: Chief Nurse** |
|---|---|

**Description of how the standard is measured:**

The number of MSSA cases for patients in hospital for more than 2 days. The local reduction target is for 20% fewer cases than in 2009/10 which equates to no more than 36 cases in year. This has been equally allocated across the 12 months (i.e. a target of no more than three cases per month). This target has no financial penalties and does not contribute to the Monitor compliance framework.

**Performance in the period, including reasons for the exception:**

There were eight Trust apportioned cases of MSSA in August 2011; five over the month target trajectory of three cases. The breakdown of cases by location is as follows.

| Division | Target | Number of target Cases | Location of patients |
|---|---|---|---|
| **Medicine** | 1 | 0 | - |
| **Surgery Head and Neck** | 0 | 2 | Ward 14; Ward 5A |
| **Specialised Services** | 1 | 3 | Coronary Care Unit; Cardiac Intensive Care Unit; Ward 52 |
| **Women and Children** | 1 | 3 | Ward 31; Ward 32; Ward 37 |

Actions to prevent MSSA are similar to those for MRSA although at present widespread screening for MSSA is not recommended nationally. The number of people who harmlessly carry MSSA (approximately one third) is far greater than MRSA. The increase in cases follows a month where no post 48 hour cases of MSSA bacteraemia were reported. No obvious links between any of the cases reported have been identified from the preliminary reviews; this will be further explored through the root cause analysis process. As with MRSA, natural variations in numbers by month is statistically expected, therefore, assessment of trend over a quarter time period is recommended. The trajectory for quarter 2 is nine cases, therefore the current position is one under quarter target. Year to date cases and trajectories by Division are outlined below.

| Division | Target | Number of target Cases |
|---|---|---|
| **Medicine** | 4 | 3 (-1) |
| **Surgery Head and Neck** | 2 | 4 (+2) |
| **Specialised Services** | 3 | 6 (+3) |
| **Women and Children** | 6 | 4 (-2) |

The cumulative number of cases for the period April to August 2010 was 23; therefore, the cumulative number of cases for April to August 2011 (17) is a 26% reduction on the previous year's cases.

**QUALITY**

All post-48 hour cases are investigated by the clinical team with learning shared at the infection control operational meeting. These investigations have informed the recovery plan outlined below.

**Recovery plan, including expected date performance will be restored:**

The actions outlined below have been identified for immediate attention; a full recovery plan will be formulated once the results of root cause analysis into all the months cases are known in October.

- The current policy for MSSA screening is being reviewed with the Microbiologists to ensure all high risk groups are included.
- A review of compliance to the current MSSA screening policy is being undertaken.
- Practice for insertion and management of intravenous lines is to be reviewed by the Divisions, with specific attention to those areas where compliance with the Saving Lives care bundle is below 95%.
- Current position and actions to prevent further cases is included in Divisional Quarterly Performance Reviews.

Medium term actions include a re-launch of the Saving Lives care bundle implementation and monitoring which focuses attention on invasive device insertion and care.

The position as at 12th September 2011 is one target case; therefore it is expected to return to monthly run rate at the end of September 2011.

**QUALITY**

| **Q4-6. EXCEPTION REPORT:** | **RESPONSIBLE DIRECTOR: Chief Nurse** |
|---|---|
| – **Pressure ulcer incidence**<br>– **Number of hospital acquired grade 2 pressure ulcers**<br>– **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 rate of hospital acquired pressure ulcers grade 2 and above reduced marginally to 13.61 per 10,000 bed days in July 2011. Reductions in rates were seen in June for three Divisions. However, the rate of pressure ulcers in the Medical Division increased from 16.98 in June to 25.47 per 10,000 bed days in July.

There were no category four pressure ulcers reported in June. There were two category three pressure ulcers reported, both patients were in the Medical Division (Ward 24 and Ward 26). Actions taken as a result of these investigations include:

- Wide dissemination of a teaching tool for the relief of pressure on heels
- Increased awareness of the use of a silicone gel protector for specific risk areas (e.g. ears)

Ward staff have been reminded regarding their accountability for care and the need to ensure care is provided through individual Matrons.

In both cases an immediate review was undertaken by the Chief Nurses Team and the Head of Nursing. Both cases have also undergone root cause analysis investigation. As well as formal reporting via the Patient Safety Group, learning from these incidents is shared across the Trust through the weekly tissue viability operational meeting.

**Recovery plan, including expected date performance will be restored:**

The 'Being the Best' programme to reduce pressure ulcers and falls launched on 13th September 2011. This Trust-wide programme focuses on embedding a 'bundle' of care across the whole organisation in 60 days. The bundle of care includes:

- Ensuring all patients are correctly assessed for pressure ulcer risk
- Repositioning patients regularly – this will be facilitated by the introduction of a visual sign that a patient is at high risk of developing pressure

ulcers and visual prompts to support regular repositioning

- Using the correct mattresses to relieve pressure
- Checking and documenting the condition of patients' skin daily

All of the above will be monitored weekly to provide assurance of implementation in practice.

The Medical Division has released a Matron to focus on the 'Being the Best' implementation within the Division. Pressure ulcer prevalence and Divisional actions is now included in Divisional Quarterly Performance Reviews.

A step-change in the rate of pressure ulcer acquisition is expected in quarter three as a result of the collaborative rapid spread programme to reduce pressure ulcers and falls.

**QUALITY**

| Q7. EXCEPTION REPORT: WHO Surgical Safety Checklist | RESPONSIBLE DIRECTOR: Medical Director |
|---|---|

**Description of how the standard is measured:**

Until May 2011 WHO checklist compliance was measured with a single question within the SwiftOp theatre management system within IHCS.

1. 'Has WHO checklist been completed?' completed in theatre

From mid May 2011 this was revised to measure the compliance with all 3 elements of the WHO surgical Safety checklist; Sign In, Time out, Sign Out. The 3rd element would be assessed by recovery staff rather than theatre staff.

1. 'Sign In complete?' Completed in theatre
2. 'Time Out complete?' Completed in theatre
3. 'Sign Out complete?' Completed in recovery

All 3 sections need to be completed with 'Yes' response for an overall 'Yes' to be achieved. This data is reviewed monthly, retrospectively, by the theatre matrons and the Perioperative Patient Safety Group.

**Performance in the period, including reasons for the exception:**

Since the decrease in performance was noted in August we have moved to weekly monitoring of compliance in key areas, (Bristol Royal Children's Hospital & Hey Groves Theatres), with a prompt feedback process to staff led by the Patient Safety representativeness in those areas. Coupled with some further communication and training within these areas we have regained previous compliance and for the month of August have achieved an overall Trust performance of 96.8%. The table below demonstrates the performance across each theatre suite.

| | May 2011 | June 2011 | July 2011 | August2011 |
|---|---|---|---|---|
| **Hey Groves Theatres** | 83% | 76% | 77% | 92.1% |
| **St Michaels Hospital** | 98% | 96% | 98% | 98.3% |
| **Bristol Eye Hospital** | 100% | 99% | 100% | 99.8% |
| **Bristol Dental Hospital** | 98% | 98% | 98% | 97% |
| **Queens Day Unit** | 92% | 99% | 100% | 100% |
| **Bristol Royal Children's Hospital** | 90% | 81% | 70% | 96.2% |
| **UHB Overall** | **93%** | **90%** | **87%** | **96.8%** |

## QUALITY

**Recovery plan, including expected date performance will be restored:**

The recovery plan is to continue as follows:

1. Continue communication and teaching with recovery staff in Hey Groves Theatres & Bristol Royal Children's Hospital by Theatre Trainers and Patient Safety Lead in Hey Groves Theatres
2. WHO checklist reports to be run weekly to support prompt review of performance and monitor improvement.
3. Review and audit of notes in October to assess compliance with recording of WHO checklist within newly issues Perioperative Record of care.
4. A revised version of the paper Swift Op form has been created and will be implemented in the theatres that use it from 26th September 2011.
5. Continue to disseminate present compliance rates and actions in this recovery plan and reinforce the need for use of WHO checklist as mitigation against Never Events e.g. Wrong Site Surgery

It is expected that an improvement in performance will be evident within 8 weeks, but weekly monitoring will continue until 98% is achieved across all Theatre Suites.

**QUALITY**

| **Q8-9. EXCEPTION REPORT:** | **RESPONSIBLE DIRECTOR: Chief Nurse** |
|---|---|
| – **Number of executive director patient safety walk rounds**<br>– **Percentage of patient safety actions completed within 2 months of safety walk round** | |

**Description of how the standard is measured:**

Number of executive director patient safety walk rounds carried out against a locally set target of 6 per month.

Percentage of patient safety actions completed within 2 months of identifying the total number of actions required as a percentage of the total number of actions identified against a locally set target of 80%. Actions are split into patient safety actions and estates actions to provide further detail.

**Performance in the period, including reasons for the exception:**

Number of Executive Director Patient Safety Walk Rounds

Number of walk rounds due to be carried out in August = 8; Number of walk rounds actually carried out in August = 5; Number of walk rounds cancelled in August = 3

Details of Walk Rounds cancelled = 1) Gloucester Ward and Pre op Assessment Area cancelled due to executive sickness - now re-booked for 26th September 2011, 2) Adult Speech and Language Therapy cancelled by the Department due to staff annual leave now re-booked for 20th September 2011 and 3) Discharge Lounge cancelled by the executive due to a bereavement - now re-booked for 19th October 2011.

Percentage of Patient Safety Actions completed within 2 months = Percentage of June's Patient Safety actions were completed by end of August 2011.

| Division | No of patient safety actions identified | Actions completed | Percentage |
|---|---|---|---|
| Surgery Head and Neck | 4 | 3 | 75% |
| Specialised Services | 1 | 1 | 100% |
| Women's and Children's Division | 1 | 1 | 100% |
| Diagnostic and Therapies | 2 | 2 | 100% |
| Medicine | 4 | 2 | 50% |
| **TRUST TOTAL** | **12** | **9** | **75%** |

Outstanding Actions:

Surgery, Head and Neck – Following a visit to Paediatric Theatres within the Dental Hospital by the Chief Nurse an action was raised for "disposable

curtains to be followed up and fitted with tracking". This action has been pursued by the Matron but unfortunately no progress made with Sunlight Services. Therefore the action remains outstanding due to the inability to progress further with the current provider of curtains rather than internally. The Chief Nurse is aware that the action remains outstanding and has suggested that the action be raised at the linen group to see if funding can come from another source.

Medicine – Following a visit to Dermatology by the Director of Workforce and Organisational Development an action was raised about patient dignity Issues as this day care area is mixed sex and, although areas are sectioned off by curtains, patients can be undressed for long periods of time and have to go out to the waiting area if they need to use a toilet. Since the visit, Dermatology have begun to group patients by gender and nursing staff are asking patients if they need to use the bathroom before undressing. The area will still need to make further changes and are currently waiting for quotes to have some new curtain tracks fitted. It is difficult to fully complete this action in the 2 month time frame but feedback shows improvements have already been made.

A second action was also raised from the Dermatology walk round in relation to the temperature in the area which gets extremely cold in the winter and becomes an issue for patients who have to undress. Again this action is being discussed with estates but will take longer than 2 months to complete.

**QUALITY**

| Q10. EXCEPTION REPORT: Reduction in elective length of stay | RESPONSIBLE DIRECTOR: Chief Operating Officer |
|---|---|

**Description of how the standard is measured:**

The CQUIN target is a 5% reduction in average length of stay for elective patients from 2010/11 performance. This equates to 3.64 days. Length of stay in hospital is calculated by counting the total days patients that were discharged in the month stayed in hospital.

**Performance in the period, including reasons for the exception:**

Average length of stay for elective patients in August 2011 increased to 4.01 days. The main reasons for the increase in length of stay were:

- Discharge of a small number of very long stay patients following Bone Marrow Transplant (which explained around a third of the increase in length of stay across the Trust)
- An increase in the number of cardiac surgery cases admitted and discharged in the month - although the average length of stay for these cardiac patients was lower than in previous months, the increase in the numbers of cases increased the overall elective length of stay for the Trust (which explained around a third of the length of stay increase for the Trust)
- An increase in the number and length of stay of colorectal and maxilla facial surgery patients, which is thought to be due to case mix, with more complex/cancer cases being discharged in the month
- An increase in paediatric surgery cases and length of stay, with fewer day-case patients being admitted and discharged in the month.

**Recovery plan, including expected date performance will be restored:**

There is an ongoing programme of work in all bed-holding Divisions to reduce elective length of stay, including the following:

- Day of surgery admission for elective surgical patients
- Enhanced recovery programmes, specifically piloted in colorectal and thoracic surgery, intended to promote rapid post-operative recovery through pre-operative optimisation of physical condition and patient counselling
- Move to day case procedures for patients previously requiring overnight stay
- Focus on discharge planning (including development of ‘ticket to go’) at pre-operative assessment so that patient involvement drives discharge
- Non-medical practitioner-led discharge

**QUALITY**

| Q11. EXCEPTION REPORT: Spontaneous vaginal births | RESPONSIBLE DIRECTOR: Chief Nurse |
|---|---|

**Description of how the standard is measured:**

Improvement of 1% in the **proportion** of spontaneous vaginal deliveries, compared with the number of all births including caesarean sections. The target is 64.4%. This is a Commissioning for Quality Indicator (CQUIN) incentive and is designed to increase the proportion of normal births. The deliveries include patients of all Primary Care Trusts and home births supervised by a UH Bristol employed community midwife

**Performance in the period, including reasons for the exception:**

The number of spontaneous vaginal deliveries, compared with the number of all births was 61.22% for August 2011. The unit is seeing an increase in women with medical complications e.g. diabetes, cardiac disease. The tertiary and quaternary services are increasing due to an increase in the number of women with congenital heart disease and foetal medicine cases with complex surgical or cardiac needs from birth. This combined with the effect of the neonatal network centralising extreme preterm births has led to increased complexity of working.

In many of these complex pregnancies induction of labour is indicated which increases the likelihood of the woman requiring intervention in labour and affects delivery outcome. The increase in previous caesarean sections also impacts on mode of delivery in the second pregnancy. The midwife to birth ratio is 1 midwife to 36 births and therefore one to one care, known to increase normal birth ratios is more difficult to achieve.

With the European Working Time Directive implementation, the skill levels of the on call doctors are changing and increasing consultant presence on Central Delivery Suite is required. The Royal College of Obstetricians and Gynaecologists recommend 24 hour cover for a unit our size. We currently have 69 hours on-site consultant presence per week. Senior presence is known to reduce unnecessary intervention. There is no separate midwifery led unit at St. Michael's Hospital.

**Recovery plan, including expected date performance will be restored:**

The service has set up a normal birth working party to ensure service is pro-active in increasing normal birth. There is also a vaginal birth after caesarean section working party (VBAC) and a VBAC clinic. Caesarean section rates by Consultant are being published. Midwives are attending normal birth workshop and study day. There are normal birth guidelines.

The service is promoting home birth. There is a new team of midwives (Team 9) who are based on delivery suite each shift and is used to triaging women and encouraging women to remain at home longer in early labour, to avoid unnecessary intervention. They are also supporting home births, going out as a second midwife to the community midwife and covering the clinics in the community when the community midwife has been up at night. The service is reviewing all maternity pathways as part of a service review and is proposing a midwifery led unit be developed within the unit.

**QUALITY**

| **Q12. EXCEPTION REPORT: Stroke care – percentage receiving brain imaging within an hour** | **RESPONSIBLE DIRECTOR: Chief Nurse** |
|---|---|

**Description of how the target is measured:**

The percentage of patients suspected as suffering from a stroke who are scanned within 1 hour of arrival in the Emergency Department. The national standard is for at least 50% of suspected strokes to be scanned within 1 hour. This is based upon the finding that around 50% of suspected strokes have clinical indications that a scan is warranted.

**Monitor measurement period:** Not applicable at present – Monitor is still to confirm which stroke indicators are to be included in its Compliance Framework.

**Performance during the period, including reasons for exceptions:**

Performance against this standard has remained unchanged at around 30% in the last 12 months. The reason for not achieving the 50% standard continues to be multi-factorial. This includes a lack of knowledge of the clinical urgency for scans and difficulties scanning within an hour out-of-hours. These two areas are the basis for the action plan.

**Recovery plan, including expected date performance will be restored:**

The actions being taken to ensure improved performance are detailed below. *Please note: actions completed in previous months have been removed from the following list*:

- Clinical Lead for Radiology has negotiated a "direct request to radiographer" for scan of suspected stroke patients out of hours (bypassing the need to discuss/ request scan with radiologist) – he is currently completing a Standard Operating Procedure for the radiographers. Date to start to be confirmed
- New juniors in Medicine have all been informed, but need further information on the ROSIER triage assessment (see below).
- Stroke Clinical Team to meet with the Emergency Department staff to encourage use of the ROSIER (Recognition of Stroke in the Emergency Room) clinical assessment by triage nurses or doctors to identify potential stroke patients earlier and scan immediately if ROSIER positive (Action complete)
- Radiology looking into whether the ROSIER questions can be used within the ICE request for CT scan (under review)

Emergency Department involvement remains key to achieving the target, as often by the time stroke patients are referred to the medical team they will be outside the one hour time window.

## QUALITY

**Progress against the recovery plan:**

Performance against this standard was 28.6% in August, compared with 42.9% in the previous month. The full effect of the above actions has not yet been felt. However, the clinical team is reviewing what additional action can be taken to ensure compliance with this standard.

**QUALITY**

| Q13. EXCEPTION REPORT: Number of complaints | RESPONSIBLE DIRECTOR: Chief Nurse |
|---|---|

**Description of how the standard is measured:**

The number of patient complaints and concerns received in a month. The target for the maximum number of complaints is 120 per month.

**Performance in the period, including reasons for the exception:**

Performance of 151 complaints received in the month. Monthly fluctuations of numbers of complaints occur. However the green threshold has been exceeded for a third consecutive month. Reasons for increased numbers of complaints are usually due to a combination of factors. Features of recent complaints include a rise in the number relating to the car parking restrictions in place because of the building work for the Bristol Royal Infirmary redevelopment and a tendency for some departments to refer patients to the complaints department rather than address the causes of complaints which are within their gift to resolve locally.

**Recovery plan, including expected date performance will be restored:**

- Where individual departments refer patients to the complaints department rather than address the cause of the complaint themselves, staff are reminded of their responsibility for addressing the complaint when it is something which can be done at the time locally, either themselves or by escalating to the Ward or Department Manager.
- Treating People Well training has been provided for front line staff which reinforces individuals' responsibilities in addressing complaints, and is currently under review. In addition, specific training is offered to individual departments.
- Issues relating to relating to the car parking restrictions in place because of the building work for the Bristol Royal Infirmary redevelopment have been fed into the Redevelopment Team. As result of these, changes have been made to improve signage and guidance has been provided to parking attendants in communicating directions to patients/visitors for alternative parking provision as appropriate.

**QUALITY**

| **Q14. EXCEPTION REPORT: Percentage of complaints resolved within of Local Resolution Plan timescale** | **RESPONSIBLE DIRECTOR: Chief Nurse** |
|---|---|

**Description of how the standard is measured:**

The number of complaints which are resolved within the timescale originally agreed (or subsequently renegotiated) with the complainant. The target each month is 98%.

**Performance in the period, including reasons for the exception:**

August 2011 performance was 92.7%, which is disappointing following last month's 97.4%. A total of 4 complaints were resolved outside of the original or renegotiated timescale.

Three of these breaches of timescale relate to the Division of Surgery, Head & Neck and one to Trust Services Division.

Of the three breaches relating to the Division of Surgery, Head & Neck, one response was late due to a further question being raised by the complainant after the response was concluded by the Division, one related to a meeting where it has been difficult to set a convenient date with the complainant and one related to a telephone response where it had proved difficult to make contact with the complainant.

The complaint breach in Trust Services Division required information from an external supplier to respond. There was difficulty in obtaining this information from the supplier which required escalation to their management team before this was provided.

**Recovery plan, including expected date performance will be restored:**

- Following the outcome of the externally commissioned review of complaints a comprehensive work plan has been agreed with Divisions which is designed to improve efficiency of systems for managing complaints and improve performance in timeliness of responses. This work includes improving the frequency of proactive and local resolutions e.g. through meetings with complainants to provide opportunity for further issues to be raised and responded to at the time. The work plan is due to be fully implemented by the end of January 2012.
- Each individual breach has been discussed with the relevant Divisional Complaints Co-ordinator.
- Performance is being closely monitored on a day to day basis by corporate team and is also reviewed the Patient Experience Group, chaired by the Chief Nurse.

**QUALITY**

| **Q15. EXCEPTION REPORT: Number of complainants dissatisfied with response** | **RESPONSIBLE DIRECTOR: Chief Nurse** |
|---|---|

**Description of how the standard is measured:** The number of complainants who are dissatisfied with the response provided to a complaint following full investigation. The target set at no more than 5 dissatisfied complainants per month.

Reasons why complainants remain dissatisfied can include:

1. The Trust's original response prompts further questions from the complainant regarding issues raised in their complaint.
2. The quality of the original response was not sufficient either in communicating clearly the outcome of the complaint investigation or by not addressing all the issues raised.
3. The complainant's expectations of a response exceed what can be delivered.

**Performance in the period, including reasons for the exception:**

Eight complainants came back as dissatisfied with their response in August 2011.

This is broken down by the following Divisions:

- 5 x Division of Surgery, Head & Neck
- 3 x Division of Women & Children

In all cases the reason for the complainant contacting us again was to ask further questions following receipt of our written response as their complaint was complex or to request a meeting to discuss the response. From a review of the case files none of the causes of dissatisfaction were linked to a poor quality investigation whereby the original investigation was incomplete, or did not address the issues raised. The Trust's checking procedures should identify any such issues and address them before the complaint response is sent.

**Recovery plan, including expected date performance will be restored:**

- Following the outcome of the externally commissioned review of complaints a comprehensive work plan has been agreed with Divisions which is designed to improve efficiency of systems for managing complaints and improve performance in timeliness of responses. This work includes improving the frequency of proactive and local resolutions e.g. through meetings with complainants to provide opportunity for further issues to be raised and responded to at the time. The work plan is due to be fully implemented by the end of January 2012.
- The Divisions involved have been notified of each case and investigations into further issues raised and/or meetings with complainants are in hand.
- The corporate Patient Support & Complaints Team continue to closely monitor response letters to ensure that all aspects of a complaint have been fully addressed and have been returning an increased number to the Division before sending the response letter if this has not happened.

**QUALITY**

- Trust level complaints metrics are now replicated at Divisional level to enable Divisions to identify their specific areas for improving performance and implement appropriate actions. The Divisional dashboards will also be used for quarterly performance reviews.
- The Chief Nurse has discussed performance with the Heads of Nursing for each Division and reiterated an expectation that this performance measure has to improve.
- A meeting has been arranged with the Division of Surgery at the end of September 2011 to identify any particular difficulties and possible solutions.

## 1.6 SUPPORTING INFORMATION

### 1.6.1 Quality Achievements –Division of Specialised Services

**Radiotherapy Peer Review**

The National Cancer Peer Review programme is led by the National Cancer Action Team and includes expert clinical and user representation in order to provide important information about the quality of services across the country.

The programme aims to improve care for people with cancer, and their families, by:

- Ensuring services are as safe as possible
- Improving the quality and effectiveness of care
- Improving the patient and carer experience
- Undertaking independent and fair reviews of services
- Providing development and learning for all involved
- Encouraging the dissemination of good practice

As part of the programme the Trust's radiotherapy services were assessed. For radiotherapy, there are eighty eight standards or measures that each service is reviewed against. The gathered evidence to demonstrate compliance with those measures, and then hosted an external review panel of seven people for a day, who scrutinised the evidence to ensure that the department complied with each measure.

The Bristol Haematology and Oncology Centre achieved 98% compliance with the standards, the highest score in the country. Pulling together the information was a huge team effort, and the department was able to demonstrate it met the standards without the need to change the way that the service is run.

**Biomedical Research Unit**

In 2008, UH Bristol and the University of Bristol were awarded funding to set up the Bristol Biomedical Research Unit in Cardiovascular Disease, situated in the Bristol Heart Institute. This designation has now been renewed, with further funding awarded, with the aim to develop and translate new scientific discoveries into ground-breaking medicines, treatments and better care for NHS patients.

The Biomedical Research Unit enables some of the best health researchers and clinicians to work together. Studies are currently been conducted in a broad range of areas such as heart disease affecting children, research into stem cell and platelet function as well as imaging.

Involving patients in the design of studies as well as discussions on how research can be improved helps ensure that research results are applicable and valuable to them. The Biomedical Research Unit recognises the crucial role that patients play in their work, and have set up successful Public and Patient

Involvement groups, and plans to use these further to foster relationships to both improve the treatment of today's patients while creating the standard of patient care for the future.

### Nursing and Midwifery Recognition Awards

International Nurses Day, on the 12th May, saw a number of awards to staff who had been nominated by their peers for their commitment and exceptional contribution to patients care, and going above and beyond what is normally expected of them within their role. The Division was very proud that three members of staff received Highly Commended awards: Sue Gibert (Sister, Cardiac Intensive Care Unit); Rachel Allan (Sister, Ward 52); Anita Twigg (Nurse Assistant, Ward 51). Helen Morgan, Head of Nursing for the Division, received the Inspirational Leader award.

### 1.6.2 Examples of Learning from Recent Complaints

**Summary of patient's complaint**

A patient was placed on the waiting list for a hysterectomy in July 2010 and in November 2010 received a standard letter asking whether she still required the operation, whether she would be available at short notice and if there were any dates that were not suitable. She returned the tear-off slip from this letter confirming that she could attend at short notice but that she did not want to come into hospital over Christmas.

In January 2011, the patient telephoned the hospital and left a message on the number on the letter – no one called her back.

The patient telephoned again in February 2011, only to be told that she had been removed from the waiting list in December 2010 as they had not received the slip she had returned in November. Staff confirmed to patient that she had however been put back on the list when they found her slip – she had not previously been informed of any of this. The patient was then advised that she would probably have her operation in March or April 2011.

When the patient originally saw the consultant in July 2010, he informed her that she would be having her hysterectomy in about 6-8 weeks from the time she saw him.

**Investigation**

The investigation showed that the patient was listed for routine surgery as she was not on a cancer pathway, and due to the high demand for urgent cases at the time, the waiting list validation (to check that the patient still required the operation) did not take place until her case was very close to breaching the 18 week target. An apology was offered for this. The 18 week breach occurred whilst waiting list validation was taking place and the patient's name was removed from the waiting list in early December 2010 as her reply had not been received within the timescale requested. Had her reply been received within the timescale requested, she would have been offered a date promptly. She was re-instated to the waiting list 11 days after removal when her reply confirming she still required the operation and could accept a short notice cancellation slot was received. An apology was offered that she was removed from the waiting list.

Due to a number of staff changes, it has not been possible to establish why the patient's telephone call was not returned

## QUALITY

### Action taken

- The need for the prompt return of phone calls has been stressed to the Admissions Team and the situation is being monitored to ensure a better standard of service is provided.

- At the time of the patient's surgery, the Emersons Green Treatment Centre was available as an alternative venue for minor surgical cases, but not for hysterectomies. From April 2011, patients undergoing hysterectomy now have the option of having the procedure at Emersons Green – this will improve waiting list management and reduce delays for patients.

- As a result of this complaint, the Admissions Team have reviewed the wording in the standard waiting list validation letter that is sent to patients. There is now an explanation of the reasons for this validation and the need to return the slip within the time period given.

- The Clerical Office Manager for Gynaecology Services has reminded all doctors of the current waiting times for procedures so that patients can be given accurate information.

### Summary of patient's complaint

A patient wished to complain about the care that she received at the Bristol Royal Infirmary leading up to her diagnosis of colon cancer. She experienced a delay of five months from when she was first admitted to hospital with suspected appendicitis until her right hemi-colectomy and resection of the abdominal wall. The patient was then discharged with no information to alert her to the seriousness of the findings during the operation – she was advised that she would be telephoned with the histology results.

The patient subsequently experienced a lack of continuity of care and received conflicting opinions from several surgeons. When the Colorectal Nurse telephoned the patient with her results, she stated that the patient had a "large Stage 4 cancer of the appendix, that 24 lymph nodes had been removed and that there was no sign of migration of the cancer cells. The nurse was very vague about when the patient might expect to start receiving chemotherapy and told the patient to "just try and relax and chill out". The patient was understandably devastated by this news but was not given any further information or offered any type of support.

When the patient visited her GP three weeks after her discharge from hospital, he knew nothing about her diagnosis – the hospital had not informed him and the patient had to tell him herself.

### Investigation

The investigation showed that the patient's clinical condition was complex requiring a number of initial diagnostic tests, which did not indicate a malignancy. As the patient's condition progressed, an emergency admission and further diagnostic tests prompted a decision for exploratory laparoscopic surgery which was converted into open surgery to remove a mass and a resulted in a subsequent cancer diagnosis. The patient received an apology that the explanation of the surgery and its findings was not communicated to her more clearly at the time.

## QUALITY

In response to her concerns regarding lack of continuity of care, the patient was provided with an explanation of the team working arrangements between the upper gastro-intestinal and colorectal surgeons which means that review and management of patients is shared according to the specific expertise required in response to an emerging clinical picture.

The patient was offered the choice to receive her histology results either by telephone or in person at a follow up appointment and chose to receive them by telephone. The patient received an apology that the results and follow up arrangements were not communicated effectively and that an explanation of lymph node removal being part of the resection of the mass was not given at the time.

The investigation showed that the discharge letter to the GP was received by the surgery two days after the patient's discharge. However, the patient attended a follow up appointment Bristol Haematology & Oncology Centre within a week of discharge and there was a delay in sending the outpatient letter from this appointment to the GP which contained confirmation of the diagnosis.

**Action taken**

- A full explanation was given to the patient for treatment she received and why surgery was not the first option when it was initially thought that she had appendicitis.

- The Bristol Haematology & Oncology Centre recognised that there was a significant delay at the time between clinics and GPs receiving their letters. An improvement plan has been put in place. This includes increasing the number of secretaries and putting processes in place to ensure urgent clinic letters reach the GP as soon as possible. The current target they are aiming for is 2 days for urgent letters and 5 days for any other letters. Work is continuing to reduce the delay between appointments, clinic typing and forwarding of letters to their destination address.

- The complaint brought to light that clarity of information from the Colorectal Nurse Specialist is of the utmost importance for all patients. The Matron has worked closely with the Colorectal Nurse Specialists to ensure they have more detailed information available to give patients on the phone should they require it and to establish a template for post Multi-Disciplinary Team meeting telephone calls. This work includes a plan for follow-up and a date for further appointments with oncology and/or the colorectal surgeons. This organisational learning will be shared with all nurse specialists who provide post Multi-Disciplinary Team meeting telephone calls.

## WORKFORCE

### 2.1 SUMMARY

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

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

## 2.2 EXCEPTION REPORTS

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

1) Workforce costs – red rated against Trust budgeted costs

## WORKFORCE

| W1. EXCEPTION REPORT: Workforce Costs | RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development |
|---|---|

**Description of how the standard is measured:**

Workforce costs compared with budget for 2011/12

**Performance in the period, including reasons for the exception:**

All Divisions except Diagnostic and Therapies, Surgery Head and Neck and Facilities and Estates are over budget on pay costs.

| | Diagnostic & Therapies | Medicine | Specialised Services | Surgery Head & Neck | Trust Services (exc Facilities & Estates) | Facilities & Estates | Women's & Children's | Totals |
|---|---|---|---|---|---|---|---|---|
| **August 2011** | £ '000 | £ '000 | £ '000 | £ '000 | £ '000 | £ '000 | £ '000 | £ '000 |
| **Workforce Costs** | £3,112 | £3,503 | £2,992 | £5,592 | £2,158 | £1,609 | £5,828 | £24,795 |
| **Budgeted Costs** | £3,126 | £3,437 | £2,865 | £5,605 | £2,124 | £1,647 | £5,617 | £24,421 |
| **variance target £ +/-** | £13 | -£66 | -£127 | £13 | -£34 | £37 | -£211 | -£374 |

Medicine:

- Bank expenditure has been incurred where vacancies have been held (awaiting redeployment following Ward closures). Further ward closures have happened in August but the reduction in expenditure has yet to be realised in the income and expenditure account. It is anticipated that this cost reduction will materialise in September.

Specialised Services:

- Slippage in CRES (Cash Releasing Efficiency Savings) schemes
- Extra session payments, mainly in the Bristol Heart Institute (BHI)
- Cardiac services agency costs, due to vacancies being filled by agency staff across the BHI
- Divisional consultant locum spend in BHI

Women's & Children's:

The Division has successfully managed a challenging 2% vacancy factor across pay budgets for the last 2 years. This was carried forward into budgets this year and was integral to Operating Plan delivery. This is failing to deliver this year, the main reasons being:

**WORKFORCE**

- Increasing patient acuity requiring 1:1 and 1:2 nursing support on general wards
- Increasing patient activity such as A&E attendances and births
- Ward maternity leave rates averaging around 5%, compared to the 4% plan
- Incremental drift, in particular for junior doctors, which had not been budgeted for

In addition, the following issues have contributed to the adverse pay spend for Women`s & Children`s:

- CRES schemes which have slipped or under achieved, for example reduced sickness rates, vacancy freezes and bed closures
- Back payments for consultants following a review of job plans
- Vacancies on the Paediatrics Registrar rota

Trust Services excluding Estates & Facilities:

- Most of the variance is due various pay advances which have been made which have not yet been charged to Divisions

**Recovery plan, including expected date performance will be restored:**

Medicine:

- As above, it is anticipated that the reduction in bank expenditure will materialise in September, following further Ward closures. The Division is also undertaking an exercise to implement bank 'quotas' according to clinical requirement and capacity.

Specialised Services:

- Overspend on extra BHI sessions will be funded through income, as the Division's operating plan includes the delivery of additional cardiac surgery cases.
- Working group set up to review agency spend in cardiac surgery juniors, with the aim of swiftly reducing agency spend in this area
- Locum in cardiology due to be reviewed at the end of September
- Tight controls on bank, including targets in nursing areas, have already been established
- Agency spend in Cardiac Physiology has ceased – the spend in Month 5 was as a result of residual invoices

Women's & Children's:

The Division has developed a recovery plan in conjunction with additional Trust support. Key pay-related actions to deliver this plan include:

- Withholding investment in Research and Innovation
- Clinical Nurse Specialists working additional ward shifts with immediate effect
- Reviewing management office posts and holding physiotherapy vacancies
- Removal of discretionary additional PAs to consultants undertaking duties outside of job plans
- Delivering Cardiac Surgery and Maternity growth at lowest safe cost

## WORKFORCE

Trust Services excluding Estates & Facilities:

- A plan is being developed to ensure that pay advances are charged to the appropriate Divisions to avoid an apparent adverse position appearing in Trust Services in future.

