University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Public Meeting of the Trust Board of Directors to be held on 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page*
1. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda.	Chairman	
3. Minutes To consider the Minutes of a Public Trust Board meeting dated Wednesday 28 September 2011 for **approval**.	Chairman	1
4. Matters Arising To review the status of matters arising from previous meetings of the Trust Board of Directors.	Chairman	
5. Chief Executive's Report To receive this report to **note**.	Chief Executive	16
Quality, Performance and Compliance		
6. Summary Quality and Performance Report To receive the standing Summary Quality and Performance Report to **note**. a. Overview – Director of Strategic Development b. Quality – Medical Director and Chief Nurse c. Workforce – Director of Workforce & Organisational Development d. Access – Chief Operating Officer	Executive Leads	19
7. Infection Control Quarterly Report To receive this report to **note**.	Chief Nurse	83
8. Half-Year Update on Corporate Quality Objectives To receive this report to **note**.	Medical Director	92
9. Complaints Annual Report To receive this report to **note**.	Chief Nurse	104
10. Audit and Assurance Committee Annual Report To receive this report to **note**.	Committee Chair	121
11. Patient Experience Action Plan Update (Including Update on the Cancer Survey Action Plan) To receive this report to **note**.	Chief Nurse	127

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Finance and Governance		
12. Committee Chairs' Reports To receive reports on the activities of Board Committees by their respective Chairs and consider any recommendations to **note**. a. Finance Committee dated 21 October 2011, including the Finance Report b. Quality and Outcomes Committee dated 25 October 2011.	Committee Chairs	138
Strategy and Business Planning		
13. Quarterly Teaching and Learning Strategy Progress Report To receive this report to **note**.	Director of Workforce and Organisational Development	157
14. Quarterly Capital Projects Status Report To receive this report to **note**.	Director of Strategic Development	166
15. Annual Business Planning Guidance 2012/13 To receive this report and consider the recommendations for **approval.**	Director of Strategic Development	171
16. Medium Term Indicative Capital Programme To receive this report and consider the recommendations for **approval.**	Director of Finance	189
Monitor Reports		
17. Quarter 2 Compliance Framework Monitoring and Declaration Report To receive this report and consider the recommendations for **approval**.	Chief Executive	197
Risk		
18. Board Assurance Framework Report (including Strategic, Corporate and Compliance Objectives Status Report) To receive this report to **note**.	Chief Executive	215
Information and Other		
19. Any Other Business To consider any other relevant matters not on the Agenda.	Chairman	
20. Date of Next Meetings Public Meeting of the Trust Board of Directors, Monday 28 November 2011 from 10:30 – 13:30 in the Conference Room, Trust Headquarters,	Chairman	

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Marlborough Street, Bristol, BS1 3NU.		

University Hospitals Bristol NHS
NHS Foundation Trust

Minutes of a Public Board Meeting, held on 28 September 2011 at 10:30 in Tutorial Room 4, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Board Members Present	
• John Savage – Chairman • Emma Woollett – Vice Chair • Iain Fairbairn – Senior Independent Director • Lisa Gardner – Non-executive Director • Paul May – Non-executive Director • Selby Knox – Non-executive Director • John Moore – 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
Present or In Attendance	
• Mark Callaway – Head of Division - Medicine Division • Paula Murphy – Chair of the Hospital Medical Committee • Peter Wilde – Head of Division – Specialised Services Division • Elisabeth Kutt – Head of Division – Diagnostics and Therapies Division • Mike Nevin – Head of Division – Surgery Head and Neck Division • Christine Perry – Director of Infection Prevention and Control • Charlie Helps – Trust Secretary • Victoria Church – Management Assistant to the Trust Secretary	• Sarah Pinch – Head of Communications • Tim Peters – University of Bristol Appointed Governor • Anne Ford – Public Governor, North Somerset • Alex Bunn – Staff Governor – Non-Clinical Healthcare • Mary Hodges – Public Governor – South Gloucestershire • Garry Williams – Patient Governor, carers of 16 years and over • Clive Hamilton – Public Governor – North Somerset • John Steeds – Patient Governor - Local

Item	*Action*
1. Chairman's Introduction and Apologies The Chairman noted apologies from Kelvin Blake, Non-executive Director.	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Board Meeting Agenda. No declarations of interest were made.	
3. Minutes The Board considered the Minutes of the Joint Public Trust Board Meeting Board and Membership Council meeting held on Thursday 25 August 2011 and **approved** them as an accurate record, subject to some minor amendments provided to the Trust Secretary.	Management Assistant to the Trust Secretary

4. Matters Arising

All items on the Board Schedule of Matters Arising were noted as complete as reflected in the Schedule of Matters Arising, subject to Item 15, which was a matter for discussion by the Chief Operating Officer, James Rimmer, as follows:

- James referred to the cancelled operations in mid-July, saying they were the result of an equipment failure and flood, which meant water was turned off for a short time. As a consequence of this failure, and also the double-booking of a consultant, the Urological list had to be cancelled. James assured the Board that tighter controls were now in place and this incident had been addressed in the Operational Report.

5. Chief Executive's Report

The Board received and considered a report by the Chief Executive, which included the activities of the Trust Management Executive to **note**.

Robert Woolley highlighted the items of relevance this month:

- The Trust signed a contract agreement with Laing O'Rourke for the Bristol Royal Infirmary Redevelopment Scheme.
- The Care Quality Commission (CQC) reviewed Histopathology in May and released the formal report in September. They found that the Trust met all of the six reviewed standards. The findings provided additional external assurance that the Histopathology service was safe, although some minor concerns were identified, and action plans put in-place to address.
- Monitor undertook a review of Board governance, following residual concerns related to the Histopathology Inquiry. The Amber-red rating had been removed, and Monitor was satisfied with the way the Board had addressed Histopathology governance, risk and safety. This provided significant external assurance for the Trust.
- The Trust was confident of declaring compliance to Monitor with regards to the Nutrition standard by the end of September, as planned.
- Robert reported good engagement with the Bristol Eye Hospital and Bristol Heart Institute open days and congratulated all who had assisted.
- Lord Robert Winston opened the Clinical Research Imaging Centre, marking the prominence of the Trust's research initiatives, in partnership with the University of Bristol.

Alison Moon expanded on the success of the initiatives undertaken to declare compliance with the Nutrition standard, and remarked on the efforts of the Divisions to achieve the action plan on time.

Paul May commented on the competency of the Governance information presented to Monitor, and remarked that it was a very well-handled meeting and the Board should be proud of the outcome.

Peter Wilde said there had been great support from governors for the Bristol Heart Institute open day, and thanked them for their hard work.

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

Quality, Performance and Compliance

6. Summary Quality and Performance Report

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

a. Overview

The Director of Strategic Development, Deborah Lee, introduced the Performance Report and noted that the overall 'health' of the Organisation remained 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 included the Number of Clostridium Difficile (C.Diff) 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.

Patient Experience

The Patient Experience Report related to a patient who was admitted as an emergency with shortness of breath and subsequently diagnosed with lung cancer, complicated by brain metastases (secondary tumours).

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.

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

- The Lead Cancer Nurse had 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 would clarify the level of support the service could provide at the first meeting with patients and families.
- The Lung Cancer Clinical Nurse Specialist now discussed all cases with the consultant prior to clinic, so that they could try to be available at key points in the treatment plan, such as when results of tests were received.
- A separate nurse-led clinic was been set up for patients who wanted face-to-face support, rather than by telephone.

Emma Woollett observed that this complaint illustrated the importance of making cross-boundary care of patients work, especially (but not only) for cancer patients as well as ensuring that the available support was clearly explained to patients and their families.

Following questions from Paul May, Alison Moon confirmed that the sub-regional issues on cancer were being considered. She continued, saying that expert contact was required, due to the specialist nature of the illness.

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 Clostridium Difficile target was extremely tight, but currently being achieved, following significant improvements made this year.

• It was confirmed that the disciplines and processes of the Methicillin-Resistant Staphylococcus Aureus (MRSA) Exception Report were similar to the new Methicillin-Sensitive Staphylococcus Aureus (MSSA) Report. • The Director of Infection Prevention and Control, Christine Perry, commented on the use of the Combined Assessment (Quality in Care) Tool, which Alison Moon confirmed would be reported on in planned future 'Ward-to-Board' reporting. • Alison Moon referred to two Complaints cases reported on pages 78 and 79 of the Board pack, which highlighted the elements of organisational learning achieved. An external review had commenced at the beginning of the year and a clear, enhanced plan had been introduced to improve the way Divisions responded to complaints. It was noted that in future, the resolution of complaints would be added to the Performance Report, which was considered by the Executive Service Delivery Group. • The Medical Director, Sean O'Kelly, referred to 'Antibiotic Prescribing Compliance (Q1. Exception Report)', saying that the Division of Surgery Head and Neck was the poorest performing Division by some degree in August. Dr Nevin and Sean O'Kelly had discussed and agreed a number of interventions, including Consultant-level responsibility for antibiotic compliance. Joint Pharmacy and Microbiology ward rounds were continuing and this raised optimism that the level would be achieved. There were some cases where antibiotic compliance was not possible (including organ-failure) and this would also be taken into account in future reporting. Sean added that the 98 prescriptions in the previous month had been prescribed by 50 clinicians, which revealed that non-compliance in any one instance had a significant impact on statistics. The Board expressed some frustration with the fact that this measure was still not being achieved. • Sean O'Kelly discussed the failings in 'Stroke Care – percentage receiving brain imaging within an hour (Q12. Exception Report)', noting that the standard had remained unchanged at 30% in the last twelve months. The reason for not achieving the 50% standard continued to be multi-factorial. Sean outlined that a significant amount of patients presented with symptoms that were not indicative of the genesis of a stroke, and were therefore not eligible for thrombolysis and imaging. These patients had been included in the denominator of the indicator. The Trust was working on ways to address the target, as it was not focussed entirely on the objective, which was to scan those patients for whom thrombolysis could be beneficial. Discussion commenced following the Chief Nurse's presentation of the Quality Report, and included the following: • John Moore reported that Alison Moon had agreed to bring a "pareto" selection of complaints to the Quality and Outcomes Committee. • Referring to Sean O'Kelly's comments on Antibiotic Prescribing Compliance (Q1. Exception Report), John Moore asked whether there was a system of cross-checking between professionals. Mike Nevin confirmed that this took place, and had advantages, but was time consuming. • Regarding 'Stroke Care – percentage receiving brain imaging within an hour (Q12. Exception Report)', John Moore asked if there was capacity in the	Chief Nurse

scanner service to achieve the target. The Chief Executive gave the Board assurance that the clinical objective was prioritised.

- Also referring to Stroke Care (Q12), Mark Callaway said that it was reassuring that patients treated with thrombolysis also received a scan and it was suggested that the "blip" in July could be attributed to very low patient numbers, and that the August trend indicated the reality.

- The Pressure Ulcer Indicator (Q4-6) was disappointing, particularly given the collaborative 90-Day Rapid Spread programme. John Moore received assurance that the Trust undertook benchmarking to assess how other Trusts achieved the indicator. Alison Moon responded that intentional rounding was looked at, and the fundamentals of patient care, and Robert Woolley added that this basic care was a "sentinel beacon for the quality of the care provided on the wards" and there was an increased focus on Pressure Ulcers and the undertaking of accurate grading. The Trust expected an improvement in this measure by December, following the initiatives currently underway.

- Iain Fairbairn felt assured that the Pressure Ulcer Indicator could be improved through the efforts of the Rapid Spread programme.

- The Chair of the Quality and Outcomes Committee, Paul May, confirmed that the Committee was monitoring Pressure Ulcers on behalf of the Board and was due to receive an update report in December.

- Paul May referred to the dips in the Hospital Standardised Mortality Ratio (HSMR) shown on page 42 of the Board pack. He gave reassurance to the Board that the Quality and Outcomes Committee would continue to review the levels. Sean O'Kelly clarified to the Board that the Ratio gave a statistical indication of the number of patients who had been *prevented* from dying, when they would otherwise have been expected to.

- John Moore asked for detail regarding the timescales of removing patients from lists, with regard to the Reduction in Elective Length of Stay (Q10) Exception Report. James Rimmer explained the process in some detail. In response to the question by Emma Woollett, James confirmed that 5% to 10% of patients came off waiting lists, and this was the NHS average.

- James Rimmer assured Deborah Lee that the GP was always alerted to the possibility of their patient being removed from a waiting list.

The Chairman noted the reassurance that the Board was alive to any changes in indicators, and that they were investigated in all cases, and explained to the extent that the Board was satisfied with patient safety.

c. Workforce

The Director of Workforce and Organisational Development, Steve Aumayer, introduced the Workforce element of the Summary Quality and Performance report. The main points of relevance were:

- Total in-post Whole Time Equivalent (WTE) had reduced by around 100 and this was attributed to both the removal of extended maternity and sabbatical leave roles that were not paid, plus an additional underlying reduction of around 30 substantive roles. More were expected in October as a result of ward-closures, and it was expected that these would be noted primarily in Bank numbers.

- Bank and Agency usage continued to reduce and was 31 Full-Time Equivalents (FTEs) down on July. Based on the same month last year the reduction is around 28%, (110 Full-Time Equivalents).
- A further reduction in Sickness Absence was reported, but it was necessary to maintain the focus on applying the policy, heading into the winter months.
- Appraisals were recorded as above 80%, a month earlier than predicted. The new appraisal process was being introduced in October, with a simplified format focussing on quality.
- Steve Aumayer referred to the actions in place to monitor and manage savings for Workforce reduction plans, and these included vacancy controls for each Division. The monthly Divisional Reviews seek assurance on forward plans for the workforce and the Human Resources Board would monitor all of the reduction plans in detail.
- There was a focus on clarifying roles across the Trust ('spans and layers'), to prevent duplication and remove unnecessary layers of management.
- Discussion commenced following the Director of Workforce and Organisational Development's presentation of the Workforce Report, and included the following:
- Following a request for clarification from Iain Fairbairn, Steve Aumayer confirmed that the new appraisal process was only officially complete once both the appraiser and the appraisee had agreed and 'signed-off' the outcomes of the appraisal.
- Responding to a question about the use of Bank versus Agency staff in July, Mike Nevin expressed a concern that the movement of substantive bank staff from weekly to monthly pay was impacting on the numbers willing to undertake bank work. Steve Aumayer confirmed that the availability of bank staff to fill posts would be carefully monitored to ensure that there was no degradation in service, whilst continuing to make the required workforce cost savings.
- Paul May said that the engagement and effectiveness of staff was a matter of key importance to the Trust Board of Directors. Robert Woolley supported this comment and expanded, noting the national context and the requirement to redefine the way the hospitals function.
- James Rimmer congratulated Estates and Facilities, who were leading the Trust in appraisal performance.

d. Access

The Chief Operating Officer, James Rimmer, introduced the Access element of the Summary Quality and Performance Report. The main points of relevance were:

- The Board was aware of the changes in the wait on the Breast Screening pathway ('62-Day Cancer Referral to Treatment for GP and Screening Referred Patients - A1. Exception Report), and that this quarter would not be achieved as a result.
- The 'Last-Minute Cancelled Operations / 28-Day Re-admission (A2.

Exception Report) was on-track for achievement. • A 'dip' was acknowledged for 'Reperfusion (call to Balloon Times) within 150 minutes (direct admissions only) – A4. Exception Report' at the Bristol Heart Institute, and this was being investigated with the Great Western Ambulance Service (GWAS). *There being no further questions or discussions, the Board resolved to **note** the Summary Quality and Performance Report.*	
7. Histopathology Action Plan Update The Board received and considered this report by the Chief Executive to **note**. Robert Woolley presented this quarterly report, and thanked Alison Moon for leading the co-ordination of the action plan. Alison Moon reported: • The action plan had evolved to note completed actions and those outstanding. Two main areas of on-going work were noted. Deborah Lee reported on the first: • The details in achieving the integration milestone included a single management tier, single reporting template and common key performance indicators across both Trusts. These would be completed by the end of December 2011. Sean O'Kelly reported on the second: • That the initial cellular pathology staffing review had been completed within the time specified by the action plan, and that this initial review had identified a number of further pieces of work requiring completion. These included a comprehensive job planning process for all Consultants working within Cellular Pathology across both UHB and NBT, and a skill mix exercise to determine what work currently performed by Consultants could be carried out by other staff. Dr O'Kelly also reported that he would be assessing the results of the further work, together with Dr Chris Burton Medical Director at NBT, once these were completed, to determine whether any adjustments to staffing levels were indicated. Paul May had met with Dr Pitcher and noted that there was considerable progress in many areas. • Alison Moon commented on the evolving role of Health Watch, saying that the Trust had engaged with the lead of Bristol Local Involvement Network (LINk) and was pleased that they had pathfinder status. The Bristol Local Involvement Network are due to attend the Patient Involvement Group in December. The Quality and Outcomes Committee also welcomed assurances from Alison Moon that there would be evidence provided at the next review of the effectiveness of actions introduced as part of the action plan. *There being no further questions or discussions, the Board resolved to **note** the Histopathology Action Plan Update Report.*	Chief Nurse
8. Safeguarding Annual Report The Board received and considered this report by the Chief Nurse to **note**.	