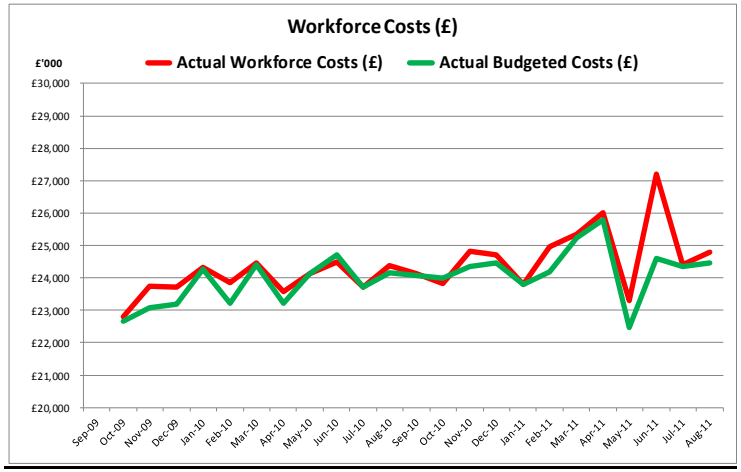
**Progress against recovery plan:**

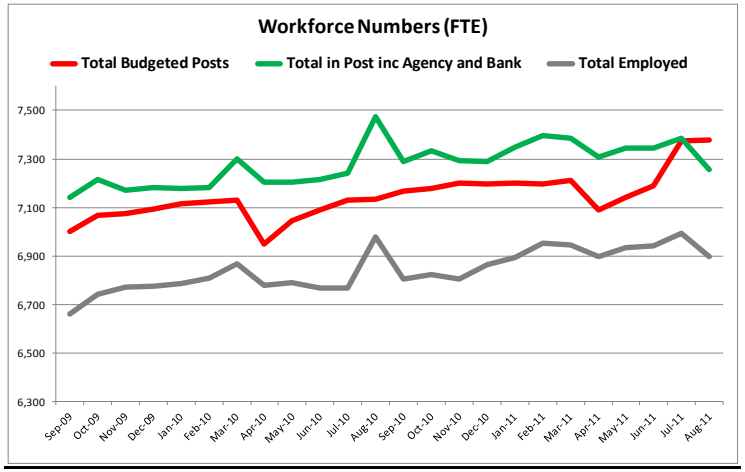
Expectation of recovery plan to impact at the various dates outlined in the previous section.

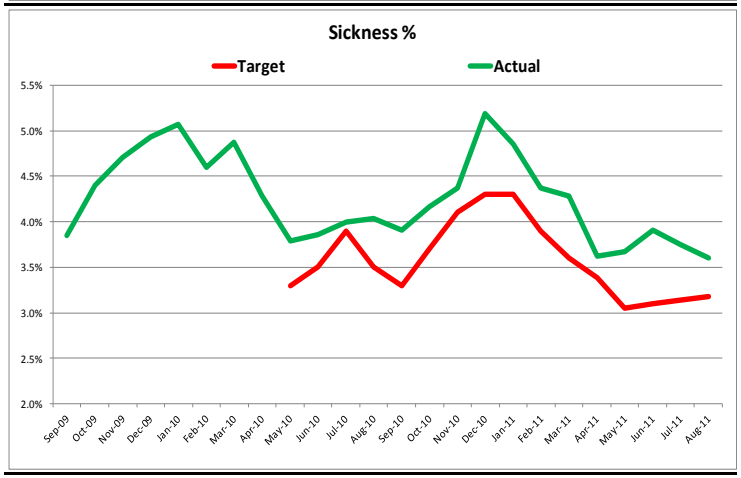
## 2.2 SUPPORTING INFORMATION

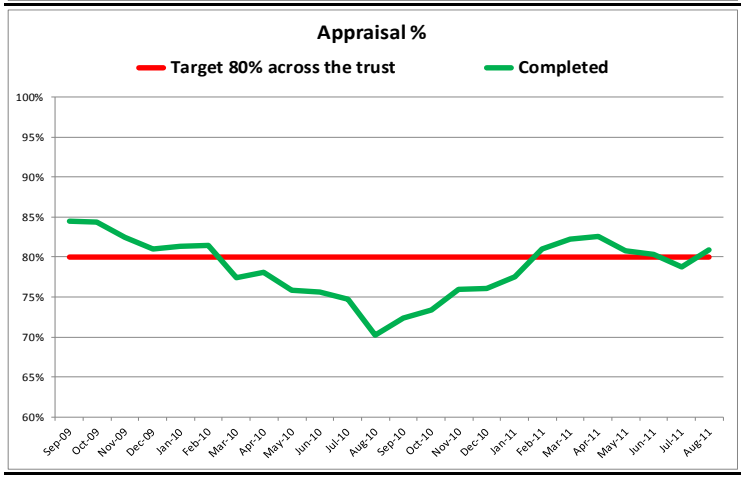
This report provides an outline of the Trust's position against key workforce standards for the month of August 2011 and year to date performance for 2011/12.

### 2.3.1 Summary



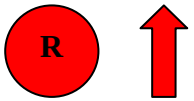
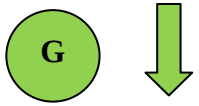
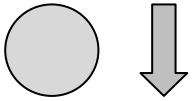
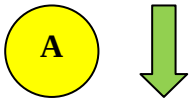
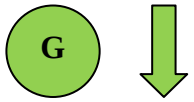



## WORKFORCE

### 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: European Working Time Directive (EWTD) (October 2011) Statutory and mandatory training (December 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 increased by 1.5% and workforce budget by 0.3% in August 2011, compared to last month`s report. August's costs were 1.3% above the budgeted workforce costs compared with 0.3% in July. | See exception report |
| Workforce Numbers |   | Workforce numbers reduced by 1.7% compared with July 2011, 1.7% below the budgeted workforce numbers. This compares with July 2011 when workforce numbers were 0.1% above budget. | See supporting information |
| Turnover |  | Rolling voluntary turnover reduced by 0.1% to 8.5%. | |
| Sickness |   | Sickness reduced by 0.1 percentage points compared with July 2011 across the Trust, 0.4 percentage points above the monthly target for 2011/12. | See supporting information |
| Bank/Agency |   | Bank and agency reduced by 31.7 fte compared with July 2011, and is 27.6% below the usage for August 2010. | |
| Appraisal |   | Appraisal rates increased by 2.0 percentage points to 80.8% compared with July 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 | Aug-10 | Sep-10 | Oct-10 | Nov-10 | Dec-10 | Jan-11 | Feb-11 | Mar-11 | Apr-11 | May-11 | Jun-11 | Jul-11 | Aug-11 | Aug 11 Forecast |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Budgeted Posts (FTE) | 7132.9 | 7167.9 | 7178.1 | 7198.8 | 7197.4 | 7201.0 | 7196.9 | 7211.5 | 7090.1 | 7140.7 | 7189.1 | 7374.1 | 7379.3 | |
| Total Employed (FTE) | 6977.2 | 6806.0 | 6821.6 | 6805.9 | 6865.4 | 6892.1 | 6951.8 | 6945.2 | 6895.7 | 6932.5 | 6940.7 | 6993.0 | 6898.2 | |
| Sickness Rate (%) | 4.0% | 3.9% | 4.2% | 4.4% | 5.2% | 4.9% | 4.4% | 4.3% | 3.6% | 3.7% | 3.9% | 3.7% | 3.6% | 3.2% |
| Bank (FTE) Admin & Clerical | 92.5 | 92.6 | 85.6 | 84.3 | 78.9 | 81.5 | 80.1 | 89.1 | 73.6 | 73.0 | 77.8 | 79.2 | 80.9 | |
| Bank (FTE) Ancillary Staff | 29.6 | 26.0 | 27.7 | 25.0 | 23.9 | 23.4 | 20.6 | 25.5 | 20.3 | 20.5 | 19.1 | 17.4 | 12.8 | |
| Bank (FTE) Nursing & Midwifery | 261.8 | 249.6 | 263.0 | 245.9 | 212.9 | 239.8 | 214.8 | 232.4 | 231.5 | 233.1 | 230.8 | 239.7 | 193.9 | |
| Agency (FTE) Admin & Clerical | 6.0 | 6.9 | 9.0 | 7.3 | 5.2 | 6.2 | 6.8 | 9.4 | 7.0 | 4.3 | 3.2 | 2.6 | 3.4 | |
| Agency (FTE) Ancillary Staff | 40.9 | 48.2 | 52.4 | 43.1 | 41.7 | 28.5 | 32.1 | 35.2 | 31.1 | 34.7 | 34.3 | 18.1 | 34.1 | |
| Agency (FTE) Nursing & Midwifery | 12.1 | 13.4 | 12.7 | 8.0 | 8.4 | 14.0 | 6.9 | 10.0 | 17.5 | 12.3 | 7.4 | 8.4 | 8.2 | |
| Overtime | 74.8 | 64.7 | 63.4 | 74.8 | 50.8 | 57.3 | 66.0 | 72.1 | 61.6 | 63.6 | 78.0 | 62.9 | 40.4 | 71.8 |
| Appraisal (%) | 70.2% | 72.4% | 73.3% | 75.9% | 76.1% | 77.6% | 81.1% | 82.3% | 82.6% | 80.8% | 80.3% | 78.8% | 80.8% | 80.0% |
| Rolling Average Turnover (%) | 15.9% | 15.5% | 15.8% | 15.6% | 15.4% | 15.3% | 15.3% | 15.4% | 15.0% | 14.9% | 14.9% | 14.6% | 14.1% | |
| Rolling Average Voluntary Turnover (%) | 9.4% | 9.6% | 9.9% | 9.6% | 9.6% | 9.5% | 9.3% | 9.4% | 9.1% | 9.0% | 9.0% | 8.6% | 8.5% | |
| Vacancy Rate (%) | 2.2% | 5.0% | 5.0% | 5.5% | 4.6% | 4.3% | 3.4% | 3.7% | 2.7% | 2.9% | 3.5% | 5.2% | 6.5% | |

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 August 2011**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 2)***, 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.

| **Achieving (13)** | **Underachieving (3)** |
|---|---|
| - 31-day diagnosis to treatment cancer standard - *first*<br>- 31-day diagnosis to treatment cancer standard – *all subsequent treatments*<br>- 2-week wait urgent GP referral cancer standard<br>- Symptomatic breast patients (cancer not initially suspected) 2-week wait<br>- Referral to Treatment Time for admitted patients (95th percentile)<br>- Referral to Treatment Time for non-admitted patients (95th percentile)<br>- Genito-Urinary Medicine (GUM) 48-hour access<br>- A&E Time to Treatment<br>- A&E Left without being seen rate<br>- A&E Unplanned re-attendance<br>- A&E Maximum waiting time (4-hours)<br>- A&E Time to Initial Assessment (ambulance arrivals) (95th percentile)<br>- Access to healthcare for patients with learning disabilities | - 62-day referral to treatment cancer standard – *Screening referred*<br>- Infant health – breastfeeding rate<br>- Reperfusion times (call to balloon time of 150 minutes) |
| **Failing (2)** | **Not reported/scored (0)** |
| - Last-minute cancelled operations / 28-day readmission<br>- 62-day referral to treatment cancer standard – *GP referred* | |

*Please note: the position shown above for the cancer standards includes the draft performance figures for July. 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

| | Target | Thresholds Green | Thresholds Red | 2010/11 to date | 2011/12 To Date | Month Sep-10 | Oct-10 | Nov-10 | Dec-10 | Jan-11 | Feb-11 | Mar-11 | Apr-11 | May-11 | Jun-11 | Jul-11 | Aug-11 | Quarterly Performance 2011/12 Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer | Cancer - Urgent Referrals Seen In Under 2 Weeks | 93% | 88% | 95.3% | 95.4% | 96.4% | 95.7% | 95.9% | 94.6% | 91.9% | 96.8% | 96.9% | 96.0% | 95.4% | 94.6% | 95.4% | Cancer standards report two months in arrears | 95.4% | 95.4% | | |
| | Cancer - Symptomatic Breast (cancer not suspected) in Under 2 Weeks | 93% | 88% | 86.4% | 98.7% | 97.1% | 95.5% | 90.9% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.1% | 98.6% | 97.7% | | 99.0% | 97.7% | | |
| | Cancer - 31 Day Diagnosis To Treatment (First Treatments) | 96% | 93% | 98.1% | 97.0% | 99.1% | 99.0% | 100.0% | 96.1% | 96.0% | 97.8% | 98.0% | 97.3% | 96.8% | 96.7% | 96.7% | | 97.1% | 96.7% | | |
| | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug) | 98% | 93% | 99.5% | 99.8% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.1% | 100.0% | 100.0% | 100.0% | | 99.7% | 100.0% | | |
| | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) | 94% | 89% | 96.1% | 98.1% | 97.7% | 96.9% | 95.7% | 91.7% | 92.3% | 93.0% | 98.0% | 98.2% | 100.0% | 96.8% | 97.8% | | 98.2% | 97.8% | | |
| | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) | 94% | 89% | Not applicable | 99.7% | Standard not in effect | | | | 99.2% | 100.0% | 99.5% | 100.0% | 99.4% | 100.0% | 99.3% | | 99.8% | 99.3% | | |
| | Cancer 62 Day Referral To Treatment (Urgent GP Referral) | 85% | 80% | 85.8% | 84.9% | 79.9% | 82.7% | 89.9% | 90.0% | 79.3% | 85.7% | 91.2% | 88.1% | 85.7% | 82.7% | 84.2% | | 85.1% | 84.2% | | |
| | Cancer 62 Day Referral To Treatment (Screenings) | 90% | 85% | 93.5% | 93.4% | 92.3% | 93.8% | 81.5% | 100.0% | 94.4% | 70.8% | 87.5% | 96.8% | 100.0% | 95.3% | 81.8% | | 97.1% | 81.8% | | |
| | Cancer 62 Day Referral To Treatment (Upgrades) | Not published | Not published | 99.5% | 95.1% | 91.8% | 81.0% | 96.8% | 92.5% | 97.9% | 100.0% | 100.0% | 100.0% | 100.0% | 88.9% | 92.6% | | 96.2% | 92.6% | | |
| Referral to Treatment | Referral To Treatment Admitted Under 18 Weeks | 90% | 80% | 93.1% | 92.2% | 93.4% | 93.0% | 92.6% | 93.4% | 94.0% | 92.7% | 91.5% | 93.0% | 92.4% | 92.7% | 91.8% | 91.3% | 92.7% | 91.5% | | |
| | Referral To Treatment Non Admitted Under 18 Weeks | 95% | 85% | 98.4% | 98.2% | 98.5% | 98.2% | 98.5% | 98.6% | 98.4% | 98.0% | 98.0% | 98.1% | 98.7% | 98.4% | 98.0% | 97.6% | 98.4% | 97.8% | | |
| | Referral to treatment time admitted patients (95th percentile - weeks) | 23 | 23 | Not applicable | 21.3 | Standard not in effect | | | | | | | 21.3 | 21.6 | 20.6 | 21.7 | 21.9 | 21.1 | 21.7 | | |
| | Referral to treatment time non-admitted patients (95th percentile - weeks) | 18.3 | 18.3 | Not applicable | 14.1 | Standard not in effect | | | | | | | 13.6 | 13.7 | 14.0 | 15.0 | 15.1 | 13.9 | 15.0 | | |
| A&E Clinical Quality Indicators | A&E Total time in A&E 4 hours - without Walk in Centre attendances | 95% | 95% | 97.4% | 98.0% | 96.1% | 95.4% | 95.9% | 90.8% | 89.5% | 90.8% | 94.2% | 97.0% | 98.8% | 98.4% | 97.7% | 98.1% | 98.0% | 97.9% | | |
| | A&E Time to initial assessment (95th percentile) - in minutes | 15 | 15 | Not applicable | 37 | Standard not in effect | | | | | | | 85 | 53 | 15 | 15 | 12 | 55 | 13 | | |
| | A&E Time to treatment decision (median) - in minutes | 60 | 60 | Not applicable | 19 | Standard not in effect | | | | | | | 24 | 20 | 20 | 18 | 15 | 20 | 16 | | |
| | A&E Unplanned reattendance rate (within 7 days) | 5% | 5% | Not applicable | 1.5% | Standard not in effect | | | | | | | 2.1% | 1.6% | 1.1% | 1.1% | 1.8% | 1.6% | 1.4% | | |
| | A&E Left without being seen | 5% | 5% | Not applicable | 1.0% | Standard not in effect | | | | | | | 1.6% | 0.8% | 0.8% | 0.9% | 0.9% | 1.1% | 0.9% | | |
| Other key access standards | Last Minute Cancelled Operations | 0.80% | 1.50% | 1.07% | 0.99% | 0.74% | 0.90% | 1.78% | 1.69% | 2.21% | 1.44% | 1.69% | 0.97% | 0.92% | 1.01% | 1.13% | 0.89% | 0.97% | 1.01% | | |
| | 28 Day Readmissions | 95% | 85% | 94.5% | 93.6% | 94.9% | 95.3% | 96.1% | 88.2% | 80.5% | 91.1% | 82.9% | 94.1% | 91.5% | 95.8% | 93.0% | 93.2% | 93.9% | 93.1% | | |
| | GUM Offer Of Appointment Within 48 Hours | 98% | 95% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.8% | 99.9% | 100.0% | 100.0% | 100.0% | 100.0% | 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 | 83.6% | 92.3% | 100.0% | 100.0% | 93.8% | 84.2% | 75.0% | 88.0% | 94.1% | 80.0% | 82.2% | 78.4% | | 85.3% | 78.4% | | |
| | Infant Health - Mothers Initiating Breastfeeding | 76.3% | 76.3% | 76.5% | 76.1% | 76.3% | 76.9% | 74.3% | 77.9% | 75.5% | 75.1% | 77.1% | 72.3% | 74.7% | 78.4% | 77.0% | 78.1% | 75.1% | 77.5% | | |

**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

The Last-minute canccled operations figures for May and June has been amedned, following late corrections to the data.

All CANCER STANDARDS are reported nationally two months in arrears.

## 3.3 CHANGES IN THE PERIOD

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

- Last-minute cancelled operations ↓ (down from 1.13% in July to 0.89% in August)
- 62-day referral to treatment cancer standard – GP referred ↑ (up from 82.7% in June to 84.2% in July)
- 62-day referral to treatment cancer standard – Screening referred ↓ (down from 95.3% in June to 81.8% in July)
- Reperfusion times (call to balloon time of 150 minutes) ↓ (down from 94.1% in April to 78.4% in July)

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

## 3.4 EXCEPTION REPORTS

Exception reports are provided for the two (2) RED and three (3) AMBER rated performance indicators.

1) 62-day cancer: referral to treatment for GP referred patients + 62-day cancer: referral to treatment for Screening referred patients
2) Last-minute cancelled operations / 28-day readmission
3) Infant health – breastfeeding rate
4) Reperfusion times (call to balloon time of 150 minutes)

## ACCESS STANDARDS

| A1. EXCEPTION REPORT: 62-day referral to treatment for GP + screening 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 five consecutive quarters, including quarter 1 2011/12. **July's** performance was however just below the 85% standard.

The breach reasons for July were as follows:

- 66.5 out of 79 (84.2%) patients were treated within 62 days during **July** (in accountability terms – with shared patients counting as 0.5) against the 85% standard
- There were 12.5 breaches of the 62-day standard (in accountability terms):
    - 2.5 x late referral to the Trust by another provider (i.e. five late referrals not reallocated in full to referring provider, each counting as 0.5 for each trust)
    - 2.5 x clinically complex cases, requiring unplanned additional diagnostic tests/staging
    - 2 x diagnostic test/reporting delays
    - 1.5 x administrative error
    - 1.5 x cancellation of surgery for emergency/patient not able to be booked for surgery within target
    - 1 x patient choice to delay
    - 0.5 x not booked in target by other provider following early referral in the pathway
    - 0.5 x medical deferral
    - 0.5 x outpatient appointment delayed

56% of the breaches in the month were outside of the Trust's control (late referrals, patient choice, clinically complex). This leaves 44% of breaches that were potentially avoidable. Diagnostic test delays remained a primary cause of avoidable breaches, although it accounted for far fewer breaches in July than in June.

The 90% standard for patients referred from one of the three national screening programmes was not achieved in July.

## ACCESS STANDARDS

The breach reasons for July were as follows:

- 13.5 out of 16.3 (81.8%) patients were treated within 62 days during **July** (in accountability terms – with shared patients counting as 0.5) against the 90% standard
- There were 3 breaches of the 62-day standard (in accountability terms), all of which were internally managed patients:
    - 1 x medical deferral / patient choice
    - 1 x breast service capacity (outpatients + elective admission)
    - 1 x delay diagnostic and clinical trials delay

The bowel screening pathway is nationally prescribed, and challenging to consistently meet a 62-day wait for. However, achievement of the screening standard has been further challenged by changes to clinical practice around the management of breast screening patients, with respect to sentinel node surgery taking place prior to proceeding to first line treatment. This change, in addition to a recent shortfall of capacity, has increased the length of pathways for breast screening patients.

A remedial action plan has been developed to support sustainable achievement of both 62-day cancer standards. This plan focuses on the main avoidable reasons for delays identified from breach analysis for the year to date.

**Recovery plan, including expected date performance will be restored:**

The actions being taken as part of the remedial action plan are detailed below. *Please note: actions completed in previous months have been removed from the following list*:

- Reduce wait for surgical diagnostics to 7 days (end September) – *on going, with escalation of individuals cases as required*
- Review the breast cancer pathway with the clinical teams, and agree actions to ensure patients can be treated within 62 days (Action complete); *Diagnostics & Therapies ability to meet a 5-day turnaround for MRI currently being scoped*
- Flexible use of theatre sessions to provide additional Head & Neck operating capacity when required to meet demand (ongoing) – *additional sessions to be established as required to meet demand*
- Consultant job plans to be amended to enable further capacity to be provided for partial nephrectomies at North Bristol Trust (end August) – *North Bristol Trust has identified additional operating from the start of October*
- All patients to be contacted within 24 hours of agreement to treat, to confirm patient availability (Action complete) – *guidance has been produced for Waiting List Office staff and implemented; ongoing monitoring of compliance*
- All thoracic patients to be offered an appointment within a week, with escalation to Deputy Divisional Manager where this is not possible (end September) – *currently being monitored via weekly operational meetings and escalation from Multi Disciplinary Team Co-ordinators*
- Trajectory and associated plan for consistently achieving a 10 day turn-around for diagnostic tests to be developed (Action complete); *capacity and demand modelling has been undertaken; trajectory had been developed for achieving a 10-day turn-around by the end of November*

## ACCESS STANDARDS

- The Trust will seek Network-wide agreement for the reallocation of breaches when patients are referred late in the pathway (end October); *policy has been drafted and circulated to the local cancer network*
- Quarterly review of breach analysis to be provided to the Trust Management Executive and discussed with clinical teams where appropriate (Action complete)

**Progress against the recovery plan:**

The dip in the 62-day screening performance is such that the 90% standard can no longer be achieved for the quarter. The 62-day standard for GP referred patients was on track to be achieved. However, the position against the 62-day screening standard means that the combined standard 62-day standard in Monitor's Compliance Framework cannot be met. Treatment dates for patients who have already breached either 62-day standards are therefore being brought forward into September where additional capacity can be provided. This will enable earlier treatment for patients and will help to minimise breaches of standards in quarter 3.

## ACCESS STANDARDS

| A2. 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.

**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 51 last-minute cancellations of surgery in **August** (0.89% of operations). The main reasons for cancellations in the month were as follows:

- 35% of cancellations (18 cancellations) were due to another more urgent patient being prioritised on the day
- 24% of cancellations (12 cancellations) were due to lack of theatre time *(this can happen for several reasons, including delays in identifying beds prior to cases being operated upon, late starts and an unexpectedly complex case*)
- 14% of cancellations (7 cancellations) resulted from equipment failure (five in urology, two in cardiology)

93.2% of patients were re-admitted within 28 days of the cancellation of surgery at last-minute in August, against 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 and achieve the 0.8% standard (*please note: actions completed in previous months have been removed from the following list*):

- The expansion of the Medical Assessment Unit (MAU) was completed in August, which will allow greater flexibility to meet demand for emergency medical admissions without impacting on the surgical bed base (Action complete)
- The Brachytherapy theatre suite has been opened in the Children's Hospital, which will create more capacity in main theatres for paediatric emergency trauma surgery (Action complete)
- A review of last-year's norovirus outbreak has been completed, and actions agreed to reduce the extent and duration of outbreaks, thereby limiting bed closures over the winter (Action complete)
- The reason for the five urology cases being cancelled due to an equipment failure has been investigated by the Division of Surgery (one of the automatic endoscopic machines used for decontaminating probes and scopes used in urology procedures was found to be leaking water on to

the floor prior to the start of the theatre session. This meant the machine could not be used, which led to the probes not being able to be processed. TRUSS probes must be decontaminated both before and after use on a patient through an automatic endoscopic reprocessor in the interests of best infection control and decontamination practices. Following the leak the machine was serviced by the company responsible for its maintenance and was operational within a day of the call to the company being made. The manager of the Queen's Day Unit is investigating whether the machine used for decontamination in Hey Groves Theatres can be adapted in order to accommodate these items of equipment in the future, and provide a back-up in the event of a sterilisation machine failing).

- The reason for the two cardiology cases being cancelled due to equipment failure is being reviewed (September)
- Compliance with the process for escalating potential last-minute cancelled operations to Divisional Managers, Heads of Nursing or Heads of Division will be audited (October)
- Implementation of the Central Sterile Service Department (CSSD) improvement plan will be completed in full, to reduce cancellations related to equipment sterilisation/availability (end November)
- The avoidance of last-minute cancellation is now a key priority of the Productive Operating Theatres Programme, with Phase 1 looking at theatre list booking rules and procedure times, to improve the booking of theatre lists (due for completion September), and Phase 2 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 (due for completion in December)
- Implementation of the Optimising Use of Beds work-steam will continue – with the aim of balancing bed capacity and demand for beds

Based upon the modelling undertaken of seasonal variation in performance against the last-minute cancelled operations standard, and the expected impact of actions in the recovery plan, it is expected the 0.8% standard will be achieved by the end of March 2012.

**Progress against the recovery plan:**

Last month NHS Bristol formally raised concerns regarding the levels of last-minute cancelled operations. The Primary Care Trust was provided with the recovery plan. Performance in August (0.89%) was a significant improvement on that of July's (1.13%). The Trust is currently on track with achievement of both the recover trajectory and the actions agreed as part of the plan.

## ACCESS STANDARDS

| A3. EXCEPTION REPORT: Infant health: breast feeding rates | RESPONSIBLE DIRECTOR: Chief Nurse |
|---|---|

**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. Home births are excluded in the figures.

**Monitor measurement period:** Not applicable

**Performance during the period, including reasons for exception:**

Breastfeeding rates are below last year's overall performance for the year to date, for reasons not well understood.

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:**

Performance has now been above the 2010/11 target level for the last three months. Any variation in monthly performance will continue to be monitored.

## ACCESS STANDARDS

| A4. EXCEPTION REPORT: Reperfusion (call to balloon times) within 150 minutes (direct admissions only) | RESPONSIBLE DIRECTOR: Chief Operating Officer |
|---|---|

**Description of how the target is measured:**

The number of patients receiving primary percutaneous cardiac interventions (PPCI) where the commencement of treatment (balloon inflation) happened within 150 minutes of the call for professional help. The standard applies for direct admissions to the Bristol Heart Institute only. The standard is for Call to Balloon times to be within 150 minutes for at least 90% of patients.

**Monitor measurement period:** Not applicable

**Performance during the period, including reasons for exception:**

At the end of August (data up to the end of July) average Call to Balloon times were 118 minutes, with Door to Balloon times averaging 50 minutes for directly admitted patients. However, Door to Balloon times are currently above the target 50 minutes for 40% of patients. Also, both Call to Balloon and Door to Balloon times are significantly higher out-of-hours. So actions are focusing on speeding-up the in-hospital part of the Call to Balloon pathway, and the way the out-of-hours service is provided.

**Recovery plan, including expected date performance will be restored**

The following actions are being investigated for implementation by the Division:

- Establish a Great Western Ambulance Service (GWAS) alert system to Bristol Heart Institute's Catheter Lab, so that the labs can be prepared ahead of every patient's arrival.
- Consultant on call to be alerted at the same time as the rest of the Catheter Lab team, so speed-up the commencement of the procedure

**Progress against recovery plan:**

The Trust is currently achieving 83.6% against the 90% standard year to date, following a deterioration in performance after achieving the standard between September and December last year. Further actions are being identified to achieve the 90% standard.

University Hospitals Bristol NHS
NHS Foundation Trust

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

| Item 7 - Histopathology Action Plan Update |
|---|
| **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 19 of the action plan dated 20 September 2011 is provided for the purpose of updating the Board on progress being made. A number of pieces of work have been completed since the Board received its last progress report in June 2011; therefore no exceptions are reported to the Board this month.<br>Monitoring of the action plan is as follows:<br>• An internal histopathology group meets monthly to drive the actions forward.<br>• Monthly meetings take place with NHS Bristol and North Bristol NHS Trust.<br>• 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. |

### Previous Meetings

| Executive Team | Trust Management Executive | Quality and Outcomes Committee | Finance Committee | Audit Committee | Other |
|---|---|---|---|---|---|
| | 14/09/2011 | | | | |

University Hospitals Bristol NHS
NHS Foundation Trust

# Recommendations from Histopathology Inquiry – Action Plan

**Actions not yet due**

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **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.** | | | | | |
| **1.2** | Develop Service Structure and Proposition for integrated cellular pathology service<br><br>Agreed sub-milestones:<br><br>• Integration of the management tier beneath Clinical Lead<br><br>• Common reporting template for each speciality<br><br>• Agreement of specialist and team roles & profiles<br><br>• Common KPI suite and associated metrics agreed and in place | 31 Dec 2011 | Rob Pitcher | These issues are being considered as part of the Pathology Services Review being led by NHS Bristol. Clinical Lead for Cellular Pathology is feeding into the review accordingly. Meanwhile, a governance structure has been put in place. | | Revised management structure.<br><br>Reporting template.<br><br>Specialist and team role profiles.<br><br>KPI suite. |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **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, adjust to ensure they are sufficient for a safe, timely and reliable service.<br><br>Further milestones:<br><br>• Complete comprehensive Job Planning process for all Consultants working in Cellular Pathology across both UHB and NBT.<br><br>• Complete skill mix exercise to determine what work currently performed by Consultants could be carried out by other staff.<br><br>• Review outcome of the Job Planning and skill mix exercises and, if necessary, adjust staffing configuration to ensure sufficient support for a safe, timely and reliable service. | Review 31 Aug 11.<br><br>30 Nov 2011<br><br>30 Nov 2011<br><br>29 Feb 2012 | Rob Pitcher<br><br>Rob Pitcher<br><br>Rob Pitcher<br><br>Sean O'Kelly/ Chris Burton. | The review is complete. A paper has been produced to include recommending an in depth Job Planning and skill mix exercise. | √ | Review paper. |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **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.<br><br>The longer term plan is subject to the outcome of the Pathology Services Review.<br><br>See actions for 1.2. | √<br><br>Linked to 1.2. | |
| **Section 10 Section Lead: Alison Moon** | **Overarching recommendation I: Patients and Histopathology**<br><br>For information: The Royal College of Pathologists has an active programme to inform the public about histopathology. Next year is designated National Pathology Year. | | | | | |
| **10.2** | 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.<br><br>Two major internal surveys of outpatients to complement the National Outpatients Survey are taking place in 2011/12. Comments Cards are being implemented in Outpatients Departments and plans for surveys using hand held devices are currently under discussion. | √<br><br>On track | |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **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 | Bristol LINk is a national pathfinder for HealthWatch status and is attending the Trust's Patient Experience Group in November 2011 to present its plans.<br><br>Meanwhile, the main thrust of engagement between the Bristol and South Gloucestershire LINk and Histopathology is through NHS Bristol's Healthy Futures Programme and the wider pathology review. UH Bristol's focus of Patient and Public Involvement in the Histopathology work has been about our patients and their stories.<br><br>UH Bristol representation on Bristol LINks Acute Hospital Group to facilitate operational activity.<br><br>UH Bristol workshop with Bristol and South Gloucester LINks has taken place to inform 2010/11 Quality Account.<br><br>Robert Woolley has met with Chair of Bristol LINk to provide assurance of positive working relations. | On-going | Notes of meetings.<br><br>Third party comments from LINks on UHB Quality Account. |
| | | | | | | |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **Section 13 Section Lead: Rob Pitcher** | **Overarching recommendation J: Specialist Pathology** | | | | | |
| **13.1** | The Royal College of Pathologists should review its guidance on specialist histopathology with the intention of making it more explicit where possible. | For RC Path to determine | RC Path | Rob Pitcher has met informally with the President of the Royal College of Pathologists.<br><br>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. | Dependent on the outcome of 1.2 | Rob Pitcher | Linked to action 1.2. | | |

**Completed Actions**

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **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 Jun 11 | Jane Luker/ Chris Burton | Complete.<br>Clinical Lead in post as of 3 May 11. | √ | Job Description and staff in post |
| **1.3** | Short term<br>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.<br><br>Cross site working in place for haemato-malignancy, Head and Neck, Lung and Her 2 Breast pathology.<br><br>Further work underway to develop greater cross site working in line with planned service reconfiguration. | √ | Letter of expectation sent to pathologists by Acting Medical Director.<br><br>Honorary contracts in place. |
| **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.<br><br>UH Bristol and NBT pathologists have all signed their honorary contracts. | √ | Honorary contracts in place. |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **1.5** | All new cellular pathology appointments to be joint | 31 Dec 10 | Jane Luker/ Chris Burton | Agreed.<br><br>March 11: Two new adult pathologists appointed on 50:50 contracts | √ | Appointment process and contracts for new staff. |
| **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. This will be evidenced through Job Planning and appraisal. The UH Bristol Medical Director team will conduct an initial assessment of compliance with the clarified responsibilities. | √ | Letters from CEO to Heads of Division. Lead Doctor Job Descriptions. Written confirmation to Lead Doctors. |
| **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. | √ | |
| **1.10** | 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. | √ | |
| **Section 2 Section Lead: Mark Callaway** | **The MDTs in both Trusts should be reviewed to promote collaboration.** | | | | | |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **2.1** | Complete MDT reviews | 31 May 11 | Mark Callaway/ Chris Burton/Rob Pitcher | UH Bristol MDT review for pathology completed.<br><br>NBT review has been completed and a report received by their Board in June 2011. | √ | MDT review papers and meeting minutes. |
| **2.2** | Agree a plan for on-going development of joint MDT | 31 July 11 | Mark Callaway/ Chris Burton/Rob Pitcher | A joint UH Bristol and NBT meeting took place on 16th June to agree a joint approach for MDT development going forward. A joint report was produced by the end of July 2011. | √ | Joint Report. Minutes of meetings SDG 25/07/2011 and Cancer Board. |
| **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. | √ | MDT audit results. |
| **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 patient information leaflet finalised and being piloted. The pilot is due to be completed by the end of August 2011. | √ | Patient Information Leaflet |
| **Section 3 Section Lead: Rob Pitcher** | **Quality Assurance**<br><br>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 | Evidence |
|---|---|---|---|---|---|---|
| **3.1** | Agree audit programme 2011/12 for Histopathology | 30 April 11 | Lis Kutt | Complete and shared with NBT<br><br>5 audits are planned, of which 3 are underway:<br><br>• An audit of the double reporting protocol (not yet started)<br>• An audit of reporting systems (not yet started).<br>• Review of supplementary reports after multi-disciplinary team meeting (started August)<br>• High grade serous carcinoma of endometrium-network audit (started August)<br>• Correlation of breast tumour grading between core biopsies and resection specimens in a screened population (started July) | √ | Clinical Audit Forward Plan 2011/12 |
| **3.2** | Develop joint audit plan across both Trusts | 30 June 11 | Rob Pitcher | Complete. | √ | Joint Audit Plan |
| **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. Relevant UH Bristol pathologists are registered for the regional lung EQA. | √ | EQA scoping document |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **3.4** | Develop full joint EQA and CPD programmes | 31 Aug 11 | Rob Pitcher | The interviews with consultants demonstrated the current position on EQA. This information is held within the consultants' appraisal folders and reviewed annually as part of their appraisal.<br>The Bristol Cellular Pathology Service in its policy statement on the recognition of specialist roles in cellular pathology recognises the need for pathologists to partake in appropriate EQA schemes. This will be monitored on an annual basis | √ | Programme of interviews.<br><br>EQA matrix. |
| **Section 4 Section Lead: Lis Kutt** | **Upgrade Histopathology Department** | | | | | |
| **4.1** | Upgrade work to be completed | 31 Jul 11 | Sven Howkins | Complete. | √ | Site visit |
| **Section 5 Section Lead: Rob Pitcher** | **Double Reporting**<br><br>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 disseminated. | √ | Double Reporting Protocol |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **Section 6 Section Lead: Rob Pitcher** | **Overarching Recommendation E: Raising Concerns about diagnostics**<br>**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.**<br><br>**Concerns should be dealt with at the lowest possible level and not escalated unnecessarily.**<br><br>**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. | √ | Raising Concerns Protocol |
| **Section 7. Section Lead Sarah Pinch** | **Overarching recommendation F: Whistleblowing**<br>**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. | √ | Revised policy |
| **Section 8 Section Lead: Sarah Pinch** | **Overarching recommendation G: Media Relationships.**<br><br>**Relationships with the media should be proactive with an emphasis on openness, honesty and the involvement of senior managers and clinicians**<br>**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 was approved by the Board on 28 June 2011. | √ | Revised Communications Strategy |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **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. | √ | Revised Media Protocols |
| **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 was launched on 1st July 2011. | √ | New website. |
| **Section 9 UHB Section Lead: Lis Kutt** | **Overarching recommendation H: Paediatric and Perinatal Pathology**<br>**Paediatric and perinatal pathology should be valued and supported by managers, pathologists and other clinicians.**<br><br>**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 were held 23 June 11 and an offer has been made subject to references and employment checks. Anticipated start date end of September.<br><br>Interim outsourcing provision in place. | √ | Staff in post |
| **9.2** | CEO to write to Southampton and Oxford to seek opportunities for joint working in principle | 31 Dec 10 | Robert Woolley | Complete.<br>Positive responses received from Southampton CEO and Oxford MD. | √ | Letters between Trusts. |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **9.3** | Establish joint working arrangement | 31 Jul 11 | Sean O'Kelly | UH Bristol Medical Director has met with the Medical Directors from Southampton and Oxford to explore networking opportunities for paediatric pathologists. Agreement in made in principle, an operational specification is being drawn up. | √ | Operational Specification. |
| **Section 10 Section Lead: Alison Moon** | **Overarching recommendation I: Patients and Histopathology**<br><br>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. | √ | Minutes and papers of Patient Experience Group and its predecessor. |
| **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 has been shared with the Pathology Services Review. | √ | Focus Group Outcome report. |
| **10.5** | Agree process to promptly inform patients of diagnostic errors | 31 Jan 11 | Jane Luker | Complete.<br>Staff Support and Being Open Policy 2009 is already in place. Next update will make link to diagnostic errors more explicit. | √ | Current and revised policy. |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **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. The planned date for completion of the pilot is 31 August 2011. | √ | Patient Information Leaflet. |
| **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 | 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. Trainees are supervised by individual consultants as befits their experience and seniority. The number of educational supervisors has been increased from 1 to 4 to further improve monitoring of progress with subsequent adjustments to individual learning plans as required. | √ | Identified supervisors. |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **11.2** | Training plans to be adjusted to provide access to all levels of case | 30 Nov 10 | Lis Kutt | Complete.<br><br>Training plans for the trainees have been revised by Dr Mohammed Sohail.<br><br>A written training plan has been in use since the January 2011 which advises on the type of case mix trainees should expect to see to ensure that they have opportunities to work with a broad range of specimens of varying complexity. | √ | Training Plan. |
| **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.** | | | | | |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| **12.1** | Develop detailed organisational development plan to support the move towards an integrated cellular pathology service | 31 Aug 11 | Steve Aumayer/ Rob Pitcher | **Integrated Cellular Pathology Service:**<br>• Joint Trust Monthly formal business meetings in place (Meeting 3 in September)<br>• Joint Trust workshop programme enabling discussion on key issues – resulted to date in:<br>o The recognition of specialist roles in cellular pathology<br>o Definitions of Lead Roles in Cellular Pathology<br>o Policy on the content of the reports from the Bristol Cellular Pathology Service<br>• Educational activities including case discussion, audit presentations, research, feedback from external educational activities being planned<br>• A series of workshops is planned to examine at specialist team level what cellular pathology service is required on which site to support the clinical service – commencement date TBA<br>**Working with NHS Improvement**<br>• Launch event 5th September for a core team who will be working on LEAN review of processes across sites.<br>• Programme supported by site visits, the purpose of which to see how others provide integrated services to more than one acute Trust and to look at the work to improve efficiency (LEAN) that some have done. | √ | Training resources, attendance records and notes of meetings. |

| Ref No | Actions | Timescale | Responsible person | Progress | Complete | Evidence |
|---|---|---|---|---|---|---|
| 12.2 | Provide Counselling and Occupational Health support to affected staff | 31 Dec 10 | Steve Aumayer | Complete.<br><br>Some staff have accessed this | √ | |
| **12.3** | Provide facilitation and mediation | As required | Lis Kutt | Facilitation and mediation are available to staff should this be required.<br><br>Externally facilitated event took place in Jan 11 with NBT and meetings of the Bristol Cellular Pathology Forum continue. | √ | Letter from Head of Division to pathologists Jan 2011.<br><br>Agenda, minutes and papers of Bristol Cellular Pathology Forum. |
| **12.4** | Support to assist in development of single service | On-going. | Lis Kutt/ Rob Pitcher | As for completed action 12.1 and ongoing. | On-going | |
| **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. A draft policy is in development. | √ | Reporting policy. |

University Hospitals Bristol NHS
NHS Foundation Trust

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

| Item 08 - Safeguarding Annual Report |
|---|
| **Purpose** |
| To brief the Board on the Trust's Safeguarding initiatives and achievements for the reporting year 2010-2011. |
| **Abstract** |
| Safeguarding has remained a key priority for the Trust and this report will outline key achievements and areas of learning for both children and adults during 2010-2011 The report also includes a review of compliance with the Care Quality Commission Outcome Seven and progress made with safeguarding training. The report also outlines the safeguarding arrangements within the trust, in line with national and local drivers and finally highlights objectives and risks for 2011-2012, which includes the risks posed through the existence of multiple sets of notes. |
| **Recommendations** |
| The Board is recommended to **note** the report. |
| **Report Sponsor** |
| Alison Moon, Chief Nurse |
| **Other Author** |
| Carol Sawkins, Nurse Consultant Safeguarding Children (Named Nurse)<br>and Anne Berry, Safeguarding Adults & Complex Discharge Lead. |
| **Appendices** |
| • Appendix A – Safeguarding Annual Report |

### Previous Meetings

| Executive Team | Trust Management Executive | Quality and Outcomes Committee | Finance Committee | Audit Committee | Other |
|---|---|---|---|---|---|
| | 14/09/2011 | | | | |

University Hospitals Bristol NHS
NHS Foundation Trust

# SAFEGUARDING ANNUAL REPORT

## APRIL 2010 – MARCH 2011

**Prepared by:**

**Carol Sawkins**
**Safeguarding Children's Nurse Consultant (Named Nurse)**

**And**

**Anne Berry**
**Safeguarding Adults & Complex Discharge Lead**

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10. 10.Key Objectives for 2011/12

## Preface for Safeguarding Annual Report

One of the fundamental responsibilities of providing healthcare services of the highest quality is that the vulnerable are protected whilst in our care. This is an important responsibility for each member of staff, whatever their role, and for the Trust as a partner in the wider health and social care system.

The Annual Report for 2010/11 demonstrates continued energy and focus in addressing this responsibility. Our staff need to be competent and confident in their approach to safeguarding, keeping the individual at the heart of what they do. We need to pay special attention to those who for whatever reason may not have a strong voice and above all we need to treat people in our care with kindness and compassion.

It is therefore timely to thank staff for all their hard work over the last year and in keeping the welfare of the patient, child or adult uppermost in their actions.

***Alison Moon***
***Executive Lead for Safeguarding / Chief Nurse***

## 1. Introduction

This annual report relates to the period 1st April 2010 to 31st March 2011 and will cover both Adult and Children's Safeguarding. Safeguarding of our patients is best-addressed under one trust agenda, although both areas continue to retain specific areas of responsibility.

This joint approach supported the Regulatory Framework developed by the Care Quality Commission where safeguarding is considered as a specific outcome. This reporting period has seen both areas of safeguarding remain an area of priority, both nationally and locally. Over the past year the safeguarding arrangements within all areas of the trust have continued to be strengthened, utilising a joint focused approach, which views safeguarding as a continuum from the unborn baby, until older age.

## 2. Key Safeguarding Achievements of 2010/11

- Significant progress has been made across the Trust in relation to awareness and compliance with safeguarding training for both adults and children.
- The Safeguarding teams have contributed to a number of multi-agency Serious Case reviews in a timely manner with Ofsted evaluation of these reports as 'Good'.
- The Safeguarding agenda remains fully embedded in Trust activities and monitored through the Safeguarding Steering Group which reports regularly to the Trust Board as well as to Bristol and South Gloucestershire Commissioners.
- The Trust continues to support the process of partnership working, with senior representation at adult and children's Local Safeguarding Boards.
- Staff across the Trust are supported in their safeguarding responsibilities by teams of safeguarding professionals who are well established and experienced, with appropriate policies and procedures in place.
- A new safeguarding supervisor has been appointed specifically to promote the 'Think Family' agenda and to consider the safeguarding needs of young people under the age of 18 years.
- Compliance with the National Vetting and Barring scheme which includes the Independent Safeguarding Authority is fully implemented and audited annually.

## 3. Brief overview of National and Local Safeguarding drivers.

The Mental Capacity Act [2005] (MCA) was introduced in April 2007 and fully implemented by October 2007. The MCA underpins the principles of safeguarding adults by legislating that the most vulnerable cannot be abused.

The Deprivation of Liberty Safeguards comes within the scope of the MCA, and was introduced through an amendment of the Mental Health Act giving a wider definition of mental disorder, and introducing Independent Mental Health Advocates (IMHA) alongside Independent Mental Capacity Advocates (IMCA). Deprivation of Liberty guidance applies to all hospitals from 2009.

However safeguarding adults is not only about people who have mental health conditions, it covers entire communities on a day to day basis. Reasonable adjustments as defined within the Disability Discrimination Act [2005], give us examples where lateral thinking can make real improvements for people.

Both the Cornwall Inquiry 2006 and more recently the Mid Staffordshire Inquiry offer us examples of how vulnerable people can be harmed by both action and omission.

In October 2008, the Department of Health launched a public consultation on its review of 'No Secrets'. In January 2010, the Government announced its response to the consultation which included:

- National leadership through an Inter-Departmental Ministerial Group (IDMG) on Safeguarding Vulnerable Adults.
- New legislation to put local safeguarding adult's boards on a statutory footing.
- A programme of work including the development of new multi-agency guidance.

The Safeguarding Vulnerable Groups Act [2006] (SVGA) has introduced a new Vetting and Barring Scheme that replaces the Protection of Vulnerable Adults list and the Protection of Children's Act list. For the first time an adults barred list will apply to the NHS. The SVGA also recognises that any adult receiving any form of healthcare is vulnerable. However some people receiving healthcare may be at greater risk of harm than others, sometimes as a complication of their presenting condition or their individual circumstances.

Safeguarding is a key priority for the Care Quality Commission (CQC), which reflects both our focus on human rights and the requirement within the Health and Social Care Act 2008. Whilst the CQC recognises that there are differences in the statutory basis and policy context between safeguarding of children and adults, they state that for both there is an overarching objective of enabling people to live their life free from abuse.

Safeguarding children, young people and the unborn baby, remains 'everyone's responsibility' (Laming 2009); and for all Trust employees, no matter what their role or responsibility, this requirement is further underpinned by the statutory responsibilities outlined in the Children Act 2004 and within Working Together to Safeguard Children (revised March 2010).

In March 2010, Ofsted and the Care Quality Commission carried out a joint inspection of safeguarding and looked after children's services in Bristol, to which a number of Trust employees contributed.

The report was published at the beginning of this reporting period. Bristol was assessed as "Good" for both safeguarding and Looked After Children, thereby becoming one of the few Local Authority areas both for existing delivery of services and capacity to improve. This provides a good foundation for partnership working across health and social care in Bristol, although it is recognised that much multi-agency team working is needed on a daily basis to minimise risks for patients.

These core safeguarding children's responsibilities continue to underpin all the Trust's health care activities, including recognising that staff who may have no direct contact with children, may be caring for a parent with a risky behaviour which may impact on their ability to care for a child. This key message has formed the focus of safeguarding children activity in this reporting period, primarily achieved through the delivery of safeguarding training, which will be discussed in more detail later in the report.

A major national review of the complete safeguarding children system, from a multi-agency perspective, commissioned by the previous government is currently being competed by Professor Eileen Munro, with the final report due to be published in May 2011. It is anticipated this will lead to significant changes in polices and practice in the next reporting period.

Although there may be some fundamental differences within the law which underpins both adults and children's safeguarding, it is important to appreciate that safeguarding should be viewed as a whole, very much following a 'Think Family' agenda. This can be managed successfully together in an organisation where appropriate experts are overseeing policy and practice.

## 4. Summary of current arrangements for Safeguarding within University Hospitals Bristol NHS Foundation Trust (UHBristol)

Safeguarding of both Children and Adults has remained an area of priority, with the requirement that 'every child in hospital is protected from harm' being one of the Trust's Corporate Objectives for 2010/11. Safeguarding activity and compliance with this objective is primarily managed through the Safeguarding Adults and Children's Steering groups, which are chaired by the Chief Nurse as Executive head for Safeguarding and have similar processes allowing for continuity and discussion of overlapping areas of concern. The Trust Board continues to hold ultimate accountability for ensuring that safeguarding responsibilities are met, supported by the Safeguarding Steering Groups.

This reporting period has seen the formation of a new group; the Safeguarding Resourcing Committee led by Deborah Tunnell (Human Resources Manager) which is now responsible for overseeing all Human Resource issues, including recruitment and selection of staff specifically in relation to safeguarding. In this reporting period much work has been undertaken setting standards of safeguarding training for agency and locum staff employed by the Trust

The full structure of the Trust's safeguarding arrangements for 2010/11 is detailed in Appendix One.

The Trust continues to have the required Safeguarding Children Named Professionals in post, who now form a well-established team supported by the Child Protection Advisor, junior trainer and administrator. This reporting period saw increased resource for the recruitment of a second Child Protection Supervisor whose remit will be to focus on 16- 18 year olds cared for outside of the Women's and Children's Division and on raising awareness of the impact of parental risk factors on children, as well as the establishment of a new Safeguarding Nurse Consultant post to provide both operational and strategic Safeguarding children expertise and leadership.

The previous annual report (2009/10) highlighted the need for re-structuring of adult services, in order to establish the requirement for a dedicated safeguarding adult team. This has been successfully implemented by incorporating a safeguarding remit into the complex discharge team.

From January 2010 the team remit was further expanded to include all the safeguarding adults training with the Trust, which became mandatory from June 2010. The adults safeguarding and complex discharge team focus is on vulnerable groups of service users, services users who require extensive packages of care, services users who are on an end of life pathway, and training for both safeguarding and the safe discharge of adults.

Both the Children's and the Adults Safeguarding teams continue to work collaboratively with other Safeguarding professionals both in a multi-agency and multi professional approach, locally and across the region. This includes representation at the Bristol, North Somerset and South Gloucestershire Safeguarding Children Boards and the Bristol Safeguarding Adults Board.

The Bristol Safeguarding Adults Board is a strategic alliance of key organisations. Partners include Bristol City Council, NHS Bristol, Avon and Somerset Constabulary, Safer Bristol, Avon and Wiltshire Mental Health Partnership Trust, North Bristol NHS Trust, Independent Provider groups and Voluntary Sector Representatives.

The Trust Board continues to hold ultimate accountability for ensuring safeguarding responsibilities are met, supported by the Safeguarding Children and Adults Steering Group. Trust safeguarding activity is monitored by the commissioning and regulating arrangements both national and local including Care Quality Commission, Monitor, Safeguarding Boards and NHS Bristol through a set of Commissioner Standards for safeguarding.

## 5. Summary of Key Safeguarding Activities within UHBristol 2010/11

Monitoring of safeguarding activity forms part of the Trust governance arrangements and is reported quarterly to the safeguarding steering groups, and also includes data required by commissioning contracts. All divisions are represented and have the responsibility to brief the divisional boards. There is also strong links operationally to the Trust Operational Group. A summary of the activity for this reporting year, according to these commissioning standards, is detailed within the data below.

### 5.1 Policy and Procedures:

The Trust has in place up to date safeguarding adult and children policies and procedures to guide staff through their contractual responsibilities to protect vulnerable adults, children, young people and the unborn baby, which includes for example, guidance on information sharing, making a referral and how to access support both within the Trust and externally. New policy developments within the year include the introduction of the 'Child Abduction' Policy and guidance for staff relating to 'people who may pose a risk'. Work is also underway to introduce new guidance to support staff from all agencies when a parent or carer may require supervised access to their child when admitted to hospital.

**5.2 Safeguarding Training**.

The provision and delivery of safeguarding training remains a key priority for both safeguarding teams with the requirement for all staff to be provided with the appropriate level of training according to their role and responsibilities. This has been highlighted as essential by many serious case reviews as well as in the recent report by Lord Laming (2009) following the death of Baby Peter.

The Mental Capacity Act (MCA) underpins safeguarding for adults as it places a duty on the Trust to give vulnerable people a voice by following the legislated process. The Act applies to all people from the age of 16 years, so we can see already where the Children's Act and the MCA will create challenges unless we have an informed workforce. In adult care this requires a different approach to practice as common law is replaced by a statutory requirement. All staff engaged in the clinical management of vulnerable people need to be aware of this act and the implications on their practice.

The Deprivation of Liberty Safeguards was developed following the Bournewood Case 2004, where an NHS hospital detained a patient under common law with no consideration for the Human Rights Act. The European Court of Human Rights held that the hospital had acted unlawfully and were in breach of Article 5, the right to liberty and security of person.

The aim of the Trust is to ensure that every member of staff is aware that safeguarding is their responsibility and that they can recognise abuse and know what to do about it, as a minimum requirement.

Compliance with all levels of training is therefore robustly monitored within the Trust as well as being fundamental to the Care Quality Commission standards and review. The aim is that a minimum 80% of staff have completed the appropriate level of training. At the beginning of this reporting period a training plan was already in place to support the achievement of this aim though the delivery of mandatory safeguarding children's training, whilst in June of this reporting period the requirement for employees to be trained in adult safeguarding also became mandatory. This led to the introduction of the joint safeguarding training plan, which was developed by the safeguarding leads and approved through the safeguarding boards with the specific aim of achieving the Trust targets for compliance.

Level One, Safeguarding awareness training for both adults and children, is now mandatory for all staff and is delivered by the safeguarding teams having been incorporated into the Trust corporate induction from January 2010. Feedback from staff has been positive indicating that it is essential to have both areas of safeguarding discussed more specifically. The training teams are clinically based and therefore have first-hand experiences of potential concerns.

The expectation is that following on from Level One awareness training recognised groups of staff will progress to complete more in-depth training as specified in both the adults and children's training matrix which details the level of training required by all staff by role across the Trust. Updates for adult safeguarding training have been aligned with safeguarding children training and are due for renewal every three years.

Data to monitor all mandatory training was transferred onto a new system (At-Learning), which resulted in initial problems with the accuracy of the data and target audiences. Much work has taken place to address these issues and, when the system is fully, established more accurate data will allow for effective reporting and allow areas to be specifically targeted.

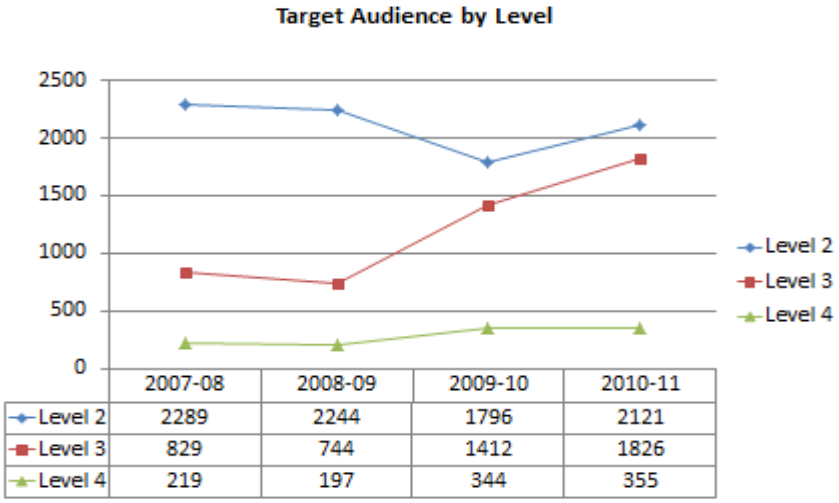
However training has remained an area of concern due to the slow rate of improvement with compliance, which will need to be addressed as a matter of urgency within the next reporting period. At this point (end of 2010/11) consideration is to be given to declaring non-compliance relevant to CQC Outcome seven Safeguarding.

**5.2.1 Safeguarding Children Training Data**:

This reporting period has seen the publication of the new Intercollegiate Roles and Competences for Health Care Staff (September 2010) which recommends a substantial increase both in the number of staff who must complete safeguarding children training as well the level of training required, in particular by all clinical staff. This requires major changes to the safeguarding children training matrix and the amount of training currently delivered by the safeguarding children's team, supported by the Paediatric Clinical Skills trainer.

These recommendations will also have a major impact of compliance reporting well into the next reporting period. The safeguarding children training matrix has therefore been reviewed for the third consecutive year, incorporating these recommendations. The numbers of staff now required to undertake a level of mandatory child protection training has therefore significantly increased, reflected in the changing target audiences detailed in table 1.

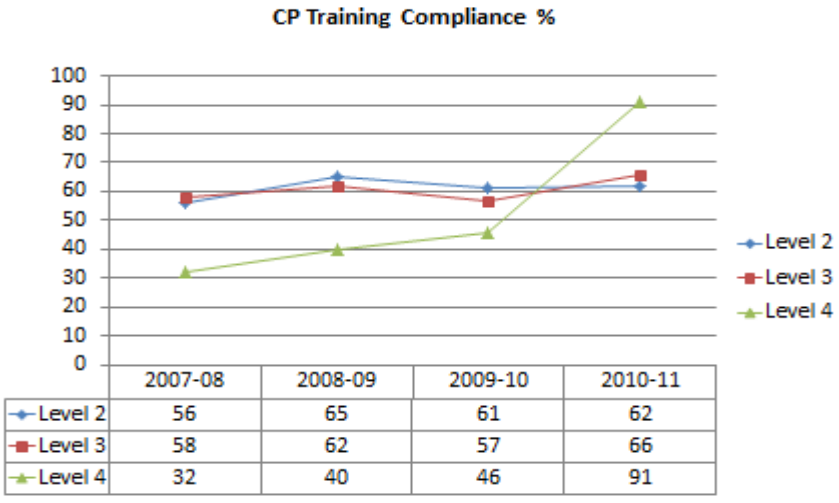
## Table 1: Number of staff required to complete Safeguarding Children Training




| | 2007-08 | 2008-09 | 2009-10 | 2010-11 |
|---|---|---|---|---|
| Level 2 | 2289 | 2244 | 1796 | 2121 |
| Level 3 | 829 | 744 | 1412 | 1826 |
| Level 4 | 219 | 197 | 344 | 355 |

Table One demonstrates how the changes recommended by the new 'Intercollegiate Roles and Competences for Health Care Staff (September 2010) have resulted in a significant increase in the number of staff who now require safeguarding children training, thereby directly impacting on improvement in compliance rates, as detailed below.

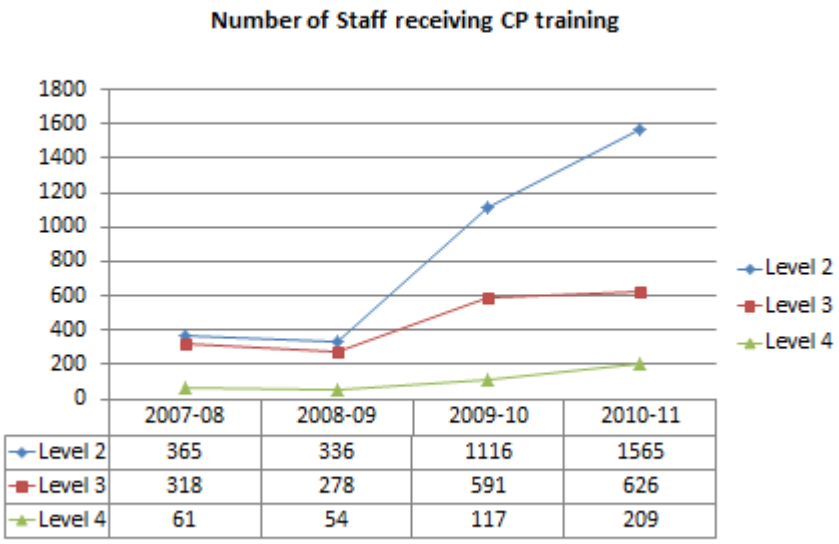
## Table 2: Annual Percentage Compliance rates for Safeguarding Children Training.




| | 2007-08 | 2008-09 | 2009-10 | 2010-11 |
|---|---|---|---|---|
| Level 2 | 56 | 65 | 61 | 62 |
| Level 3 | 58 | 62 | 57 | 66 |
| Level 4 | 32 | 40 | 46 | 91 |

Table Two highlights the impact the changes in the target audience on the percentage compliance rate and despite the fact that significantly larger numbers of staff have completed safeguarding training (detailed in table three), there has been minimal improvement in the overall compliance rates It is hoped that in the next reporting period the rate of improvement will increase significantly.

Table 3: Numbers of staff receiving Safeguarding Children Training.




| | 2007-08 | 2008-09 | 2009-10 | 2010-11 |
|---|---|---|---|---|
| Level 2 | 365 | 336 | 1116 | 1565 |
| Level 3 | 318 | 278 | 591 | 626 |
| Level 4 | 61 | 54 | 117 | 209 |

Table Three highlights the year on year increase in the numbers of staff completing training.

It should also be noted that Level 4 training as recorded within this reporting period will, under the recommendations of the new Intercollegiate document, subsequently be recorded as Level 3 (Specialist). Level 4 training will in future apply to the requirements for Named Professionals only.

### 5.2.2 Safeguarding Adults Training Data

Safeguarding training became mandatory in June 2011, therefore within this reporting period mandatory training had been in place for ten months, which helps to explain the poor compliance. The safeguarding adult training matrix is due for review in August 2011.

Table 4: Safeguarding Adults training compliance 2010/11

| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|
| Level 1 | 25.4% | 29.7% | 32.5% | 38.5% |
| Level 2 | 1.2% | 1.2% | 4.4% | 8.4% |
| Level 3 | 19.6% | 19.6% | 20.0% | 27.7% |

Table 4 needs to be viewed with the appreciation that Levels 2 and 3 training only became available in November 2010. Up until that period essential staff groups such as the clinical site team and

safeguarding adult's team were trained on a bespoke arrangement in order to mitigate the risk to the trust whilst a training programme was being developed.

Level 1 training was incorporated within corporate induction from January 2010, becoming mandatory in the June 2010.

### 5.3 Inter-agencies and Inter-Professional Working.

Inter-agency standards set out the framework within which the planning, implementation and monitoring of safeguarding work should take place. The key structure in this framework is a multi-agency partnership that leads the development of the work at a local level. A selection of data in relation to partnership working is detailed below.

### 5.4 Safeguarding Adults Activity Data

As part of the 2010/11 work plan it is vital that there was joint working with the governance team in order to ensure that our reporting systems are aligned to capture all current adult safeguarding concerns, which includes safeguarding referrals and incidents. From the data reviewed in 2009/10 we can identify that the introduction of mandatory training in this area has had an increasing effect on the numbers of referrals received on a quarterly basis.

Table 5: Safeguarding Adults Referrals by Month

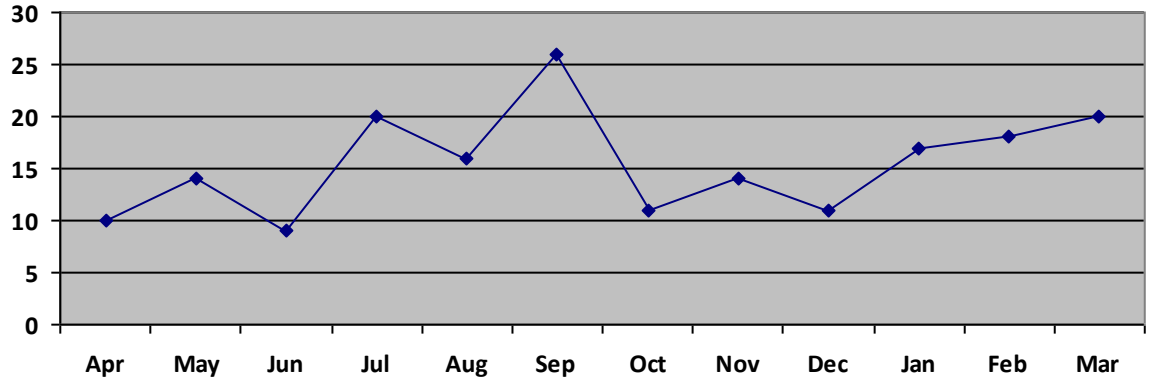



Table 5 provides an overview of the number of referrals made to the safeguarding adult team from within the Trust on a monthly basis. All referrals are investigated and progressed in partnership with the social service department relevant to the patients post code. In some instances, depending on the nature of the alleged abuse, the police would be the initial investigators. The expectation is that the number of safeguarding adult referrals will increase in the next reporting period, as a result of an increased staff awareness of risk factors, resulting from safeguarding training.

## Table 6: Safeguarding Adults referrals by Category

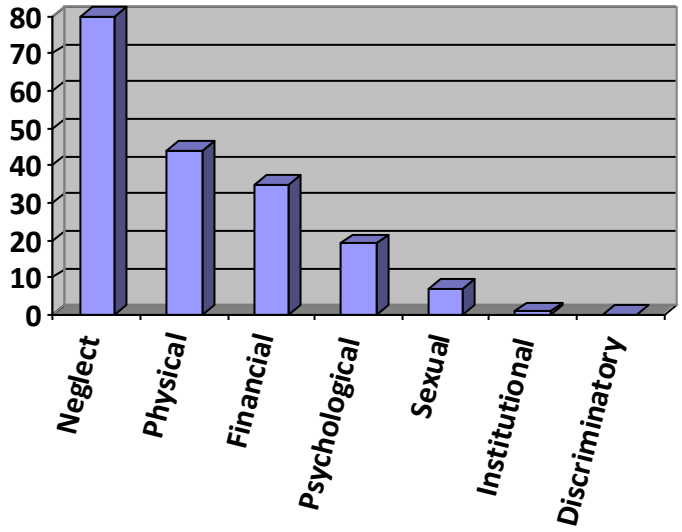
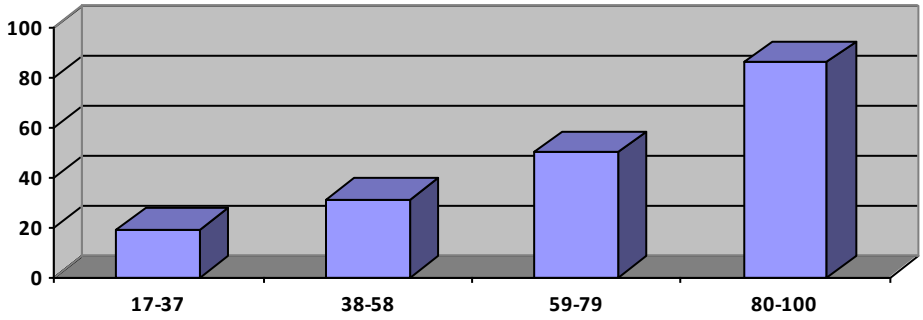



Table 6 provides us with the presenting concern. The seven categories named are nationally agreed categories of adult abuse. It may be the case that during the investigation other cause groups arise. This information is shared with local authority social service departments through our usual referral




pathway, and provided to the Bristol Safeguarding Adults Board and mirrors national statistics.

## Table 7: Safeguarding Adult referrals by Age group

Table 7 demonstrates how vulnerable adults are part of an entire age spectrum, rather than only older people. Whilst the numbers in age range 81 -99 is high, this in part reflects the fact that people are living longer, and this category generally require care from others which automatically places them in a vulnerable situation.

Table 8: Deprivation of Liberty Requests

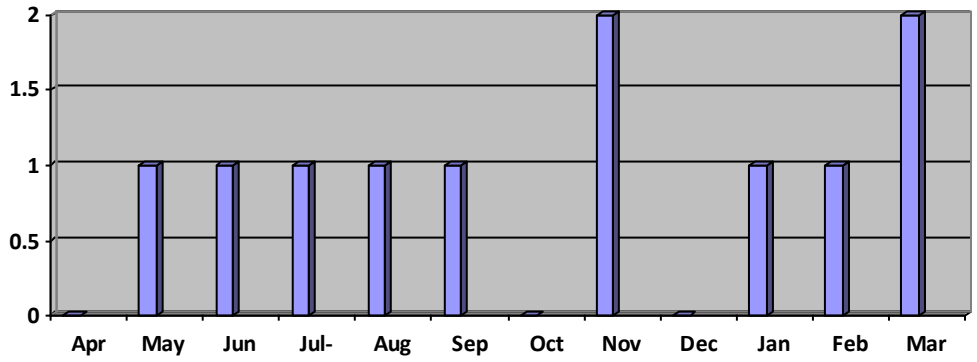
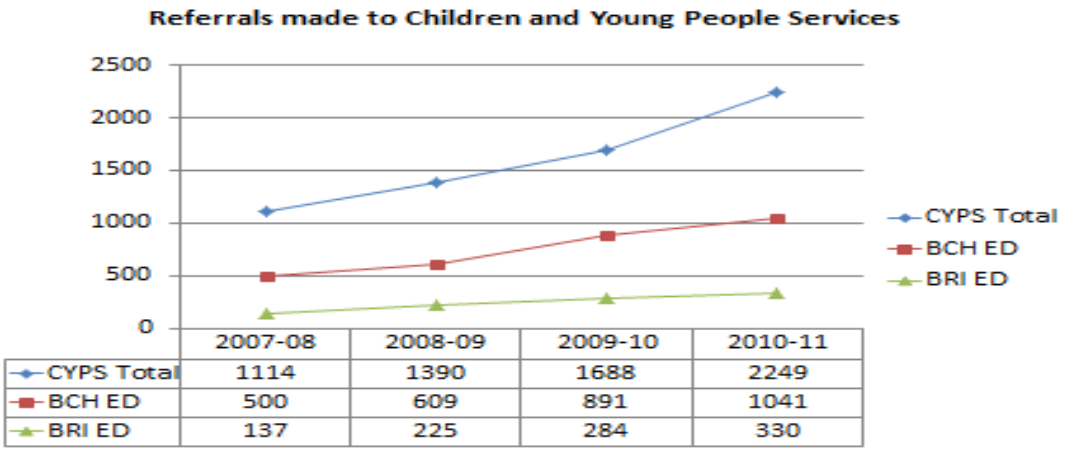



Table 8 indicates that, since the introduction of the Deprivation of Liberty Safeguards in 2009, the number of requests to detain patients within our Trust is slowly growing. Nationally it is reported that 9,000 requests were received in 2010/11; it is thought that this will continue to grow year on year as this new legislation becomes embedded into training programmes.