Alison Moon presented the report, saying that it charted progress throughout 2010/2011. In addition, it referred to higher reporting of safeguarding concerns due to education and awareness and communication with people with learning difficulties.

The key risks for 2011/2012, identified in March 2010, were listed as:

1. The requirement to overcome the safeguarding risks posed by the existence of multiple sets of notes for any one child would remain a key priority within the Trust and remained on the Corporate Risk Register.
2. In relation to safeguarding training, there was a risk that the Trust would be non-compliant with Outcome 7 after the 31 October 2011, which might lead to the Care Quality Commission providing the Trust with an improvement notice.
3. The new Safeguarding Children training requirements specified within the intercollegiate guidance (2010) might have a significant impact on the Trust's compliance with the Care Quality Commission Outcome 7 training target.

Alison Moon stressed that significant progress had been made in 2011/2012 to mitigate these risks and to achieve compliance by 31 October.

In general it was noted that:

- The current process of flagging-up vulnerable children receiving services from different parts of the Trust was described as "clunky". Alison gave assurances that the new electronic clinical information system promised a significant improvement. Alison informed the Board that there was a current system in place which ensured that all children in receipt of a protection plan were updated monthly onto the Patient Administration System.

Discussion included:

- Paul May asked for assurances relating to the Trust's consideration of the Munro Report, which Alison Moon confirmed had been considered and taken into account in the Trust's safeguarding provisions.
- The Governor, Garry Williams, asked if the Trust's electronic register gave the same regard to vulnerable elderly patients, and Alison Moon confirmed that it did.
- Following a request by Iain Fairbairn, Paul Mapson confirmed that the electronic clinical information system was compatible with the Bristol City Council system.
- Emma Woollett asked if the system would address the issue of multiple notes and Paul Mapson explained the transition to scanned documentation in the short-term, and the full reliance on the electronic system in the future.

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

9. Security Annual Report

The Board received and considered this report by the Chief Operating Officer to **note**.

James Rimmer highlighted the 'positive' report and the success in respect of reductions in crime, accompanied by successful prosecutions. This indicated

the zero-tolerance approach to violence and aggression across the Trust.

There was an on-going focus on the Emergency Department, where 77% of incidents were recorded.

Discussion included:

- Iain Fairbairn asked if the security of the perimeter of the Emergency Department had formed part of the design criteria for the new building. Robert Woolley confirmed that it had been considered for the Welcome Centre, and was included in the lock-down procedure.
- Alison Moon said that 523 staff had been identified as needing training to de-escalate issues and use 'breakaway' techniques. This was primarily as a result of non-intentional violence and aggression from patients.
- Selby Knox commented that the statistics in the report did not detail the broad range of violence and aggression, from assault to racial abuse. A themed approach to reporting was currently in development.
- Paul May asked James Rimmer if the report covered security on and off the premises. James Rimmer confirmed that consideration was given to the locality. He outlined that it was a Trust security report, and included all incidents reported by staff, including those that took place outside of Trust property. James added that that lone-workers had devices and safe routes had been recommended to staff, and Steve Aumayer confirmed off-site incidents were identified and dealt with through Health and Safety management.

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

Finance and Governance

10. Committee Chairs' Reports

The Board received and considered reports on the activity of Board Committees by their respective Chairs to **note**.

a. Audit Committee dated 12 September 2011

John Moore gave a verbal report on the main issues discussed at the Audit Committee meeting held on Monday 12 September 2011:

1. External Auditor Report
   - The Trust's accounts for 2010/2011 were approved, unqualified
   - The Trust had proper arrangements in place to achieve value for money.
   - The Trust's Quality Report met Monitor's requirements.
   - The UK Treasury Alignment Project may result in a shortening of the timetable for drawing up accounts, by two weeks.
2. Internal Auditor Report
   - It was noted that 50% of actions following the previous recommendations were overdue. (The Chief Executive Lead assured the Audit Committee that this was being addressed).
   - The Red Rating on the "Sleep Unit" was due to procedures for lending of machinery to patients. New procedures have since been implemented.

- An Amber Rating was reported for Information Governance, and this was important as the potential fine was £500k if confidential data was misused or disclosed. Corrective actions are now in place.
- Regarding the Quality Accounts Review, it was noted that the 2010/2011 Falls data that was presented publicly recently, may have been amended following publication of the Quality Report. The Audit Committee and Chief Executive had agreed that the same rigour should be applied to activity figures as was applied to financial data.

3. Risk Register
   - The Audit Committee wished to highlight how reassured they were that the Risk Register was now collated and reviewed by the Trust Management Executive collectively.

b. Finance Committee dated 21 September 2011, including the Finance Report

Lisa Gardner reported on the main issues discussed at the Finance Committee meeting held on Wednesday 21 September 2011:

1. The Trust had delivered a surplus of £2.157m for the five months to 31 August. This was in line with the Annual Plan at this stage in the year. The Trust's Financial Risk Rating remained at 3, although the detailed calculation was now 3.45 (July 3.25) – this was in line with the Annual Plan forecast for the half year position.

2. The Committee noted the further deterioration in the Divisional financial position with the cumulative overspending increasing by £0.762m in the month to £3.490m. The significant adverse movement recorded against the Surgery, Head and Neck Division has moved the Division's RAG rating from Green to Amber/red this month. The Committee was also concerned to note the move away from trajectory for the Division of Medicine.

- Total pay expenditure for August at £24.8m was higher than July and in line with the monthly average over the first quarter. The delivery of the Trust's financial plan for the year required a sustainable reduction in pay costs over the next 3 months. It was agreed that the Director of Workforce and Organisational Development should be invited to the October meeting to give an overview of the HR issues which feature in the Cash Releasing Efficiency Savings programme and how Executives would be delivering workforce savings.
- The continuing overspending recorded against non-pay budgets was noted with concern. Two divisions (Surgery, Head and Neck at £0.632m and Medicine at £0.529m) accounted for over half of the total adverse variance of £2.042m. Slippage on non-pay Cash Releasing Efficiency Savings schemes totalled £2.689m.
- Income from Activities, after adjustment for the March 2011 over performance which was settled in 2011/12 year, was less than plan. Given the increasingly challenging situation that commissioners find themselves in, it was clear that the Trust had to put greater emphasis on securing recurring savings rather than expect to maintain

financial balance with higher than planned income.

3. It was noted that the significant feature for the August position continued to be slippage on the delivery of the Cash Releasing Efficiency Savings programme. The Finance Committee received a progress report on Cash Releasing Efficiency Savings from the Director of Transformation. The forecast savings for the year currently totalled £20.526m or 77% of the 2011/12 target of £26.636m. The actual Cash Releasing Efficiency Savings achieved for April to August totals £6.249m, equivalent to slippage of £2.793m when compared with the Plan for the period of £9.042m. In addition, 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 – this resulted in a further adverse variance of £2.056m, giving a total adverse variance on the Cash Releasing Efficiency Savings programme of £4.849m.

4. The Committee, after an in depth discussion of the principal Cash Releasing Efficiency Savings workstreams [nurse and midwifery staffing (standardisation of rosters and review of staffing levels); medical staffing (development of rules for Divisions to follow on consultant job planning); Pathology services (switch from looking at savings on the Avon-wide review and look in the meantime at reducing diagnostic testing) and out-patient service transformation (Paul Mapson to do a presentation shortly to the Trust Management Executive)], were encouraged by recent progress, which indicated savings of more than £20m this year.

Discussion included the following:

- The Non-executive Directors commented that after the delays in starting this year's programme it was important that momentum was progressed with regard to Cash Releasing Efficiency Savings over the years, as opposed to starting from a standing position on 01 April. The improvement in management processes around the delivery of Cash Releasing Efficiency Savings and Transformation was also welcomed.

c. Quality and Outcomes Committee dated 27 September 2011

Paul May gave a verbal report on the main issues discussed at the Quality and Outcomes Committee meeting held on Tuesday 27 September 2011:

- The Committee undertook a self-assessment of its performance at half-year compared with the requirements of its Terms of Reference. This included:
    - A detailed check that the Committee was addressing its Terms of Reference in their entirety.
    - Updating the Committee Annual Plan to include reports in any areas not already addressed.
- The Committee asked the Trust Secretary to review governance arrangements associated with engaging the Governor Quality Group in the work of the Quality and Outcomes Committee.
- A number of additional issues for further work and timescales were agreed at the meeting, which would fit in with the forward plan.
- With respect to the Corporate Risk Register, Paul May explained that the role of the Committee was to ensure that the risk mitigation actions outlined

were reviewed, in terms of the impact on patient experience.

- With that in mind, it was recommended that action detail/progress columns could be developed to improve comments about the potential impacts for patients.
- Regarding the Quality and Outcomes Committee Annual Plan, the Trust Secretary and Chair submitted a detailed plan of issues considered and planned for the balance of the Financial Year.
- Future additional matters for review included:
  - Antibiotic compliance
  - Stroke services
  - Multi-Disciplinary Team effectiveness linked to the Histopathology action plan
  - Dementia services
  - Patient pathways
  - Learning from low grade incidents
  - 62-Day Cancer detail performance review
  - Wide patient information/complaints assurance overview
  - Follow up of the new catastrophic incidents process for assurance purposes.
- It was noted with concern that several of the issues previously reviewed had seen reductions in performance in this month's papers, so the issue of long-term sustainability would be scrutinised strongly in the future.
- Regarding the Committee's assessment of the Trust's provisions for compliance with the Monitor Quality Governance Framework:
  - At the July meeting, a format for the review was agreed and a report considered, which outlined the current evidence against the 103 indicators. Well in excess of twenty of these indicators required the Non-executive Director Committee members' input.
  - This was a significant and important role for the Committee to advise the Board, so the Non-executive Directors would input their views by the next meeting, some of the evidence would be further developed, and the Clinical Quality Group would recommend the current (Red, Amber, Green (RAG)) status by the November meeting.
- Regarding the Quality and Performance report to the Board:
  - Some detailed analysis issues still required clarification and both the content/style of the Workforce and Access sections may be reviewed at some stage in the future.
- Key issues for attention included:
  - Hospital Standardised Mortality Ratio (HSMR) one month jump only. It was important that any upward "trend" was scrutinised.
  - Elective length of stay (previous review)
  - Outpatient follow-up to new ratio (ditto)
  - The contract penalties where this may have an adverse impact on

patient service quality.

- Cancer 62-Day Referral to Treatment (screenings)
- Workforce issues were not considered at the meeting but the Committee sought statistical information about appraisal effectiveness and the potential performance opportunities for joint working across trusts.

Last Minute Cancelled Operations and 28-Day Readmissions both showed small declines, but as they had significant patient impacts they were already reviewed by the Committee.

*There being no further questions or discussions, the Board resolved to **note** the Committee Chairs' Reports.*

Strategy and Business Planning

11. Bristol Haematology and Oncology Centre (BHOC) Business Case Development

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

Deborah Lee introduced the report, noting that the Finance Committee was unable to recommend approval for the Outline Business Case for the redevelopment of the Bristol Haematology and Oncology Centre at its August meeting. As a consequence of this, Board approval was not secured.

The Committee did 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 Outline Business Case stage in the preferred option and requested the completion of further work to a revised do minimum option. The focus was therefore on developing the preferred third option.

Discussion included:

- Emma Woollett asserted that it was important to ensure that the Bristol Haematology and Oncology Centre (BHOC) Scheme was not compromised by timescale issues.
- Iain Fairbairn sought assurance that the introduction of two Linac bunkers was sufficient. Robert Woolley assured him it would be, and this had been proved during robust testing to ensure sufficient coverage.

The Chairman confirmed that that Board approved the additional expenditure as outlined in the recommendations of the report.

*There being no further questions or discussions, the Board resolved to **approve** the Bristol Haematology and Oncology Centre (BHOC) Business Case Development.*

12. Partnership Programme Board Terms of Reference

The Board received and considered this report by the Chairman and considered the recommendations for **approval**.

Robert Woolley explained that the two Trusts had reviewed and agreed to make changes to the Terms of Reference, and these were set out in the draft paper provided, and included minor changes to the membership of the Board.

The Trust Board of Directors approved the changes as recommended, noting

that the Chairmanship would rotate every six months. *There being no further questions or discussions, the Board resolved to **approve** the Partnership Programme Board Terms of Reference.*	
13. Partnership Programme Board Report The Board received and considered this report by the Chief Executive to **note**. Robert Woolley presented the report, which was also being received by the North Bristol NHS Trust Board of Directors. The report summarised the main areas of focus and objectives for the Programme Board, with a view to report to both Trust Board's in due course. Paul May made a request for more detailed reporting on any issues with a direct impact on the Trust. Robert Woolley confirmed that the current activity of the Programme Board focussed on planning, and any future significant proposals would be reported. *There being no further questions or discussions, the Board resolved to **note** the Partnership Programme Board Report.*	
Monitor Reports	
14. Results of Q1 Monitor Assessment of NHS Foundation Trusts Compliance The Board received and considered this report by the Chief Executive to **note**. Robert Woolley presented the report and took comments and questions from the Board: • John Moore asked whether the Trust's planned declaration of compliance with the Care Quality Commission (CQC) outcome for Nutrition would lead to an Amber-green risk rating. Robert Woolley explained that this was the decision of the Regulator and may hinge on the Care Quality Commission's future follow-up visit. *There being no further questions or discussions, the Board resolved to **note** the Results of Q1 Monitor Assessment of NHS Foundation Trusts Compliance report.*	
Risk	
15. Corporate Risk Register The Board received and considered this report by the Chief Executive to **note**. Robert Woolley introduced the Corporate Risk Register and explained that it was actively owned and managed by the Trust Management Executive. He expressed concern about the algorithm used by the Risk Management system, which allowed for a 'extreme' risk to be triggered where the risk reporter classified mitigation actions as 'weak'. It was proposed that the system be deployed differently to provide a residual risk rating that was more indicative of the reality. Discussion included:	

• Following a request for clarity on the handling of incidences of tuberculosis in the Trust (Risk 1837) by the Governor, Clive Hamilton, Steve Aumayer confirmed that thorough plans had been implemented as a result of a recent Root Cause Analysis. • James Rimmer confirmed that he was meeting with the Grown-up Congenital Heart (GUCH) team to implement plans for Risk 1776, which referred to patients not receiving a timely review. • Robert Woolley confirmed to Lisa Gardner that the Risk Management Group assessed each risk, including those high risks on the Divisional Risk Registers. This review gave the Executive the opportunity to assess risks in context across the Trust, as opposed to individually. • Iain Fairbairn gave support to the proposed changes to the methodology. *There being no further questions or discussions, the Board resolved to* ***note*** *the Corporate Risk Register.*	
Information and Other	
16. Any Other Business No items of other business were discussed.	
17. Date of Next Meetings Public Meeting of the Trust Board of Directors, Wednesday 26 October 2011 from 10:30 – 13:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 05 - Chief Executive's Report
Purpose
To report to the Board on matters of topical importance to the Trust, including a report of the activities of the Trust Management Executive.
Abstract
The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Trust Management Executive in the month.
Recommendations
The 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
Robert Woolley, Chief Executive.
Appendices
• Appendix A – Report from Trust Management Executive.

APPENDIX A

TRUST MANAGEMENT EXECUTIVE

REPORT TO TRUST BOARD - OCTOBER 2011

1. INTRODUCTION

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

2. COMMUNICATIONS

The group **noted** the latest version of the Trust-wide events calendar and considered a number of current communications issues.

3. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** delivery of the remedial action plan for Outcome 5 of the Care Quality Commission's essential standards by the end of September, as planned. Subject to regulatory confirmation, this would give the Trust an amber-green governance rating on Monitor's compliance framework, as a result of under-achievement against the 62 day cancer referral to treatment time standard in Quarter 2.

Deteriorating performance against the total accident and emergency wait time target was **noted**, with corrective measures focused on internal flow and capacity and system-wide escalation processes. The group **noted** excellent work to stay within challenging Trust-level trajectories for rates of *Clostridium Difficile* and methicillin-resistant *Staphyloccus aureus* infection.

The Trust Management Executive **noted** a level of confidence about compliance with Care Quality Commission Outcomes 7 and 14 by the end of October 2011 and **agreed** that further assurance should be sought about plans to comply with Outcomes 11 and 21 by the end of the calendar year.

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

- agreement to prepare contingency plans for a possible national day of action called by public sector unions on 30 November 2011
- review of progress against corporate quality objectives, showing satisfactory performance in all areas except the Trust's participation in the South West Quality and Patient Safety Initiative, where new focus had recently been applied
- continuing progress with the implementation of new Pharmacy Stock Control and Patient Administration systems
- successful development of PhD research studentships in the Trust, which the Research & Innovation Department was in the process of advertising
- continuing development of a performance management and staff engagement framework for the Transforming Care programme

- issues with the Trust's learning management system and a related review of statutory and mandatory training requirements and support for all staff, which will be reported in November.