## 5.5 Safeguarding Children Activity Data

The ability to recognise safeguarding risks to the unborn baby, children and young person and to know 'what to do' next is an essential component of the Trust's mandatory safeguarding training. It is of note that there is a continuing level of direct correlation between the increased numbers of staff trained per year to the increased number of safeguarding children referrals made to Children's Social Care, as detailed in the tables below. As well as being seen as a positive outcome as a result of increased training, this year on year increase in referral rates is in line with the national picture and the more recent increased rate of referrals following the death of Baby Peter and the subsequent review by Lord Laming in 2009.

Table 9: Referrals made to Children's Social Care




| | 2007-08 | 2008-09 | 2009-10 | 2010-11 |
|---|---|---|---|---|
| CYPS Total | 1114 | 1390 | 1688 | 2249 |
| BCH ED | 500 | 609 | 891 | 1041 |
| BRI ED | 137 | 225 | 284 | 330 |

Table Nine demonstrates the year on year increase in the total number of child protection referrals correlating with the year on year increase in the total number of staff completing training.

The introduction of the system in 2010/11 to electronically 'flag' all children and young people under the age of 18 years who are subject to a Child Protection Plan in Bristol, North Somerset or South Gloucestershire, within the 'PAS' system has contributed to the increased number of referrals made for 'information only', a positive example of information sharing between agencies.

### 5.5.1 Common Assessment Framework

The Common Assessment Framework (CAF) is an early intervention tool which is designed to recognise and support families who may be in need of additional support to enable children to achieve their full potential. Within the Women's and Children's Division certain staff groups, primarily those who will be responsible for managing their own case load for a period of time are required to undertake further training to be able to complete a CAF. Within this reporting period a total of 27 Paediatric Specialist Nurses, Community Midwives, the teenage pregnancy midwife and drug liaison midwife have now completed their CAF (Common Assessment Framework) training and 4 CAFs have been completed during this reporting period.

### 5.5.2 Midwifery and the unborn baby

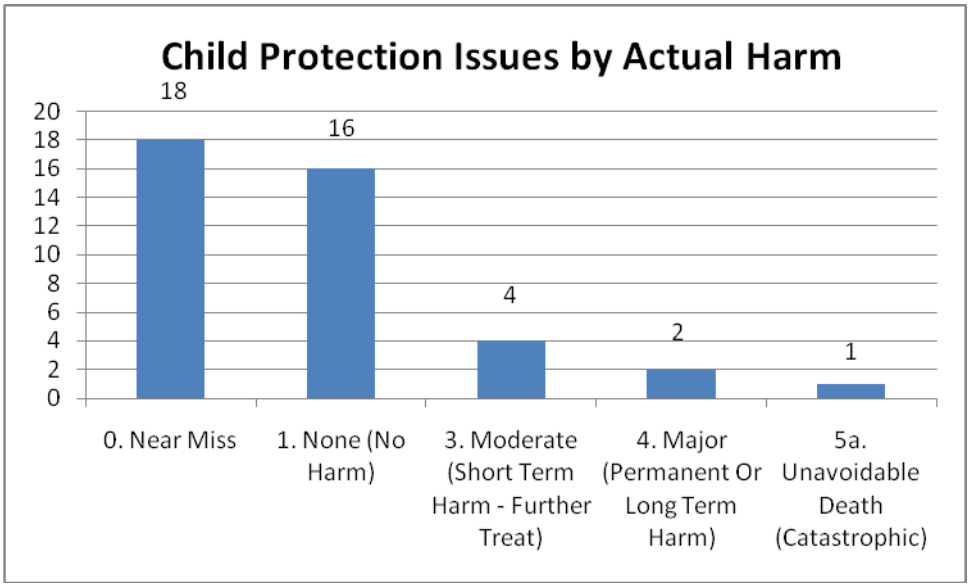
The Named Midwife for child protection is now supported in her role by 0.10 wte Band 7 midwife, whose remit includes providing safeguarding supervision to the community midwives and teenage pregnancy midwife, who are dealing with complex child protection cases.

There continues to be an increase in complex child protection cases involving the unborn baby and more identification of domestic abuse. The police continue to inform the midwifery service when they are called to a domestic violence incident involving a pregnant woman. There also appears to be an increase in the number of removals at birth, for child protection reasons, by social services.

A concern for the midwifery service has been the timeliness of child protection plans in place for unborn babies. This has been highlighted as an issue by the named midwife for child protection through liaison with hospital and locality social services. This issue is being addressed jointly with representatives from North Somerset Children's Social Care, in particular, with a plan currently being made to resolve the issue.

### 5.5.4 Safeguarding Children Clinical incidents

Table 10: Total number and type of clinical incident forms completed.




The one unavoidable death and two major incidents were the subject of multi-agency serious case reviews. There were 12 clinical incidents reported in the last financial year due to untimely social reports in place for unborn babies, as discussed above. All safeguarding incidents are monitored by the safeguarding leads.

### 5.6 Safeguarding and Domestic Violence

A key achievement in 2010/11 is the development of a pilot project in the adult Emergency Department to establish a service provision for Independent Domestic Violence Advisors (IDVA). Up to 12 % of emergency department attendances are due to domestic violence and the service will aim to address the safety of domestic violence victims who present within the Emergency Department who are at high risk

of harm from intimate partners, ex-partners or family members, to secure their safety and the safety of their children.

The project, lead by Sarah Brierley a Senior Nurse in the Emergency Department, and supported through the provision on Public Health monies, will begin at the beginning of the next reporting period (April 2011).

The safeguarding Children's team also continue to engage fully with the process of Multi-Agency Risk Assessment Conferences (MARAC) which shares information about the risk of serious harm or homicide to people experiencing domestic abuse and their children, these meetings are held once a month for the south of Bristol.

The Named Midwife also attends the Bristol Domestic Abuse Strategy meetings and the practice development midwife attends the Bristol domestic abuse forum meetings.

### 5.7 Serious Case and Child Death Review

During this reporting period the Safeguarding Children team have continued to co-operate with the Multi agency process of Serious Case Reviews, having completed two full Individual Management Reviews (IMRs) for Bristol and South Gloucestershire Local safeguarding Children Board, and contributes to two further investigations in Hampshire and North Somerset. Action plans resulting from these cases will continue to implemented and monitored through the Child Protection Operational Group, reporting the safeguarding Children Steering Group.

The Trust continues to be fully engaged with the Child Death Review Process lead by James Fraser as the Designated Doctor and Paediatric Intensive Care Consultant. The Child Death Overview Panel is an example of effective partnership working across agencies which provide a rigorous overview of all child deaths in or from the West of England, with the overall aim to improve outcomes for children by identifying areas for reducing the risk of preventable deaths. Full details of the key findings from the Child Death Overview Panel have been published in a separate report.

### 5.8 Learning Disability Research Studies and Confidential Inquiry

The demand for a Confidential Inquiry into premature deaths of adults with a learning disability was made over a decade ago, but was first mentioned 'officially' in Valuing People, the Learning Disability White Paper in 2001.

Since then, successive Mencap reports, such as Treat me right 2004; Death by Indifference 2007; reporting on the care of people with learning disabilities have recommended a confidential inquiry. The tipping point came with the report by Sir

Jonathan Michal 2008, regarding the care that people with learning disabilities receive from the NHS. The government accepted the findings of the report and committed to implementing its recommendations, which included the establishment of a Public Health Observatory for Learning Disabilities, and of a time limited Confidential Inquiry into premature deaths of people with learning disabilities.

The current inquiry team, provided by the University of Bristol, is part of a three year study into premature deaths where the person died within an NHS institution. The Trust has been contributing to this study for the past year.

A recent case which was under review (March 2011) has been highlighted as a case for which the Trust needs to undertake an Independent Management Review. This will help the Trust to review its systems and practices when managing people with specific vulnerabilities. The safeguarding adult lead is part of a panel reviewing the case, and as part of this work will develop a template for further IMRs where adults are the focus. The outcome will form part of the report for 2011/12.

### 5.9. Care Quality Commission Outcome Seven

From the beginning of this reporting period the Trust was required to maintain compliance with Care Quality Commission outcome 7, which includes the standards of both children and adult safeguarding for the first time. Compliance with this outcome is also required as part of NHS Bristol's Commissioning Standards.

This standard is monitored quarterly within the Trust via the Care Quality Commission committee. The standard alerted us to three main areas of concern which includes compliance of safeguarding training which has previously been discussed, restraint procedures, implementation and training, as well as services user involvement. There is a robust action plan in place to address all three areas.

## 7. Learning to take forward from 2010/11

The major learning from this past year has been that education and training is the key both to safer practice but also improved standards for people in our care. Whilst initially it was thought that training such a large group of 8,500 staff face to face was an impossible task, the reality is that clinical staff want to know how to improve practice. The training evaluations demonstrate this and send a positive message to employers.

The development and delivery of Safeguarding training, for both adults and children, is undertaken by staff who work in the safeguarding arena. This allows staff to ask specific clinical questions and discuss challenges that they find in their areas. The safeguarding trainers have the expertise to both answer the questions and take the challenge forward with them.

## 8. Conclusion

Whilst there are many pieces of legislation, policy and guidance from multi agencies in the area of safeguarding, the principles of empowerment, protection, prevention, proportionality, partnership and accountability remain the same for all. In order to ensure that the Trust continues to demonstrate learning from experience, and improving standards for vulnerable children and adults the following recommendations will be considered for 2011/2012.

## 9. Recommendations

- There is an on-going requirement for the Trust to ensure that the need to safeguard children and adults is fully embedded into all activities, developments, policies and procedures, and that safeguarding leads are included in this development. This includes the proactive requirement to work in multi-agency partnership.

- To ensure that safeguarding communication channels are fully embedded within the Trust: such as the process to ensure the dissemination of safeguarding information from the Trust Steering Groups into divisions, that information relating to safeguarding vulnerable service users is shared between specialities, and that safeguarding learning is shared between divisions

- To support safeguarding improvement, which will continue into the next reporting period, led by the Chief Nurse and safeguarding leads, through the work of both the safeguarding steering groups and their associated work plans for 2011/2012.

## 10. Key objectives for 2011/12 will include

- To continue to implement the Care Quality Commission action plan which will include ongoing focus on achieving and maintaining the compliance target of 80% for all levels of safeguarding training, as well as the implementation of bespoke restraint training for staff in high risk areas.
- Transitional care arrangements are improved to ensure that both service user and parent/guardians are provided with the necessary information prior to the child becoming an adult.
- To support the recommendation that safeguarding leads should examine service changes to ensure that safeguarding is fully considered and improved if possible with service changes.
- To continue to work towards mitigating potential safeguarding children risks posed by the existence of multiple sets of notes for any one child.

- To process map the safeguarding journey for both children and adults whilst in our care.

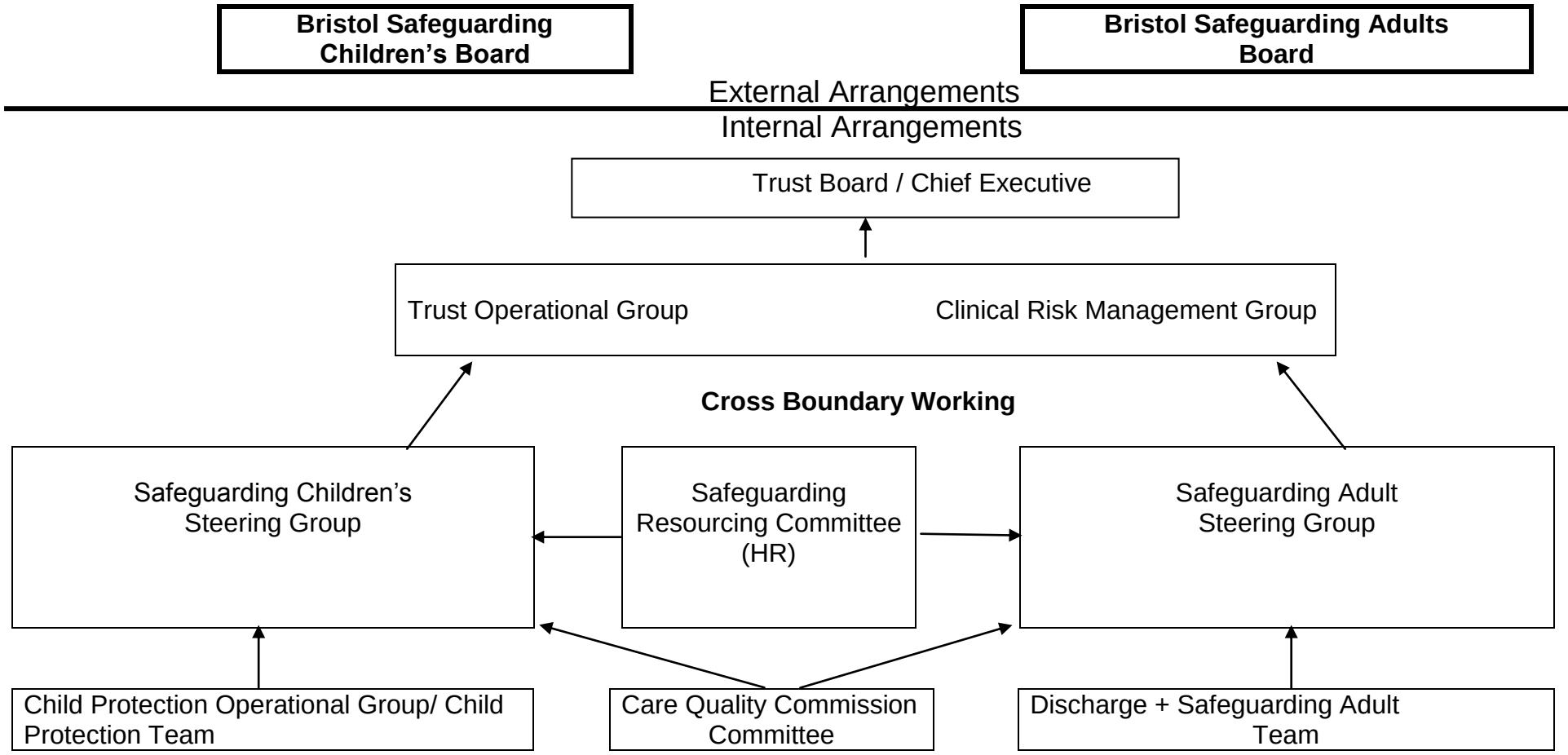
## 11. Key Risks for 2011/12 are

- The requirement to overcome the safeguarding risks posed by the existence of multiple sets of notes for any one child will remain a key priority within the Trust and remains on the Corporate Risk Register. Mitigating actions already in place include; highlighting through mandatory safeguarding training, the potential risks resulting from the fragmentation of safeguarding information. A local system has also been established whereby “an electronic flag” is now in place to highlight to practitioners any child in Bristol, North Somerset or South Gloucestershire who are subject to a Child Protection Plan. The Safeguarding Children Team also support practitioners in collating key information to contribute to safeguarding assessments.

  Significant progress is also being made between partner health agencies across Bristol, North Somerset and South Gloucestershire, to ensure that key safeguarding information relating to a specific child is effectively shared via the central electronic data base ‘Care Plus’. The safeguarding team will be working closely with the providers of the new Trust electronic patient data base, due to be implemented in the next reporting period, to ensure that safeguarding risks are fully considered. The end goal will be for each child to have a single electronic, chronological and multi-disciplinary record.
- In relation to safeguarding training, the risk is that the Trust will be non-compliant with Outcome 7 after the 31 October 2011, which may lead to the Care Quality Commission providing the Trust with an improvement notice.
- The new safeguarding children training requirements specified within the intercollegiate guidance (2010) are likely to have a significant impact on the Trust’s compliance with the Care Quality Commission Outcome Seven training target.

Achieving these objectives in 2011/2012 will be challenging for the Trust, both divisionally and corporately. Progress will be monitored through the Safeguarding Steering Groups, and compliance with the Care Quality Commission standards will be monitored by the Trust Care Quality Commission Committee. Areas of concern or poor progress will be highlight through the Trusts internal Governance arrangements as well as being entered on the Trusts risk register.

# Safeguarding Arrangements: Organisational Chart 2010/11



University Hospitals Bristol NHS
NHS Foundation Trust

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

| Item 09 – Security Annual Report |
|---|
| **Purpose** |
| To brief the Board on the Trust's Security initiatives and achievements for the reporting year 2010-2011. |
| **Abstract** |
| This report contains a review of Security activity and issues during the 2010 / 11 financial year. It cites evidence of a system that is in place to identify and eradicate or mitigate risks associated with Security. |
| **Recommendations** |
| The Board is recommended to **note** the report. |
| **Report Sponsor** |
| The Chief Operating Officer, James Rimmer |
| **Other Author** |
| The Head of Security and Transport, Paul Wood |
| **Appendices** |
| • Appendix A – Safety Annual Report |

### Previous Meetings

| Executive Team | Trust Management Executive | Quality and Outcomes Committee | Finance Committee | Audit Committee | Other |
|---|---|---|---|---|---|
| | 14 September 2011 | | | | Trust Risk Management Group -18 August 2011 |

# ANNUAL SECURITY REPORT APRIL 2010- MARCH 2011

## 1. Introduction and Highlights

1.1 2010-2011 has been another year of achievement, the highlight being the retention of the National Security Inspectorate's Guarding Gold Scheme Award consisting of BS ISO9001-2000, BS7499-2002, BS7858-2006 by successfully passing our 6-monthly and 3-yearly re-assessment audit inspections.

1.2 Further to this all our security team remains the first and only NHS Trust to gain accreditation from the Northern College of Further Education in Managing Conflict for Enforcement Personnel via our Trainers, Niton.

1.3 Recorded crime, in particular theft, burglary and car crime remain low and in line with previous achievements.

1.4 Our Police have been successful in prosecuting 37 offenders. This has resulted in gaining a range of sanctions including 11 offenders receiving prison sentences of between 4 and 18 weeks, and fines of between £60 to £200 for public order offences. Other sanctions include community orders ranging of up to 12 months, compensation, curfews and electronic tagging, attendance at drug and alcohol rehabilitation programs.

1.5 The continued low recorded crime, particularly theft, burglary and car crime has also had a positive result in reducing Trust and personal losses. The number of arrests by the Security / Police Liaison Unit was 79 (30 of which were handcuffed by Security Officers due to violent behaviour) this is on a par with last year.

1.6 The Emergency Department continues to be the greatest area of concern, particularly immediately following the arrival of patients (70% of arrests). The Target patrols and overnight presence, together with more effective policing by the Security and the Police Liaison team, has enabled us to keep better control of this area.

1.7 Over and above the Emergency Department incidents, Security officers attended 896 incidents ranging from showing presence for violent patients and restraining them, to attending emergency activated nurse alarms on Wards.

1.8 640 staff have been fully trained and issued with Lone Worker Devices by Reliance through the Department of Health; to date we have had no real red alerts.

1.9 To enhance our objective to promote a pro-security culture within the Trust, the Local Security Management Specialist participates in the Trust induction process. The awareness session highlights the work of the Security department, the duty of all employees to report security incidents and employees contribution to the security of the Trust. The Local Security Management Specialist has also undertaken security risk assessments for various departments within the Trust. He has also undertaken covert audits of the security across the Trust to test the existing security culture. These audits have highlighted the need for formalized security audits which the Local Security Management Specialist will be developing in 2011/2012. The audits will inform localised crime prevention plans and risk assessments.

## 2. Crime Reduction Strategy

2.1 The Crime Reduction Strategy was launched in April 2003 to identify 'key risks' and set performance targets to ensure that they were addressed.

2.2 This enabled effective benchmarking of the Security Department's performance (see Figure 1). Over the last year Theft, Violence and Aggression offences, Burglary and Vehicle crime has remained almost unchanged with very low rates reported.

| Offence Type | 2001/2 | 2002/3 | 2003/4 | 2004/5 | 2005/6 | 2006/7 | 2007/8 | 2008/9 | 2009/10 | 2010/11 |
|---|---|---|---|---|---|---|---|---|---|---|
| Violence and Aggression | 722 | 794 | 647 | 611 | 658 | 470 | 323 | 423 | 426 | 501 |
| Burglary | 54 | 89 | 37 | 20 | 15 | 7 | 4 | 5 | 4 | 6 |
| Vehicle Crime | 129 | 84 | 40 | 24 | 26 | 8 | 3 | 3 | 3 | 4 |
| Theft | 181 | 96 | 81 | 85 | 102 | 71 | 65 | 22 | 22 | 48 |
| **TOTALS** | **1,086** | **1,063** | **805** | **740** | **801** | **556** | **395** | **453** | **455** | **559** |

**(Figure 1)**

2.3 The Personal Assault Reporting System was introduced by the NHS Counter Fraud and Security Management Service in 2003. In the last year there have been a total of 168 incidents, a decrease of 13 from the year before.

2.4 The increase in Figure 1 of violence and aggression is accounted for, not so much from more activity, but by there being a more robust reporting and recording system under verbal abuse (316 of the 501 incidents were verbal). Added to this, staff are increasingly adopting a zero tolerance approach to this type of behaviour and are being encouraged to report all incidents.

2.5 We would like to thank our colleagues in the Health and Safety Department for encouraging staff to report incidents and for supplying information for this report.

2.6 Given the fact that 168 Personal Assault Reporting System events were recorded this year, the level was benchmarked against a number of other similar sized Trusts as follows: North Bristol Trust (221), Nottingham University Hospitals (187) University Hospitals Leicester (180) and, Derby Hospitals NHS Foundation Trust (171) Heart of England NHS Foundation Trust (161).

2.7 Of the 168 recorded Personal Assault Reporting System events where Common Assault took place on our staff, 104 had no further action taken against them due to the patients being confused / medical condition or lack of capacity. There were 64 further cases of PARS where prosecution was sought and 37 offenders received sanctions ranging from fines to imprisonment.

2.8 All IT and cleaning equipment continues to be marked with 'SmartWater' tracer and vulnerable computers continue to be locked down, the details updated on the electronic database.

2.9 Vehicle crime has remained very low during the year. This, we believe, is due to the continued presence of a uniformed car parking patrolman from Total Parking Solutions, the contracted car parking management service.

2.10 The Closed Circuit Television system within the Trust has now increased to 200 cameras. Some of the locations where cameras were fitted this year were the Clinical Research Imaging Centre, Trust Headquarters Cycle Centre, and the Old Building management corridor and rear Yard. The Closed Circuit Television system is registered for data protection purposes with the Information Commissioners office in London.

## 3. Security Officers Training

3.1 In terms of ensuring that security remains responsive to change, a comprehensive training plan has been developed. Basic training takes up to two weeks to complete - this includes some law input, awareness of the Police and Criminal Evidence Act, as well as physical intervention techniques such as physical restraint and handcuffing.

3.2 Refresher training continues every six months, often incorporating issues identified by customer feedback or changing demands and all Security Officers are now trained in the use of leg restraints. This additional method of restraint was identified following a risk assessment and has the full backing of Avon and Somerset Police. A restraint policy to cover this has been approved for the Trust. All security staff has received this training, which is also incorporated into the 6-monthly refresher training.

3.3 All members of the Security team have completed an NVQ Level 2 course with City of Bristol College in Providing Security Services, and three of the Officers have finished an NVQ Level 3 in Security Management. All Security Officers are currently undertaking NVQ Level 2 in Customer Service and all have completed the Trust's Child Protection course, and statutory and mandatory updates.

3.4 The Security Department staff have all retained and passed the Niton Training Package and have been awarded their accredited certificates by the Northern College of Further Education. This training continues on a 6-monthly basis with the next training planned for July 2011.

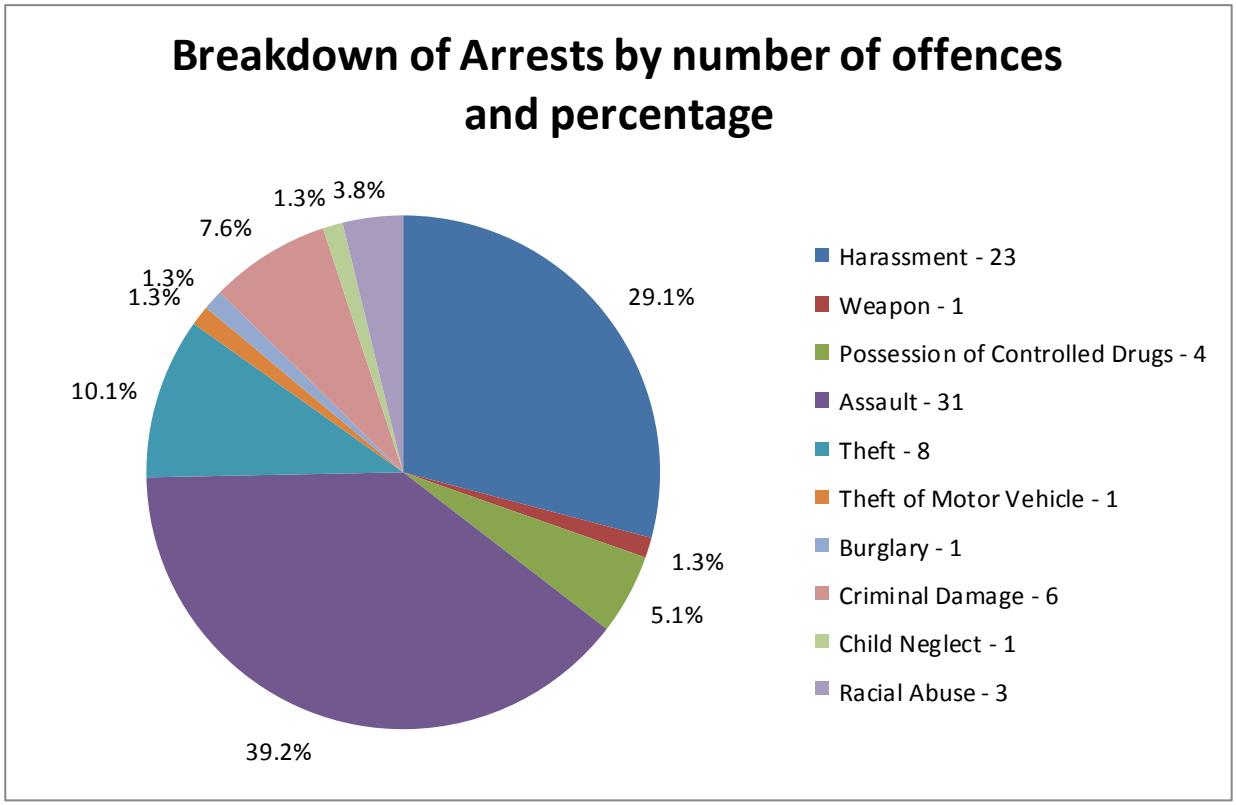
## 4. Police

4.1 The effectiveness of the Police Liaison Unit is measured in terms of their valuable contribution to the success of the Crime Reduction Strategy, especially in successfully prosecuting offenders.

4.2 In 2010/11 there were 79 offenders arrested by Police / Security staff. Our Police have been successful in prosecuting 37 offenders, and this has resulted in gaining sanctions ranging from fines of between £60 to £300 for public order offences, to 11 offenders receiving prison sentence of 4 to 18 weeks. Other sanctions include community orders ranging from 4 to 12 months. The Police Liaison Unit has also benefited from networked access to the Home Office IT infrastructure. This is achieved by having a Police computer installed in the Police Liaison Office, giving direct access to the Police National Computer database.

4.3 Due to Cash Reduction Efficiency Savings demands and the retirement of one of our police liaison officers the decision was made to reduce our police liaison to one officer.

4.4 Breakdown of arrests is in Figure 2 below




**[Figure 2]**

## 5. Safe Treatment Facility

5.1 The Trust continues to operate its Safe Treatment Facility in support of Local PCTs and mental health organisations. These provide treatment for patients who are categorised as 'high risk' and have been excluded from GP surgeries. The same facility has also been extended to similar UHBristol patients as an alternative to exclusion, under the "Withdrawal of Treatment" Policy. The facility is now used on a daily basis by the South Bristol Assessment team and Avon and Wiltshire Partnership. The security team and police liaison have dealt with 382 high risk patients this year. This is an increase on last year of 23 patients, and has put additional strain on our small team.

## 6. Baby/Paediatric Abduction

6.1 UHBristol's policy has been adopted across Bristol, North Somerset and South Gloucestershire. Staff vigilance remains very high, especially at St. Michael's and Bristol Children's Hospital. The abduction policy is tested annually after event debriefs are held with senior staff to understand the issues that arose from such events which will aid us to learn and add to the next exercise.

## 7. Tactics/Strategy

7.1 Making use of the computer flagging system, to enable nursing staff to alert Security to provide an earlier presence to deter or prevent the opportunity for violent or disruptive behaviour, is proving to be particularly successful especially in the Emergency Department where over 70% of security incidents occur. Security staff provide a presence and have removed an average of 30 'belligerents' a month, to avoid further escalation of an incident.

7.2 The Police Liaison Unit introduced "Target Patrols" for at risk areas. These patrols can also be requested by any member of staff. Targeted Patrols, along with regular security patrols of the precinct, have been another considerable factor in the reduction of burglaries.

## 8. Lost and Found Property

8.1 A Lost Property Store has been running now for the last seven years, supported by procedures to account accurately for items of lost and found property via our National Security Inspectorates ISO and British Standard Accreditation.

## 9. Lone Worker Devices

9.1 During 2009 the Trust, through the NHS Security Management Service, successfully bid for funding of 654 Lone Worker devices from the Department of Health which through our Health and Safety risk assessment were the number of lone workers the Trust employed and needed safeguarding. To date 640 staff have received their training and received their devices.

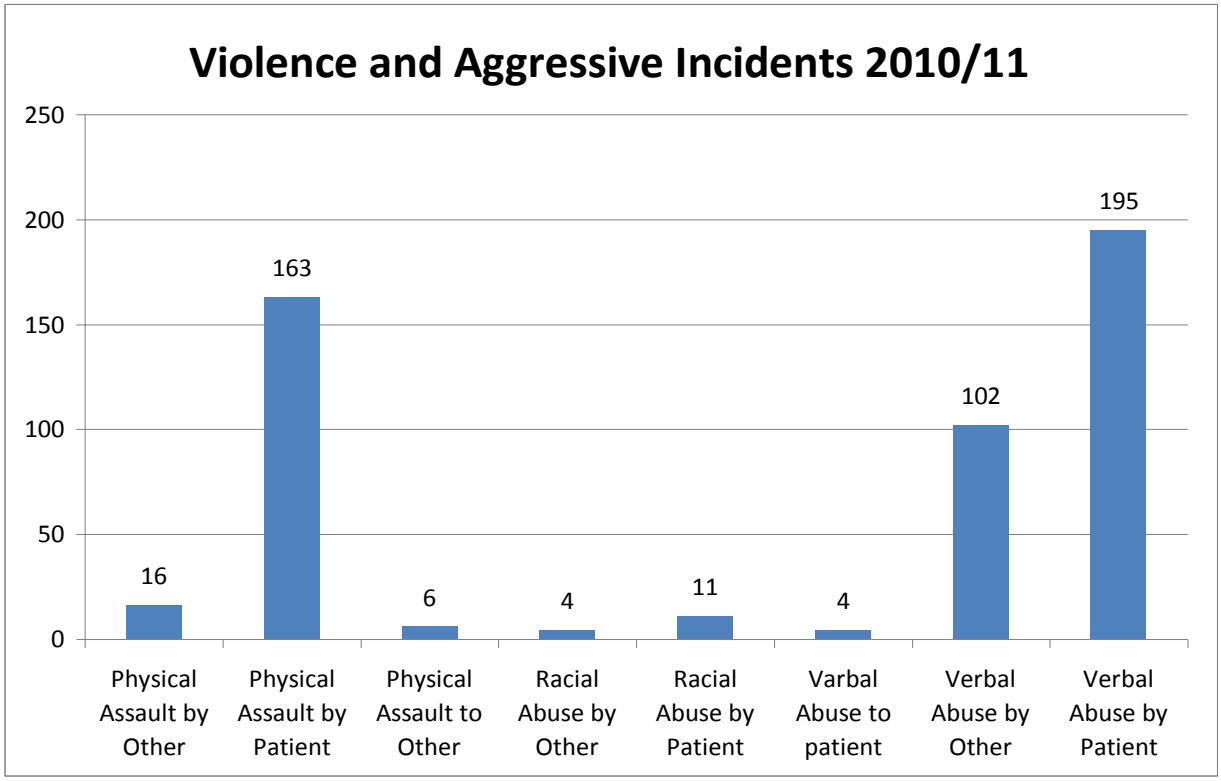
## 10. Overall Picture

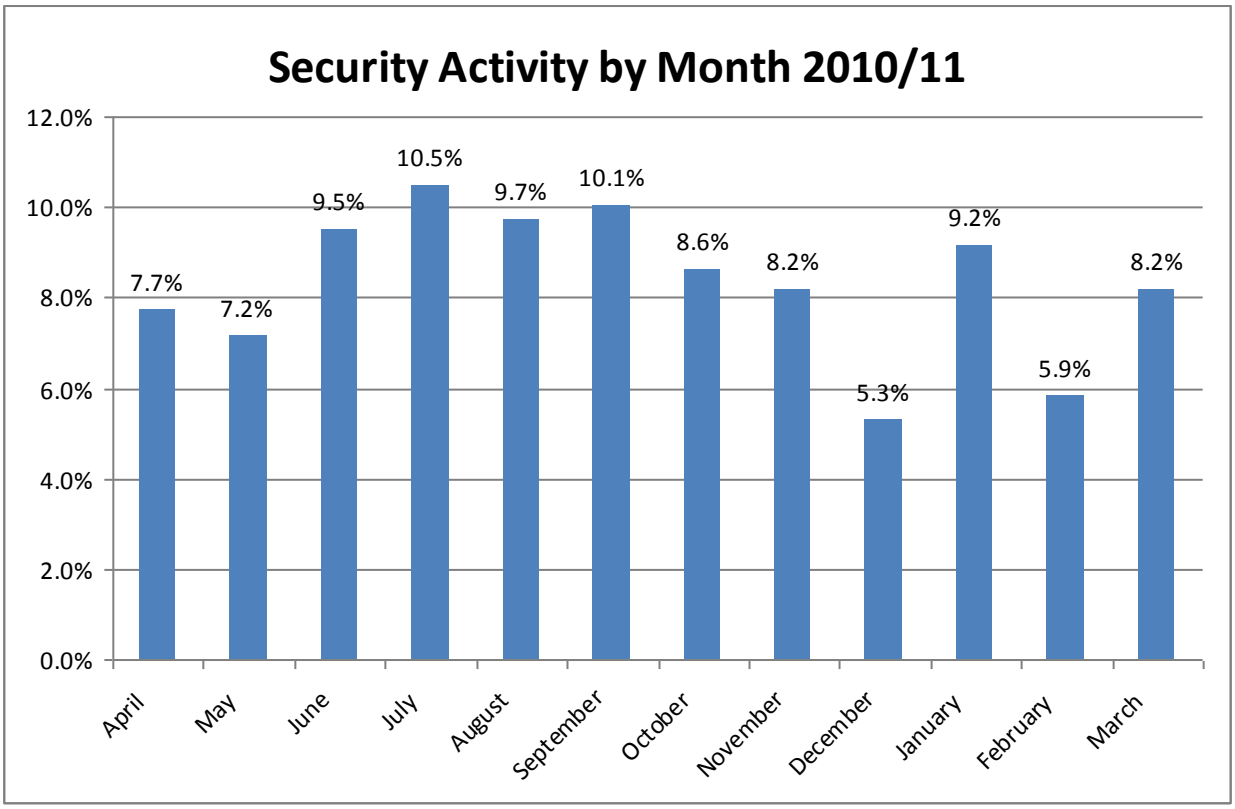
10.1 Overall a pro-security culture is now a fundamental part of Trust thinking and the appointed Local Security Management Specialist will be tasked via an agreed work plan to support staff throughout the organization. Regular articles in Voices, Newsbeat and global email alerts maintain communication channels with the staff. Staff are encouraged to make direct contact with the Head of Security, Local Security Management Specialist, Security Manager, Security staff or the Police Liaison Unit to report any untoward occurrences. Very often the reports provided by staff lead directly to successful apprehension of offenders.

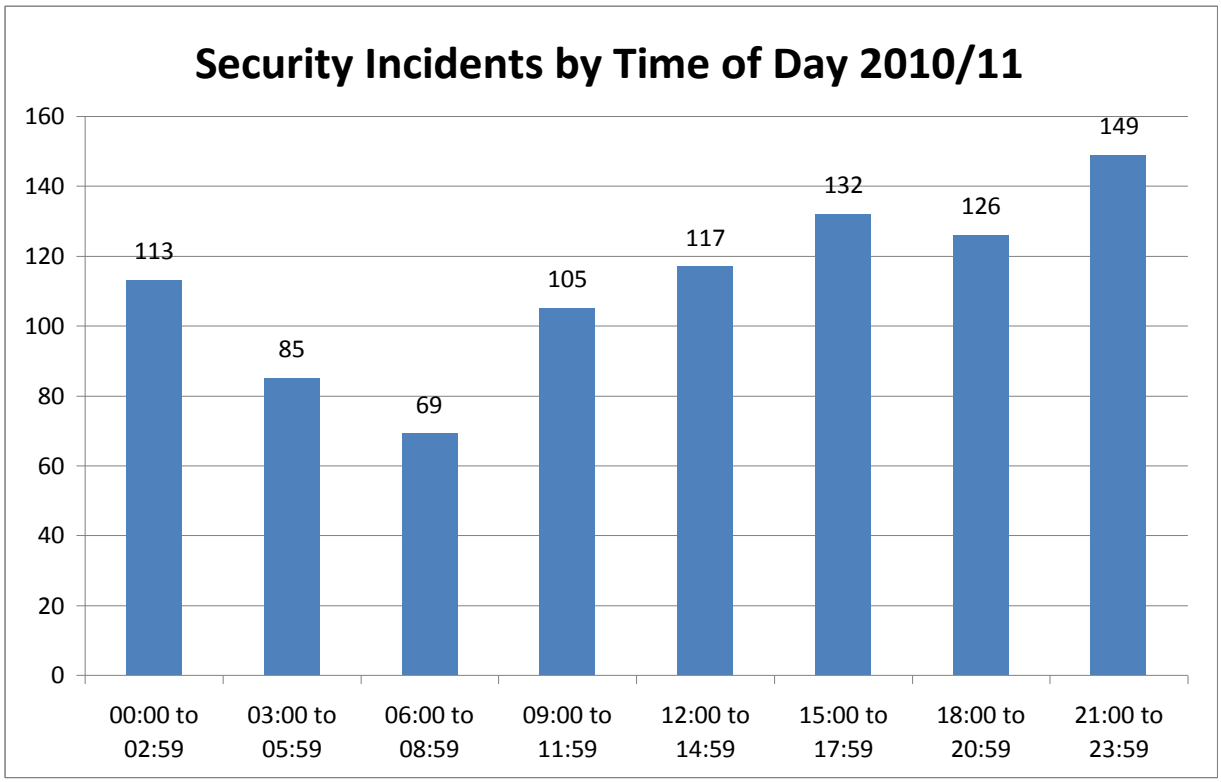
## 11. Looking Forward

11.1 Primarily, the aim over the next year is to consolidate the progress that has been made so far and not to become complacent. The emphasis will be on reviewing Violent and Aggressive incidents. The Personal Assault Reporting System will analyse data from these incidents which will highlight areas of concern such as location, times, day and altering our resources to meet the demand. We will strive to perfect security systems and through reliance on our International Organisation for Standardisation procedures continue to improve the overall delivery of service.

11.2 Breakdown of incidents shown below.




Security Activity by Month 2010/11
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
7.7%
7.2%
9.5%
10.5%
9.7%
10.1%
8.6%
8.2%
5.3%
9.2%
5.9%
8.2%
April
May
June
July
August
September
October
November
December
January
February
March


Security Incidents by Time of Day 2010/11
160
140
120
100
80
60
40
20
0
113
85
69
105
117
132
126
149
00:00 to 02:59
03:00 to 05:59
06:00 to 08:59
09:00 to 11:59
12:00 to 14:59
15:00 to 17:59
18:00 to 20:59
21:00 to 23:59

University Hospitals Bristol NHS
NHS Foundation Trust

## Cover Sheet for the Private Meeting of the Trust Board of Directors, to be held on 28 September 2011 at 10:00 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

| Committee Chairs' Reports - Item 10b– Finance Report |
|---|
| **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 income and expenditure statement shows a surplus of £2.157m for the five months ending 31 August 2011. This is marginally better than the Annual Plan projection for the first five months of the year. The adverse movement in Divisional positions is of concern. There are overspendings recorded against pay and non pay budgets with slippage on the CRES being a significant contributory factor. Income from Activities less than Plan after account is taken of the settlement of the March 2011 over performance in 2011/12. |
| **Recommendations** |
| To note the financial position at 31 August 2011. |
| **Report Sponsor** |
| Director of Finance, Paul Mapson. |
| **Other Author** |
| Head of Finance, Paul Tanner |
| **Appendices** |
| • Appendix1 – Summary Income and Expenditure Statement<br>• Appendix 2 – Divisional Income and Expenditure Statement<br>• Appendix 3 – Analysis of pay expenditure<br>• Appendix 4 – Executive Summary<br>• Appendix 5 – Financial Risk Matrix<br>• Appendix 6 – Financial Risk Ratings |

### Previous Meetings

| Executive Team | Trust Management Executive | Quality and Outcomes Committee | Finance Committee | Audit Committee | Other |
|---|---|---|---|---|---|
| | | | 21/09/11 | | |

**REPORT OF THE FINANCE DIRECTOR**

## 1. Overview

The summary income and expenditure statement shows a surplus of £2.157m for the five months ending 31st August 2011. This is marginally better than the Annual Plan projection for the first five months of the year. The operating surplus (EBITDA[1]) is £13.858m. This is £0.389m (or 2.9%) greater than Plan for the period. The Financial Risk Rating is 3 (actual 3.45), further information on this is given in section 5 below.

The main area of concern continues to be the achievement of cash releasing efficiency savings. The headline message is that August has seen an increase in the rate of delivery of CRES savings with £1.643m achieved. This equates to 80% of the Plan for the month.

The August report reflects an adverse variance of £4.849m on the CRES programme. Actual savings of £6.249m represents slippage of £2.793m when compared with phased planned savings for the first five months of £9.042m. The adjustment is to bring CRES plans on to a 1/12ths basis adds a further £2.056m to the reported non achieved CRES in the August report.

The revised CRES forecast is that savings of £20.526m will be achieved this year of which the non recurring element is £3.695m. This represents an under achievement of £6.11m when compared with the Plan for the year of £26.636m. The full year effect of the 2011/12 CRES programme is estimated, at this stage, to be £21.52m. Clearly there is a great deal of further work to do to identify schemes to deliver the balance of the CRES programme for this year and develop and implement proposals for 2012/13.

The adverse movement in Divisional positions of £0.762m is concerning. The Medicine and Surgery, Head and Neck Divisions have moved significantly away from their trajectories. Their positions will be assessed in forthcoming monthly reviews. Detailed information and commentary for each Division is to be considered by the Finance Committee (report included under agenda item 5.3 below). A summary table setting out the variances on the four main income and expenditure categories together with a note on the impact of CRES slippage to date, on a 1/12ths basis is provided below.

| | Variance to 31st July | Variance this month | Variance to 31st August | Memorandum CRES Variance |
|---|---|---|---|---|
| | Fav/(Adv) £'000 | Fav/(Adv) £'000 | Fav/(Adv) £'000 | Fav/(Adv) £'000 |
| Pay | (1,295) | (374) | (1,669) | (2,003) |
| Non Pay | (1,853) | (189) | (2,042) | (2,689) |
| Operating Income | 104 | 38 | 142 | (33) |
| Income from Activities | 316 | (237) | 79 | (124) |
| **Totals** | **(2,728)** | **(762)** | **(3,490)** | **(4,849)** |

It can be seen that the non achievement of savings within the CRES programme is a significant feature in each of the lines shown in the table to the extent that had the savings been achieved then a surplus would be reported on each of the pay, non pay and income headings.

[1] Earnings Before Interest Depreciation Taxation and Amortisation

Total pay costs at £24.795m[2] in August have increased by £0.375m in the month (although £0.155m relates to payment of arrears). There has to be a visible and sustainable reduction in pay expenditure over the next three months if we are to deliver a satisfactory outturn for 2011/12. It is noted that a number of pay related CRES schemes are reported as having progressed but so far there has not been a corresponding net reduction in pay expenditure. The introduction of 'Pay Reports' to track pay expenditure throughout the year and enable comparisons to be made with Divisional Plans will become an increasingly important control feature for use in Divisional Reviews.

Non pay budgets show a further overspending in August to a cumulative adverse variance of £2.042m. Slippage on CRES schemes of £2.689m is embedded within this position. Areas of particular concern at this stage are the overspendings recorded against the Surgery, Head and Neck Division (£0.632m) and the Division of Medicine (£0.529m).

Income from Activities shows an under performance of £0.237m for August (July activity reported a month in arrears). Whilst the cumulative position on Income from Activities shows a surplus to date it should be borne in mind that this reflects the balance of the over performance for March 2011 (£0.81m) which has been received in 2011/12. The underlying pattern that can be observed from activity and income so far this year is that we cannot expect to 'trade our way' out of an adverse financial position and need increasingly, through the Trust's CRES programme, to reduce expenditure on pay and non pay headings.

**2.** The main Divisional Budget changes in August include the following:-

| | £'000 |
|---|---|
| Plasma Exchange (Women's and Children's Division) | 300 |
| Capital to Revenue transfers | 233 |
| European Working Time Directive | 140 |
| Reproductive Health and Care of Newborn increase in student numbers | 77 |
| Clinical Systems Implementation Programme | 67 |

## 3. Income

For the year to date, contract income is £0.4m lower than plan. This position includes £0.81m related to 2010/11 activity. The majority of the over-performance is within BNSSG.

| **Clinical Income by Worktype** | **Plan** | **Actual** | **Variance** |
|---|---|---|---|
| | **£m** | **£m** | **£m** |
| Accident & Emergency | 3.59 | 3.79 | 0.20 |
| Emergency Inpatients | 24.15 | 24.93 | 0.77 |
| Day Cases | 10.95 | 11.32 | 0.36 |
| Elective Inpatients | 15.52 | 14.97 | (0.55) |
| Non-Elective Inpatients | 9.88 | 10.45 | 0.57 |
| Excess Bed days | 2.93 | 2.60 | (0.33) |
| Outpatients | 21.15 | 21.44 | 0.29 |
| Bone Marrow Transplants | 3.67 | 3.30 | (0.37) |
| Critical Care Bed days | 11.43 | 10.85 | (0.58) |
| PbR Exclusions / NICE | 11.90 | 10.75 | (1.15) |
| Contract Penalties | (2.30) | (2.88) | (0.59) |
| Other | 15.35 | 15.42 | 0.17 |
| **Sub-Totals** | **128.13** | **126.92** | **(1.21)** |
| 2010/11 Estimate v Actual | - | 0.81 | 0.81 |
| **Totals** | **128.13** | **127.73** | **(0.40)** |

This month's income position also reflects the following assessment of contract penalties / rewards.

[2] See Appendix 3 – Analysis of Pay Spend 2011/12

| | Month 3 Year to Date £m | Current Month £m | Month 4 Year to Date £m |
|---|---|---|---|
| Clostridium Difficile | - | - | - |
| CQUINS | - | - | - |
| Emergency Readmissions | (0.23) | (0.37) | (0.60) |
| Emergency Marginal Tariff | (0.38) | 0.47 | 0.09 |
| First To Follow Up Ratio | - | - | - |
| Others | (0.07) | (0.01) | (0.08) |
| **Totals** | **(0.68)** | **0.09** | **(0.59)** |

There are also a number of significant SLA risks from potential fines and limiters including cancelled operations, 18 week referral to treatment, INNF (interventions not normally funded) cases subject to prior approval etc. These are currently being reviewed.

The income over-performance position can be summarised as follows:

| SLA Variances - £m | BNSSG[3] | South West Specialist Commissioner | Other Commissioners | Totals |
|---|---|---|---|---|
| Over / (Under) performance at Month 4 | 3.76 | (1.68) | (3.29) | (1.21) |
| QIPP | (3.53) | - | 3.53 | - |
| A&E / Emergencies | 0.37 | 0.04 | 0.43 | 0.84 |
| **Residual Over (Under) performance** | **0.59** | **(1.64)** | **0.67** | **(0.37)** |

This demonstrates that, for example, of the £3.76m over-performance to date for BNSSG £3.17m is due to QIPP and A&E / Emergency activity. In total there is, therefore, a net residual over performance of £0.59m.

## 4. Expenditure

In total, Divisions are shown as overspent by £3.490m for the five month period to 31st August. The position for each Division, together with comparable results with CRES accounted for on the Divisional Phased Plan basis, is summarised below:

| **Division** | CRES on 1/12ths profiling | | CRES on Phased Plan | |
|---|---|---|---|---|
| | Variance to 31st August Favourable / (Adverse) | Memorandum CRES Variance to 31st August | Variance to 31st August Favourable / (Adverse) | Memorandum CRES Variance to 31st August |
| | £'000 | £'000 | £'000 | £'000 |
| Diagnostic and Therapies | (140) | (380) | 24 | (216) |
| Medicine | (697) | (899) | (9) | (211) |
| Specialised Services | (806) | (630) | (551) | (375) |
| Surgery, Head and Neck | (818) | (1,822) | (240) | (1,244) |
| Women's and Children's | (870) | (682) | (607) | (419) |
| Facilities and Estates | (32) | (135) | 51 | (52) |
| Trust Services | (63) | (87) | (37) | (61) |
| Other Services | (64) | (214) | (65) | (215) |
| **Totals** | **(3,490)** | **(4,849)** | **(1,434)** | **(2,793)** |

[3] Bristol, North Somerset and South Gloucestershire Commissioner

It can be seen from the above that the adverse variance on the CRES programme is the major factor for all of the divisions.

The **Diagnostic and Therapies Division** reports a cumulative over spending of £140k – an overspending of £26k in the month. The Division has significant (greater than £100k) overspendings on pay, non pay and operating income. These are partially offset by income from activities which is reported as favourable by £288k.

The **Division of Medicine** reports an adverse variance of £697k for the five months ending 31st August, an overspending of £281k in the month. To date, pay and non pay budgets are over spent by £420k and £529k respectively. Expenditure overspendings are partially offset by favourable income variances of £252k. The Division forecasts a breakeven outturn with the plan to close 43 beds from September being a key factor in achieving this target.

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £806k. The overspending of £9k in August is in line with the Division's financial forecast. Pay budgets continue to overspend with a cumulative adverse variance of £642k. This is as a result of slippage on the CRES programme and overspendings on consultant pay of £154k and agency staff (£306k). Income from Activities shows an adverse variance of £214k – an improvement of £51k in the month.

**The Surgery, Head and Neck Division** reports an adverse variance on its income and expenditure position of £818k – an overspending of £310k in August. The significant adverse movement this month moves the Division's RAG scoring from Green to Amber / Red. Pay budgets have a cumulative overspending of £168k as a result of higher than planned used of bank / agency staff, waiting list initiative payments and slippage on CRES schemes. Non pay budgets are overspent by £632k to date with the principal cause being slippage on CRES at £836k. The under achievement on Income from Activities (£160k) is partially offset by the over achievement on Income from Operations (£142k) budgets.

**The Division of Women's and Children's Services** reports an adverse variance on its income and expenditure position of £870k – an overspending of £64k in August. Pay budgets are overspent by £621k for which an adverse CRES variance (£153k) and staffing being greater than funded establishment are the significant factors. Non pay budgets show a cumulative overspending of £257k against which the adverse variance of the CRES programme is £630k. Income budgets show a favourable variance of £8k to date.

**The Facilities and Estates Division** reports a cumulative overspending to date of £32k, an improvement of £15k in the month.

**Trust Services** report a cumulative overspending to date of £63k, an improvement of £4k in the month. Non achievement of CRES accounts for £88k of the adverse variance.

## 5. Financial Risk Rating

The Trust's overall financial risk rating, based on results to 31st August 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 August 2011 Metric Result | Metric Score | Weighted Average Score |
|---|---|---|---|
| EBITDA | | | |
| Margin | 6.72 | 3 | 0.75 |
| Plan achieved | 102.9 | 5 | 0.50 |
| Return on Capital Employed | 4.97 | 3 | 0.60 |
| I&E surplus margin | 1.19 | 3 | 0.60 |
| Liquidity ratio (days) | 38.3 | 4 | 1.00 |
| | | | **3.45** |

| Weighting | Rating categories | | | | |
|---|---|---|---|---|---|
| % | 5 | 4 | 3 | 2 | 1 |
| | | | | | |
| 25 | 11 | 9 | **5** | 1 | <1 |
| 10 | **100** | 85 | 70 | 50 | <50 |
| 20 | 6 | 5 | **3** | -2 | <-2 |
| 20 | 3 | 2 | **1** | -2 | <-2 |
| 25 | 60 | **25** | 15 | 10 | <10 |

| | |
|---|---|
| **Overall Financial Risk Rating** | **3** |

The Trust is operating well within the 4 metrics specified in the Prudential Borrowing Limit. Further information is given at Appendix 6.

## 6. Capital Programme

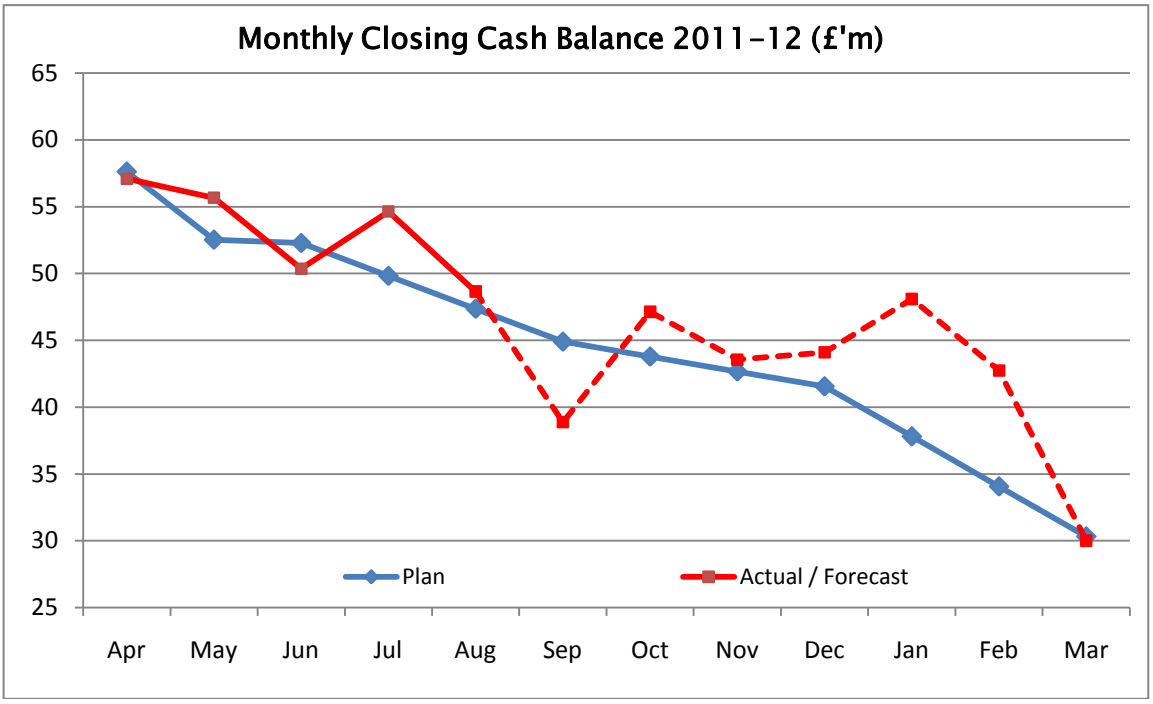
A summary of actual income and expenditure for the five months to 31st August is given in the table below.

| Plan for Year | | 5 Months Ended 31st August 2011 Plan | Actual | Variance Favourable / (Adverse) |
|---|---|---|---|---|
| £'000 | | £'000 | £'000 | £'000 |
| | **Sources of Funding** | | | |
| 1,299 | Donations | - | - | - |
| 16,833 | Retained Depreciation | 6,955 | 7,063 | 108 |
| 1,500 | Sale of Property | 583 | 879 | 296 |
| 24,219 | Cash balances | 4,263 | 4,677 | 414 |
| **43,851** | **Total Funding** | **11,801** | **12,619** | **818** |
| | **Expenditure** | | | |
| (21,223) | Strategic Schemes | (4,819) | (6,716) | (1,897) |
| (5,563) | Medical Equipment | (323) | (268) | 55 |
| (4,907) | Information Technology | (639) | (1,447) | (808) |
| (2,398) | Roll Over Schemes | (784) | (436) | 348 |
| (4,351) | Refurbishments | (1,679) | (1,305) | 374 |
| (10,039) | Operational / Other | (3,557) | (2,447) | 1,110 |
| 4,630 | Anticipated Slippage | - | - | - |
| **(43,851)** | **Total Expenditure** | **(11,801)** | **(12,619)** | **(818)** |

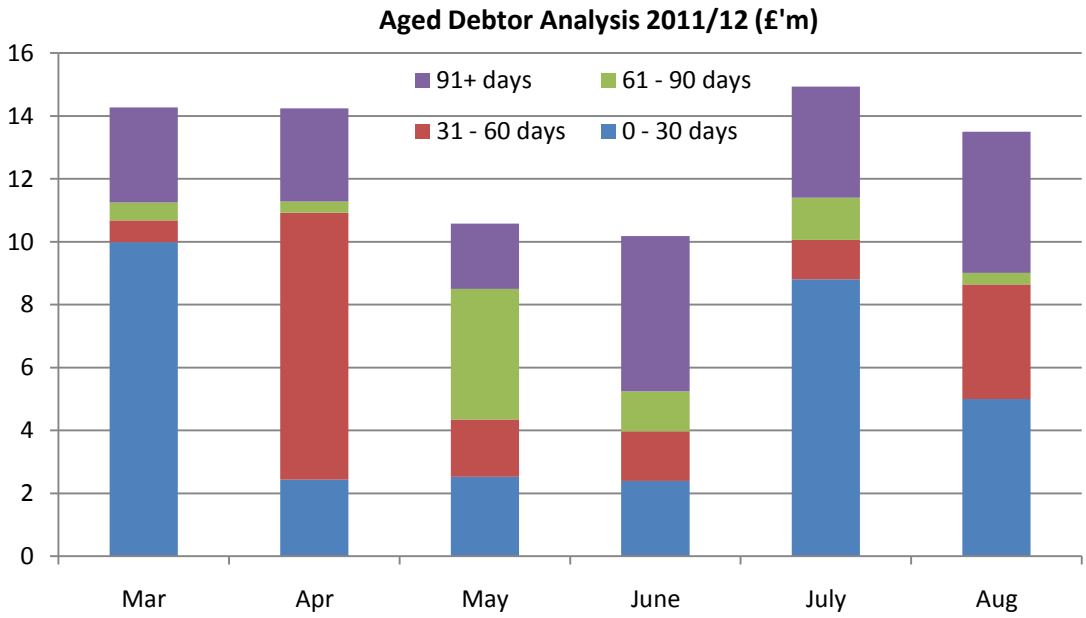
Expenditure for the five months to 31st August is £12.619m. Progress has been particularly strong on the Strategic and Information Management schemes where expenditure is ahead of plan by £1.897m and £0.808m respectively.

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

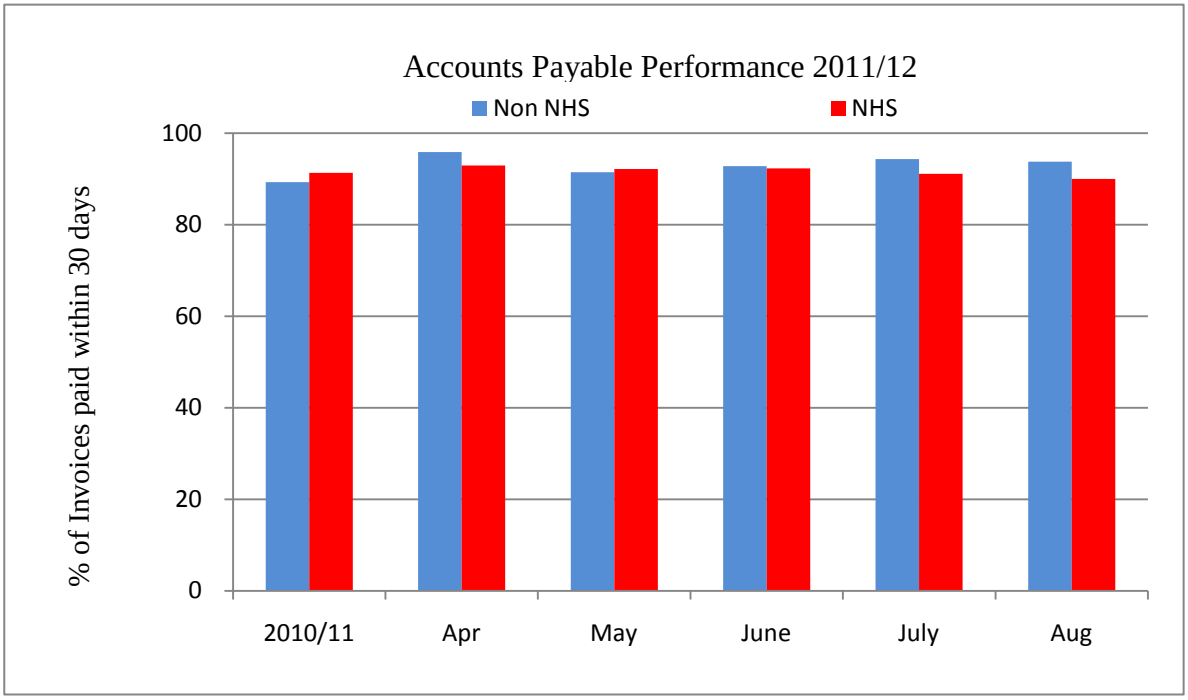
**Cash** - The Trust held a cash balance of £48.651m as at 31st August. The cash position is marginally greater than the forecast made at this point in the Annual Plan. The graph, shown below, sets out the current forecast for month end cash balances to March 2012.




**Debtors** - The total value of invoiced debtors has decreased by £1.431m during August to a closing balance of £13.498m. The principal change relates to the receipt of moneys from the Department of Health. The total amount owing is equivalent to 11.5 debtor days.



**Accounts Payable Payments** - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In August the Trust achieved 90% and 94% 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 August 2011 – Summary Income & Expenditure Statement

| Approved Budget / Plan 2011/12 | Heading | Position as at 31st August: Plan | Actual | Variance Fav / (Adv) | Actual to 31st July | Forecast Outturn |
|---|---|---|---|---|---|---|
| £'000 | | £'000 | £'000 | £'000 | £'000 | £'000 |
| | **Income (as per Table I and E 2)** | | | | | |
| 394,470 | From Activities | 162,623 | 162,684 | 61 | 129,181 | 398,415 |
| 104,620 | Other Operating Income | 43,385 | 43,482 | 97 | 34,852 | 102,794 |
| **499,090** | Sub totals income | **206,008** | **206,166** | **158** | **164,033** | **501,209** |
| | **Expenditure** | | | | | |
| (305,204) | Staffing | (127,767) | (129,467) | (1,700) | (103,438) | (306,198) |
| (146,676) | Supplies and services | (60,751) | (62,841) | (2,090) | (50,165) | (161,073) |
| **(451,880)** | Sub totals expenditure | **(188,518)** | **(192,308)** | **(3,790)** | **(153,603)** | **(467,271)** |
| (13,793) | **Reserves** Reserves | (4,021) | – | 4,021 | – | – |
| **(13,793)** | Sub Total Reserves | **(4,021)** | – | 4,021 | – | – |
| **33,417** | **EBITDA** | **13,469** | **13,858** | **389** | **10,430** | **33,938** |
| **6.70** | **EBITDA Margin – %** | | **6.72** | | **6.36** | **6.77** |
| – | Profit / loss on asset disposals | – | – | – | – | – |
| (305) | Fixed asset impairments | (305) | (305) | – | (244) | (732) |
| (17,742) | Depreciation & Amortisation | (7,578) | (7,578) | – | (6,044) | (17,949) |
| 193 | Interest Receivable | 80 | 157 | 77 | 116 | 300 |
| (428) | Interest payable on loans & leases | (178) | (171) | 7 | (137) | (428) |
| (9,129) | PDC Dividend | (3,804) | (3,804) | – | (3,043) | (9,129) |
| **6,006** | **NET SURPLUS / (DEFICIT)** | **1,684** | **2,157** | **473** | **1,078** | **6,000** |
| **1.20** | **Net margin – %** | | **1.05** | | **0.66** | **1.2** |

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

| Approved Budget / Plan 2011/12 | Division | Total Net Expenditure / Income to Date | Position as at 31st August [Favourable / (Adverse)] Pay | Non Pay | Operating Income | Income from Activities | Total Variance to date | Memorandum CRES Variance to Date | Cumulative Variance to 31st July | Forecast Outturn Variance |
|---|---|---|---|---|---|---|---|---|---|---|
| £'000 | | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| | **Service Agreements** | | | | | | | | | |
| 389,204 | Service Agreements | 160,684 | – | – | (41) | 41 | – | – | – | – |
| (1,000) | Overheads | (1,059) | – | – | – | (59) | (59) | – | (669) | – |
| 40,077 | NHSE Income | 16,764 | – | – | – | – | – | – | – | – |
| **428,281** | **Sub Total Service Agreements** | **176,389** | **–** | – | **(41)** | **(18)** | **(59)** | **–** | **(669)** | **–** |
| | **Clinical Divisions** | | | | | | | | | |
| (42,228) | Diagnostic & Therapies | (17,426) | (112) | (149) | (167) | 288 | (140) | (378) | (114) | – |
| (54,663) | Medicine | (23,719) | (420) | (529) | 143 | 109 | (697) | (899) | (416) | – |
| (65,047) | Specialised Services | (26,690) | (642) | 42 | 8 | (214) | (806) | (630) | (797) | (757) |
| (86,704) | Surgery Head & Neck | (36,640) | (168) | (632) | 142 | (160) | (818) | (1,822) | (508) | – |
| (84,807) | Women's & Children's | (36,414) | (621) | (257) | (31) | 39 | (870) | (682) | (806) | – |
| **(333,449)** | **Sub Totals (1)** | **(140,889)** | **(1,963)** | **(1,525)** | **95** | **62** | **(3,331)** | **(4,411)** | **(2,641)** | **(757)** |
| | **Corporate Services** | | | | | | | | | |
| (1,318) | Trust Wide Accruals | (1,318) | | | – | – | – | – | – | |
| (1,844) | Central Services | (843) | (21) | (62) | 2 | – | (81) | (55) | (66) | (120) |
| (52) | Community | (10) | – | 11 | – | – | 11 | (1) | 10 | – |
| (6,499) | Trust HQ | (2,945) | 54 | (141) | 47 | – | (40) | (7) | (44) | (120) |
| (5,240) | Human Resources | (2,098) | 75 | (32) | (18) | – | 25 | 5 | 20 | – |
| (5,174) | Information Technology | (2,176) | 96 | (75) | (16) | – | 5 | – | 1 | – |
| (5,058) | Finance | (2,046) | 61 | (11) | (22) | – | 28 | (30) | 22 | 30 |
| (25,799) | Facilities & Estates | (10,513) | 69 | (95) | 6 | (12) | (32) | (135) | (47) | – |
| (6,557) | Misc Support Services | (3,058) | (92) | (62) | 42 | 29 | (83) | (215) | 27 | (410) |
| 8,388 | Research and Development | 2,834 | 52 | (50) | 6 | – | 8 | – | (10) | 29 |
| (25,940) | Capital Charges | (11,172) | – | – | – | – | – | – | – | – |
| **(75,093)** | **Sub Totals (2)** | **(33,345)** | **294** | **(517)** | **47** | **17** | **(159)** | **(438)** | **(87)** | **(591)** |
| | | | | | | | | | | |
| **(408,542)** | **Sub Totals (1) and (2)** | **(174,234)** | **(1,669)** | **(2,042)** | **142** | **79** | **(3,490)** | **(4,849)** | **(2,728)** | **(1,348)** |
| – | **Skills for Health** | 2 | (31) | 36 | (4) | – | 1 | – | 6 | |
| **(408,542)** | **Totals I & E** | **(174,232)** | **(1,700)** | **(2,006)** | **138** | **79** | **(3,489)** | **(4,849)** | **(2,722)** | **(1,348)** |
| | **Reserves** | | | | | | | | | |
| (13,733) | General | – | – | 4,021 | – | – | 4,021 | – | 3,604 | 1,348 |
| **(13,733)** | **Sub Total Reserves** | **–** | **–** | **4,021** | **–** | **–** | **4,021** | **–** | **3,604** | **1,348** |
| | | | | | | | | | | |
| **6,006** | **TRUST TOTALS** | **2,157** | **(1,700)** | **2,015** | **97** | **61** | **473** | **(4,849)** | **213** | – |