4. STRATEGY AND BUSINESS PLANNING

The Trust Management Executive considered the arguments for and against the development of a single pathology hub in Bristol, as proposed in the Bristol, North Somerset and South Gloucestershire Pathology Services Review. The group **agreed** that the single hub model could have significant benefits, which would need to be tested through detailed quality and economic appraisal, while **noting** that significant uncertainty persisted about the future design of specialist services, including clinical Haematology, and the appropriate retention on Trust premises of satellite services in general.

The Trust Management Executive **noted** plans by NHS Bristol to tender out a number of facilities management services for the new South Bristol Community Hospital. The group **agreed** that timely and effective communications to affected staff would be put in place.

The group **approved** the indicative medium term capital programme and **agreed** to recommend a revised business planning approach to the Trust Board.

5. RISK, FINANCE AND GOVERNANCE

The Trust Management Executive **approved** the Complaints Annual Report for onward submission to the Trust Board.

The group **noted** the addition of a new item to the log of serious concerns, relating to the timeliness of reporting of invasive cancer cervical audits to the Public Health department, and **noted** the action in hand to investigate and rectify the issues raised.

6. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
17 October 2011

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 06 – Quality and Performance Report

Purpose

To brief the Committee 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.

Executive Report Sponsor or Other Author

'**Health of the Organisation**' - Deborah Lee (Director of Strategic Development)

'**Quality**' - Alison Moon (Chief Nurse) & Sean O'Kelly (Medical Director)

'**Workforce**' - Steve Aumayer (Director of Workforce & Organisational Development)

'**Access**' – James Rimmer (Chief Operating Officer)

Authors:

- Xanthe Whittaker (Head of Performance Assurance / Deputy Director of Strategic Development)
- Anne Reader (Assistant Director of Governance & Risk Management)
- Heather Toyne (Assistant Director of Workforce Planning)

Appendices

- Appendix A – Summary Quality & Performance Report

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
		25 Oct 2011			

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

October 2011

CONTENTS

PERFORMANCE OVERVIEW

SECTION A – Performance Overview

Summary

Overall, the 'health' of the organisation has improved relative to last month, with an increase in the number of GREEN rated indicators by one, and a decreased in RED rated indicators by three. This net change includes the Same Sex Accommodation Breaches going from GREEN to RED, the Number of *Clostridium difficile* (C diff) cases going from a RED to a GREEN rating, and Cash Releasing Efficiency Savings (CRES) achievement moving from RED to an AMBER rating.

Three of the four Efficiency measures are now GREEN rated, as are the two Effectiveness measures, which represents a significant improvement on the previous period. Performance against two measures of accessibility deteriorated in the month, reflecting the dip in performance against the cancer standards in quarter 2, and A&E 4-hour performance being below the local target of 98%. Financial performance remained strong, with three of the four measures retaining their GREEN rating both for the month and year to date, and the previously RED rated CRES achievement indicator moving to an AMBER rating.

At the end of September the Trust is now rated AMBER-GREEN against Monitor's Compliance Framework, having improved from a position of AMBER-RED. This reflects the completion of the Compliance Actions required to meet the Care Quality Commission's Nutrition standard, but with performance against the 62-day cancer standard remaining being below the national target as forecast.

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)	74.4	75.3	N/A	Green: >= 74.4 Red: <72.4	↑	Current month is August 2011.
A02	Number of Patient Complaints	151	121	754	Green: <120 Red: >=135	↓	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	0	7	55	Green: 0 Red> >0	↑	

Delivering High Quality Care

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
B01	Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4)	2	3	13	Green: 0 Red: > 1	↑	No RAG rating for YTD. Current month is August 2011.
B02	Number of Inpatient Falls Per 1,000 Beddays	5.12	3.55	4.65	Green < 5.6 Red: >= 5.6	↓	Current month is August 2011.

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
C01	Number of Serious Incidents (SIs)	2	10	38		↑	
C02	Number of C.Diff cases	7	5	33	Below Trajectory	↓	

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
D01	18 Weeks Admitted Pathways	91.3%	91.9%	92.1%	Green: >=90% Red: <85%	↑	
D02	Number of Cancer Standards Failed	0	2	0	Green: 0 Red: >=2	↓	Previous and YTD is Quarter 1 2011/12. Current is provisional Q2 (July & August)
D03	A&E 4 Hour Standard	98.14%	97.12%	97.84%	Green: >=98% Red: <95%	↓	This standard now excludes the Walk In Centre (WIC). It is only the combined totals for the three Trust Emergency Departments.

PERFORMANCE OVERVIEW

Being Effective

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
E01	Hospital Standardised Mortality Ratio (HSMR)	87.0	72.9		Green: <80 Red: >=90	↓	Previous and Current totals are April and May 2011.
E02	30 Day Emergency Readmissions	350	292	2280	Below 10/11 volumes	↓	

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
F01	Elective Length of Stay Reduction	4.01	3.37	3.65	Green: <= 3.64 Red: >= 3.83	↓	
F02	Emergency Length of Stay Reduction	5.21	4.96	5.11	Green: <= 5.07 Red: >= 5.34	↓	
F03	Theatre Productivity - Percentage of Sessions Used	95.5%	95.1%	94.6%	Green: >= 90% Red: < 90%	↓	
F04	Outpatient Follow-Up To New Ratio	2.05	2.03	2.03	Green: <2.03 Red: >=2.03	↓	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
G01	Workforce Costs	1.7%	-5.1%	1.2%	above current month and ytd budget	↓	
G02	Staff Sickness	3.7%	3.9%	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)	£1,458	£1,724	£1,724	Green:>Same Period Last Year Red:<Same Period Last Year		Previous is Apr-Aug cumulative total. Current (and YTD) is Apr-Sep cumulative total. Trend arrow is not applicable, as Current will always be higher than Previous.
H02	Weighted Patients Recruited Into NIHR Trials	1,657	1,641	8,295	Green: > YTD Last Year Red: < YTD Last Year	↓	Previous and Current are rolling 3 month totals (May-Jul 2011 and Jun-Aug 2011 respectively). YTD is Apr-Aug 2011

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
J01	Monitor Governance Risk Rating	3	3	N/A	Green: < 1 Red: > = 4	→	

Delivering Our Contracts

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
K01	Financial Performance Against CQUINs (£millions)		£3.11	£3.11	> 50% Green < 50% Red		YTD/Current = Forecast year-end rewards. The Trust is taking a prudent view at this stage and has assumed 75% of the forecast.
K02	Contract Penalties Incurred (£millions)	-£0.09	-£0.04	£0.55	Green: Below Plan Red: Above Plan	↓	Previous is July; Current is August; YTD April to August. Values now shown as variances above (+) or below (-) plan, with a higher negative value representing better performance.

Managing Our Finance

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
L01	Monitor Financial Risk Rating	3	4	4	Green: >3 Red: <3	↑	
L02	EBIDTA (Compared To Plan)	103%	103%	103%	Green: 100% Red: <95%	→	
L03	CRES Achievement	69%	79%	71%	Green: >=90% Red: <75%	↑	
L04	Liquidity (in Days)	38.3	36.8	36.8	Green: 25+ days Red: <=14 days	↓	

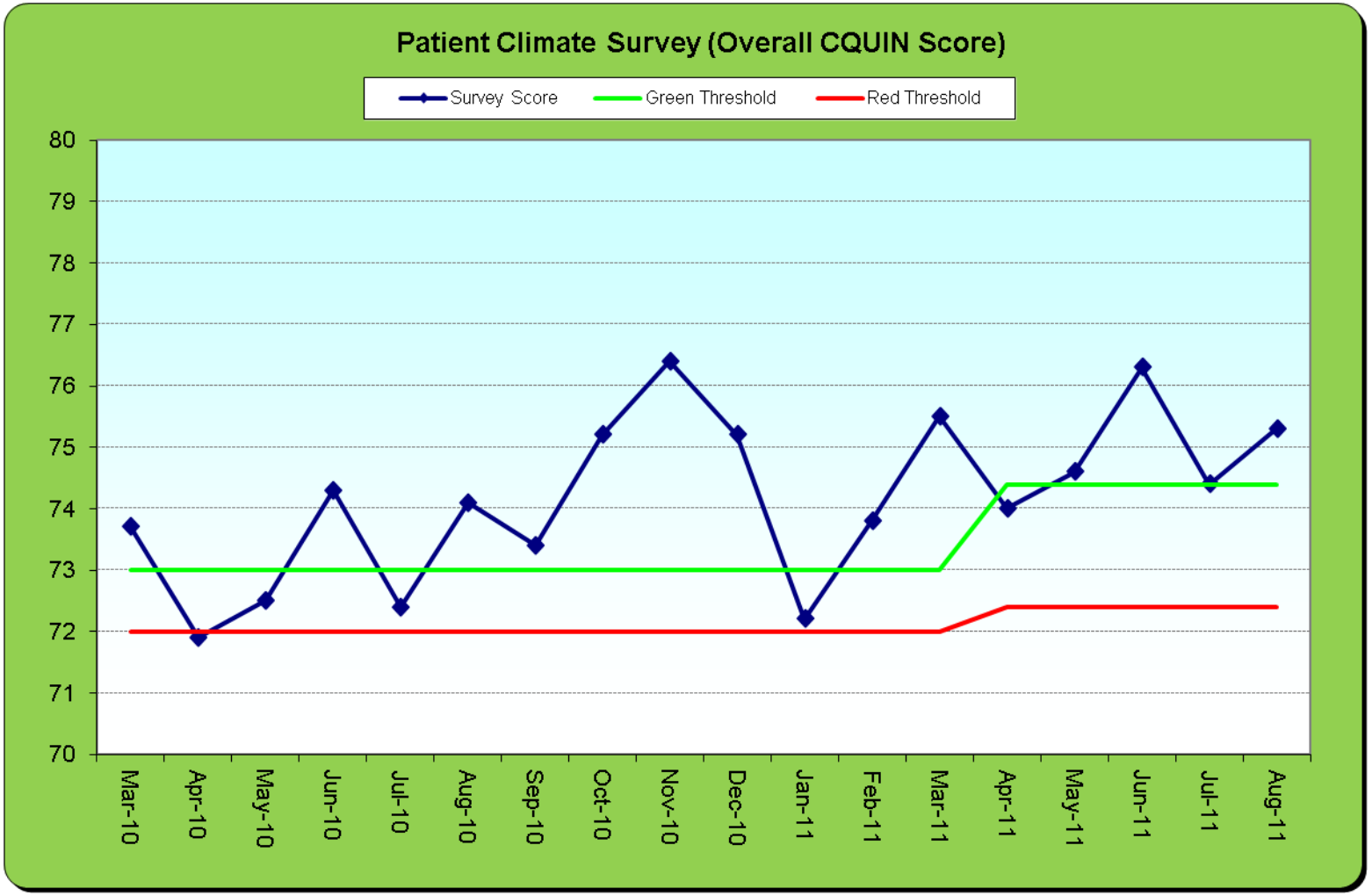
Notes

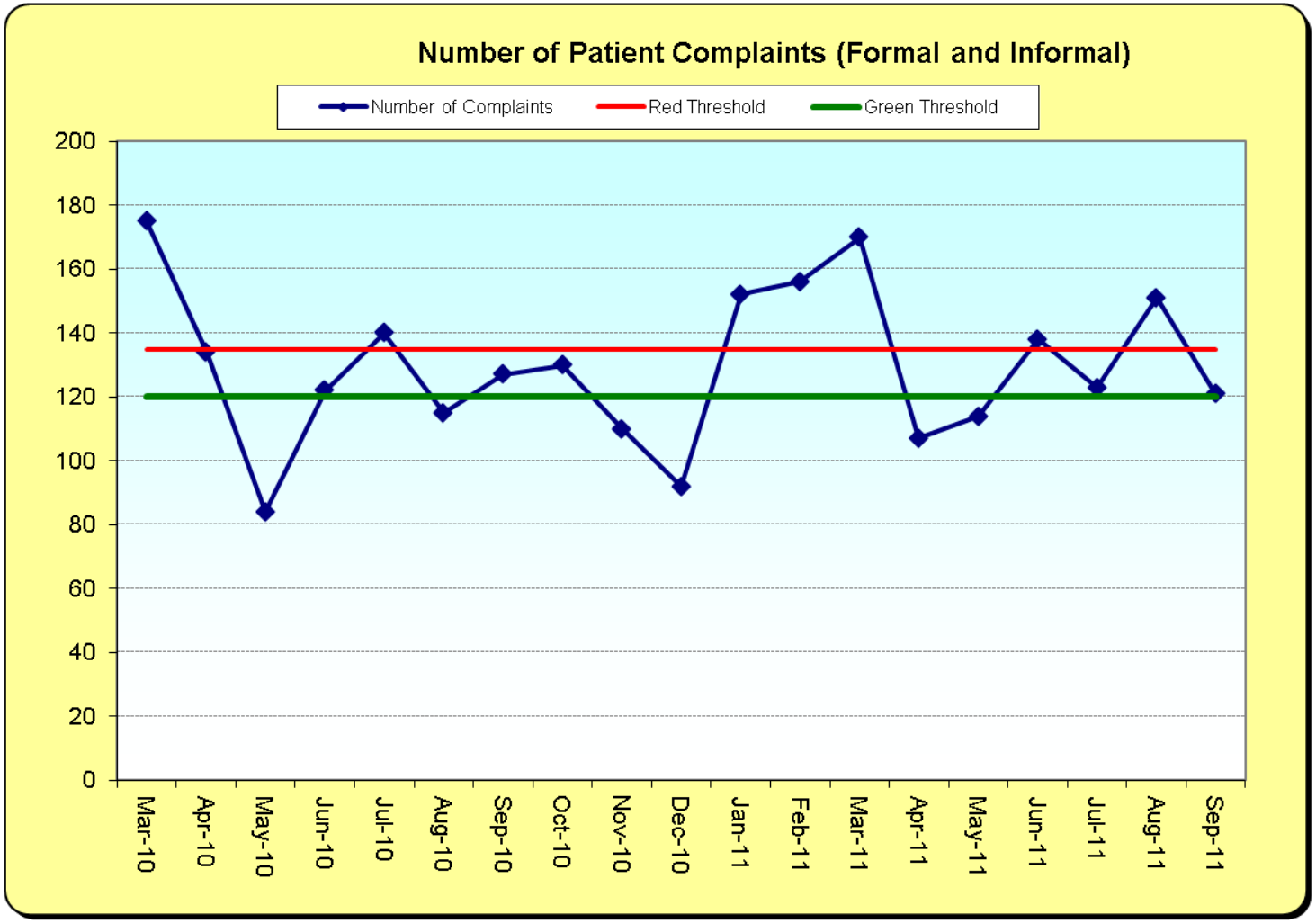
Unless otherwise stated, Previous is August 2011 and Current is September 2011

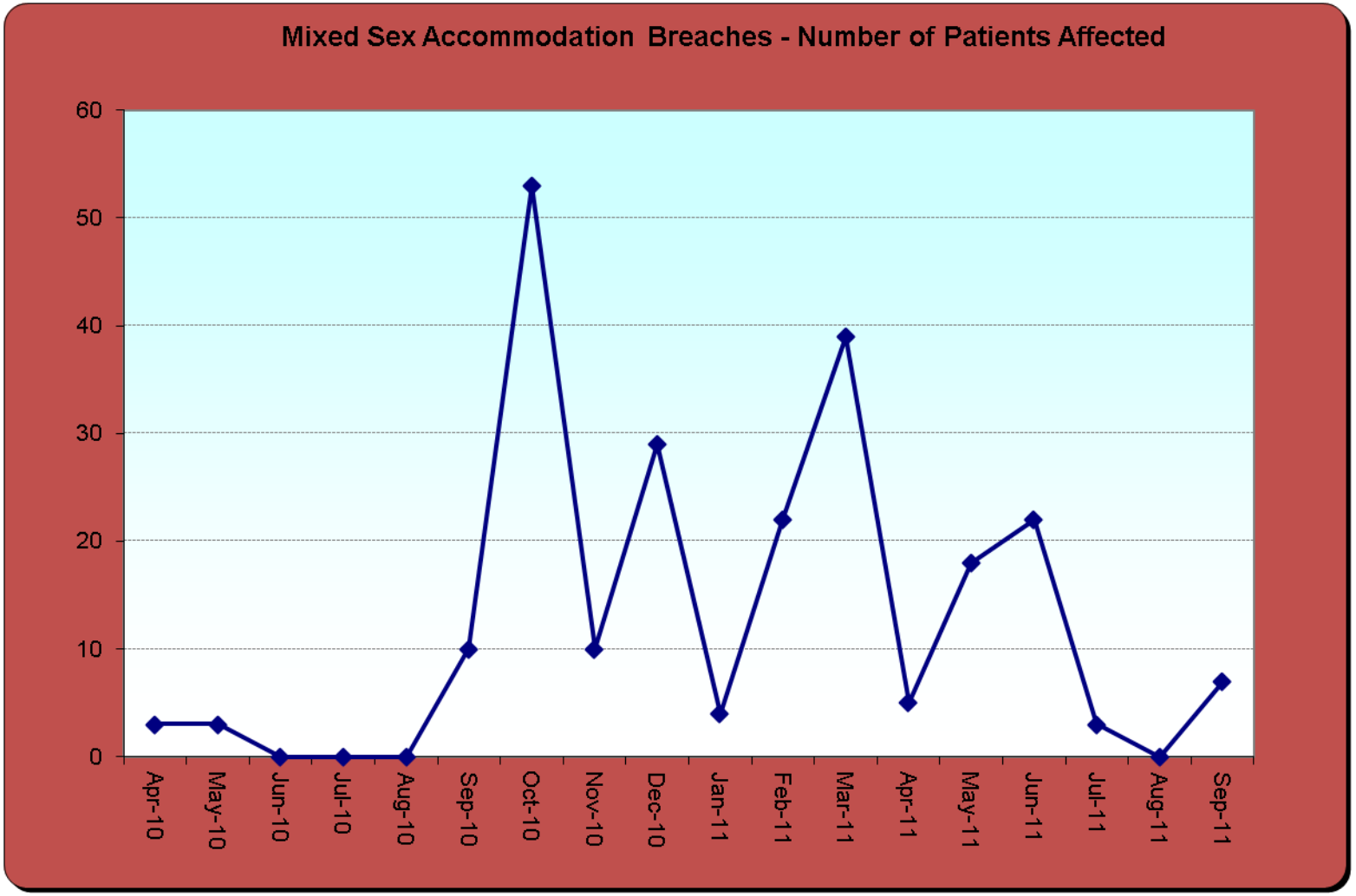
YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2011 up to and including the current month