**Analysis of pay spend 2010/11 and 2011/12**

| Division | | 2009/10 Total £'000 | 2010/11 Total £'000 | 2011/12 April £'000 | May £'000 | June £'000 | Q1 £'000 | July £'000 | August £'000 | YTD Total £'000 | Mthly Average £'000 | 2009/10 Mthly Average £'000 | 2010/11 Mthly Average £'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Women's and Children's | Pay budget | 62,853 | 65,891 | 5,560 | 5,526 | 5,552 | 16,638 | 5,535 | 5,617 | 27,790 | 5,558 | 5,238 | 5,491 |
| | Bank | 1,946 | 2,076 | 119 | 165 | 212 | 496 | 169 | 165 | 830 | 166 | 162 | 173 |
| | Agency | 370 | 654 | 39 | 88 | 55 | 182 | 40 | 59 | 281 | 56 | 31 | 55 |
| | Waiting List initiative | 502 | 304 | 26 | 25 | 22 | 73 | 16 | 24 | 113 | 23 | 42 | 25 |
| | Overtime | 90 | 91 | 4 | 5 | 5 | 14 | 5 | 3 | 22 | 4 | 8 | 8 |
| | Other pay | 61,039 | 62,798 | 5,401 | 5,447 | 5,371 | 16,219 | 5,372 | 5,577 | 27,168 | 5,434 | 5,087 | 5,233 |
| | Total Pay expenditure | 63,947 | 65,923 | 5,589 | 5,730 | 5,665 | 16,984 | 5,602 | 5,828 | 28,414 | 5,683 | 5,329 | 5,494 |
| | Variance Fav / (Adverse) | (1,094) | (32) | (29) | (204) | (113) | (346) | (67) | (211) | (624) | (125) | (91) | (3) |
| Medicine | Pay budget | 40,756 | 41,745 | 3,391 | 3,635 | 3,537 | 10,563 | 3,477 | 3,437 | 17,477 | 3,495 | 3,396 | 3,479 |
| | Bank | 3,763 | 3,434 | 220 | 260 | 326 | 806 | 222 | 269 | 1,297 | 259 | 314 | 286 |
| | Agency | 521 | 559 | 30 | 62 | 65 | 157 | 59 | 21 | 237 | 47 | 43 | 47 |
| | Waiting List initiative | 361 | 315 | 9 | 10 | 11 | 30 | 3 | 0 | 33 | 7 | 30 | 26 |
| | Overtime | 48 | 69 | 4 | 6 | 13 | 23 | 5 | 5 | 33 | 7 | 4 | 6 |
| | Other pay | 37,314 | 38,883 | 3,262 | 3,253 | 3,346 | 9,861 | 3,225 | 3,208 | 16,294 | 3,259 | 3,110 | 3,240 |
| | Total Pay expenditure | 42,007 | 43,260 | 3,525 | 3,591 | 3,761 | 10,877 | 3,514 | 3,503 | 17,894 | 3,579 | 3,501 | 3,605 |
| | Variance Fav / (Adverse) | (1,251) | (1,515) | (134) | 44 | (224) | (314) | (37) | (66) | (417) | (83) | (104) | (126) |
| Surgery Head and Neck | Pay budget | 62,265 | 66,148 | 5,541 | 5,245 | 5,630 | 16,416 | 5,607 | 5,605 | 27,628 | 5,526 | 5,189 | 5,512 |
| | Bank | 2,592 | 2,100 | 119 | 127 | 204 | 450 | 183 | 152 | 785 | 157 | 216 | 175 |
| | Agency | 1,730 | 1,206 | 41 | 69 | 11 | 121 | (2) | 53 | 172 | 34 | 144 | 101 |
| | Waiting List initiative | 2,158 | 1,209 | 98 | 127 | 79 | 304 | 16 | 27 | 347 | 69 | 180 | 101 |
| | Overtime | 276 | 152 | 7 | 7 | 8 | 22 | 15 | 8 | 45 | 9 | 23 | 13 |
| | Other pay | 58,271 | 61,071 | 5,143 | 5,327 | 5,314 | 15,784 | 5,337 | 5,352 | 26,474 | 5,295 | 4,856 | 5,089 |
| | Total Pay expenditure | 65,027 | 65,738 | 5,408 | 5,657 | 5,616 | 16,681 | 5,549 | 5,592 | 27,822 | 5,564 | 5,419 | 5,478 |
| | Variance Fav / (Adverse) | (2,762) | 410 | 133 | (412) | 14 | (265) | 58 | 13 | (194) | (39) | (230) | 34 |
| Specialised Services | Pay budget | 32,323 | 33,790 | 2,669 | 3,066 | 2,900 | 8,635 | 2,829 | 2,865 | 14,329 | 2,866 | 2,694 | 2,816 |
| | Bank | 1,025 | 1,049 | 61 | 74 | 95 | 230 | 87 | 93 | 410 | 82 | 85 | 87 |
| | Agency | 363 | 654 | (69) | 230 | 82 | 243 | 116 | 104 | 463 | 93 | 30 | 55 |
| | Waiting List initiative | 587 | 537 | 51 | 42 | 45 | 138 | 34 | 29 | 201 | 40 | 49 | 45 |
| | Overtime | 119 | 20 | 2 | 0 | 1 | 3 | 1 | 1 | 5 | 1 | 10 | 2 |
| | Other pay | 30,949 | 32,290 | 2,684 | 2,813 | 2,786 | 8,283 | 2,857 | 2,765 | 13,905 | 2,781 | 2,579 | 2,691 |
| | Total Pay expenditure | 33,043 | 34,550 | 2,729 | 3,159 | 3,009 | 8,897 | 3,095 | 2,992 | 14,984 | 2,997 | 2,754 | 2,879 |
| | Variance Fav / (Adverse) | (720) | (760) | (60) | (93) | (109) | (262) | (266) | (127) | (655) | (131) | (60) | (63) |

## Analysis of pay spend 2010/11 and 2011/12

| Division | | 2009/10 Total £'000 | 2010/11 Total £'000 | 2011/12 April £'000 | May £'000 | June £'000 | Q1 £'000 | July £'000 | August £'000 | YTD Total £'000 | Mthly Average £'000 | 2009/10 Mthly Average £'000 | 2010/11 Mthly Average £'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Diagnostic & Therapies | Pay budget | 35,327 | 36,929 | 3,045 | 2,998 | 3,078 | 9,121 | 3,089 | 3,126 | 15,336 | 3,067 | 2,944 | 3,077 |
| | Bank | 537 | 544 | 46 | 50 | 48 | 144 | 35 | 43 | 222 | 44 | 45 | 45 |
| | Agency | 692 | 389 | 24 | 32 | 17 | 73 | 13 | 29 | 115 | 23 | 58 | 32 |
| | Waiting List initiative | 131 | 156 | 14 | 15 | 8 | 37 | 15 | 6 | 58 | 12 | 11 | 13 |
| | Overtime | 169 | 264 | 22 | 20 | 26 | 68 | 17 | 19 | 104 | 21 | 14 | 22 |
| | Other pay | 33,437 | 35,515 | 2,937 | 2,961 | 3,017 | 8,915 | 3,025 | 3,015 | 14,955 | 2,991 | 2,786 | 2,960 |
| | Total Pay expenditure | 34,966 | 36,868 | 3,043 | 3,078 | 3,116 | 9,237 | 3,105 | 3,112 | 15,454 | 3,091 | 2,914 | 3,072 |
| | Variance Fav / (Adverse) | 361 | 61 | 2 | (80) | (38) | (116) | (16) | 13 | (119) | (24) | 30 | 5 |
| Facilities & Estates | Pay budget | 17,714 | 18,706 | 1,398 | 1,532 | 1,727 | 4,657 | 1,567 | 1,647 | 7,871 | 1,574 | 1,476 | 1,559 |
| | Bank | 572 | 483 | 29 | 29 | 35 | 93 | 26 | 22 | 141 | 28 | 48 | 40 |
| | Agency | 1,295 | 1,300 | 128 | 105 | 118 | 351 | 148 | 99 | 598 | 120 | 108 | 108 |
| | Waiting List initiative | 19 | 7 | 1 | 1 | 0 | 2 | 0 | 0 | 2 | 0 | 2 | 1 |
| | Overtime | 1,178 | 1,160 | 79 | 95 | 112 | 286 | 97 | 53 | 436 | 87 | 98 | 97 |
| | Other pay | 14,944 | 15,591 | 1,164 | 1,300 | 1,448 | 3,912 | 1,281 | 1,435 | 6,628 | 1,326 | 1,245 | 1,299 |
| | Total Pay expenditure | 18,008 | 18,541 | 1,401 | 1,530 | 1,713 | 4,644 | 1,552 | 1,609 | 7,805 | 1,561 | 1,501 | 1,545 |
| | Variance Fav / (Adverse) | (294) | 165 | (3) | 2 | 14 | 13 | 15 | 37 | 65 | 13 | (25) | 14 |
| Trust Services | Pay budget | 26,181 | 26,763 | 4,191 | 472 | 2,177 | 6,840 | 2,240 | 2,124 | 11,204 | 2,241 | 2,182 | 2,230 |
| | Bank | 619 | 609 | 54 | 34 | 66 | 154 | 52 | 75 | 281 | 56 | 52 | 51 |
| | Agency | 196 | 209 | 13 | (4) | 0 | 9 | 21 | 5 | 35 | 7 | 16 | 17 |
| | Waiting List initiative | 3 | 7 | 1 | 1 | (3) | (1) | 0 | 0 | (1) | (0) | 0 | 1 |
| | Overtime | 88 | 108 | 8 | 6 | 4 | 18 | 3 | 4 | 25 | 5 | 7 | 9 |
| | Other pay | 25,114 | 26,087 | 4,244 | 514 | 2,228 | 6,986 | 1,927 | 2,074 | 10,987 | 2,197 | 2,093 | 2,174 |
| | Total Pay expenditure | 26,020 | 27,020 | 4,320 | 551 | 2,295 | 7,166 | 2,003 | 2,158 | 11,327 | 2,265 | 2,168 | 2,252 |
| | Variance Fav / (Adverse) | 161 | (257) | (129) | (79) | (118) | (326) | 237 | (34) | (123) | (206) | 13 | (21) |
| Trust Total (excl Skills for Health) | Pay budget | 277,419 | 289,972 | 25,795 | 22,474 | 24,601 | 72,870 | 24,344 | 24,421 | 121,635 | 24,327 | 23,118 | 24,164 |
| | Bank | 11,054 | 10,295 | 648 | 739 | 986 | 2,373 | 774 | 819 | 3,966 | 793 | 921 | 858 |
| | Agency | 5,167 | 4,971 | 206 | 582 | 348 | 1,136 | 395 | 370 | 1,901 | 380 | 431 | 414 |
| | Waiting List initiative | 3,761 | 2,535 | 200 | 221 | 162 | 583 | 84 | 86 | 753 | 151 | 313 | 211 |
| | Overtime | 1,968 | 1,864 | 126 | 139 | 169 | 434 | 143 | 93 | 670 | 134 | 164 | 155 |
| | Other pay | 274,844 | 286,411 | 24,835 | 21,615 | 23,510 | 69,960 | 23,024 | 23,426 | 116,411 | 23,282 | 22,904 | 23,868 |
| | Total Pay expenditure | 283,018 | 291,900 | 26,015 | 23,296 | 25,175 | 74,486 | 24,420 | 24,795 | 123,701 | 24,740 | 23,585 | 24,325 |
| | Variance Fav / (Adverse) | (5,599) | (1,928) | (220) | (822) | (574) | (1,616) | (76) | (374) | (2,066) | (413) | (467) | (161) |

NOTE: Other Pay includes all employer's oncosts.

| Key Issue | RAG | Executive Summary | Table |
|---|---|---|---|
| Service Level Agreement Income and Activity | G | For the year to date contract income is £0.40m lower than plan. This is net of the over performance adjustment of £0.81m which relates to 2010/11. The reported position includes the impact of the emergency marginal tariff reduction which is valued at £0.09m favourable (last month £0.38m adverse) and SLA Contract Penalties / Rewards at a net cost of £0.67m (July £0.29m).<br><br>A&E Attendances at 39,069 are 1,753 **higher** than planned. The average number of daily attendances is 320.<br>Emergency activity at 12,774 is 0.9% or 118 spells **higher** than planned.<br>Non Elective activity at 5,428 is 6.1% or 314 spells **higher** than planned.<br>Elective activity at 4,628 is 5.6% or 273 spells **lower** than planned.<br>Day case activity at 15,910 is 5.2% or 782 spells **higher** than planned.<br>Outpatient Procedure activity at 9,092 is 10.4% or 856 attendances **higher** than planned.<br>New Outpatients activity at 43,217 is 1.1% or 493 attendances **lower** than planned.<br>Follow up Outpatient activity at 102,903 is 0.2% or 139 attendances **lower** than planned.<br><br>An income analysis by commissioner is shown at Table INC 2.<br><br>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 five months to 31st August is £2.157m.<br>The EBITDA surplus of £13.858m equates to 102.9% of the Annual Plan target for the period.<br>Total income to date £206.2m is £0.158m greater than planned. This includes £0.810m of residual over performance relating to 2010/11.<br>Expenditure at £192.3m is higher than planned by £3.79m, this reflects higher than planned expenditure in a number of areas and slippage to date on CRES plans.<br>Financing costs are lower than plan by £84k. | I&E 1<br>I&E 2<br>I&E 3a<br>I&E 3b |
| Cash Releasing Efficiency Savings | R | The 2011/12 CRES programme totals £26.635m. Actual savings achieved for the five months to 31st August total £6.249m compared with a target for the period of £9.042m, a shortfall of £2.793m. | I&E 4a – 4b |

| Key Issue | RAG | Executive Summary | Table |
|---|---|---|---|
| Statement of Financial Position & Treasury Management | G | The cash balance on 31st August was £48.651m. The forecast cash balance for 31st March 2012 is £30.0m a small reduction when compared with the Annual Plan forecast of £30.312m.<br>The balance on Invoiced Debtors has decreased by £1.431m in the month to £13.498m. The invoiced debtor balance equates to 11.5 debtor days.<br>Creditors and accrual account balances total £62.479m although £10.889m relates to deferred income.<br>Invoiced Creditors - payment performance for the five months to 31st August for Non NHS invoices and NHS invoices within 30 days was 94% and 90% respectively. | BS 1<br>BS 2<br>BS 3<br>BS 4 |
| Capital | G | Expenditure for the five months to 31st August totals £12.619m - this is £0.818m greater than profiled for the period.<br>This reflects the position whereby the Strategic and Information Management schemes are progressing ahead of plan by £1.897m and £0.808m respectively. This is offset by slippage to date on Operational capital schemes (£1.110m) and Refurbishment / Maintenance schemes (£0.722m). | Capital 1<br>Capital 2 |
| Financial Risk Rating | G | The Trust's overall financial risk rating using the results for the five months to 31st August 2011 has been calculated to be 3 (actual score 3.45). 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 £1.113m or 0.68% of total patient related income. This is well below the Trust's Private Patient Cap of 1.1%. | |

**UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST**

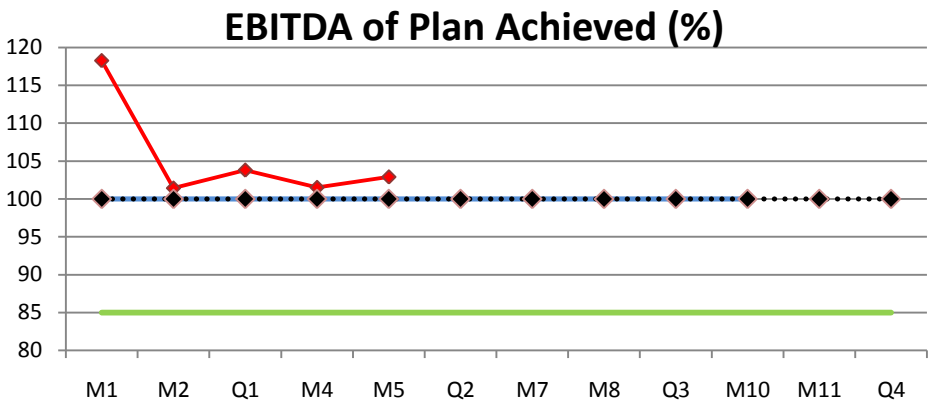
**Finance Report August 2011 - Risk Matrix**

| 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 | 12.0 | Programme Steering Group established. Monthly Divisional reviews to ensure targets are met. Benefits tracked and all schemes risk assessed. | JR | Medium | 6.0 | 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. | JR | 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 – August 2011 Performance

### 1. Financial Risk Rating

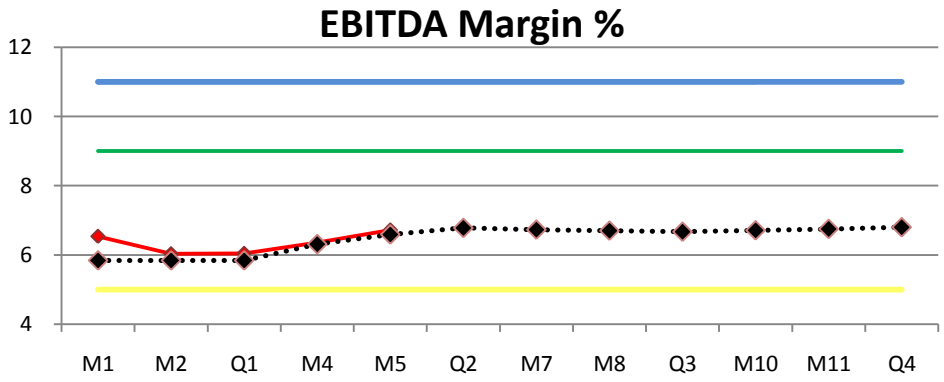
The following graphs will show performance against the 5 Financial Risk Rating metrics. The 2011/12 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 5 (blue line)**; **FRR 4 (green line)** and **FRR 3 (yellow line)**.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

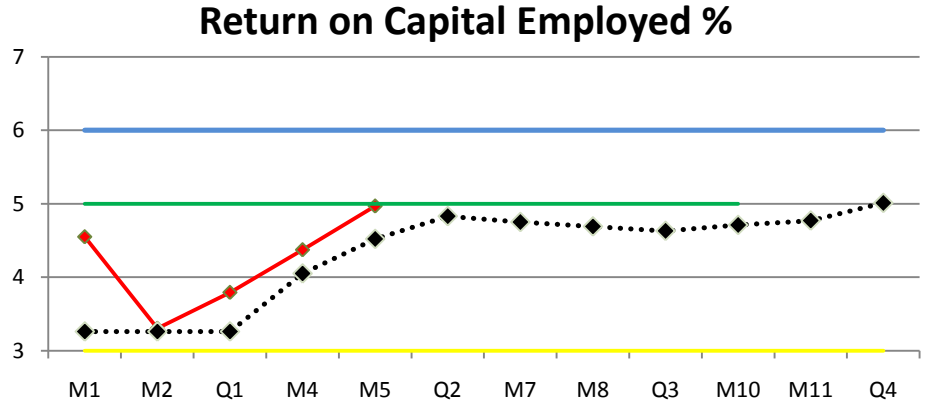



An EBITDA of £13.858m was achieved. This is 2.9% better than the proportion of the Annual Plan for the period value of £13.469m.

EBITDA Achievement of 102.9% of Plan earns a metric score of 5.

The EBITDA Margin of 6.72% for August achieves a metric score of 3. This is slightly better than the Annual Plan forecast of 6.59% to date.

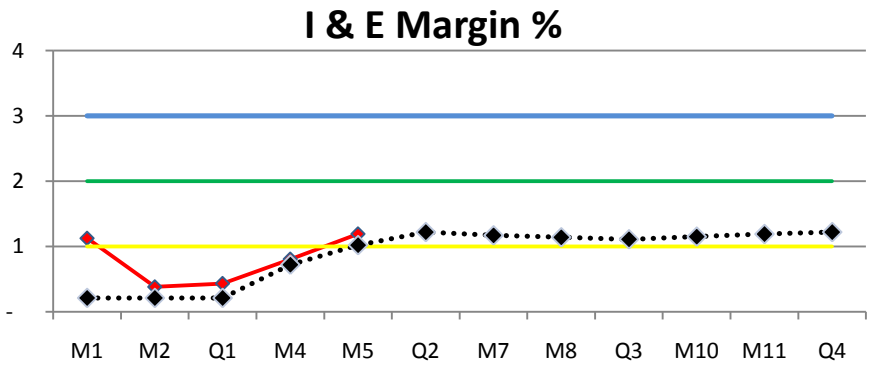


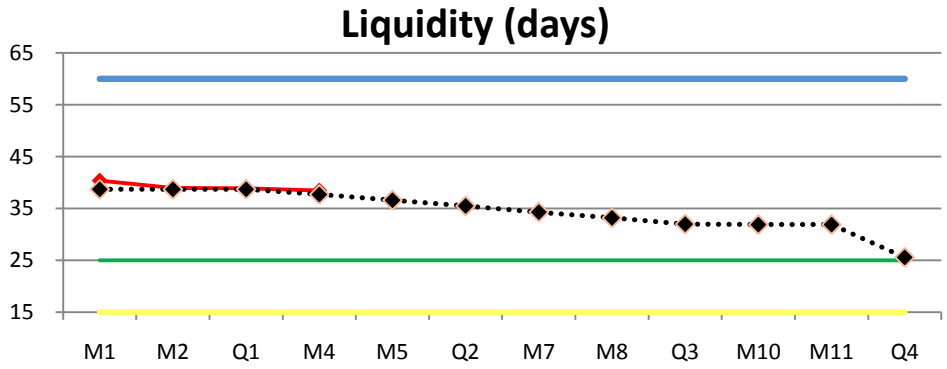




The planned Return on Capital Employed for the five months to August is 4.97%. The result earns a metric score of 3.

2011/12 Annual Plan Income & Expenditure surplus margin is 1.02% for the five months to 31st August.

The Income and Expenditure surplus margin for the period is 1.19%, a metric score of 3.




2011/12 Annual Plan liquidity ratio is 38.6 days at 31 August.

The actual liquidity ratio for August is 38.3 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 3.45. The improvement of 0.20 when compared with the FRR for July (3.25) is as a result of the increase in the income and expenditure margin in August. The Trust has therefore achieved a Financial Risk Rating of 3 for the five months to 31st August 2011.

## 2. Prudential Borrowing Limit

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

| Prudential Borrowing Limit Performance | Monitor Ratio Tier 1 | 31st August 2011 |
|---|---|---|
| Minimum Dividend Cover | >1x | 3.7x |
| Minimum Interest Cover | >3x | 82x |
| Minimum Debt Service Cover | >2x | 58x |
| 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 Public Trust Board Meeting, to be held on 28 September 2011 at 10:30 in the Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE**

## Item 11 – Bristol Haematology and Oncology Centre Business Case Development

### Purpose

To seek the Board's approval to proceed to Full Business Case Development in the absence of an approved Outline Business Case.

### Abstract


The Trust's Capital Investment Policy requires capital schemes in excess of 2% of Trust turn over to secure Board approval for both Outline and Full Business Cases.

The Outline Business Case for the £13.5m redevelopment of the BHOC was considered by the Finance Committee at its August meeting with a view to recommending approval to the Trust Board.

The Finance Committee was unable to recommend approval on the basis that the financial parameters set out within the Trust's Long Term Financial Plan (LTFP) were not met in either of the two options developed at OBC stage; as a consequence Board approval was not secured.

The Committee noted that the current do minimum option had even greater financial risk (capital) than the preferred option and represented poor value for money.

The Committee did however approve further expenditure on fees to enable work to be progressed with the aim of eliminating, as far as possible, the revenue and capital shortfall present at the OBC stage in the preferred option and requested that further work be done on a revised do minimum option.

A review of the BHOC programme and the programme interdependencies with the Centralisation of Specialist Paediatrics scheme, has confirmed that further work on the development of the OBC will jeopardise the CSP programme timeline for achievement of the milestone relating to transfer out of the Adult BMT service.

Extension of the current operational "work around" that is enabling Adult BMT to be retained in the Children's Hospital beyond the original programme timeline and now on to December 2013 will prevent completion of the CSP scheme as it was approved at FBC.
In light of the position described above, Board approval is now being sought to progress direct to Full Business Case noting that the FBC will present both the preferred option (4a) as presented in the OBC and an alternative do minimum option that retains adult BMT in the Children's Hospital either as a continuation of the current work around or an alternative solution.


### Recommendations

The Board is asked to **approve** the recommendation to proceed to development of a Full Business Case for the BHOC on the basis that the FBC fully develops two options and is developed in parameters consistent with the Long Term Financial Plan and Medium Term Capital Programme.

### Report Sponsor

| |
|---|
| Deborah Lee, Director of Strategic Development |
| **Appendices** |
| • Appendix A – Executive Summary, BHOC Outline Business Case |

**Previous Meetings**

| Executive Team | Trust Management Executive | Quality and Outcomes Committee | Finance Committee | Audit Committee | Other – partnership Programme Board |
|---|---|---|---|---|---|
| N/A | N/A | N/A | 22 August 2011 | N/A | 30 August 2011 |

# Executive Summary

## Executive Summary

### Introduction

1. This Outline Business Case (OBC) sets out the proposals for the redevelopment of the Bristol Haematology and Oncology Centre (BHOC) site to achieve:

   - a combined adult Bone Marrow Transplant (BMT) and Haematology service, including the transfer of Specialised Therapeutic Services from Southmead Hospital;
   - a new Teenage and Young Adults (TYA) cancer unit;
   - enhanced radiotherapy services to provide radiotherapy to modern standards.

2. The adult BMT service is situated within the Bristol Royal Hospital for Children (BRHC) in a combined unit with paediatric BMT and the Specialised Therapeutic Service (hereafter known as Apheresis Service) is located on the North Bristol Campus.

3. A full business case was approved in March 2011 for the centralisation of specialist paediatrics services in Bristol which will require additional capacity in the BRHC. The increasing numbers of adult patients treated within the unit has led to a growing view that it is inappropriate to continue to develop an adult service within the BRHC. This transfer will ensure that adult BMT is provided in an age appropriate environment.

4. Allogeneic BMT facilities are typically co-located with other adult haematology services, in particular those treating patients with haematological malignancies. There are compelling clinical reasons why such an arrangement is beneficial to patient care. The combination of the two units will enable the delivery of more flexible and cost-effective patient care.

5. BHOC is the nominated TYA Principle Treatment Centre (PTC) for the South-west and has received notification that designation has been approved. However, one major area of non-compliance is the lack of age appropriate facilities, the provision of which the Teenage Cancer Trust (TCT) wish to fund. This proposal will ensure that teenage and young adults with cancer are treated in an age appropriate environment.

6. BHOC provides the majority of radiotherapy within the Avon, Somerset and Wiltshire Cancer Network (ASWCS). BHOC provides regional services for stereotactic radiotherapy, total body irradiation and paediatrics. There are some cross-border flows with Wiltshire, Dorset and Gloucestershire. The current service provides a full range of radiotherapy services from six bunkers housing five linacs, open 9am – 5pm, Monday to Friday.

7. In order to maintain this capacity there is a need for a new build of two bunkers given the constraints in the current estates provision, ie that two bunkers are too small in shape, size and shielding for current treatment machines.

8. In addition this business case supports the Trust's vision for specialist services to deliver the highest quality specialist services to the population of the South West and beyond in order to secure the best possible outcomes for patients with complex and less common conditions, which are recognised as needing specialist treatment.

### Strategic Context and Case for Change

9. The haematology unit, which is one of the largest four units in the UK, is internationally recognised and has documented excellent clinical outcomes. In 2010 there were 53 allografts and >35 donor lymphocyte infusions which resulted in over £6 million income.

10. Allogeneic BMT facilities are typically co-located with other adult haematology services, in particular those treating patients with haematological malignancies.

11. The NICE IOG (Improving Outcomes Guidance) for Children and Young People with Cancer (CYPC) recommends that TYA services are developed to help improve the impact of the diagnosis of cancer in this group as well as survival rates. The IOG suggests a similar model of care to paediatrics, with care divided between a Principle Treatment Centre (PTC) (which must be co-located with the paediatric PTC, ie Bristol) and shared care hospitals across the region. A strong recommendation in the IOG is that those under 19 years must be treated in age appropriate facilities under the direction of the PTC and 19-24 years must have unhindered access to age-appropriate facilities and can choose treatment in PTC or within shared-care hospitals.

12. The rationale for transferring adult BMT from BRHC is as follows:

- A major service reconfiguration is planned so that paediatric services provided throughout Bristol may be housed within the BRHC. This will require reorganisation and the generation of additional space. Moving the adult BMT service out of the BRHC is a major component of this reorganisation.
- All care for adult patients will be delivered by medical staff and nurses trained in adult haemato-oncology in an age-appropriate environment.
- Merging of the adult BMT unit with the AHU will consolidate adult level 3 and level 4 haemato-oncology services into one unit enabling reconfiguration of the medical and nursing staff and greater flexibility in the provision of beds. Haematological nursing expertise (including clinical nurse specialists) would be concentrated in one unit with possible increased efficiency.
- Improved access to adult support services within the BHOC eg physiotherapy /OT /discharge planning/psychology services.
- Provision of a seamless service for local transplant patients who will be cared for within one ward unit as opposed to two separate hospitals and there would be increased input from AHU consultants in the care of the patients they refer for transplant.

13. The rationale for transferring specialised therapeutic services to UH Bristol is as follows:

- Reduced clinical risk - less movement of complex and sick patients across the city;
- Improved communication between apheresis and clinical haematology services;
- Research and Development opportunity;
- Greater control over costs for UH Bristol and potential revenue generation with service expansion and development in joint partnership with NHSBT;
- Opportunity for the development of extracorporeal photo chemotherapy (ECPC).

14. Teenage Cancer Trust (TCT) have commissioned research into the effects of the built environment on patients and their families which clearly indicated that age appropriate facilities have a positive impact on cancer treatment delivery and compliance for this vulnerable age group and allow a normalisation of life despite cancer. TCT have confirmed their wish to support the Trust in developing age-appropriate facilities. They have already launched a local appeal and are happy to consider funding either internal refurbishment or a new build.

## Capacity Planning

15. The conclusion of the capacity planning assessment is that, in 2012/13:

- The BMT transfer from BRHC is assessed at 5.3 Inpatient beds. A further 2.9 Day Case and Regular Attender spaces also transfer at this time. This leaves a demand for an estimated 6.1 Inpatient beds and 0.8 Day Case spaces at the BRHC for Paediatric BMT;
- For Adult BMT already at the BHOC, the total Inpatient demand is estimated at 3.1 beds, with a further 0.2 Day Case and Regular Attender spaces required;
- The assumed repatriation of c.10 BMT cases per annum from outside the region is estimated to have an impact of 1.0 Inpatient bed;
- For Haematology, the requirement is circa 12.1 Inpatient beds and 13.4 Day Case spaces;
- A combined Inpatient BMT & Haematology Unit of 21.5 beds is therefore required to accommodate average Inpatient demand at 80% occupancy, in addition to facilities with capacity for 16.5 Day Case spaces;
- The transfer of one Adult BMT Outpatient Clinic per week from BRHC to BHOC is assumed to be absorbed within existing BHOC capacity.

16. The table below summarises the overall BHOC bed requirements as at 2012/13.

*Summary BHOC BMT & Haematology Requirements, 2012/13*

| 2012/13 | Inpatient Beds | Day Spaces | Outpatient Clinics |
|---|---|---|---|
| BMT from BRHC | 5.3 | 2.9 | 1 |
| BMT already at BHOC | 3.1 | 0.2 | - |
| BMT repatriation | 1.0 | 0 | - |
| Haematology | 12.1 | 13.4 | - |
| **Total** | **21.6** | **16.5** | **1** |

17. This assessment suggests that the proposed built facility for the combined Adult BMT & Haematology Unit should be at a minimum of 21 beds in 2012/13. Further provision for 17 day spaces and one Outpatient clinic is also required. However, this assessment has been challenged by the clinicians based upon their working knowledge of the demand for beds in the existing units The current build solution is therefore designed to 24 Inpatient bed spaces and 17 day spaces to be reviewed at full business case stage following additional capacity planning assessments.

18. The remaining demand for the Paediatric BMT service at BRHC is assessed as 6.1 Inpatient beds and 0.8 day spaces, in 2012/13. The future accommodation solution for Paediatric BMT is described as part of the CSP Full Business Case.

19. The capacity planning assessment indicates an average demand for 2.9 Inpatient beds and 1.2 Day Case chairs that fall within the criteria of the TYA facility. The TYA inpatient unit design is currently for 5 beds as supported by the Teenage Cancer Trust. Again, this will be reassessed at full business case.

*Summary TYA Facilities Required (2012/13)*

| TYA 2012/13 | Inpatient Beds | Day Spaces |
|---|---|---|
| From BRHC | 1.3 | 0.4 |
| From BHOC | 1.7 | 0.8 |
| **Total** | **2.9** | **1.2** |

## Model of care

### Haematology and Adult BMT.

20. Within the NHS, combined adult haematology/BMT units are the norm and are considered a standard model of care. Examples of such units are those found in Nottingham, Oxford (visited by the clinical team from Bristol) and Leeds. A merged unit would significantly improve continuity of care, patient flows and the support given to patients and their families as well as providing greater flexibility in the provision of beds**.**

21. The skills required of nursing and medical staff looking after haematology and transplant patients are virtually identical as are the facilities required to provide such care. It is clear that recruitment, particularly nursing staff, for specialist units can at times be difficult, and these problems would be compounded by the necessary duplication required if the units were separate.

22. Bed numbers need to be adequate for re-admission of patients with complications of therapy, both immediate and long term if transplant-related**.** A combined unit will give greater flexibility as it will be able to manage the peaks and troughs of demand more ably and will mitigate against any requirement for additional beds should repatriation or growth result in an increase in activity.

23. Patient accommodation also needs to be flexible enough to be able to cope with changes in practice over time e.g. reduced intensity conditioning (RIC) transplants which are increasing in numbers when compared to full intensity conditioning transplants. These tend to be initially relatively free of complications because of the reduced toxicity associated with lower doses of chemotherapy. There needs to be enough flexibility to introduce innovative ways and working, and to be able to be responsive to changes in clinical practice.

24. Facilities for the isolation and assessment of infectious out-patients are crucial for all haematology/BMT patients. In a combined unit, the same facilities could be used. However, if the units were separate, two facilities would be required.

25. The continuity of care for Bristol and Weston patients with leukaemia and lymphoma who proceed to allogeneic stem cell transplantation would be significantly improved and the practical and administrative difficulties of working across two sites would be resolved. Currently patients have two sets of notes, care is frequently transferred back and forth between the two units and perfect communication is hard to achieve under these circumstances.