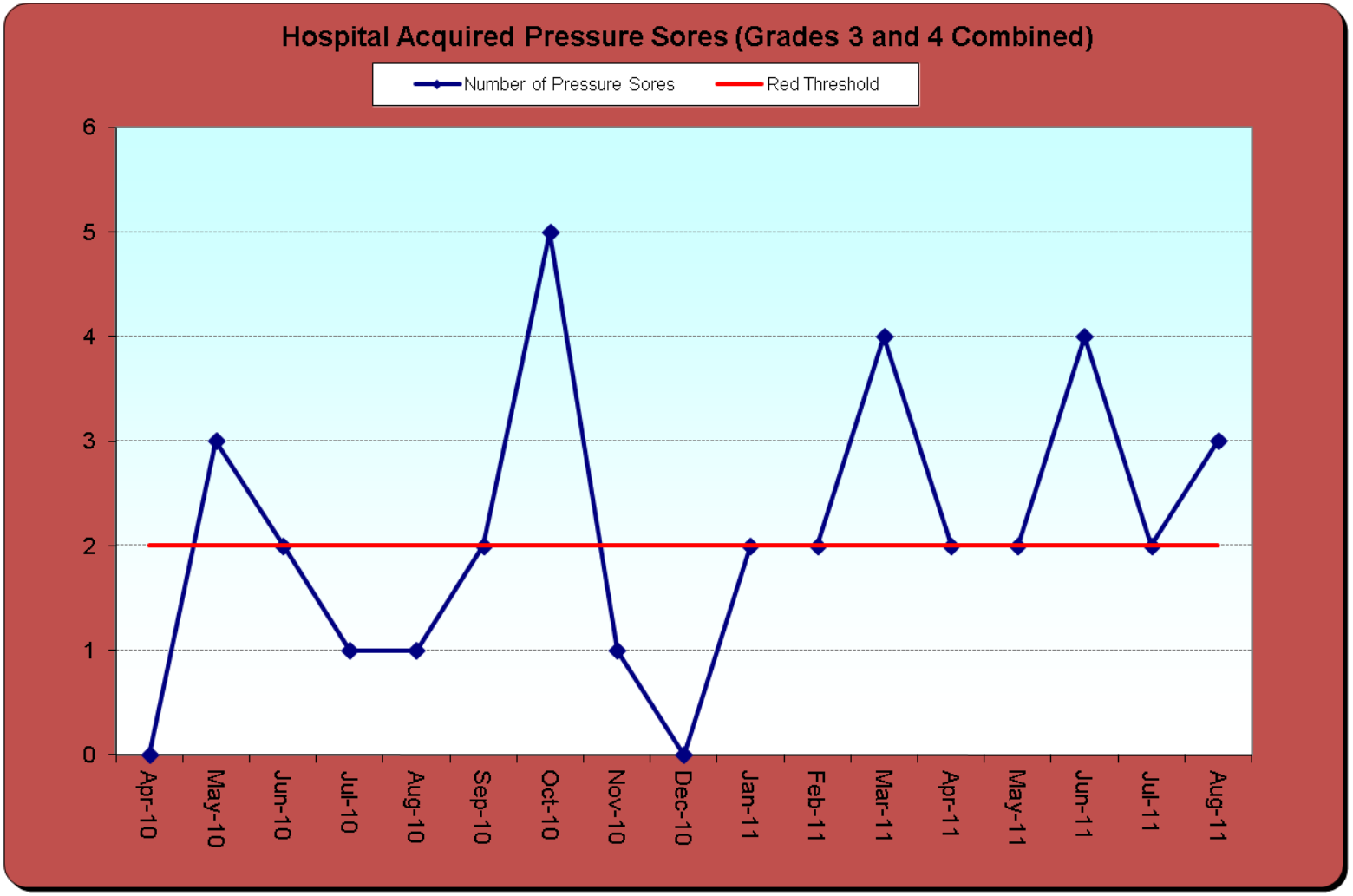
RAG (Red/Amber/Green) rating only applied to YTD where an agreed target number of cases/score exists for the year.

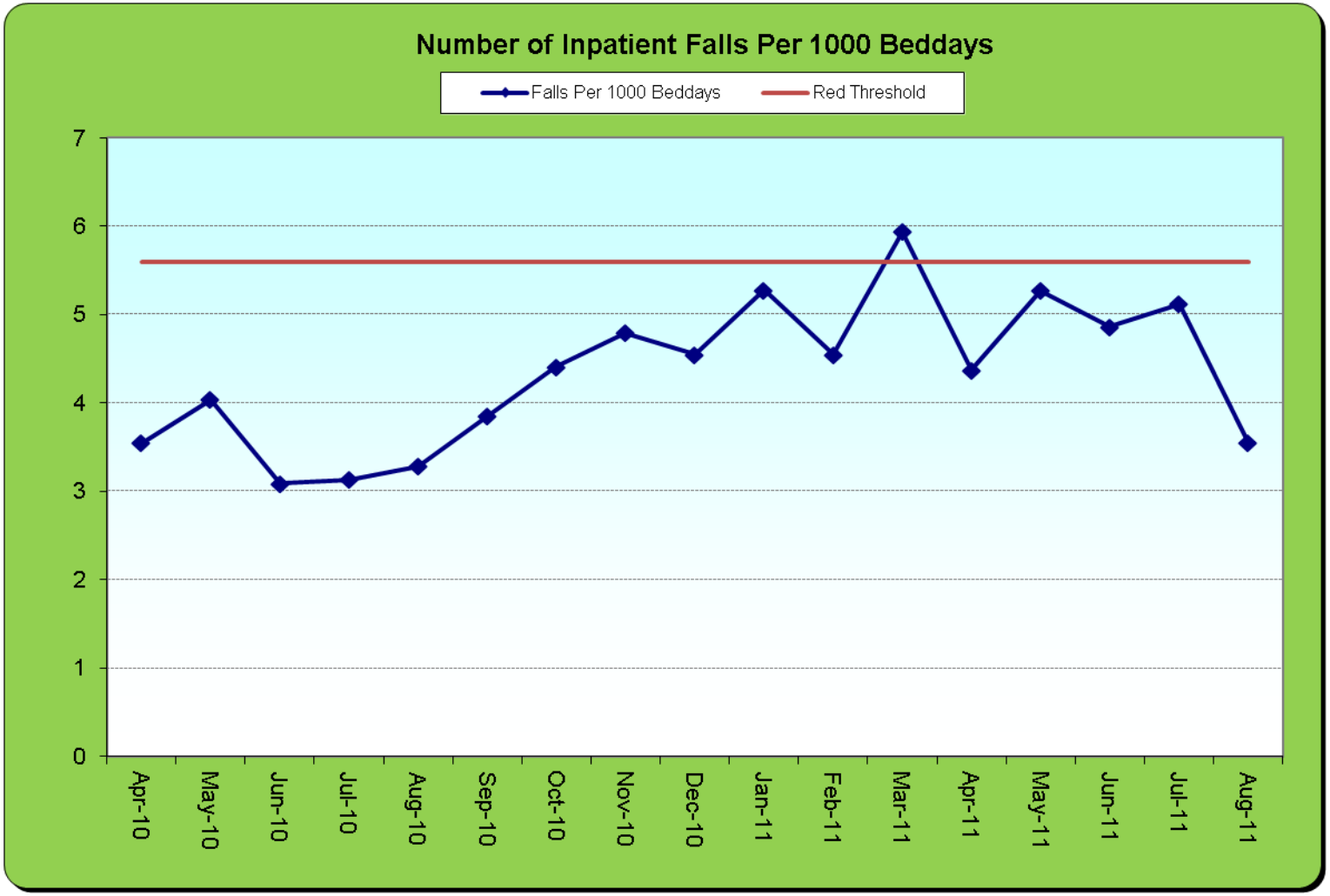
PERFORMANCE OVERVIEW

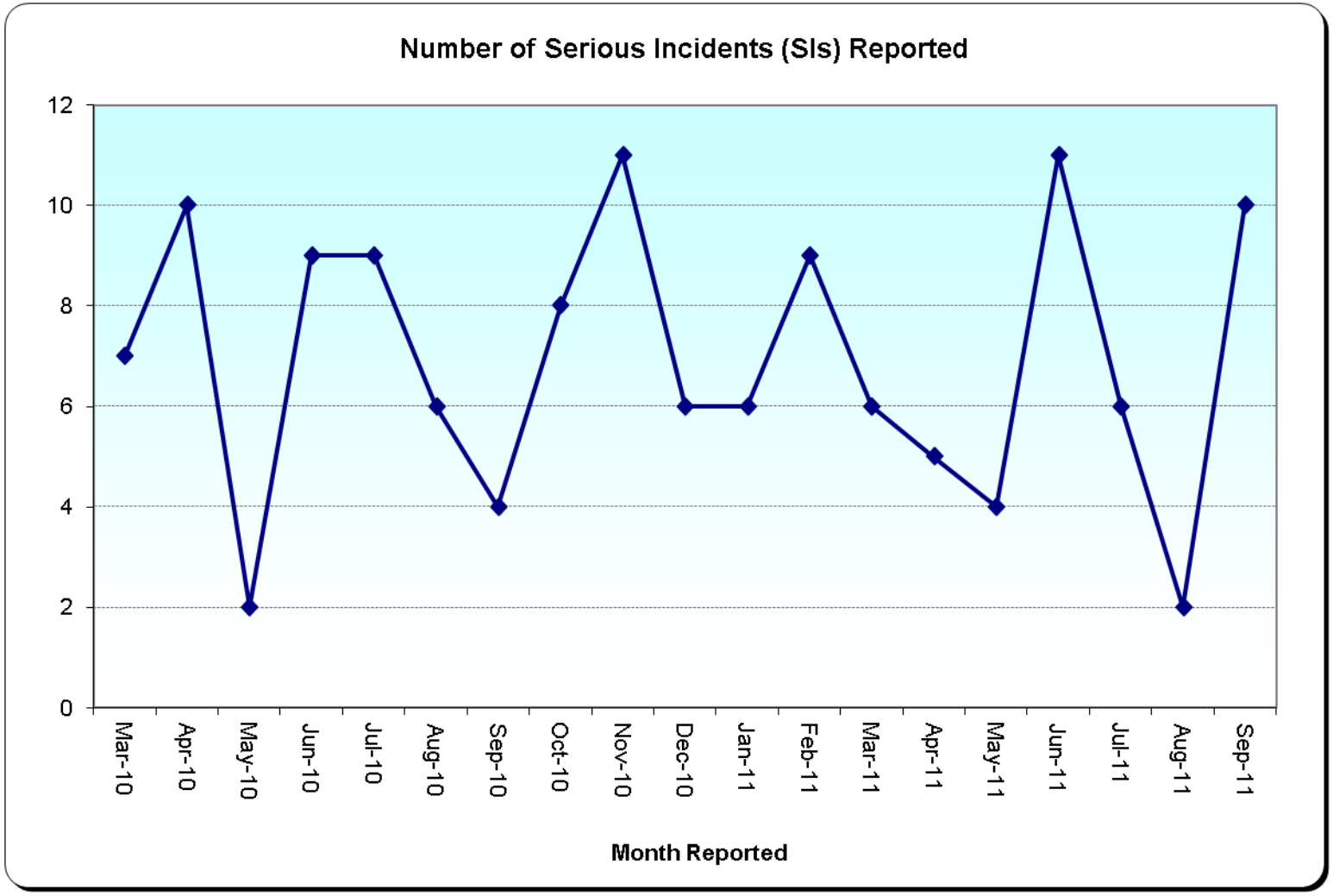


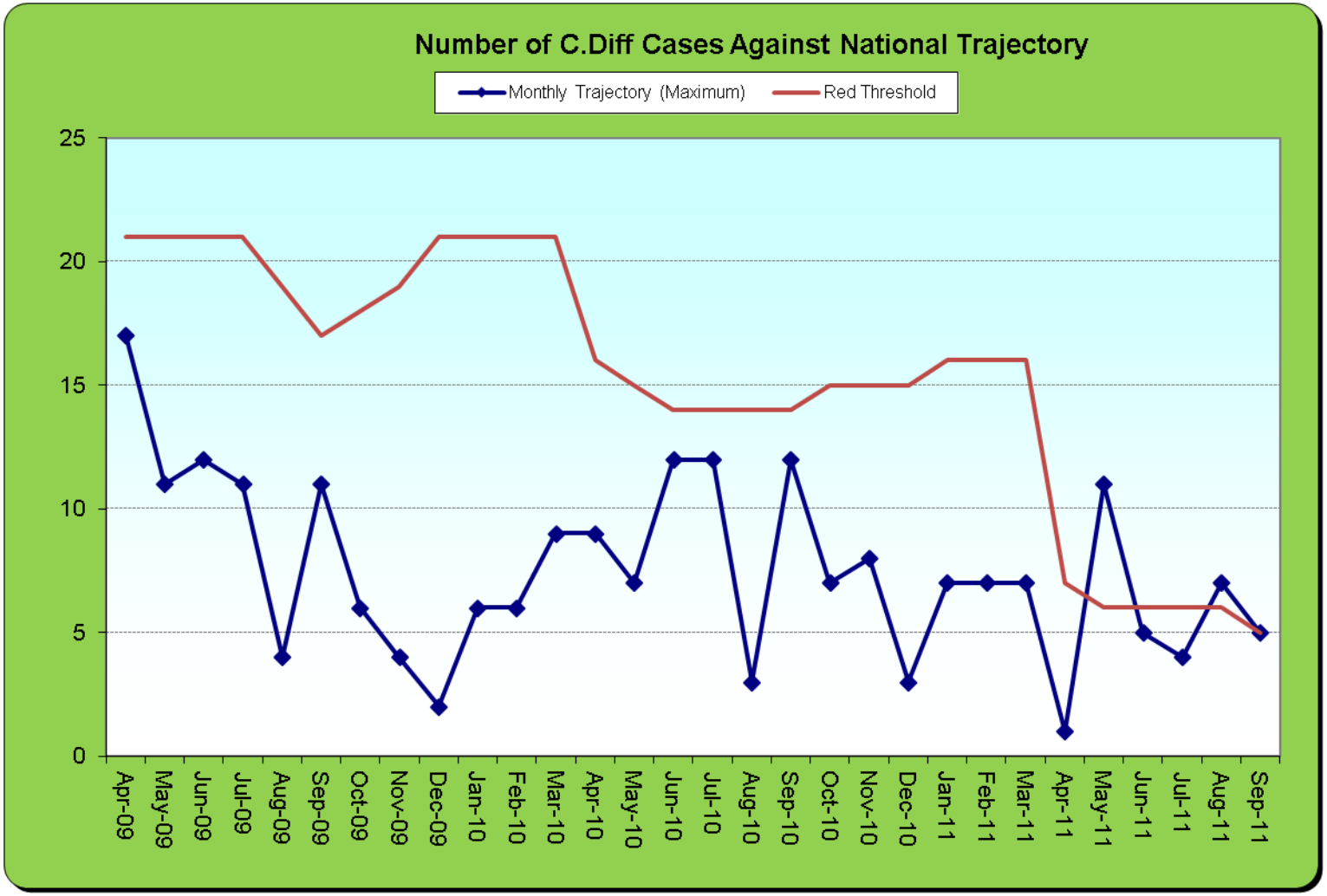

Number of Patient Complaints (Formal and Informal)
Number of Complaints
Red Threshold
Green Threshold
200
180
160
140
120
100
80
60
40
20
0
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11


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
Sep-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
Aug-11


Number of Inpatient Falls Per 1000 Beddays
Falls Per 1000 Beddays
Red Threshold
7
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
Aug-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
Sep-11
Month Reported