26. The matrix shown below seeks to represent the key adjacencies that exist between the various services.

*Key adjacencies*

| | Haem day unit | BMT day unit | Haem in-patients | BMT in-patients | Apheresis Service | Haemophilia | Appropriate office space* |
|---|---|---|---|---|---|---|---|
| **Haematology day unit** | N/A | High | Medium | Medium | Medium | High | High |
| **BMT day unit** | High | N/A | Medium | Medium | Medium | Low | High |
| **Haematology in-patients** | Medium | Medium | N/A | High | Low | Medium | High |
| **BMT in-patients** | Medium | Medium | High | N/A | Low | Low | High |
| **Apheresis Service** | Medium | Medium | Low | Low | N/A | Low | High |
| **Haemophilia** | High | Low | High | Low | Low | N/A | High |
| **Appropriate office space*** | High | High | High | High | High | High | N/A |

***** Appropriate office space is for staff working directly with patients (e.g. medical co-ordinators, clinical nurse specialists, unit sister and hot desks for other clinical staff

27. A summary of the adjacencies in order of priority:

**High priority:**

- Haematology and BMT in-patient beds
- Haematology and BMT day unit facilities
- Haemophilia with day unit facilities
- Appropriate clinical office accommodation to facilitate clinical working in all areas

**Medium priority:**

- All inpatient with all day unit facilities
- Apheresis with day unit facilities

**Low priority:**

- Apheresis with inpatient facilities
- Haemophilia with BMT

28. The clinicians and divisional management team supported a stand-alone, single floor integrated unit as opposed to a split level option within BHOC. This is supported by the more objective measures in the clinical and financial option appraisals.

### Patient pathways

29. **Planned.** Planned admissions for haematology and BMT will be jointly considered before TCIs agreed in order to reduce peaks and troughs of activity. Long stays for BMT patients (3-4 weeks) to be expected

30. **Unplanned**. The same process will exist for both BMT and haematology patients. Emergencies will attend 24 hours a day (in hours, to the day unit; out of hours to the ward where they will be reviewed in an assessment room adjacent to the ward). Patients may be: direct admissions, via A&E, via GP referral

31. **Day cases**. Day cases fall into a number of categories depending on the patient group. These fall into 2 main categories –emergency and planned attendances. A proportion of all these patients require ward admission.

### TYA

32. There has been extensive discussion between the paediatric service, adult service and patients, about the model of care, facilities and workforce required to become IOG compliant, and to deliver best care to the TYA age group. This has resulted in the following agreed model (working on the principle that all patients up to the age of 16 must be treated in the Principle Treatment Centre).

*TYA model of care*

| | **BRHC** | **BHOC** |
|---|---|---|
| **Two inpatient areas** | All patients aged 13-15<br>Patients aged 16 to their 18th birthday can choose to be treated at BCH | Patients from 16 to 24 |
| **Two day care areas** | Patients up to 16 | Patients from 16-24<br>Including “chill out”/ social area |

33. In addition there would be off-site accommodation for families and parents and a drop-in centre for young people and their families/ friends.

34. This outline business case concentrates on the inpatient and day care area within BHOC.

## Option Appraisal

### Benefits Criteria

35. Previously, option appraisal exercises have been undertaken for the individual elements of the BHOC strategy. For consistency, a standardised set of benefits criteria was agreed by the Programme Board for the purposes of this OBC.

*Benefits criteria*

| Benefit criteria | Supporting definition |
|---|---|
| I. Model of care adjacencies | Maximise clinical service provision by providing optimal clinical adjacencies |
| II. Maintenance of Clinical Service | Minimise disruption to services during construction and refurbishment |
| | Minimise need for decanting requirements |
| III. UH Bristol Strategic Fit | Support estate rationalisation |
| | Improve the efficiency and value for money of services |
| IV. Achievability | Meets required programme |
| | Complexity of construction |

## Long List of Options

36. A process was adopted that considered a range of benefit criteria and options to meet those requirements.

37. A long list of options was developed, though this was limited given the constraints of the project. The options were then evaluated against the benefits criteria, project objectives, constraints and dependencies to produce a short-list of options. These are set out in Table 3 overleaf.

*Long List of Options*

| Option | |
|---|---|
| | **Adult BMT, STS & TYA** |
| 1 | New build two storey over existing side car park to BHOC |
| 2 | Three storey over existing side car park to BHOC plus new build extension to Level 4 (over flat roof) |
| 3 | New Build two storey on Marlborough Hill Car Park |
| 4 | New build three storey in front of BHOC |
| 5 | Do Minimum |
| 6 | Do Nothing |
| | **Radiotherapy** |
| A | New Linacs Under BHOC Car Park |
| Aa | New Linacs on Car Park |
| B | New Linacs in extension to rear of BHOC |
| C | Remodelling of existing linac bunkers |
| D | Part demolition/part extension to rear of BHOC |
| E | Do Nothing |

## Short-listing of Options

38. The long list of options has been compared against their ability to meet the objectives and constraints of the project. The results of this are set out below, where ✓ indicates the option meets the objective.

*Short-listing against Objectives*

| Criteria | Option | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | A | Aa | B | C | D | E |
| **Model of Care Adjacencies** | ✓ | ✓ | × | ✓ | × | × | ✓ | ✓ | ✓ | × | × | × |
| **Maintenance of Clinical Services** | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | × | ✓ |
| **UHB Strategic Fit** | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | × | × | × |
| **Achievability** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

39. The following options 1, 2, 4, A, Aa and B meet all the project objectives:-

- Option 1 - New build two storey over existing side car park to BHOC
- Option 2 - Three storey over existing side car park to BHOC plus new build extension to Level 4 (over flat roof)
- Option 4 - New build three storey in front of BHOC
- Option A – Two replacement Linacs Under BHOC Car Park
- Option Aa – Two replacement Linacs on Car Park
- Option B – Two replacement Linacs in extension to rear of BHOC

40. These options have therefore been short-listed and taken forward into the non-financial appraisal against benefits criteria.

41. Although the Do Minimum option (option 5) for Adult BMT and STS does not support the preferred Model of Care, it does meet the other benefit criteria and so should also be shortlisted for further consideration accordingly.

## Non-Financial Benefits Appraisal

### Benefit Criteria and Weights

42. The benefit criteria were ranked individually to provide an overall ranking, and then allocated a weighting as a group using the weighted pairs technique, as recommended in the Capital Investment Manual. The results are shown in the table below.

*Weighting of Benefit Criteria*

| Benefit Criteria | Ranking | Weighting |
|---|---|---|
| Model of Care Adjacencies | 1 | 4 |
| Achievability | 2 | 3 |
| Maintenance of Clinical Services | 3 | 2 |
| UH Bristol Strategic Fit | 4 | 1 |
| **Total** | | **10** |

### Scoring of Options

43. At a benefit appraisal workshop, each of the short-listed options was then scored against each of the benefit criteria. In order to ensure consistency of scoring by each member involved

44. The groups discussed and agreed a score for each option. This score was then multiplied by the weighting for each of the benefit criteria to give a weighted score. The result of the scoring exercise is shown in the tables overleaf.

*Scoring of Options*

| LINAC Option | Weighting | A | | Aa | | B | |
|---|---|---|---|---|---|---|---|
| | | score out of 10 | weighted score | score out of 10 | weighted score | score out of 10 | weighted score |
| Model of Care Adjacencies | 4 | 10 | 40 | 6 | 24 | 6 | 24 |
| Maintenance of Clinical Service | 2 | 7 | 14 | 6 | 12 | 6 | 12 |
| UHB Strategic Fit | 1 | 10 | 10 | 10 | 10 | 6 | 6 |
| Achievability | 3 | 5 | 15 | 9 | 27 | 3 | 9 |
| TOTAL | 10 | | 79 | | 73 | | 51 |

| Accommodation Option | | 1 | | 2 | | 4 | | 5 | |
|---|---|---|---|---|---|---|---|---|---|
| | | score out of 10 | weighted score | score out of 10 | weighted score | score out of 10 | weighted score | score out of 10 | weighted score |
| Model of Care Adjacencies | 4 | 8 | 32 | 8 | 32 | 8 | 32 | 2 | 8 |
| Maintenance of Clinical Service | 2 | 7 | 14 | 8 | 16 | 7 | 14 | 10 | 20 |
| UHB Strategic Fit | 1 | 10 | 10 | 8 | 8 | 10 | 10 | 8 | 8 |
| Achievability | 3 | 6 | 18 | 5 | 15 | 7 | 21 | 5 | 15 |
| TOTAL | 10 | | 74 | | 71 | | 77 | | 51 |

| Combined | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Accommodation Option** | | **1** | | **2** | | **4** | | **5** | |
| **Bunker Option** | | | | | | | | | |
| **A** | | | 153 | | 150 | | 156 | | 87 |
| **Aa** | | | 147 | | 144 | | 150 | | 124 |
| **B** | | | 125 | | 122 | | 128 | | 102 |

| DESCRIPTION OF OPTIONS | | | |
|---|---|---|---|
| **Radiotherapy Options** | | **Adult BMT, STS & TYA Options** | |
| A | Replacement Linacs Under BHOC Car Park | 1 | Adult BMT & STS new build accommodation linking to Level 3 of BHOC (existing Ward 62)<br>TYA on single level linking to Level 2 of BHOC |
| Aa | Replacement Linacs on BHOC Car Park | 2 | Adult BMT, STS and Haematology combined inpatients on Level 3 with combined day units on Level 4.<br>TYA on two storey linking to Level 1 & 2 of BHOC.<br>CTU and PSU displaced. |
| B | Replacement Linacs in extension | 4 | Adult BMT & STS new build accommodation linking to Level 3 of BHOC.<br>TYA new build accommodation linking to Levels 1 & 2 of BHOC. |
| | | 5 | Adult BMT & STS refurbished standalone unit on Level 4.<br>Displaces CTU and PSU. TYA |

| | | | |
|---|---|---|---|
| | | | undertakes separate new build as standalone, externally funded project. |

45. The non-financial appraisal has resulted in combined option 4A scoring the highest with a very small marginal difference between Options 1A, 2A and 4Aa.

46. Option 4A and the Do Minimum option will be subject to financial appraisal in the following section to assess their financial affordability and demonstrate value for money.

## Financial Appraisal

47. The recurring revenue financial appraisal considers three options all with scheme completion by Autumn 2013. The three options are:

- Option 5 is the do minimum. This option accommodates the BMT transfer of 6 inpatient beds and 5 day spaces as a standalone facility on level 4 of the BHOC and includes the extension of two underground bunkers to house the linear accelerators.
- Option 4A. This option provides BMT and Haematology services as a 24 bedded integrated unit with 17 day spaces. It also includes the provision of a 5 bed and Teenage and Young Adult facility, accommodates the NHS Blood and Transplant Service's Apheresis Service currently located at Southmead Hospital and includes the extension of two underground bunkers to house the linear accelerators.
- Option 4Ai. This option provides BMT and Haematology services as a 21 bedded integrated unit. It also includes the provision of a 3 bed and Teenage and Young Adult facility, accommodates the NHS Blood and Transplant Service's Apheresis Service currently located at Southmead Hospital and includes the extension of two underground bunkers to house the linear accelerators.

48. The recurring revenue consequences are summarised below:

*Summary of recurring revenue cost*

| | 2012/13 | | |
|---|---|---|---|
| | **Option 5** | **Option 4A** | **Option 4Ai** |
| | **£'000** | **£'000** | **£'000** |
| Income | 0 | 0 | 0 |
| Revenue cost | -608 | -618 | -361 |
| **Net Revenue Cost** | **-608** | **-618** | **-361** |

49. The recurring revenue cost of option 5 is £0.608 million. Option 4A and option 4Ai incur on-going revenue costs of £0.618 million and £0.361 million respectively.

50. The capital financial appraisal considers the build solutions for the three options outlined above.

51. Option 4A and 4Ai includes charitable donations from two charities. The value of the confirmed charitable donations is displayed below. A further £2m of charitable donations are anticipated but as yet unsecured, so not included in the table below:

*Summary of capital cost*

| | 2012/13 | | |
|---|---|---|---|
| | **Option 5** | **Option 4A** | **Option 4Ai** |
| | **£'000** | **£'000** | **£'000** |
| Gross capital cost | 10,847 | 13,580 | 13,580 |
| Charitable donations | 0 | -4,500 | -4,500 |
| **Net Capital Cost** | **10,847** | **9,080** | **9,080** |

52. The net capital cost of option 5 is the highest at £10.847 million. The receipt of £4.5 million in charitable donations under options 4A and 4Ai result in a net capital cost of £9.08 million. This would reduce to £7.08m once the additional £2m charitable donations are secured.

53. The Trust's 2011/12 – 2016/17 capital programme includes funding of £7.0 million for the BHOC scheme.

## Affordability

54. The capital cost of the BHOC OBC is £10.847 million under option 5 and £13.58 million under option 4A and 4Ai. The Trust's 2011/12 – 2016/17 Capital Programme provides funding of £7.0 million.

55. The capital cost of option 5 exceeds the available funding within the Trust's 2011/12 – 2016/17 Capital Programme and is therefore unaffordable.

56. The affordability of option 4A and 4Ai is dependent upon secured charitable donations of £4.5 million cost. Both options assume secured charitable donations of £4.5 million in support of the scheme. In addition, a further £2m of charitable donations is required which is as yet unsecured.

57. The overall recurring revenue cost of option 5 is £0.608 million, £0.618 million under option 4A and £0.361 million under option 4Ai.

58. The project will also incur non-recurring revenue or transitional costs. Such costs are excluded from the recurring financial appraisal. These are summarised below:

*Transitional costs*

| | **Option 5 £'000** | **Option 4A £'000** | **Option 4Ai £'000** |
|---|---|---|---|
| Car parking income loss | | 104 | 104 |
| Other | | | |
| **Total** | **0** | **104** | **104** |

59. The car parking income loss is due to the temporary loss of car parking spaces at BHOC during the construction phase.

60. The Trust's Financial Strategy was approved in December 2006 by the Trust Board and includes the following key principles:

- Key Strategic schemes will be afforded by the creation of a Strategic Reserve which will grow from the use of tariff funds for capital growth plus 25% of new activity tariff income. The Strategic Reserve then funds the infrastructure costs of strategic developments;
- Surpluses generated by positive balances in the Strategic Reserve will only be used for non-recurring purposes including improving liquidity, supplementing the capital programme, funding work in progress charges and repayment of loan balances;
- Savings requirements will be set between 0.25% and 0.5% above the level of national tariff efficiency savings. From this balance non-nationally funded cost pressures will be met. These may include the loss of Research and Development funding, local cost pressures, under-funded National initiatives etc.;
- The decisions on which cost pressures will be funded are from a prioritisation programme with unfunded proposals subject to risk mitigation assessments; and
- Non-recurring measures required to achieve break-even in any year must be below 1% of turnover as a proxy for recurring balance.

### The Long Term Financial Plan

61. The LTFP is underpinned by the Trust's Financial Strategy and ensures a financially sound position is maintained from 2011/12 until 2016/17. The LTFP considers how the Trust intends to proceed in respect of:

- Clinical Services Development / Strategy;

- Capital / Estates planning;
- Workforce changes; and
- Implementation of the NHS Plan.

62. The Finance Department updated its LTFP in May 2011 as part of the Trust's response to Monitor's significant transaction due diligence exercise.

63. The LTFP cannot support the investment of the BHOC as described in this OBC. Work is required to close the financial shortfall.

## Preferred Option

64. The Do Minimum option achieved the lowest score in the non-financial benefits appraisal and has a higher net capital cost to the Trust.

65. The option that delivers a fully integrated Adult BMT and Haematology inpatient and day unit and a new TYA unit has a lower net capital cost to the trust due to the charitable funding contributions and delivers the desired service benefits. This is the preferred option.

## Risk Management

66. Risk Management is a programme control which is managed through the mechanism of a Risk Register. The risk register is owned by the Project Director and managed by the Project Manager.

67. The Risk Register includes the risk, the probability and impact of each risk on the project together with its proximity. Each risk has an associated mitigation strategy and a risk owner responsible for managing the risk and escalating it to the Project Team or Project Board, if required.

68. The Risk Register is maintained by the Project Manager, but risks are the responsibility of the allocated risk owner. Relevant risks are reported to the Project Board via the monthly highlight report. All members of the Project Team and Project Board are responsible for risk identification and mitigation. Any identified risks are reported to the Project Manager for entry onto the risk register.

## Equality Impact Assessment

69. An Equality Impact Assessment is a way of systematically and thoroughly assessing, and consulting on, the effects that a proposed service, function or policy change is likely to have on people, depending on e.g. their racial group, disability status, gender, sexual orientation etc. It will enable us to ensure we focus our attention on areas where we can make a difference to improving patient, public and staff experience.

70. An equality impact assessment screen for each service area has been conducted.

71. No significant negative impacts were noted when completing the screens.

72. A Full Equality Impact Assessment will be completed for any service identified as having a significant negative impact as part of the Full Business Case process. Knowledge would be sought from user/focus groups, lead clinicians and nursing, divisional managers and any external support groups to complete the full assessment and set out a plan to remedy and monitor any negative impact.

## Programme

73. The Adult BMT transfer element of the project is driven by the need to achieve vacation of its existing accommodation in the BRHC by December 2013. This is a key enabler for the successful delivery of the CSP scheme.

74. The initial construction work relating to the bunkers may need to be phased to conform to the Trust indicative capital programme

75. The key indicative milestone dates that have been established as are follows:

- Trust Board Approval of OBC 25/08/11
- Obtain Planning Approval 22/01/12
- FBC Approval 26/02/12
- Agree GMP & Contract 12/03/12
- Start on site 18/04/12
- Handover Levels 1 & 2 extension to TCT 07/10/13
- Transfer Adult BMT service 18/11/13

## Conclusion

76. The preferred option that delivers a fully integrated Adult BMT and Haematology inpatient and day unit and a new TYA unit has a lower net capital cost to the trust at £7.08m due to the secured and anticipated unsecured charitable funding contributions and delivers the desired service benefits.

77. Capacity planning assessments currently indicate demand for a 21 bed BMT and Haematology unit and 3 TYA beds. However, this is subject to challenge from the clinical teams so the current build design contains a 24 bed inpatient Adult BMT and Haematology and 5 TYA inpatient beds. This will be reviewed as part of the full business case process.

78. The net recurring revenue costs of this option, however, are currently assessed at £618,000 for the 24 and 5 bed option or £361,000 for the 21 and 3 bed option. This is unaffordable and therefore the scheme as currently costed is not supported within the Trust's Long Term Financial Plan. Further work to reduce revenue costs is planned prior to FBC approval.

79. The Adult BMT transfer element of the project is a key enabler for the successful delivery of the CSP scheme. Authority to proceed to full business case is necessary to achieve vacation of its existing accommodation in the BRHC by December 2013.

80. Further work will be undertaken leading up to full business case to bring the scheme down to an affordable position with specific focus at the following areas:-

- Review capacity planning assessments to confirm the final inpatient bed numbers for Adult BMT/Haematology and TYA

- Reconfiguration of the design to reduce the new build footprint and so reduce the associated FM costs
- Review of the workforce model and assumed releaseables from the BRHC
- Conclude on-going negotiations to secure the additional £2m charitable donations

University Hospitals Bristol NHS
NHS Foundation Trust

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

| Item 12 - Partnership Programme Board Terms of Reference |
|---|
| **Purpose** |
| To present proposed changes to the Partnership Programme Board Terms of Reference for consideration by the Trust Board of Directors for approval. |
| **Abstract** |
| The Partnership Programme Board considered its own Terms of Reference at a meeting dated 30 August 2011 and agreed to recommend changes for approval by the Trust Boards of Directors of North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust.<br>The recommended changes are marked in the attached version of the document. |
| **Recommendations** |
| The Board is recommended to **approve** the changes as marked in the Terms of Reference. |
| **Report Sponsor** |
| Chairman |
| **Other Author** |
| Trust Secretary |
| **Appendices** |
| • Appendix A – Partnership Programme Board Terms of Reference Appendix B |

### Previous Meetings

| Executive Team | Trust Management Executive | Quality and Outcomes Committee | Finance Committee | Audit Committee | Other – partnership Programme Board |
|---|---|---|---|---|---|
| N/A | N/A | N/A | N/A | N/A | 30 August 2011 |

# Terms of Reference - Partnership Programme Board

| Version Tracking | | | | |
|---|---|---|---|---|
| Version | Date | Revision Description | Editor | Approval Status |
| 0.1 | 27/01/2011 | Draft for consideration by the Trust Boards of Directors of UH Bristol and NBT | HH & DL | Draft |
| 0.2 | 08/02/2011 | Revisions recommended by Trust Secretary of UH Bristol with regard to Foundation Trust governance | CH | Draft |
| 0.3 | 10/02/2011 | Redraft agreed | CH | Draft |
| 1.0 | 28/02/2011 | Approved by the Trust Board of Directors | CH | Approved |
| 2.0 | 09/07/2011 | Revisions requested by June Partnership Programme Board | DL | Draft |

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## 1. Constitution

1.1. The Trust Boards of Directors (the Boards) of University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust have resolved to establish a joint overview board that shall be known as the North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust Partnership Programme Board (the Partnership Programme Board).

1.2. The Partnership Programme Board is established to oversee the collaboration and joint working described in the Partnership Agreement approved by both Trust Boards in November 2010 – See "Appendix A – Partnership Agreement".

1.3. The creation of the Partnership Programme Board is recognition by the two Trust Boards of Directors of the importance of collaboration and joint working for the benefit of the patients, carers and staff of both Trusts, and that of the wider health community.

1.4. The Partnership Programme Board has no executive powers other than those derived from its membership (i.e. the powers of Executive Directors) or those specifically delegated in these Terms of Reference.

## 2. Authority and Accountability

2.1. Members of the Partnership Programme Board remain accountable to the Boards of Directors of their respective Trusts

2.2. The Partnership Programme Board is authorised by the Boards to investigate any activity within its terms of reference.

2.3. The Partnership Programme Board is authorised to seek any information it requires from any officer of the Trusts via their respective Chief Executive, and all officers are directed to co-operate with any request made by the Partnership Programme Board via their respective Chief Executive.

2.4. The Partnership Programme Board may obtain whatever professional advice it requires[1], and may require Directors or other officers to attend meetings.

### *2.5. Limitations*

2.5.1. Save as is expressly provided in Standing Orders and Standing Financial Instructions of the respective Trusts, the Partnership

[1] The Partnership Programme Board may, from time to time, contract specialists to advise and support the discharge of these terms of reference. This shall be funded by both Trusts subject to Partnership Programme Board recommendation and budgetary approval by both Trusts.

For legal advice, this shall be subject to consultation with the Trust Secretary of University Hospitals Bristol NHS Foundation Trust and the designated legal services lead for NBT, and the availability of an approved budget.

Programme Board shall have no further power or authority on behalf of the Trust Boards of Directors of University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust.

## 3. Purpose

3.1. The purpose of the Partnership Programme Board is:

3.1.1. to ensure that the Partnership Agreement continues to benefit the patients, carers and staff of both Trusts and that of the wider health community; and,

3.1.2. to make recommendations to the Trust Boards of Directors on any changes to the Partnership Agreement considered necessary and appropriate.

3.2. The Partnership Programme Board shall:

3.2.1. endeavour to enable the maximum contribution of staff of both organisations towards the success of the Partnership Agreement,

3.2.2. support the spirit of collaboration and joint working between the two Trusts,

3.2.3. ~~oversee~~determine the ~~implementation~~priorities for partnership working between the two Trusts

~~3.2.3.~~3.2.4. Oversee and ensure delivery of the ~~Partnership Agreement,~~work programme priorities

3.2.5. ~~sponsor~~Identify and resolve any obstacles that impede the ~~production~~progress of partnership working

~~3.2.4.~~3.2.6. Sponsor the ~~outline strategic business case~~work to ~~assess~~identify the ~~feasibility of alternative organisational models, and, initiate~~optimal acute service configuration(s) for the City and ensure any subsequent work ~~that arises~~arising from this ~~feasibility assessment.~~is progressed satisfactorily

## 4. Membership

4.1. The following shall be members of the Partnership Programme Board:

4.2. North Bristol NHS Trust:

~~4.2.1. Chairman~~

~~4.2.2.~~4.2.1. Chief Executive

~~4.2.3.~~4.2.2. Director of Organisation, People & Performance

~~4.2.4.~~4.2.3. Medical Director

~~4.2.5.~~4.2.4. Two [2] Non-executive Directors, both of whom shall be independent[2] Non-executive directors.

4.3. University Hospitals Bristol NHS Foundation Trust:

~~4.3.1. Chairman~~

~~4.3.2.~~4.3.1. Chief Executive

~~4.3.3.~~4.3.2. Director of Strategic Development

~~4.3.4.~~4.3.3. Chief Nurse

~~4.3.5.~~4.3.4. Two [2] Non-executive Directors, both of whom shall be independent[3] Non-executive directors.

4.4. The Chairmanship of the Partnership Programme Board shall alternate between ~~the Chairmen~~two nominated Non-executive Directors of the two Trusts.

4.5. In the absence of both of the ~~Trust~~Programme Board Chairmen, the remaining members present shall elect one of the other Non-executive Director members to chair the meeting.

### *4.6. Quorum*

4.6.1. The quorum necessary for the transaction of business shall be four [4] members, of whom two must be Non-executive Directors (Non-executive Directors ~~or the Chairman~~), and two [2] must be Executive Directors (Executive Directors or the Chief Executive)[4].

4.6.2. A duly convened meeting of the Partnership Programme Board at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Partnership Programme Board.

### *4.7. Secretariat Services*

4.7.1. The Chief Executives of each Trust shall, in consultation with the Trust Secretary, make available such secretariat services as are necessary to support the work of the Partnership Programme Board.

[2] i.e. shall not have been employed by the Trust in the three [3] years preceding their appointment as Non-executive Director.

[3] i.e. shall not have been employed by the Trust in the three [3] years preceding their appointment as Non-executive Director.

[4] i.e. One Executive Director and one Non-executive Director from each Trust.

4.7.2. This shall include the provision of a secretary[5] to the Partnership Programme Board, and such other services as are required from time to time.

## 5. Attendance

5.1. Only members of the Partnership Programme Board have the right to attend meetings. However, other officers and external advisers may be invited to attend for all or part of any meeting as and when appropriate and where no conflict of interest exists.

5.2. The University Hospitals Bristol NHS Foundation Trust Secretary shall attend from time-to-time to provide advice to the Directors; and to facilitate the formal evaluation of the Partnership Programme Board's performance.

## 6. Meetings

6.1. Meetings of the Partnership Programme Board shall be conducted in accordance with the following provisions:

### *6.2. Frequency of meetings*

6.2.1. The Partnership Programme Board shall meet ~~once a month until the end of July 2011, and~~ every two months ~~thereafter,~~ and at such other times as the Chairmen of the Partnership Programme Board shall require as advised by the Secretary.

### *6.3. Notice of meetings*

6.3.1. Meetings of the Partnership Programme Board shall be called by the Secretary of the Partnership Programme Board at the request of the Chairmen.

6.3.2. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Partnership Programme Board, any other person required to attend and all other members of the Trust Boards of Directors, no later than five [5] working days before the date of the meeting.

6.3.3. Supporting papers shall be made available to Partnership Programme Board members and to other attendees as appropriate, and to all other members of the Trust Boards of Directors no later than five [5] working days before the date of the meeting.

### *6.4. Minutes of meetings*

[5] It is recommended that an independent secretary to the Partnership Programme Board be provided to ensure independent and impartial record keeping.

6.4.1. The secretary shall minute the proceedings and resolutions of meetings of the Partnership Programme Board, including the names of those present and those in attendance.

6.4.2. Draft Minutes of meetings shall be made available promptly to all members of the Partnership Programme Board and, once agreed, to all other members of the Trust Boards of Directors[6].

### *6.5. Public Access and Confidentiality*

6.5.1. There is nothing within the Constitution of the University Hospitals Bristol NHS Foundation Trust Constitution which requires the meetings of this Partnership Programme Board to be held in public, or to allow public access. Personal information shall be subject to the provisions of the Data Protection Act 1998; other information shall remain subject to the Freedom of Information Act 2000.

6.5.2. All members and attendees shall have due regard to the confidentiality of any discussions relating either to identifiable individuals, or to commercially confidential information.

### *6.6. Annual General Meeting*

6.6.1. The Partnership Programme Board Chairmen shall attend the Annual General Meeting of the partner organisation and be prepared to respond to any stakeholder questions on the Partnership Programme Board's activities.

## 7. Reporting

7.1. The Chairman of the Partnership Programme Board (or Chief Executive of each Trust) shall report formally to his Trust's Board of Directors on all proceedings and matters within the duties and responsibilities of the Partnership Programme Board.

7.2. The minutes of Partnership Programme Board meetings shall be formally recorded and submitted to the Trust Boards according to the Boards' Annual Reporting Cycles.

7.3. The Chair of the Partnership Programme Board shall make whatever recommendations to his Trust's Board of Directors he deems appropriate on any area within the Partnership Programme Board's remit where disclosure, action or improvement is needed.

7.4. The Partnership Programme Board shall make available, in the form of a report, suitable information on Partnership Programme Board policy, practices and undertakings for publication in the Trusts' annual reports.

[6] Unless a conflict of interest exists.

## 8. Monitoring and Review

8.1. The Trust Secretary shall, at least once a year, review the performance, constitution and terms of reference of the Partnership Programme Board to ensure it is operating at maximum effectiveness.

University Hospitals Bristol NHS
NHS Foundation Trust

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

## Item 13 - Partnership Programme Board Report

### Purpose

To brief the Trust Board of Directors on the highlights of a meeting of the University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust Partnership Programme Board.

### Abstract

The Partnership Programme Board met on 30 August 2011. The following points were discussed:

- The Partnership Programme Board Terms of Reference were revised for approval by both Trust Boards of Directors in September 2011
- Community Developments – Both Trusts undertook to keep each other informed of all major community hospital developments
- Histopathology – the Partnership Programme Board would be periodically updated on progress against the action plan
- Corporate Support Services – the Trusts would explore any potential for sharing back-office functions. Other areas for joint working include training and development, Human Resources processes, etc.
- Centralisation of Clinical Services – The Partnership Programme Board is to receive a highlight report on all centralisations of services – i.e. major trauma, breast, urology, head and neck, Ear Nose and Throat, specialist paediatrics and pathology
- Academic Health Sciences Centre – An Academic Health Sciences Centre would provide significant opportunities for joint working. The proposal for an Academic Health Sciences Centre proposal is to be considered by both Trust Boards of Directors
- Board-to-Board sessions –The Partnership Programme Board supported a future programme of Board-to-Board engagement

### Recommendations

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

### Report Sponsor

Robert Woolley, Chief Executive.

### Other Author

Deborah Lee, Director of Strategic Development

University Hospitals Bristol NHS
NHS Foundation Trust

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

| Item 14 - Results of Q1 Monitor Assessment of NHS Foundation Trusts Compliance |
|---|
| **Purpose** |
| To brief the Board on the assigned Monitor risk rating for Quarter 1 of the 2011-2012 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 1 of the 2011-2012 financial year.<br><br>Monitor has based the following ratings on its analysis of Quarter 1 across NHS Foundation Trusts:<br><br>• Financial risk rating - 3<br>• Governance risk rating - AMBER-RED<br><br>The Trust has been assigned an Amber-Red governance risk rating, which reflects a Care Quality Commission (CQC) compliance action in relation to outcome 5 (Regulation 14 : Meeting nutritional needs).<br><br>Compliance with targets, national priorities and CQC registration conditions is a requirement of the Trust's terms of Authorisation. The Compliance Framework sets out the significance that Monitor attaches to a failure to comply.<br><br>Monitor expects the Trust to have plans in place such that the Trust Board of Directors will be in a position to submit unqualified self-certifications in future monitoring cycles. |
| **Recommendations** |
| The Board is recommended to **note** the report. |
| **Report Sponsor** |
| Robert Woolley, Chief Executive. |
| **Other Author** |
| Charlie Helps, Trust Secretary |
| **Appendices** |
| • Appendix A – Executive Summary |

# University Hospitals Bristol NHS FT
# Q1 2011-12 reporting executive summary

Monitor
Independent Regulator of NHS Foundation Trusts

## Risk ratings

| Financial Risk Rating: | | | | | |
|---|---|---|---|---|---|
| **11/12 Plan:** | YTD | FY | | **YTD Actual:** | **Q1** |
| | 3 | 3 | | | **3** |

| Governance Risk Rating: | | | | | |
|---|---|---|---|---|---|
| **11/12 Plan:** | AMBER-RED | | **YTD Actual:** | AMBER-RED | |
| **Risks declared:** | • C. Difficile<br>• 4hr 95% A&E target | | **Breaches:** | • CQC compliance actions in place relating to outcome 5. | |

## 2011/12 & Authorisation limits

| | | | | | |
|---|---|---|---|---|---|
| **Long term borrowing** | £102.5m | **Working Capital Facility** | £37.5m | **Private Patient Income** | 1.1 % |

## Summary Income & cash flow vs Plan

| £m | Quarter | | | Year to date | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance |
| **Operating revenue** | **121.2** | **121.7** | **0.5** | **121.2** | **121.7** | **0.5** |
| Pay | -76.7 | -77.2 | -0.5 | -76.7 | -77.2 | **-0.5** |
| PFI operating expense | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| All other Op. costs | -37.5 | -37.2 | 0.3 | -37.5 | -37.2 | 0.3 |
| **EBITDA** | **7.1** | **7.4** | **0.3** | **7.1** | **7.4** | **0.3** |
| **Surplus** | **0.3** | **0.3** | **0.1** | **0.3** | **0.3** | **0.1** |
| **EBITDA %** | 5.8% | 6.0% | 0.2% | 5.8% | 6.0% | 0.2% |
| CapEx | -6.9 | -6.4 | 0.4 | -6.9 | -6.4 | 0.4 |
| Net cash flow | -0.7 | -2.5 | -1.8 | -0.7 | -2.5 | -1.8 |
| **Cash & Equiv** | **52.3** | **50.5** | **-1.8** | **52.3** | **50.5** | **-1.8** |
| FRR Liquidity days | 38.7 | 38.9 | 0.2 | 38.7 | 38.9 | 0.2 |
| CIP % OpEx less PFI | 3.1% | 3.0% | -0.1% | 3.1% | 3.0% | -0.1% |
| Net current assets | **19.6** | **20.0** | 0.4 | **19.6** | **20.0** | 0.4 |
| **Borrowing** | **-6.3** | **-6.1** | **0.1** | **-6.3** | **-6.1** | **0.1** |

- FRR 3 delivered at Q1 which is in line with plan. Trust continues to forecast achievement of its full year plan.

| Key risks | Action taken / committed | Gaps and residual concerns |
|---|---|---|
| • **Corporate and clinical governance concerns**. Independent review commissioned by the Trust into its Histopathology services identified various failings and governance concerns. | • The Trust has reported that it continues to implement its action plan to address recommendations and related governance matters. This action plan is being monitored by CQC. Monitor met with the Trust on 26 August to discuss progress. At this meeting the Trust demonstrated its progress and Monitor has removed the amber-red governance risk rating override.<br>• CQC has completed a responsive review with a particular focus on Histopathology, which found no areas of non-compliance. | • No material concerns. Trust will report to Monitor by exception where it is experiencing material issues in addressing Histopathology recommendations. |
| • **Major investment.** Delivery of 'significant' capital scheme (BRI). | • This investment has been risk assessed by Monitor as it meets the 'significant' threshold. Risk ratings of amber-green/FRR 3 provided. | • None. |
| • **Patient safety and quality.** CQC moderate concerns and compliance action in place (outcome 5: meeting nutritional needs). | • Trust has in place an action plan to address the CQC's compliance action. | • Trust has been non-compliant with this outcome since at least April 2010, raising concerns around the effectiveness of the Trust's remedial actions. |
| • **Financial risks.** 1 Financial Risk Indicator triggered.<br>  • >5% debtors >90 days | • Provisions have been made for all potential bad debts.<br>• Trust made some progress resolving longstanding debtors and further work is being done to enhance cash collection. | • This particular FRI has been triggered for five consecutive quarters. |
| • **Regulated services.** Trust is currently providing an activity (transport services, triage and medical advice provided remotely) which it is not registered by CQC to provide. | • Trust was requested by the PCT in-year (ie post-contract) to provide a patient transport service as a fixed-term pilot. Trust is currently in the process of retrospectively applying for this service to be regulated. | • Trust may have not have appropriately considered CQC registration requirements. |
| **Next steps** | • **Continue quarterly monitoring. Trust to update Monitor by exception if material issues arise in addressing Histopathology recommendations.** | |

University Hospitals Bristol NHS
NHS Foundation Trust

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

## Item 15 – Corporate Risk Register

### 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 June 2011 the following key changes have been made:

Risks closed

Risk 1823: Funding for Multi-Professional Education and Training has been closed as it is a subset of risk 962

Risk 1082: Unforeseen cost pressures i.e. 0.5% over allowance in long term financial plan has been closed as it is a subset of risk 962

New risk added

Risk 1867: No obligation from agencies that supply the Trust with clerical, allied health professionals and medical staffing to screen their staff for Tuberculosis. Patients and other staff are potentially put at risk if an agency worker is infected and the agency worker could be at risk if they don't have immunity.