Number of C.Diff Cases Against National Trajectory
Monthly Trajectory (Maximum)
Red Threshold
25
20
15
10
5
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
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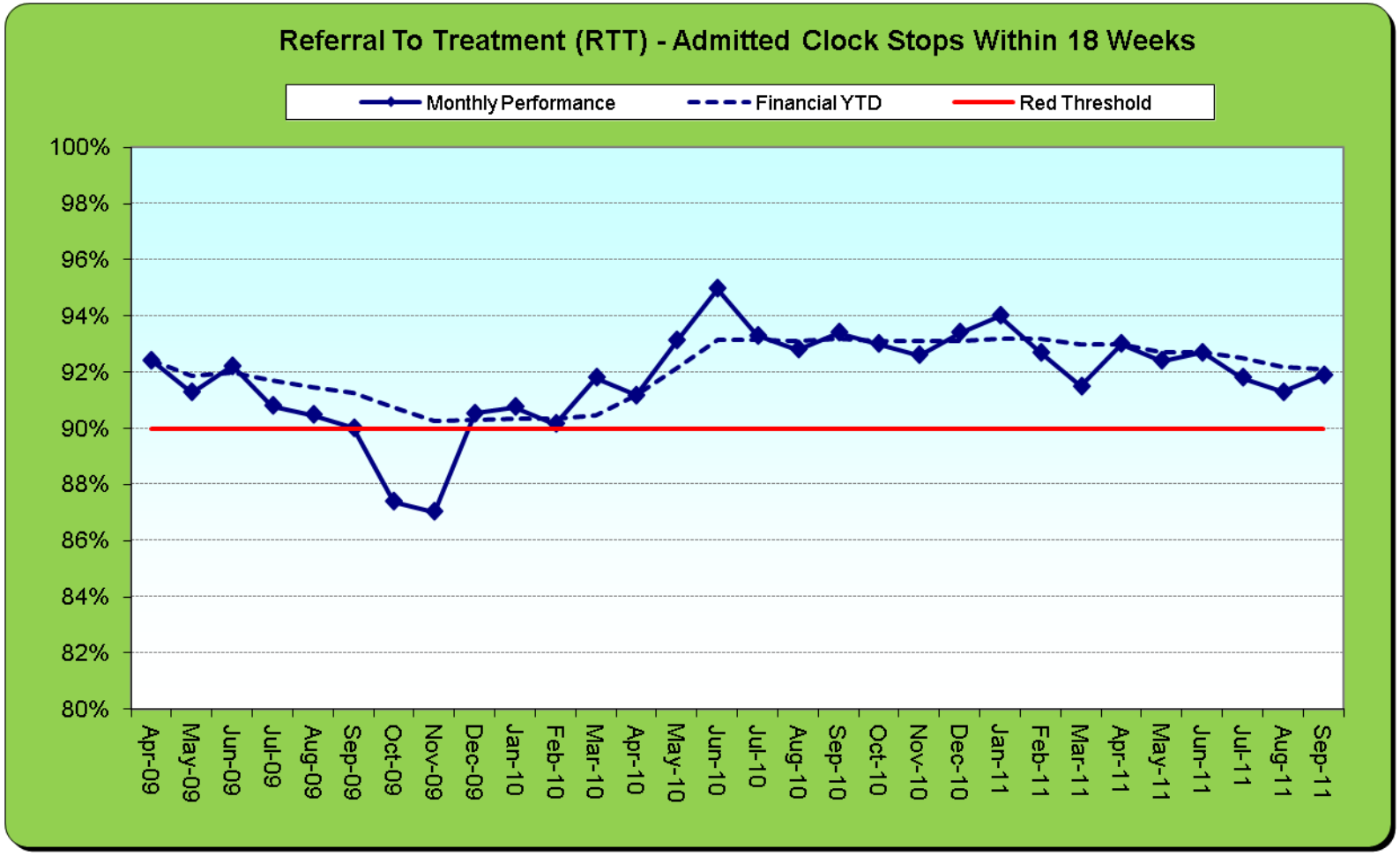
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11


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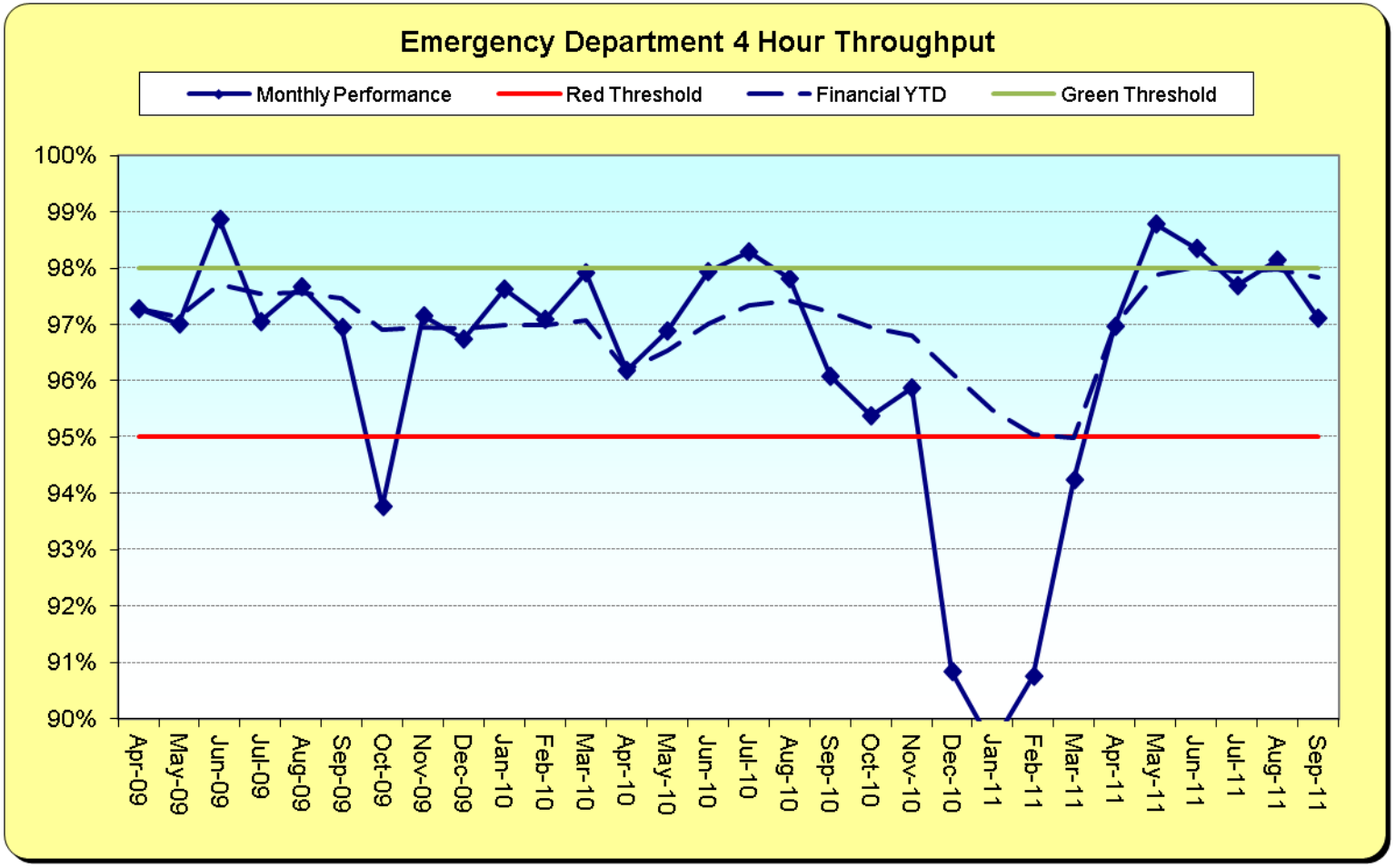
Jul-11
Aug-11
Sep-11


Emergency Department 4 Hour Throughput
Monthly Performance
Red Threshold
Financial YTD
Green Threshold
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
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
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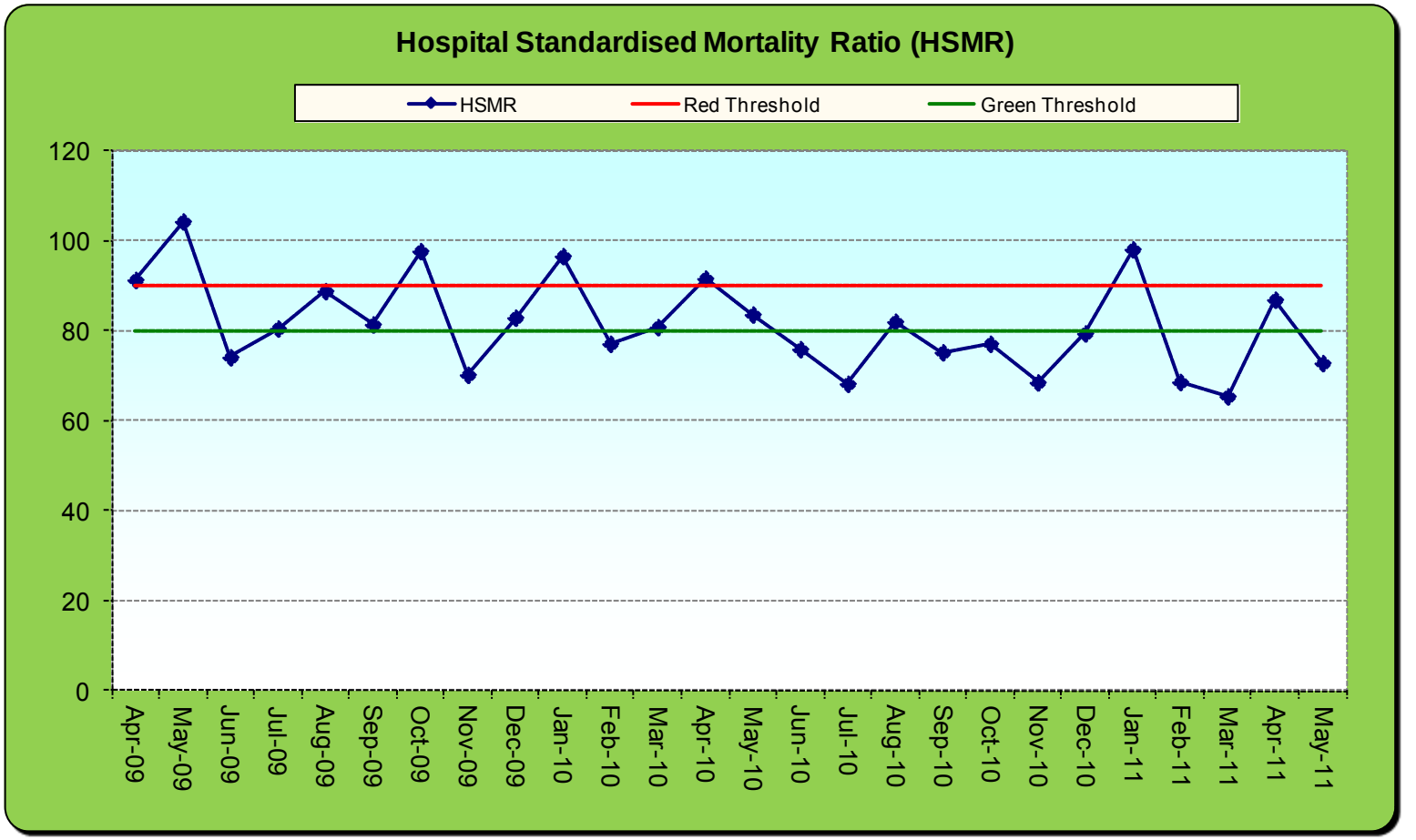
May-11
Jun-11
Jul-11
Aug-11
Sep-11


Hospital Standardised Mortality Ratio (HSMR)
HSMR
Red Threshold
Green Threshold
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
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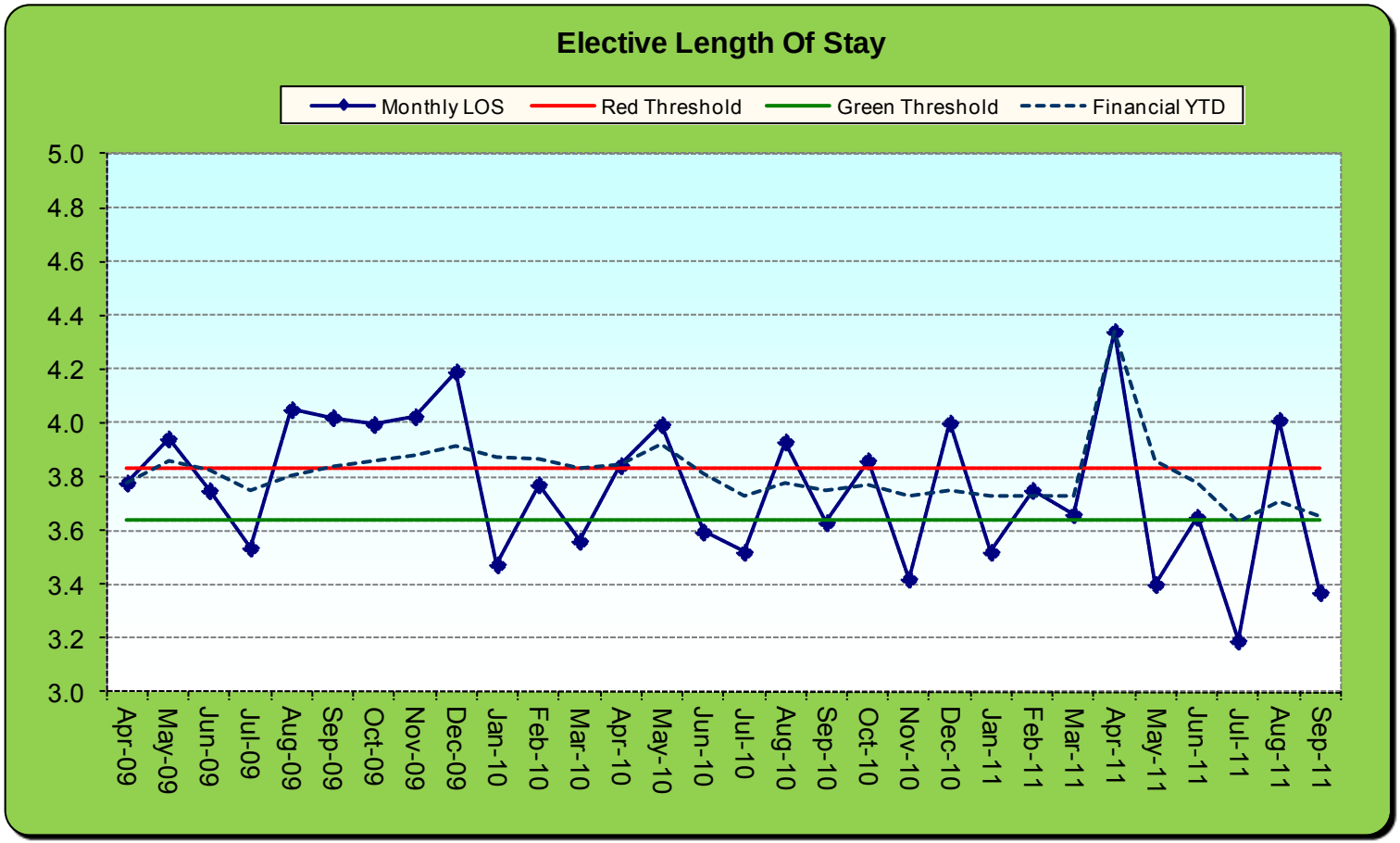
Jan-11
Feb-11
Mar-11
Apr-11
May-11


Elective Length Of Stay
Monthly LOS
Red Threshold
Green Threshold
Financial YTD
5.0
4.8
4.6
4.4
4.2
4.0
3.8
3.6
3.4
3.2
3.0
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
Jul-10
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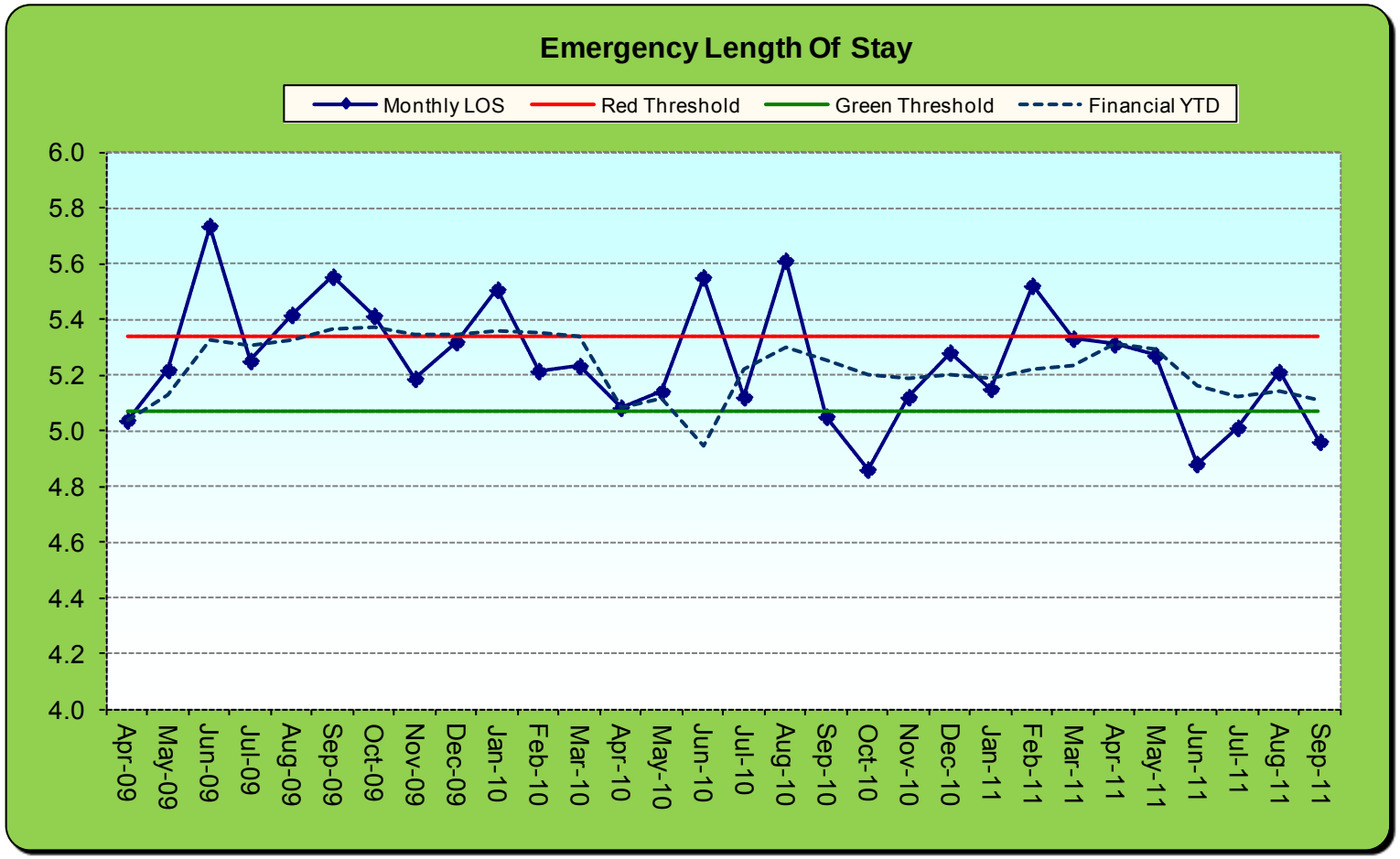
Emergency Length Of Stay
Monthly LOS
Red Threshold
Green Threshold
Financial YTD
6.0
5.8
5.6
5.4
5.2
5.0
4.8
4.6
4.4
4.2
4.0
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
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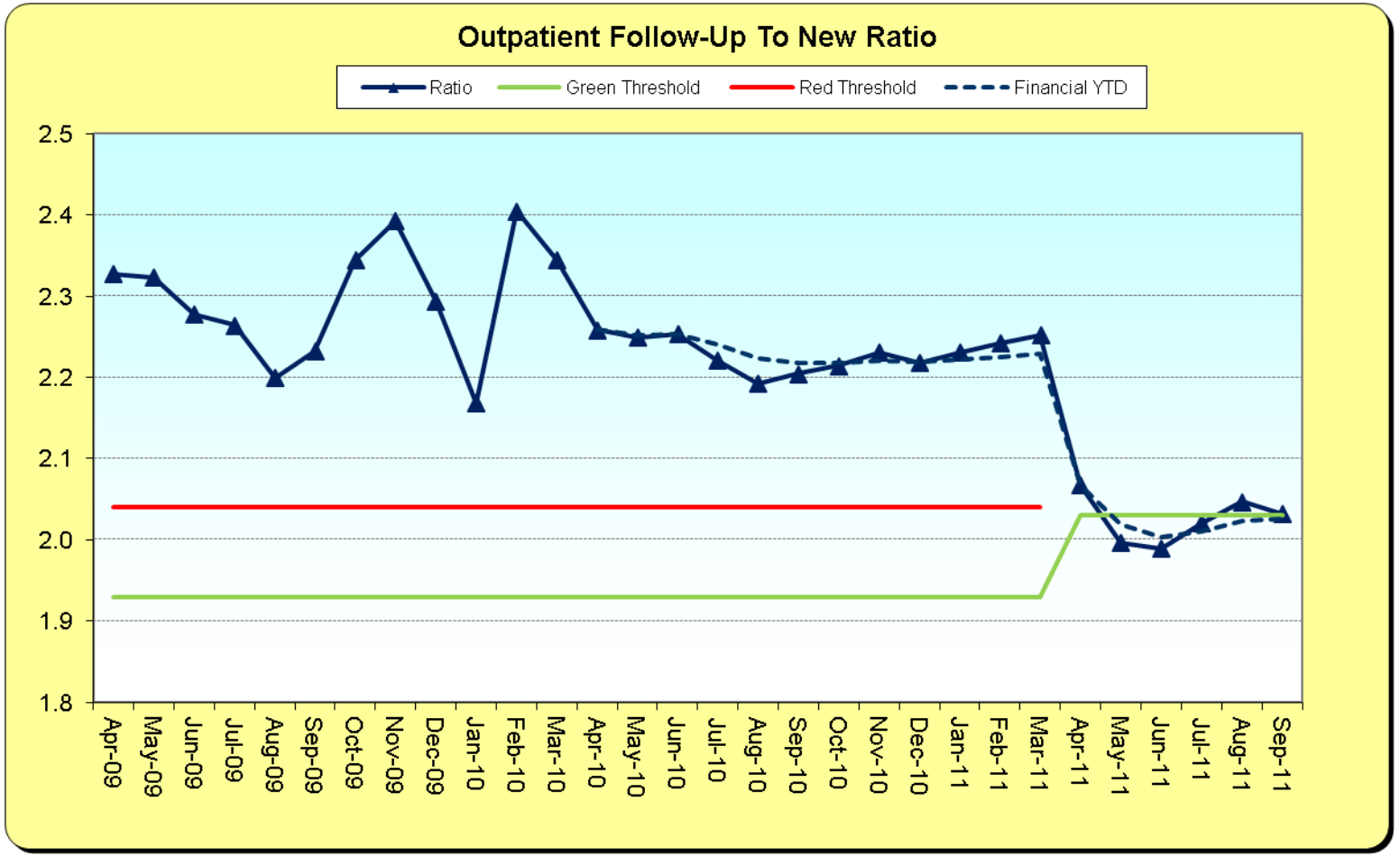
Aug-11
Sep-11



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
Same Sex Accommodation breaches	In the *Quality* section of this report	
Incidence of Hospital Acquired Pressure Sores	In the *Quality* section of this report	
Weighted Patients Recruited into NHIR Trials	See additional information	Recruitment into National Institute for Health Research (NIHR) studies is approximately 26% off target at the end of August 2011. A project has commenced to formally identify why recruitment is below target, using a number of methodologies including root cause analysis. It is unlikely that the agreed target will be reached this financial year. The Western Comprehensive Research Network has been advised of the expected shortfall and we are working closely with them to identify ways of addressing the shortfall in the short, medium and long term.
Contract penalties	Finance Report	

SECTION C – Monitor's Compliance Framework

At the end of September the Trust achieved 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 September.

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

As planned the Trust implemented in full the actions arising from the Care Quality Commission's (CQC) report on the Nutrition (Outcome 5). Based upon our declaration of compliance and the evidence submitted to the CQC, Monitor has confirmed that the Compliance Actions are no longer considered to be outstanding. This gives the Trust a total score of 1.0 and an AMBER-GREEN Governance Risk Rating at the end of quarter. This is the second lowest risk rating out of four.

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	Q2 Actual*	Notes	Current Q2 Governance rating
Monitor Compliance Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	33	✓	✓	✓	16	✓	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%	✓	✓	✓	96.4%	✓		
	3c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	99.7%	✓	✓	✓	99.4%	✓		
	4a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85.0%	84.9%	✓	✓	✓	85.5%	✓	62-day screening standard forecast not to be achieved; see exception report	Not achieved (1.0)
	4b	Cancer 62 Day Referral To Treatment (Screenings)		90.0%	93.4%	✓	✖	✓	87.6%	✖		
	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	21.7	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	15.0	Achieved each month		Achieved
	7	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	0.5	96%	97.0%	✓	✓	✓	98.0%	✓		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	0.5	93%	95.4%	✓	✓	✓	94.9%	✓		Achieved
	8b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	98.7%	✓	✓	✓	98.1%	✓		
	9	A&E Total time in A&E 4 hours (95th percentile)	1.0	5%	98.0%	✓	✓	✓	97.6%	✓		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 Actions completed	CQC Actions completed	Nutrition plan currently implemented and signed-off.	Achieved
					rating	GREEN	AMBER-RED	AMBER-RED	AMBER-GREEN	AMBER-GREEN		1.0
												AMBER-GREEN

Please note: If the same 1.0 weighted indicator is failed in three successive quarters, an automatic RED rating is applied. 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/August figures and draft figures for September 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 U was admitted to the Bristol Heart Institute for an angiogram. He was transferred to a ward to await Coronary Artery Bypass Graft surgery. His wife sent a letter to the Trust which raised issues about the care he had received whilst he was a patient. She also included some positive comments, which were shared with the staff involved in looking after him. The first issue was that room in which he was initially accommodated had a broken phone/television unit.

Mr U also had an existing diagnosis of metastatic prostate cancer and his wife was allowed open visiting on the ward in view of this. He was transferred to another ward the day before his operation and again Mrs U was allowed to visit her husband early and stay with him until he left the ward.

Following his surgery, Mrs U was asked to leave the Cardiac Intensive Care Unit (CICU), at the end of evening visiting, despite her wish to remain until Mr U woke up and had been taken off of the ventilator. The following day Mr U was moved to the High Dependency area of CICU. Mrs U arrived early at the hospital, but was not allowed to visit until 2pm, despite the fact she had previously expressed to staff that she did not know how much longer her husband had to live, due to his cancer, and that she was keen to spend every moment that she could with him.

When Mrs U was allowed onto the unit, she found her husband in pain. He was receiving morphine but this did not seem adequate. The doctors prescribed extra morphine, but Mr U then found difficulty in using the patient controlled analgesia pump, as he was too drowsy and subsequently woke in pain.

Mrs U did not wish to leave her husband after afternoon visiting time as her husband found some comfort from her rubbing his back and was able to stay until late into the evening. When Mrs U left the unit she asked that someone contact her during the night should her husband experience any problems, as she knew the staff would not have time to rub her husband's back. Mrs U had a sleepless night due to worrying about her husband. She received a phone call from a nurse the following morning to say that her husband had had a poor night. Mrs U was naturally upset that she had not been contacted during the night. She went straight to the unit and was allowed in to visit her husband outside of visiting hours.

Mr U explained that he had been in pain during the night and that the nurse looking after him did not understand English. The nurse caring for Mr U that morning ensured that he received his prescribed analgesia and was given additional pain relief to control his breakthrough pain. This had a good effect and Mr U was comfortable. He was assessed by the medical team on the ward round and his clinical condition had improved enough for him to be transferred back to a ward.

Mrs U explained to the ward staff about her husband's cancer and was informed that it would be the Ward Sister's decision whether she could stay all day. Mr U was due pain medication at 8 pm and Mrs U telephoned him at 9pm to find that he had not yet received his medication. At 10pm Mr U rang his wife to inform her that he had still not received his medication and that he was again in pain. Mr U finally received his medication at 10:45pm.

The Ward Sister met with Mrs U the following afternoon, she ensured that all the team were aware that Mrs U should have open visiting and apologised for her experience.

Mr U continued to experience break through pain from his cancer. The drug round route normally meant that he would be last to receive his medication on every round. Sister explained that this did not need be the case and that his pain relief could be given at any time regardless of whether a medicine round was in progress or not. Unfortunately when she was not on duty the drug round continued in the same way. The following day Mrs U assisted staff in ensuring her husband received his medications on time and enabled him to be pain free for the last 2 days of his stay.

Mr U was pleased to be home and commented to his wife about the noise at night from night staff, which he found to be disturbing.

Outcome

Wider learning

- Inclusion of carers as partners in patient's care is an underpinning value of the Trust care strategy. Using the model of the 'This is Me' dementia pathway, a passport for carers is being developed for launch in 2012.
- Noise at night surveys are proactively being undertaken on a quarterly basis in all divisions to understand experiences of a wide range of patients. Since the latest survey many wards, including those in the Bristol Heart Institute, have ordered silent closing bins and the night buzzers have been adjusted to be quieter. Staff have been reminded at handovers and ward meetings about the importance of a quiet environment to promote sleep for patients.
- Whilst staff are skilled in caring for patients with cardiac pain, Mr U's experience has highlighted a training need for the team who have less understanding of cancer pain and its management. Matron and the Sisters have organised a series of training sessions for the BHI with the Palliative Care team. These are due to take place in October. These training sessions will concentrate on the stages of pain, the help available from elsewhere within the Trust and the types of different analgesia that can be used at different stages of pain management.

Divisional Learning

- Matron has ensured that the television / telephone unit has been repaired and replaced in the room where Mr U was initially accommodated.
- The impact of the experiences Mr and Mrs U faced have been fed back to the staff involved. Matron has also discussed at length with the Sisters of both the Cardiac Intensive Care Unit and the wards about the need to appreciate individual patient needs and circumstances. Matron emphasised that discretion needs to be used by all staff around visiting hours. Staff have been encouraged to discuss individual requests with the Matron when the Ward Sister is unavailable, if they feel unable to make this decision themselves. This has been passed on to staff at every shift change handover and at the September ward meetings.
- Mr and Mrs U were assured that all nurses within the Division are required to undertake an English assessment before undertaking employment in the Trust to ensure that high standards of quality care are maintained.