Key changes to existing risks

Risk 1776: Actions updated

Risk 1504: Actions updated

Risk 1467: Controls and actions updated

Risk 1414: Controls and action updated

Risk 1407: Actions updated

Risk 1406: Actions updated

### Recommendations

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

| Sponsor & Other Author |
|---|
| Sponsor – Robert Woolley, Chief Executive<br>Author – Anne Reader, Assistant Director of Governance and Risk Management. |
| **Appendices** |
| • Appendix A – Corporate Risk Register |

## Previous Meetings

*Date the paper was presented to the relevant Management Group or Committee.*

| Executive Team | Trust Management Executive | Quality and Outcomes Committee | Finance Committee | Audit Committee | Other |
|---|---|---|---|---|---|
| | | | | | Risk Management Group<br>19/05/2011 |

| Number | Description | Source Of Risk | Risk Type | Monitoring Group | Date | Last Review Date | Next Review Date | Owner | Likelihood | Severity | Risk Rating | Target Risk Rating | Controls In Place | Details | Effectivenes of all controls | Residual Risk | Action Details | Progress | Target Date | Completed Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1798 | Risk escalated from Division of Surgery Head and Neck Risk Register no: 1346<br><br>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 | Service Delivery Group | 29/03/2011 | 09/09/2011 | 08/12/2011 | James Rimmer | 4 Likely | 4 Major | 4. Extreme | 2. Moderate | Performance Management | The risk relates particularly to the use of Queen's Day Unit to care for inpatients during winter 2010/2011 due to inadequate capacity on wards (emergency admissions and norovirus outbreaks) | Low | Extreme | Immediate controls were put in place around additional staffing, cancellation of elective lists and a control total of inpatients to be cared for in this inadequate environment. The patient flow KPIs (patients >14 days LOS, % patients discharged by 12.30 each day, reducing inpatients who are medically fit but delayed in discharge - red patients) act as 'early warning' triggers for patient flow performance. | Progress is monitored monthly through the bed optimisation programme, the test of the controls will come as winter pressures begin and threrefore until this test has been passed the residual risk remains high. | 30/11/2011 | Not yet due |
| | | | | | | | | | | | | | Service Redesign | A trust-wide operations centre has been established which is responsible for managing patient flow across the Trust, with improved understanding of prospective escalation triggers and divisional actions in response. | | | A longe term programme of work has been put in place during 2011 to redesign patient flow, focussing around front door, patient flow and discharge. | Progress is monitored monthly through the bed optimisation programme; the test of the controls will come as winter pressures begin and therefore until this test has been passed the residual risk remains high. | 30/11/2011 | Not yet due |
| | | | | | | | | | | | | | Planning | Winter Planning for 2011/2012 has commenced and it is clear that there is greater focus on and use of early warning signs. | | | The escalation policy has since been amended and 'flex' capacity identifed in more suitable locations (including closed medical wards) and the winter plan for 2011/2012 will be based on divisional 'ownership' of bed base. | Progress is monitored monthly through the bed optimisation programme; the test of the controls will come as winter pressures begin and therefore until this test has been passed the residual risk remains high. | 30/11/2011 | Not yet due |
| 1812 | 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 | Clinical Quality Group | 19/04/2011 | 16/09/2011 | 15/12/2011 | Stephen Aumayer | 3 Possible | 4 Major | 3. High | 1. Low | 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 employed and are expected to complete their vaccination history and programme as appropriate through visits to Occupational Health Department | Low | Extreme | Action plan in place following incident review to strengthen processes for ensuring staff fitness to work and vaccination from an infection control perspective. | Reviewed in August 2011 and further actions added | 01/04/2012 | Not yet due |
| | | | | | | | | | | | | | Designated Accountability | Letter to line managers sent April 2011 remiding of their responsibilities regarding staff fitness to work | | | | | | |
| 1467 | Risk of damage to the Trust's reputation to deliver high quality and effective care. | Individual Or Group Concern | Enhance Trust's Positive Rep | Trust Management Executive | 20/04/2011 | 09/09/2011 | 08/12/2011 | Robert Woolley | 4 Likely | 3 Moderate | 3. High | 2. Moderate | Audit - External To Trust | Claims that mistakes made in histopathology. Independent Inquiry concluded. CQC review concluded with minor concerns. | Medium | High | Action Plan shared with Overview and Scrutiny and regulators. | Regulatory review in progress. | 30/09/2011 | Not yet due |
| | | | | | | | | | | | | | Monitoring Board/Commitee | Histopathology Core Group Chaired by Chief Nurse | | | Action Plan in response to recommendations from the Independent Inquiry approved by the Trust Board. | Short term actions completed. Further actions in progress. | 30/11/2011 | Not yet due |
| | | | | | | | | | | | | | Planning | Detailed and robust action plan from the Independent Inquiry being implemented. | | | BNSSG Pathology Services Review in progress. | See Review reports. | Ongoing | Ongoing |
| | | | | | | | | | | | | | Partnership Working | Partnership working with North Bristol Trust and commissioners on future development of histopathology services in Bristol. | | | Further management integration proposal, following consultation. | N/A | TBC | TBC |
| | | | | | | | | | | | | | Designated Accountability | Joint Clinical Lead for Histopatholgy appointed and in post. | | | Response to report from CQC review May 2011. | Response prepared. | 19/09/2011 | 19/092011 |
| | | | | | | | | | | | | | | | | | Review workload levels across the two Trusts. | Initial review concluded. Detailed job-planning and benchmarking exercises to progress. | 30/11/2011 | Not yet due |
| | | | | | | | | | | | | | | | | | Progress integration of histopathology departments. | Integration plan in progress. | TBC | TBC |
| 1776 | 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.<br><br>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.<br><br>Associated risk of failure to meet waiting times, reduction in patient experience and loss of service to other areas.<br><br>Escalated from Specialised Services Risk Register: risk no 1046. | Incidents Or Near Misses | Improve Patient Safety | Service Delivery Group | 06/01/2011 | 19/09/2011 | 20/12/2011 | James Rimmer | 3 Possible | 4 Major | 3. High | 2. Moderate | Planning | Capactity modelling undertaken and backlog action plan in place. Target to clear backlog by Dec 2011. | Low | Extreme | Locum appointed for 9 months. Increased consultant outpatient clinics at Children's Hospital. Implementation of nurse led clinic. | Complete | 28/02/2011 | 31/03/2011 |
| | | | | | | | | | | | | | Service Redesign | Completion of current review of service 29/01/2011<br>Weekly performance reporting on OP waiting lists.<br>Clinical validation of patients overdue to be seen.<br>Discharge to local spoke hospital where possible.<br>Escalation process for patient led review.: | | | Revised prioritisation process for new and follow up GUCH patients to ensure those needing to be seen as a priority are flagged in future | Backlog is reducing; progress ongoing. | 31/03/2012 | Not yet due |
| | | | | | | | | | | | | | Performance Management | Review of job plans to be undertaken before end of May 2011<br>Weekly performance reporting on OP waiting lists.<br><br>Monthly risk management of backlog to be undertaken as follows:<br>1)Full spread sheet of patients who do not have a date for a follow up to be run on last working day of the month.<br>2)All patients on list reviewed by designated GUCH consultant - consultants rotate in a monthly basis. | | | Implementation of UH Bristol spoke service involving trained speciality doctor and nurse specialist. | GUCH strategy session being held 29th September 2011 to define hub and spoke model for the south-west, including Bristol 'spoke'. | 31/12/2011 | Not yet due |
| | | | | | | | | | | | | | Workforce Management | Locum Consultant appointed for 9 months, commenced in February 2011.<br>Specialist nurse hours increased. | | | Training and skills development to reduce specialist consultant input to maternity clinics | Following strategy session, an assessment of required capacity will be completed. | TBC | TBC |
| | | | | | | | | | | | | | | | | | Guch clincis are only to be cancelled with Head of Division agreement | Strategy Session with GUCH team to be held end of September 2011. | 31/10/2011 | Not yet due |
| 1483 | 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:<br><br>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<br>2. Insufficient compliance with mandatory Safeguarding Children and Adult Training. | Performance Monitoring | Improve Patient Safety | Clinical Quality Group | 21/08/2009 | 21/09/2011 | 20/12/2011 | Alison Moon | 2 Unlikely | 5 Catastrophic | 3. High | 1. Low | Monitoring Board/Commitee | Non- compliance with Care Quality Commission Outcome 7 (Safeguarding) declared due to poor compliance with staff safeguarding training ( Adults and Children)<br><br>Detailed action plan draw up reported quarterly to Safeguarding Adult and Children Steering Group and Care Quality Commission Committee.<br><br>Quarterly reports to the Board re CQC outcome 7 Safeguarding, following declaration of non-compliance with this outcome. | Medium | High | 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.<br><br>2. Training - a robust action plan continues to be implemented and compliance figures are monitored through the Safeguarding Children Steering Group. | 31/10/2011 | Not yet due |

| Number | Description | Source Of Risk | Risk Type | Monitoring Group | Date | Last Review Date | Next Review Date | Owner | Likelihood | Severity | Risk Rating | Target Risk Rating | Controls In Place | Details | Effectivenes of all controls | Residual Risk | Action Details | Progress | Target Date | Completed Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3. insufficient staff knowledge of Restraint / clinical holding procedures and techniques | | | | | | | | | | | | Training | Additional training provision for both Adult and children training<br><br>Training Compliance Figures produced weekly by safeguarding Adult and Children's Teams, figures monitored weekly by Divisional Leads (all Divisions).<br><br>Training Compliance figures monitored Monthly by Service Delivery Group | | | 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 | Not yet due |
| | | | | | | | | | | | | | 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. | | | 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 | Not yet due |
| | | | | | | | | | | | | | Workforce Management | Safeguarding Teams are in place to support staff as well as polices and procedure for both Adult and Children. | | | | | | |
| 1755 | 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 | Clinical Quality Group | 22/12/2010 | 05/09/2011 | 04/12/2011 | Alison Moon | 3 Possible | 5 Catastrophic | 4. Extreme | 1. Low | Local Policy In Force | Policy for the prevention and management of pressure ulcers | High | High | 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.<br>Internal prevalence completed in July 2011. Prevalence lower than in previous survey.<br>External prevalence survey scheduled for October 2011 | 31/10/2011 | Not yet due |
| | | | | | | | | | | | | | Audit - External To Trust | Audit of pressure ulcers carried out annually by Huntleigh Arjo bi-annually | | | | | | |
| | | | | | | | | | | | | | Equipment | Availabilty of electric profiling beds to prevent pressure ulcers. At present this represents only 50% of bed stock | | | Implement a rapid spread programme to embed best practice in preventing pressure ulcers | Project group meeting weekly<br>Launch scheduled for 13th September 2011 | 01/12/2011 | Not yet due |
| | | | | | | | | | | | | | Equipment | Availability of pressure relieving mattresses | | | | | | |
| | | | | | | | | | | | | | Local Policy In Force | Pressure ulcer prevention protocols. | | | | | | |
| 1660 | Changes in the external environment jeopardise achievment of the Trust's strategic aims | Economy Changes | Partnership Working For Servic | Trust Management Executive | 05/04/2011 | 09/09/2011 | 08/12/2011 | Deborah Lee | 3 Possible | 3 Moderate | 3. High | 1. Low | 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. | Medium | High | Annual business planning process captures commissioner impacts and communicates to Division. Coherence of Operating Plans to commissioner contrcat tested through OP sign off. | 2011/12 QEPP impacts have not materialised. Business planning process for 2012/13 being revised in light of current context. | Ongoing | Ongoing |
| 1837 | No obligation from agencies that supply us with A&C AHPs and medical staffing to screen their staff for Turberculosis. Patients and other staff are potentially put at risk if an agency worker is infected and the agency worker could be at risk if they don't have immunity. | Incidents Or Near Misses | Improve Patient Safety | HR Board | 02/08/2011 | 13/09/2011 | 13/10/2011 | Stephen Aumayer | 3 Possible | 3 Moderate | 3. High | | Workforce Management | All nursing and medical staffing agency contracts require TB screening. Agencies confirm this is in place.<br><br>AHP agency contracts being assessed for appropriate screening and will be ammended where required (September 2011).<br><br>Admin and Clerical agency contracts do not require TB screening. New contracts being put in place September 2011 which will require this screening. | Medium | High | All contracts are up for retender for A&C, ancillary and AHP, and in the process for negotiating contracts for medics, and all of these will have now have screening. | This is currently with purchasing | TBC | TBC |
| 962 | The Trust's Financial Strategy may not be deliverable in the likely national economic climate | Economy Changes | Remain Financially Sustainable | Finance Committee | 11/05/2011 | 16/09/2011 | 15/12/2011 | Paul Mapson | 3 Possible | 3 Moderate | 3. High | 2. Moderate | | Update of Integrated Business Plan on a regular basis | Medium | High | Annual review of key assumptions - reporting to Finance Committee and Trust Board. | Annual Plan 2011/12-2013/14 produced in May 2011. | Ongoing | Ongoing |
| | | | | | | | | | | | | | Monitoring Board/Commitee | Financial Monitoring through Finance Committee and Trust Board. | | | | | | |
| | | | | | | | | | | | | | Planning | Monitor Downside Plan showing impactproduced Sept 2009 and submitted to Monitor. | | | | | | |
| 741 | Cash Releasing Efficiency Savings Plans underachieve and impact on trust annual and planned outturn. | Annual Planning Process | Deliver Agreed Cash Releasing | Service Delivery Group | 08/12/2010 | 09/09/2011 | 08/12/2011 | James Rimmer | 4 Likely | 3 Moderate | 3. High | 2. Moderate | Performance Management | Monthly Divisional CRES reviews, Monthly Divisional Performance reviews , Quarterly reviews, Monthly review by CRES Programme Steering Group, monthly updated at a glance reports | High | Moderate | 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. All Divisions signed off. Corporate CRES workstream plans being developed to merge any gaps | 31/03/2012 | Not yet due |
| | | | | | | | | | | | | | Performance Management | 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 | | | | | | |
| | | | | | | | | | | | | | Performance Management | 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. | | | | | | |
| | | | | | | | | | | | | | Performance Management | Regular Reporting to the Finance Committee and Trust Board | | | | | | |
| | | | | | | | | | | | | | 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. | | | Bed optimisation workstream to address patient flow. | Workstream established. | 30/03/2012 | Not yet due |
| | | | | | | | | | | | | | Performance Management | New performance metrics that map to the patient journey and move Trust towards measuring performance within ED rather than at 4 hours | | | Winter Plan developed. | Draft winter plan submitted. | 30/09/2011 | Not yet due |

| Number | Description | Source Of Risk | Risk Type | Monitoring Group | Date | Last Review Date | Next Review Date | Owner | Likelihood | Severity | Risk Rating | Target Risk Rating | Controls In Place | Details | Effectivenes of all controls | Residual Risk | Action Details | Progress | Target Date | Completed Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 743 | 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 Contracte | Service Delivery Group | 09/09/2010 | 09/09/2011 | 08/12/2011 | James Rimmer | 3 Possible | 4 Major | 3. High | 2. Moderate | Service Redesign | Length of stay, delayed discharge and outlier reduction | High | Moderate | Ambulatory care pathways developed. | 8 pathways developed; not all fully implemented. | 30/03/2012 | Not yet due |
| | | | | | | | | | | | | | 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 | | | | | | |
| | | | | | | | | | | | | | Service Redesign | New pathways for expected patients through use of Ambulatory Care centre reducing quantum of activity to ED | | | | | | |
| | | | | | | | | | | | | | 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. | | | | | | |
| 1384 | Norovirus outbreaks which will introduce significant risk to the achievement of the 4hour target and elective targets | Performance Monitoring | Reduce Incidence Of Healthcare | Clinical Quality Group | 10/05/2011 | 19/08/2011 | 17/11/2011 | Alison Moon | 4 Likely | 3 Moderate | 3. High | 1. Low | Partnership Working | Review of 07/08 outbreaks across health economy to manage future more effectively and collectively<br><br>Regular meetings with Commissioners and Providers across the former Avon area includes discussion on Norovirus | Medium | High | 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 action with no stop date | Ongoing | Ongoing | Ongoing |
| | | | | | | | | | | | | | Local Policy In Force | Outbreak Policy | | | Action plan developed following review of Norovirus 2010/11 internally and externally by health protection agency | August 2011 - plan approved at infection control group. To be presented to Service Delivery Group for implementation | 31/12/2011 | Not yet due |
| | | | | | | | | | | | | | Planning | 08/09 Norovirus Outbreak Plan for Trust<br>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<br><br>5/9/11 Report received and discussed at Infection Control Group, Clinical Quallity Group and Service Delivery Group | | | | | | |
| 1412 | Failure to meet Cancer Targets, specifically 2-week, 31-day and 62-day target. | Performance Monitoring | National And Locally Contracte | Service Delivery Group | 20/04/2009 | 09/09/2011 | 08/12/2011 | James Rimmer | 3 Possible | 4 Major | 3. High | 2. 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. | High | Moderate | 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 | Not yet due |
| | | | | | | | | | | | | | Service Redesign | Choose and book - implemeted for 14 day breast and seen performance improve to 98%. needs to be sustained 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 | | | | | | |
| 1764 | Delays in finidng an affordable and acceptable service solution to the relocation of adult BMT services from the Children's Hospital to BHOC may result in delay to completion of approved CSP scheme | Captial And Service Developmen | Redevelop BRI And Centralisati | Redevelopment Projects | 06/01/2011 | 09/09/2011 | 09/10/2011 | Deborah Lee | 3 Possible | 4 Major | 3. High | | Governance - All Types | Development moved from Division to Strategic Development Team and full Project / Programme disciplines implemented | High | Moderate | Develop FBC that is affordable and supports CSP critical timeline | Finance Committee did not approve OBC. Permission to further invest in design work to enable programme to remain on track pending further work on OBC / FBC. Target date for FBC March 2012. | 31/03/2012 | Not yet due |
| | | | | | | | | | | | | | Funding | £11.5m capital funding identified, further £2m being sought | | | | | | |
| | | | | | | | | | | | | | Planning | OBC developed, proceeding to FBC by March 2012 | | | | | | |
| 753 | 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 Pote | Partnership Working For Servic | Service Delivery Group | 20/08/2010 | 09/09/2011 | 08/12/2011 | James Rimmer | 3 Possible | 3 Moderate | 3. High | 2. Moderate | 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. | Medium | High | Contingency plans identified alongside Outline Business Case for Bristol Royal Infirmary redevelopment. | Bed tracker developed and reviewed routinely. | 01/04/2012 | Not yet due |
| | | | | | | | | | | | | | 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 | | | Work with commissioners on serrvice design/service reviews/demand management and capacity planning. | Meetings ongoing | Ongoing | Ongoing |
| | | | | | | | | | | | | | Service Redesign | Whole system approach to be developed through Urgent Care Network. | | | | | | |
| | | | | | | | | | | | | | Service Redesign | Drive to reduce Length of Stay and improve bed efficiency. | | | Optimising bed workstream launched with routine benchmark information by HRG and procedure to enable MOHB programme to focus on individual team bed use | CHKS to launch monthly reporting from February 2011 - shape and FTN to launch in same month | 31/03/2012 | Not yet due |

| Number | Description | Source Of Risk | Risk Type | Monitoring Group | Date | Last Review Date | Next Review Date | Owner | Likelihood | Severity | Risk Rating | Target Risk Rating | Controls In Place | Details | Effectivenes of all controls | Residual Risk | Action Details | Progress | Target Date | Completed Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1411 | Risk of compromised patient outcomes due to failure to meet cancelled operations national standard. | Performance Monitoring | Improving Quality And Effectiv | Service Delivery Group | 20/04/2009 | 13/09/2011 | 12/12/2011 | James Rimmer | 3 Possible | 3 Moderate | 3. High | 1. Low | 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. | High | Moderate | 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 | Ongoing | Ongoing |
| | | | | | | | | | | | | | Local Policy In Force | Three times 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. | | | Escalation Policy agreed for all Divisions. | Escalation agreed in 4 out of 5 clinical divisions. | 31/03/2012 | Not yet due |
| | | | | | | | | | | | | | Service Redesign | Productive theatre initiative successfulyl brings on additional controls over theatre utlisation increaidng capacity and reducing cancllations | | | | | | |
| | | | | | | | | | | | | | 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<br><br>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 | | | Plan to be agreed in respect of cancelled operations. | Plan agreed and sent to Primary Care Trust. | 31/03/2012 | Not yet due |
| | | | | | | | | | | | | | 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. | | | | | | |
| 1599 | Risk of lack of service continuity due to the age of parts of the estate with increased likelihood of breakdown and down time whilst faults are remedied e.g. lifts, roof coverings, heating and ventilation plant etc.<br><br>The consequence of such events is disruption to planned clinical care and possible adverse effect on performance. | Strategic Decision Making | Invest In Estate And Patient A | Service Delivery Group | 04/12/2009 | 09/09/2011 | 08/12/2011 | James Rimmer | 3 Possible | 3 Moderate | 2. Moderate | 1. Low | 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.<br><br>Programme of additional assurances and measures agreed in the Facilities and Estates Operating Plan approved by the Exec team for 2011/12 increase the effectiveness of the mitigations.<br><br>The previous risk assessment was added to the risk register under my name but not by myself. I have now reviewed the risk and identified what the actual risk is i.e. lack of service continuity (with its appropriate consequences). BP 13/9/2011 | High | Low | 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 | 30/04/2010 |
| | | | | | | | | | | | | | 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 | Not yet due |
| | | | | | | | | | | | | | 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 | An annual programme of capital investment is prioritised by Service Development Group and Trust Management Executive. | | | | | | |
| | | | | | | | | | | | | | Designated Accountability | Range of Authorised Persons identified for tasks identified in Health Technical Memeoranda who have received appropriate training for the role | | | | | | |
| 1407 | Non compliance with Equalities Legislation | Regulatory Compliance | Embed Equality And Diversity I | HR Board | 06/06/2011 | 02/08/2011 | 31/10/2011 | Stephen Aumayer | 3 Possible | 3 Moderate | 3. High | 2. Moderate | Governance - All Types | Trust required to assess all functions, policies and services | High | Moderate | 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.<br><br>Process regarding policy update/approval will manage ongoing risk.<br><br>Board paper on E&D presented in May 2011 | Ongoing | Ongoing |
| | | | | | | | | | | | | | Training | External training provided since June 2009. Now delivered twice a month to all trust staff bands 1-4. Training for managers, band 5+ being delivered from October 2011. E&D training also included in induction since January 2011. | | | | | | |
| | | | | | | | | | | | | | Funding | Funding obtained for E & D Manager for 12 months | | | | | | |
| | | | | | | | | | | | | | | All new policies and policies for review have an Equality Impact assessment. | | | | | | |

| Number | Description | Source Of Risk | Risk Type | Monitoring Group | Date | Last Review Date | Next Review Date | Owner | Likelihood | Severity | Risk Rating | Target Risk Rating | Controls In Place | Details | Effectivenes of all controls | Residual Risk | Action Details | Progress | Target Date | Completed Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1406 | Non compliance with European Working Time Directive | Regulatory Compliance | Enable Staff To Deliver To The | HR Board | 15/09/2011 | 15/09/2011 | 14/12/2011 | Stephen Aumayer | 3 Possible | 3 Moderate | 3. High | 2. 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.<br><br>Monitoring exercise currently being undertaken across the Trust. Exceptions/concerns to be raised through Dircetor of Workforce | High | Moderate | All rota's compliant at August 2011 in line with European Working Time Directive requirements. All rota's monitored in June-July 2011. No issues identified. Next monitoring round will take place in January 2012. | No derogated rota's in the Trust. | 31/07/2011 | 31/07/2011 |
| 1405 | Lack of controlled assurance for all staff groups for mandatory training, induction. | Performance Monitoring | Improve Patient Safety | Risk Management Group | 10/02/2011 | 01/08/2011 | 30/10/2011 | Stephen Aumayer | 3 Possible | 3 Moderate | 3. High | 1. Low | Training | Continuous training carried out as per risk management training plan. Annual training needs analysis in place and training prospectus developed | High | Moderate | 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. | 31/03/2011 | 31/03/2011 |
| | | | | | | | | | | | | | | | | | Procurement of At Learning system underway. | | 01/04/2010 | 01/05/2010 |
| | | | | | | | | | | | | | | | | | Plans in place to charge all departments for non-attendance at statutory and mandatory training courses. | | 31/03/2011 | 31/03/2011 |
| | | | | | | | | | | | | | | | | | A pan-avon skills passport is being developed to make skills transferable between organisations | | 31/03/2011 | 31/03/2011 |
| | | | | | | | | | | | | | | | | | Passport prepared and going for approval. | Passport approved | 30/04/2011 | 30/04/2011 |
| | | | | | | | | | | | | | | | | | Slkills passport for cross BNSSG stat and mand training now in place. Full review of stat and mand requirements and delivery methodologies underway, and will report in September 2011. | | 30/09/2011 | Not yet due |
| 1383 | Failure to reduce the Incidence of Health Care Acquired Infection, specifically Clostridium Difficile and MRSA.<br><br>May 2011 - new targets for reduction of MSSA and E. coli bacteraemias added in 2011 | Performance Monitoring | Reduce Incidence Of Healthcare | Clinical Quality Group | 10/05/2011 | 05/09/2011 | 04/12/2011 | Alison Moon | 3 Possible | 3 Moderate | 3. High | 1. Low | 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 implemented in advance of December 2010. | High | Moderate | 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. | August 2011 - progress with action plan presented to infection control group - no outstanding actions | Ongoing | Ongoing |
| | | | | | | | | | | | | | 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 | | | | | | |
| 1504 | Adult in-patients could develop venous thrormbo-emboli and come to harm if not risk assessed and appropriate thrombo-prophylaxis prescribed. | NICE Guidance | Improve Patient Safety | Clinical Quality Group | 20/04/2011 | 21/09/2011 | 20/12/2011 | Sean O'Kelly | 2 Unlikely | 4 Major | 3. High | 1. Low | Documentation -Trust Paperwork | Risk Assessment tools avaiable for completion.Risk assessment tool to be integral to new prescription chart. | High | Moderate | 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 | 30/04/2011 |
| | | | | | | | | | | | | | Workforce Management | Each Division has elected a clinical champion for VTE. | | | Programme of systematic audits of thormbo prophylaxis compliance commenced May 2011. | Ongoing | Ongoing | Ongoing |
| | | | | | | | | | | | | | 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 being 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. | | | | | | |
| | | | | | | | | | | | | | Governance - All Types | Robust programme management and programme governance structure in place. | | | | | | |

| Number | Description | Source Of Risk | Risk Type | Monitoring Group | Date | Last Review Date | Next Review Date | Owner | Likelihood | Severity | Risk Rating | Target Risk Rating | Controls In Place | Details | Effectivenes of all controls | Residual Risk | Action Details | Progress | Target Date | Completed Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 759 | 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 Developmen | Redevelop BRI And Centralisati | Redevelopment Projects | 05/04/2011 | 09/09/2011 | 09/10/2011 | Deborah Lee | 2 Unlikely | 4 Major | 2. Moderate | 1. Low | Monitoring Board/Commitee | Programme structure mirrors OGC best practice. Programme Board, reporting to Trust Management Executivee in place. | High | Low | Major Risk to CSP Programme (transfer of Adult BMT) now removed from clinical pathwway with resulting reduction in level of risk. Scheme completion now required by Dec 2013 | OBC not approved by Finance Committee but approval to proceed with design work pending agreement by September Board to proceed direct to FBC. | 31/05/2014 | Not yet due |
| | | | | | | | | | | | | | Audit - External To Trust | External OGC Gateway Review in place. Gateway 3 review GREEN rated | | | | | | |
| | | | | | | | | | | | | | Designated Accountability | Director of Strategic Development is Senior Responsible Officer | | | | | | |
| | | | | | | | | | | | | | Planning | FBC approved, contingency planfor delayed BMT transfer identified | | | | | | |
| 1240 | National contract mandates financial penalties on under-performance against key indicators presenting a financial risk to the Trust. | Annual Planning Process | Remain Financially Sustainable | Finance Committee | 20/03/2008 | 16/09/2011 | 15/12/2011 | Paul Mapson | 3 Possible | 2 Minor | 2. Moderate | 2. Moderate | Local Policy In Force | Operational plans (especially infection control plan) : delivery of key targets by year end | High | Low | Robust performance management in year. Prioritise service redesign initiatives to key performance issues. | Ongoing | 31/03/2010 | 31/03/2010 |
| | | | | | | | | | | | | | Performance Management | Corporate and divisional performance management framework. | | | 2010/11 Monitor financial exposure in-year. | Ongoing | Ongoing | Ongoing |
| | | | | | | | | | | | | | | Transformation programme. | | | Reports routinely to the Finance Committee as part of the finance report. Continually reassessed. Provision made in 2010/11 budget. | Ongoing. | Ongoing | Ongoing |
| 1415 | 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 Effectiv | Service Delivery Group | 24/08/2011 | 24/08/2011 | 22/11/2011 | Alison Moon | 3 Possible | 2 Minor | 2. Moderate | 1. Low | 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. | High | Low | 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 | 01/08/2011 |
| | | | | | | | | | | | | | Environment | Fixed screens in place in adult emergency department from May 1st 2011. | | | | | | |
| | | | | | | | | | | | | | Environment | The MAU has moved to Ward 17 with an increased bed base of 9 with more separation of 4 bed bays and a single side room. | | | | | | |
| 1414 | Risk that patient safety is compromised due to failure to comply with revised Care Quality Commission Standards on decontamination | Regulatory Compliance | Improve Patient Safety | Clinical Quality Group | 12/09/2010 | 20/09/2011 | 19/12/2011 | Alison Moon | 2 Unlikely | 3 Moderate | 2. Moderate | 1. Low | Monitoring Board/Commitee | Review at Trust Infection Control Committee. Decontamination Committee to report to the Trust Audit and Assurance Committee. | High | Low | Comprehensive and detailed action plan in place being monitored by Decontamination Committee, Infection Control Committee and Trust Board. | Decontamination Action plan due for review at September's Board Decontamination Board meeting (23rd September) - completed actions will be removed, new work discussed and added to plan. | 31/12/2011 | Not yet due |
| | | | | | | | | | | | | | 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. | Stock take of trust wide practices completed – risks identified and actions put into place to mitigate risks identified | 31/03/2011 | 20/09/2011 |
| | | | | | | | | | | | | | 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. | BHI plant installed. Awaiting delivery of a new chemical for the sanitation of system, once this has arrived full connection can take place and the system will be running. In Hey Groves Theatres there has been a need to find an alternative location for the plant which has caused a delay in installation which is expected to be resolved by end November 2011 | 30/11/2011 | Not yet due |
| | | | | | | | | | | | | | Local Policy In Force | Decontamination policy in place | | | Project to address clean steam situation underway. | Clean steam up-date.Tenders due back in by 30th September. Company who is awarded the tender will be asked to provide a comprehensive work schedule to ensure that the work is undertaken and complete before 31st March 2012. | 31/03/2012 | Not yet due |
| | | | | | | | | | | | | | | | | | Actions from 2011 internal audit:<br><br>A formal annual review of the dissemination of decontamination policies at departmental level-target date 31st January 2011.<br><br>The Standard Operating Procedure for the manual washing of clinical equipment to be reviewed and disseminated throughout the Trust – target date for action to be completed – 31st December 2011<br><br>Decontamination User Group consider the use of a standard staff training monitoring spreadsheet based upon the Queens Day Unit?s model, for use by all Named Lead Users – target date for action to be completed 31st January 2012<br><br>Decontamination User Group to consider using the training package developed by the Queens Day Unit for all other departments – target date for action to be completed January 2012 | Underway. | 31/01/2012 | Not yet due |
| | | | | | | | | | | | | | Audit - External To Trust | Authorising Engineer (Decontamination) annual audit report | | | Internal audit on decontamination underway. | Complete. Results and recommendations presented to Decontamination Board. | 31/07/2011 | 20/09/2011 |
| | | | | | | | | | | | | | Local Policy In Force | Policy for water testing and acting on results | | | | | | |
| 1623 | Risk to University Hospitals Bristol of fraudulent activity within Divisions.<br><br>There are two types of fraud risk that could affect the Trust.<br>1.High number of low value cases such as working whilst sick, time sheet fraud, expenses fraud etc.<br>2. High value small number of cases such as purchasing, contract or corruption. | External Investigations | Remain Financially Sustainable | Finance Committee | 03/03/2010 | 16/09/2011 | 15/12/2011 | Paul Mapson | 2 Unlikely | 3 Moderate | 2. Moderate | 1. Low | Monitoring Board/Commitee | Reports to Audit and Assurance Committee | High | Low | Regular detailed review with Director of Finance. | Ongoing. | Ongoing | Ongoing |
| | | | | | | | | | | | | | Documentation -Trust Paperwork | CounterFraud and Speaking Out Policies | | | | | | |
| | | | | | | | | | | | | | Designated Accountability | Local Counterfraud Service | | | | | | |
| | | | | | | | | | | | | | Audit -Trust Origin | Proactive Councterfraud work | | | | | | |
| 1418 | Risk of breaching private patient cap. | Regulatory Compliance | Remain Financially Sustainable | Finance Committee | 11/05/2011 | 16/09/2011 | 15/12/2011 | Paul Mapson | 1 Rare | 2 Minor | 1. Low | 1. Low | Performance Management | Board and Finance committee receive regular reports on private patient income against cap. | Medium | Low | Continue to monitor private patient income through Finance Committee. | Ongoing | Ongoing | Ongoing |