1.2 QUALITY DASHBOARD

		ID	Title	Green Threshold	Year To Date	Monthly Totals											Quarterly Totals			
						Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Q3	Q4	Q1	Q2
Patient Safety	Infection Control	PS-A1	MRSA Pre-Op Elective Screenings	100%	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%	100.0%	100.0%
		PS-A2	MRSA Emergency Screenings	90%	92.7%	59.9%	79.9%	80.6%	90.4%	92.0%	91.7%	91.5%	93.3%	92.5%	92.7%	93.1%	93.2%	72.2%	91.3%	92.4%	93.0%
		PS-A3	Hand Hygiene Audit Compliance	95%	97.7%	95.7%	97.1%	95.3%	96.1%	96.0%	97.3%	97.8%	95.0%	98.3%	99.1%	98.8%	97.3%	96.1%	96.4%	97.0%	98.4%
		PS-A4	Antibiotic Compliance	95%	79.2%	70.6%	72.8%	78.6%	77.5%	79.4%	76.5%	81.5%	78.4%	84.1%	80.1%	76.3%	76.7%	73.2%	77.7%	81.4%	77.4%
		PS-A5	Matron's Checklist	95%	94.0%	94.8%	94.5%	94.4%	94.8%	94.8%	93.7%	94.8%	93.1%	93.7%	94.2%	93.8%	94.5%	94.6%	94.4%	93.8%	94.2%
		PS-A6	Cleanliness Monitoring - Overall Score	95%		93%	96%	96%	96%	95%	95%	95%	96%	96%	95%	95%	96%				
		PS-A7	Cleanliness Monitoring - Very High Risk Areas	95%		97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	96%	97%				
		PS-A8	Cleanliness Monitoring - High Risk Areas	95%		97%	97%	99%	97%	96%	96%	96%	96%	96%	96%	97%	97%				
		PS-A9	Number of GRE Bacteraemias	<=2	4	2	0	0	3	1	1	1	0	0	0	3		2	5	1	3
		PS-A10	Infection Control - C.Diff Infections Against National Trajectory	<Traj.	33	7	8	3	7	7	7	1	11	5	4	7	5	18	21	17	16
		PS-A11	MSSA Cases Against Trajectory	<Traj.	21							3	2	4	0	8	4			9	12
	Incidents	PS-B1	Number of Serious Incidents (SIs) Reported		38	8	11	6	6	9	6	5	4	11	6	2	10	25	21	20	18
		PS-B2	Serious Incidents Reported Within 48 Hours	80% (Q3)	76%							60%	100%	91%	83%	100%	50%			85%	67%
		PS-B3	Percentage of Serious Incident (SI) Investigations Completed Within Timescale	80% (Q3)	100%									100%	100%	100%	100%			100%	100%
		PS-B4	Total Never Events	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
		PS-B5	Total Number of Patient Safety Incidents Reported		3566	762	768	704	862	748	860	645	790	740	710	681		2234	2470	2175	1391
	Falls	PS-C1	Number of Inpatient Falls Per 1,000 Beddays	<5.6	4.65	4.41	4.79	4.55	5.28	4.55	5.94	4.37	5.27	4.86	5.12	3.55		4.59	5.28	4.83	4.36
		PS-C2	Repeat Inpatient Falls		24.5%	11.8%	16.7%	21.7%	21.2%	26.9%	20.0%	31.9%	15.4%	31.8%	21.7%	20.3%					
		PS-C3	Number of Inpatient Falls - Patients Aged 65 And Over		428	83	94	92	100	88	132	79	104	88	94	63		269	320	271	157
		PS-C4	Number of Inpatient Falls - Patients With Cognitive Impairment		207				28	41	73	40	53	45	43	26			142	138	69
	Pressure Ulcers	PS-D1	Total Pressure Ulcer Incidence per 10,000 Bed Days	6.51	12.38	10.30	10.31	5.06	7.06	9.84	9.84	7.16	14.15	14.37	13.61	12.70		8.46	8.89	11.88	13.17
		PS-D2	Percentage of Hospital Acquired Pressure Ulcers Not Graded	<5%	0.0%	4.3%	3.8%	0.0%	0.0%	4.2%	14.8%	0.0%	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	140	17	24	13	17	21	19	16	34	31	32	27		54	57	81	59
		PS-D4	Number of Hospital Acquired Grade 3 Pressure Ulcers	<1	13	3	1	0	2	2	3	2	2	4	2	3		4	7	8	5
		PS-D5	Number of Hospital Acquired Grade 4 Pressure Ulcers	<1	0	2	0	0	0	0	1	0	0	0	0	0		2	1	0	0
	Venous Thrombo-embolism (VTE)	PS-E1	Adult Inpatients who Received a VTE Risk Assessment	90%	96.6%	59.2%	75.8%	69.3%	82.4%	84.4%	91.6%	94.2%	95.1%	97.0%	97.5%	98.0%	97.6%	68.2%	86.8%	95.5%	97.7%
		PS-E2	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	90%	90.4%										87.5%	93.3%	89.6%				90.4%
	Nutrition	PS-F1	Patients who Received Fully Completed Nutritional Screening Within 24 Hours	90%	78.5%			76.6%			76.1%			66.2%			92.0%	76.6%	76.1%	66.2%	92.0%
	Safety	PS-G1	WHO Surgical Checklist Compliance	98%	93.7%	97.1%	98.4%	97.8%	97.7%	98.7%	98.0%	98.6%	92.6%	90.2%	87.3%	96.8%	97.7%	97.8%	98.1%	93.5%	93.9%
		PS-G2	Reduction in Medication Errors	<2.84%	1.09%	2.42%	1.92%	3.39%	3.73%	5.10%	5.93%	2.08%	0.79%	0.85%	0.85%			2.60%	4.86%	1.17%	0.85%
	Leadership	PS-H1	Number of Executive Director Patient Safety Walk-arounds	>=6	48	6	5	7	5	5	5	7	11	9	6	5	10	18	15	27	21
		PS-H4	Percentage of Non-Estates Actions Completed Within 2 Months	80%	88%	82%	71%	29%	100%	80%	67%	100%	100%	77%	95%	75%	91%	62%	75%	89%	88%

QUALITY

		ID	Title	Green Threshold	Year To Date	Monthly Totals												Quarterly Totals			
						Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Q3	Q4	Q1	Q2
Clinical Effectiveness	Mortality	CE-A1	Hospital Standardised Mortality Ratio (HSMR)	<=80		77.3	68.6	79.5	98.1	68.8	65.5	87	72.9								
	Length of Stay	CE-C1	Average Length Of Stay - Elective	<=3.64	3.65	3.86	3.42	4.00	3.52	3.75	3.66	4.34	3.40	3.65	3.19	4.01	3.37	3.76	3.64	3.78	3.53
		CE-C2	Average Length Of Stay - Emergency	<=5.07	5.11	4.86	5.12	5.28	5.15	5.52	5.33	5.31	5.27	4.88	5.01	5.21	4.96	5.09	5.33	5.16	5.06
	Learning Disability	CE-D1	Risk Assessment of Patients with Known Learning Disability within 48 Hours	90%	55.3%							50.0%	37.5%	60.0%	33.3%	42.9%	87.5%			51.7%	61.1%
	Readmissions	CE-E1	Emergency Readmissions Within 30 Days	<412 mth	2280							431	404	405	398	350	292			1240	1040
	Maternity	CE-G1	Percentage of Spontaneous Deliveries Compared to All Births	64.4%	62.71%	66.13%	65.02%	59.63%	64.67%	62.34%	65.04%	63.83%	65.01%	63.53%	64.88%	61.22%	57.79%	63.58%	64.05%	64.13%	61.32%
	Fracture NoF	CE-H1	Fracture Neck of Femur Patients Treated Within 24 Hours		36.9%	43.3%	43.8%	56.0%	50.0%	54.5%	23.5%	64.3%	22.7%	40.0%	45.5%	20.0%	38.9%	47.9%	41.7%	39.2%	35.0%
	Stroke Care	CE-J1	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	50%	30.3%	22.9%	26.8%	32.5%	20.0%	30.0%	39.4%	25.7%	23.1%	25.0%	42.9%	28.6%	37.9%	27.6%	29.5%	24.7%	35.9%
		CE-J2	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	80%	85.7%	78.0%	90.0%	89.8%	82.1%	62.9%	80.6%	81.4%	86.5%	82.9%	81.8%	85.4%	97.1%	86.4%	75.5%	83.5%	87.9%
		CE-J3	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	64.21%	60.00%	81.25%	63.16%	78.95%	52.38%	74.07%	70.00%	75.00%	42.86%	50.00%	63.16%	77.78%	67.27%	68.66%	63.04%	65.31%
	Specialist Commissioning	CE-K1	Percentage of Haemophilia Patients Undergoing Pharmocokinetic Study		74%												74%				74%
		CE-K2	Lobectomy Patients - Median Length of Stay	<=5 days	5							6	5	6	4	5	4				
Patient Experience	Single Sex Accom.	PE-A1	Same Sex Accommodation Breaches - Number of Patients	0	55	53	10	29	4	22	39	5	18	22	3	0	7	92	65	45	10
	Patient Experience	PE-B1	Patient Survey - Overall CQUIN Score	74.4					72.2	73.8	75.5	74	74.6	76.3	74.4	75.3				75	74.9
		PE-B2	Monthly Patient Survey - Noise At Night	81								83	83	81	82	83				82	83
		PE-B3	Monthly Patient Survey - Help To Eat Meals	76								77	81	80	80	76				79	78
		PE-B4	Monthly Patient Survey - Patients Who Would Recommend The Trust	92%								96%	96%	96%	97%	96%				96%	97%
		PE-B5	Monthly Patient Survey - Local Score	83								87	87	89	86	88				88	86
	Complaints/Compliments	PE-C1	Number of Patient Complaints	<=120	754	130	110	92	152	156	170	107	114	138	123	151	121	332	478	359	395
		PE-C3	Percentage of Complaints Resolved Within Timeframe (Formal Compalints)	98%	92.1%	89.4%	93.4%	95.5%	100.0%	98.7%	98.4%	88.9%	92.2%	89.5%	97.4%	92.7%	92.6%	92.4%	99.1%	90.4%	93.9%
		PE-C4	Number of Complainants Disatisfied with Response	<=5	43	7	8	5	4	6	9	3	4	14	10	8	4	20	19	21	22

1.3 SUMMARY

The key feature of this month's quality report is the significant improvement in the percentage of patients who receive fully completed nutritional screening within 24 hours of admission to 92%, which means we have achieved the 90% target.

Also of note is the significant improvement in the percentage of patients with a known disability being risk assessed within 48 hours following the appointment to a vacant key Learning Disabilities Nurse post, and the continued steady improvement in regaining compliance with WHO surgical safety checklist following a refocus.

Challenges remain in reducing pressure ulcer incidence and stroke imaging within one hour. The Quality & Outcomes Committee has requested a more detailed assurance report on stroke indicators.

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. The robustness of data is currently being checked before the change is made.

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

 **Achieving set threshold (30)**	 **Thresholds not met or no change on previous Month (6)**
- MRSA (Meticillin Resistant *Staphylococcus aureus*) screening – elective - MRSA screening – emergency - Hand Hygiene Audit - *Clostridium difficile* cases against national trajectory - Cleanliness monitoring overall Trust score - Cleanliness monitoring very high risk areas - Cleanliness monitoring high risk areas - Never Events - Serious incident investigations completed within required timescales - In-patient falls incidence per 1,000 bed days - Percentage of hospital acquired pressure ulcers not graded at all - Number of hospital acquired grade 4 pressure ulcers - Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment - Patients who received fully completed nutritional screening within 24	- Matrons checklist (*C. difficile* dashboard) - Glycopeptide Resistant Enterococci (GRE) Bacteraemias - Percentage adult in-patients who received thrombo-prophylaxis - WHO surgical checklist compliance - Total number of complaints - Percentage of complaints resolved within agreed timescale

hours - Reduction in medication errors - Number of executive director patient safety walk rounds - Percentage of all actions completed with 2 months of patient safety walk round - Hospital Standardised Mortality Ratio - Reduction in average elective length of stay - Reduction in average emergency length of stay overall - 30 day emergency readmissions - Stroke care: percentage spending 90% + time on a stroke unit - High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours - Lobectomy patients median length of stay - Patient experience overall CQUIN score - Monthly patient survey: noise at night - Monthly patient survey: help to eat meals - Monthly patient survey: patients who would recommend the Trust - Monthly patient survey local score - Number of complainants dissatisfied with the response	
Quality metrics not achieved or requiring attention (10)	**Quality metrics with thresholds not yet finalised (6)**
- MSSA (Meticillin Sensitive *Staphylococcus aureus*) cases against trajectory - Antibiotic prescribing compliance - Serious Incidents reported with 48 hours - Total pressure ulcer incidence per 10,000 bed days - Number of hospital acquired grade 2 pressure ulcers - Number of hospital acquired grade 3 pressure ulcers - Risk assessment of patients with known learning disability within 48 hours - Percentage of spontaneous deliveries compared to all births - Stroke care: percentage receiving brain imaging within 1 hour - Number of breaches of the single sex accommodation standard	**Thresholds not yet applicable** - Fractured neck of femur patients treated with 24 hours **Metrics for information** - Number of serious incidents - Total number of patient safety incidents reported - Falls in in-patients over 65 - Falls in patients with cognitive impairment - Repeat in-patient falls

QUALITY

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

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 97.6% in September against the monthly target of 90%.
- Spontaneous vaginal births. Performance of 57.79% in September against a target of 64.4%
- Patient Experience overall score relating to the discharge survey. Score for August 75.3 against target of 74.4.
- Patient Experience: reducing noise at night. Score for August 83 against target of 81.
- Patient Experience: assistance at mealtimes. Score for August 76 against a target of 76.
- Reduction in medication errors of 15% on 2010/11 outturn of 3.5%. Performance of 0.85% in July 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 days in September 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. This CQUIN is definitely on target. There are only 2 or 3 patients left who require this testing before we reach the 70% target. These patients are booked to come in during November /December and we anticipate achieving this CQUIN by the end of December 2011.

1.4 CHANGES IN THE PERIOD

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

- *Clostridium difficile* infections against national trajectory decreased ↓ to 5 cases in September from 7 in August.
- Pressure Ulcer incidence per 10,000 bed days, again down slightly ↓ from 13.61 in July to 12.70 in August.
- Number of Serious Incidents reported with 48 hours down ↓ from 100% in August to 50% in September.
- Nutritional screening fully completed within 24 hours up significantly ↑ from 66.2 % in Quarter 2 to 92% in Quarter 3.
- Number of Executive Patient Safety Walk Rounds up ↑ from 5 in August to 10 in September.
- Risk assessment of patients with a known learning disability with 48 hours up ↑ significantly from 42.9% to 87.5% in September.
- Stroke care brain imaging within an hour up ↑ from 28.6% in August to 37.9% in September, but remaining below target.
- Same sex accommodation breaches up ↑ from 0 in August to 7 in September.
- Number of complaints down ↓ from 151 in August to 121 in September.
- Number of dissatisfied complainants down ↓ from 8 in August to 4 in September.

1.5 EXCEPTION REPORTS

Exception reports are provided for twelve (12) indicators in total, nine (9) which are RED rated and a further three* (3) which is AMBER rated and have been of particular interest to the Board:

1. MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory
2. Antibiotic prescribing compliance
3. Serious Incidents reported with 48 hours
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. Percentage of spontaneous deliveries compared to all births
8. Stroke care: percentage receiving brain imaging within 1 hour
9. Number of breaches of the single sex accommodation standard
10. WHO surgical checklist compliance*
11. Number of complaints*
12. Percentage of complaints resolved within timescale*

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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 increased to 77% in September (from 76% in August).

Compliance fell in Medicine (77%, down from 83% in August) and Specialised Services (79%, down from 80% in August), increased in Surgery (73%, up from 58% in August), and remained the same in Women's & Children's (76%). Compliance figures for the Division of Surgery improved on August's result; however at 73% they remain lower than they have been for the 7 months prior to August.

We have not seen the anticipated level of improvement in adding a stop or review date or indication with the introduction of the new drug charts. The new charts contain specific boxes for this information to be recorded, but these fields are not being completed for all antimicrobial prescriptions, so we remain below target.

Recovery plan, including expected date performance will be restored:

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

Division of Surgery Head & Neck have put the following actions into place with immediate effect.

- Lead surgical trainee identified to continue indoctrination
- All antibiotics to be charted for 3 days duration (up to first dark blue line on chart) as standard and then reviewed
- Antibiotics to be added to checklist for all patients on consultants/senior trainee ward rounds
- Ward 5 nurse agreed to add daily chart surveillance to additional nursing duties (VTE, protected, meals, skincare)
- Spot-check ward round on ward 5/6 and identified issues with trainees
- Head of Division met with ITU trainee medical staff and reiterated need for compliance with all 3 requirements when transferring from Innovian to paper chart
- List of non-compliant prescribers for August identified who will be contacted individually

The Anti-infective Steering Group met on 10th October and discussed further actions to improve antibiotic compliance. In summary these are:

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- Medical Director will recommend to each Head of Division that each speciality must provide an exception report to the Divisional board if compliance within that subdivision is <80%.
- The quarterly report on antibiotic compliance is now being produced and will be communicated to service leads through Heads of Division.
- Lead Antimicrobial Pharmacist to contact Deanery representatives and F1/F2 teaching organisers to ascertain whether antibiotics and antibiotic prescribing can be given regular teaching slots in the annual timetable.
- A poster campaign is being launched. The poster has been drafted and the Lead Anti-microbial Pharmacist is working with the Communications Team regarding publicity and media for distribution.
- The Medical Director will write to all Heads of Divisions summarising the discussions around performance, actions and acknowledgement of what the Head of Division is doing within Division of Surgery Head & Neck.
- Lead Antimicrobial Pharmacist has produced a new compliance sticker which more clearly alerts prescribers to a non-compliant antibiotic prescription and reason for non-compliance with a request to correct it immediately.

All actions included above will be completed within 3 months.

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Q2. 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 four Trust apportioned cases of MSSA in September 2011; one over the month target trajectory of three cases. The breakdown of cases by location is as follows.

Division	Monthly Target	Number of target Cases in month	Location of patients
Medicine	1	0	
Surgery Head and Neck	1	3	ITU, Ward 9 x 2
Specialised Services	0	0	
Women and Children	1	1	Ward 37

Three cases have been reported in the Division of Surgery Head & Neck in October with two of these cases on Ward 9. The Infection Control Team 1s working with the Division to review infection control practice in the areas where infections were reported.

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 trajectory for quarter 2 is nine cases, therefore the current position is three over quarter target. Year to date cases and trajectories by Division are outlined below.

Division	Target	Number of target Cases
Medicine	5	3 (-2)
Surgery Head and Neck	3	10 (7)
Specialised Services	3	7 (+4)
Women and Children	7	5 (-2)

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:

Following root cause analyses, there are no further actions to be added to those currently being progressed as outlined in the September Quality & Performance Report.

These actions are:

- 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 by Specialised Services Division.
- 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.

A return to monthly run rate is expected by November 2011

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Q3. EXCEPTION REPORT: Serious Incidents reported within 48 hours	RESPONSIBLE DIRECTORS: Medical Director / Chief Nurse

Description of how the standard is measured:

There is a contractual requirement to report Serious Incidents with 48 working hours of identification on the STEIS national reporting system. Targets for 2011/12 are: Quarter 1 - 70%, Quarter 2 - 75%, Quarters 3 and 4 - 80%. There is a financial penalty of £1000 for every percentage below the target each quarter. The number of Serious Incidents reported is small therefore it only takes a few late reported incidents to fail to achieve the target for the quarter.

Performance in the period, including reasons for the exception:

Of the ten serious incidents reported in September, five were reported outside of the 48 working hour deadline = 50%. For Quarter 2 as a whole performance (subject to confirmation with NHS Bristol) is 67%.

Of the five incidents not reported with 48 hours:

- Two were not reported on the Trust's incident reporting system by the department in which the incident occurred within 48 hours,
- Two were grade 3 pressure ulcers originally risk assessed as moderate incidents and subsequently reviewed by a manager who identified them as needing executive review as serious incidents.
- There was delay in Trust Headquarters in processing one incident.

Recovery plan, including expected date performance will be restored:

- This has been discussed at the Patient Safety Group and Divisional Patient Safety Managers are reminding staff within their in their division of the requirement to report all incidents as soon as the safety of those involved has been assured and their immediate care needs met.
- We have identified an anomaly in the National Patient Safety Agency risk assessment matrix and the guidance in the National Framework for the Reporting and Learning from Serious Incidents, and are therefore looking again at automatic triggers in our systems for grade 3 pressure ulcers to feed into the serious incident process.
- We are revisiting the covering arrangements for the processing of serious incidents in Trust Headquarters in the absence of key personnel.

We are expecting the impact of these actions to be taking effect by November 2011 to achieve the target for Quarter 3.

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Q4-6. EXCEPTION REPORT:	**RESPONSIBLE DIRECTOR: Chief Nurse**
– **Pressure ulcer incidence** – **Number of hospital acquired grade 3 pressure ulcers** – **Number of hospital acquired grade 4 pressure ulcers**	

Description of how the standard is measured:

Pressure Ulcers identified at nursing/medical assessment are Categorised 1-4 (Category 1 being non-blanching erythema, Category 2 being a serum-filled blister or partial loss of skin, Category 3 is full-thickness skin loss with adherent slough, Category 4 is full thickness skin loss with exposed bone which may be obscured by necrotic tissue. 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 category 2 and above was to 12.70 per 10,000 bed days in August 2011. Reductions in rates were seen in June and July for three Divisions, however, the rate of pressure ulcers in Specialised Services Division increased from 6.98 in July to 21.77 per 10,000 bed days in August.

There were no category 4 pressure ulcers reported in August.

Actions taken as a result of these investigations include:

- Wide dissemination of a teaching tool for the relief of pressure on heels
- Wide dissemination of the new risk assessment documentation and "Being the Best" project.
- Ward staff have been reminded regarding their accountability for care and the need to ensure care is provide through individual Matrons.
- In all cases an immediate review was undertaken by the Chief Nurses Team and the Head of Nursing. All 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 has moved from the increasing awareness stage to embedding the changes in practice. Monitoring of completion of risk assessments, completion of re-positioning (turning) charts and use of correct mattresses is being monitored weekly. Results of this are being discussed at the weekly tissue viability operational meeting.

The process for reporting and holding to account has been strengthened in September. The Ward Sister and Matron now meet formally with the Assistant Chief Nurse to account for the development of category two pressure ulcers and to outline immediate actions being taken to prevent future

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occurrences. For category three and above ulcers a formal meeting with the Ward Sister, Matron, Head of Nursing and Assistant Chief Nurse will now take place once the root cause analysis is completed. These actions are in addition to the immediate actions on identification of category three and four ulcers. Heads of Nursing, Matrons and Divisional Managers are receiving regular (at least every 48 hours) reports on newly acquired pressure ulcers and the running total of pressure ulcers across the Trust to raise real-time awareness of progress towards the reduction target.

As noted by the Chief Nurse at the September Board meeting, reductions in the rate of pressure ulcers as a result of the 'Being the Best' programme will not be evident in Board reports until December due to the timescales for reporting.

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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.

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 is assessed by recovery staff rather than theatre staff.

1. 'Sign In complete?' Completed in theatre staff
2. 'Time Out complete?' Completed in theatre staff
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 Peri-operative Patient Safety Group.

Performance in the period, including reasons for the exception:

Performance for September was 97.7% Trust-wide which has increased from 96.8% in August. Weekly monitoring continues in both Hey Groves Theatre (HGT) and Bristol Royal Children's Hospital (BRCH) and allows prompt feedback of the positive progress we have been making since the drop in performance was noted in August. HGT improved in the month to 95.7% from 92.1%. Weekly monitoring has continued as described previously.

We have demonstrated an improvement within 8 weeks as agreed in Board Exception report in August. The table below shows the performance across each theatre suite.

	May	June	July	August	September
Hey Groves Theatres (HGT)	83%	76%	77%	92.1%	95.7%
St Michaels Hospital (SMH)	98%	96%	98%	98.3%	98.7%
Bristol Eye Hospital (BEH)	100%	99%	100%	99.8%	99.6%
Bristol Dental Hospital (BDH)	98%	98%	98%	97%	95.1%
Queens Day Unit (QDU)	92%	99%	100%	100%	96.8%

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Bristol Royal Children's Hospital (BRCH)	90%	81%	70%	96.2%	98%
UH Bristol Overall	**93%**	**90%**	**87%**	**96.8%**	**97.7%**

Recovery plan, including expected date performance will be restored:

The recovery plan is to continue as follows:

1. Continue communication & teaching with recovery staff in HGT & BRCH by Theatre Trainers and Patient Safety Lead in HGT (Kevin Meredith & Sally Denton)
2. WHO checklist reports to be run weekly to support prompt review of performance and monitor improvement (Clare Evans & Anna Lelievre)
3. Review and audit of notes in October to assess compliance with recording of WHO checklist within newly issues Perioperative Record of care with feedback to Clare Evans (Theatre Matrons & Sisters)
4. To review the decrease in Bristol Dental Hospital performance (Annette Giles/Shelley Thomas)
5. A revised version of the paper Swift Op form has been created and will be implemented in the theatres that use it, (HGT, SMH & BEH), from 26th September (Liz Varian)
6. 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. 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 57.79% for September 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 risk 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 presence per week. Senior presence is known to reduce unnecessary intervention. There is no separate midwifery led unit at St. Michael's.

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 used to triage women and encourage 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.

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Q9. 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: 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 varied month on month, but has averaged around 30% over the last year. However, in September performance improved to 37.9%. 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 ongoing 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*:

- An in-depth analysis of suspected stroke patients has been carried out by one of the Emergency Department consultants. This has identified a group of patients who may wait more than an hour in the Emergency Department (ED) to see a doctor and therefore be scanned. A meeting has been arranged with the ED for October to review the pathway for the patients and whether additional resources are required to ensure these patients can be seen by a doctor and scanned more quickly.
- Radiology is looking into whether the ROSIER (Recognition of Stroke in the Emergency Room) questions can be used within the ICE request for CT scan (under review)

Progress against the recovery plan:

Performance against this standard was 37.9% in September, which is a significant improvement on the 28.6% reported in August. 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.

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Q10. EXCEPTION REPORT: Mixed sex accommodation	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the standard is measured:

The data is submitted as total occurrences of unjustified mixing in relation to sleeping accommodation only. If a patient is placed in mixed sex accommodation more than once during their stay each occurrence is counted separately. 'Sleeping accommodation' includes areas where patients are admitted and cared for on beds or trolleys, even where they do not stay overnight (i.e. it includes admissions and assessment units plus day surgery and endoscopy units. It does not include accident and emergency cubicles).

Performance in the period, including reasons for the exception:

In September there was one incidence of a mixed sex accommodation breach. This occurred on an inpatient medical ward. The only bed available in the hospital was a cubicle in the male end of this ward. There were no men suitable to move into the cubicle so a female patient was transferred. She was clinically appropriate for the ward but was also thought to be infectious hence she would have to be isolated and not come out of the cubicle. This patient was subsequently found not to be infectious and therefore free to mobilise in the main ward.

The incident affected seven patients in total and lasted for sixteen hours at which point the female patient was transferred to another ward.

Recovery plan, including expected date performance will be restored:

There have been no further breaches during September.

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Q11. 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 121 complaints received in the month, a reduction of 30 complaints compared to last month. Monthly fluctuations of numbers of complaints occur. However the green threshold has been exceeded for a fourth consecutive month, albeit by just 1 complaint for the month of September 2011. 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.
- A comprehensive work plan is in place and being implemented jointly by the Patient Support and Complaints Team and Divisions. The programme includes a focus on resolving straightforward complaints as and when they initially occur.

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Q12. EXCEPTION REPORT: Percentage resolved outside of Local Resolution Plan timescale	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

September 2011 performance was 92.6%, which shows no change from August 2011 but is disappointing following July's 97.4%. A total of 4 complaints were resolved outside of the original or renegotiated timescale. Three (3) of these breaches of timescale relate to the Division of Surgery, Head & Neck and 1 to the Division of Women & Children's. Of the 3 breaches relating to the Division of Surgery, Head & Neck, 1 response was late due to part of a consultant's statement being missing and late input from North Bristol Trust; 1 related to a response to the Parliamentary & Health Service Ombudsman that was delayed due to a key member of staff being on annual leave; and 1 is still outstanding in that a meeting date has not yet been agreed with the complainant. The case from the Division of Women & Children's that breached the deadline was due to a key member of staff being away on sick leave.

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, which should allow more focus on investigating more complex complaints. 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 monthly by the Service Delivery Group. It is also reviewed the Patient Experience Group, chaired by the Chief Nurse, on a quarterly basis.

1.6 SUPPORTING INFORMATION

1.6.1 Quality Achievements –Division of Surgery, Head & Neck.

The Division has been active on many quality issues over the last few months with success;

- There has been no Meticillin Resistant *Staphylococcus Aureus* bacteraemia for over a year in the Division.
- Smoking Cessation – the referral rate for smoking cessation has greatly improved led by Clare Evans, Nurse Consultant. The Trust is on track to make the 500 required referrals to reach the CQUIN target.
- Enhanced recovery CQUIN success for Thoracic Surgery - we are aiming to improve the quality of pre, intra and post-operative care for patients undergoing major elective surgery through implementation of the enhanced recovery model of care, leading to a reduction in length of stay for patients undergoing two key procedures, lung lobectomy and mediasteinoscopy. We are planning to use some of the CQUIN money to support ward staff to drive the Enhanced Recovery program on ward 6 and are also looking at increasing physiotherapy input at the weekend.
- Nutritional Training – the Division has achieved over 85% staff completion of on-line nutritional training.
- Ward safety briefings at handover is already in place on Surgical and Trauma Assessment Unit and Ward 6 and are being rolled out to all the surgical wards
- The Division is piloting surgical site infection surveillance in vascular and upper gastro-intestinal specialities as part of a national surveillance programme.
- The Division is improving on our Quality in Care audit results in all ward areas.

1.6.2 Examples of Learning from Recent Complaints

Summary of Complaint One

A patient was admitted to Ward 78 at St Michael's Hospital for day surgery. She subsequently required more extensive surgery than originally anticipated and she felt that the nursing staff were not aware of the extent of her problems. The patient was eventually admitted for four days due to complications. In her complaint she said was made to feel like a "malingerer"; she felt that nursing staff attempted to give her Tramadol when this had already been administered by staff on the Recovery Unit; she was then not given sufficient pain relief and was left to lie in a bed covered in blood. The nurses on the ward were unable to provide the patient with ice packs when requested. Upon discharge, the patient was not given her antibiotics and her husband had to return to the hospital to collect these. The consultant who saw the patient on the ward advised that she needed a follow-up appointment but this was not made and the patient was spoken to rudely by reception staff when she phoned to rectify this.

Investigation Outcome

The investigation showed that the nurse on the ward offered the patient more Tramadol, when she had already received some in Recovery, as the Recovery nurse had omitted to document that it had been administered earlier on the drug chart or anaesthetic chart. After speaking to the patient, the

ward nurse completed an incident form to highlight the near miss/drug error.

The investigation highlighted that the patient's padded sheet was not changed in a timely manner and an apology was offered for this. Also, not all nurses were aware there is an ice making machine on the Central Delivery Suite and had been making ice packs from scratch, waiting for water to freeze, meaning there was a delay in the patient receiving ice packs. An apology was offered for this and all staff have been advised about the ice machine.

The investigation found that at the time of the patient's discharge, the usual pharmacist was not on duty at the St Michael's Hospital dispensary and there were delays in patients receiving their medication. The situation has been resolved and apologies were offered to the patient and her husband.

As a result of the investigation, it was found that the patient was not offered a follow-up appointment when she should have been.

Action taken

Organisational Learning

- Theatre Care Plans have been developed to prompt recovery staff to record that analgesia has been administered. Recovery staff will also be required to write and document the Discharge Summary for the ward to read.
- A new peri-operative document has been devised, covering the whole period of a patient's surgery, including ward admissions and is now in place

Departmental Learning

- All reception staff have been reminded of the importance of communication with patients on the telephone. Twenty staff have already completed additional training and this is being extended to other staff across the hospital.
- All staff have been made aware of the ice machine on the Central Delivery Suite.
- The Ward Manager has instigated a new process for ensuring follow-up appointments are made, by flagging this up on the outside of patients' notes. This new process will be closely monitored to ensure the situation improves. The investigation was not able to identify which member of reception staff spoke rudely to the patient and it has been reiterated to staff that such behaviour is not acceptable.

Individual Learning

- The Recovery nurse has been advised of the near miss drug error involving the Tramadol and has re-familiarised herself with the UH Bristol drug administration policy.

Summary of Complaint Two

A patient was transferred from the Bristol Heart Institute to the Discharge Lounge. His complaint stated that he was sent home without any appropriate information relating to his discharge and his GP was not informed of his admission or discharge. The patient's wound subsequently became infected as a result of a suture which had not been removed. The patient's GP details were not recorded throughout his hospital stay and were not input onto the Electronic Discharge Summary. No arrangements were made by staff to ensure the patient's suture was removed in the community and the patient was not provided with any information about caring for the suture site or the removal of the suture. The patient was also not provided with any information regarding his discharge medications from staff in the Discharge Lounge.

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Investigation

The investigation found that the patient's GP details were not recorded on admission to the Intensive Care Unit (ICU), on transfer to the Coronary Care Unit or on Ward 53. In addition, the missing GP details were not identified when the discharge letter was produced by the medical staff and, as a result, the patient's GP was not informed of any details of his hospital admission.

The investigation also found that the patient was not provided with a copy of the discharge letter or information and an explanation from staff in relation to his medications, nor was he given a letter of explanation for the community nurse about the need to remove a suture that held a drain in place whilst he was in ICU. Apologies were given to the patient for all of these omissions.

Action taken

Organisational Learning

- Staff have met with the Electronic Discharge Summary (eDiS) team and agreed a way in which they can prevent discharge letters being processed without GP details. The eDiS System Administrator and Senior Pharmacy Technician will conduct a regular review of eDiS to identify any patients discharged across the Trust without GP details – this information will be fed back to the Divisions as a way of monitoring any further incidents.

Departmental Learning

- Ward Sisters have met with Ward Clerks to identify a process that ensures all patients have their GP details documented whilst in hospital. A process is now in place for Ward Clerks in respect of GP registration since recording of real time admissions were introduced. All staff have been sent an email reminding them of their individual responsibilities in this respect.
- Ward Sisters within the Division have used the issues raised in this complaint as a development tool to identify the importance of co-ordinating vital discharge arrangements and communicating these arrangements with the patient and their family.

WORKFORCE

2.1 SUMMARY

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

 **Achieving (4)**	 **Underachieving**
- Workforce costs – *compared with budget* - Workforce numbers – *compared with budget* - Appraisal compliance - *compared with target* - European Working Time Directive- *compared with target*	
 **Failing (2)**	 **Not reported/scored (1)**
- Sickness absence - *compared with target* - Bank and agency usage - *compared with target*	- Turnover *(no target)*

2.2 EXCEPTION REPORTS

Exception reports are provided for the two RED-rated indicators, which in September 2011 were as follows:

1) Sickness absence – red rated against Divisional targets
2) Bank and agency usage – red rated against Divisional targets

WORKFORCE

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

Description of how the standard is measured:

Sickness absence figures are shown as percentage of available FTE (Full Time Equivalents) absent

Performance in the period, including reasons for the exception:

Absence has increased from 3.7% in August to 3.9% in September; all Divisions are above monthly target. In Medicine, there has been a reduction from 4.8% to 4.3% this month.

	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (excluding Estates & Facilities)	Estates & Facilities
Absence September 2010	3.9%	2.2%	3.8%	4.1%	4.6%	3.7%	3.1%	5.6%
Target September 2011	3.1%	2.2%	2.7%	3.3%	3.4%	3.2%	3.3%	4.3%
Absence September 2011	3.9%	2.5%	4.3%	3.4%	3.7%	4.3%	4.2%	5.3%
Cumulative absence September 2011	3.8%	2.5%	4.4%	3.5%	3.5%	4.1%	3.5%	5.1%

Recovery plan, including expected date performance will be restored:

Divisions are working with Employee Services to give support on managing sickness absence, with a specific focus on the worst performing areas in relation to long term sickness. This will include targeting managers of absent staff to prompt them to take action, provide advice and support and ensure that the Supporting Attendance policy is being applied robustly and consistently. Employee Services and the Business Partners are planning a day, facilitated by the Transformation Team, looking at the most effective approaches to absence management, so that they can be replicated throughout the Trust.

Progress against recovery plan: See above**.**

WORKFORCE

W2. EXCEPTION REPORT: Bank and Agency usage	RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development

Description of how the standard is measured: Bank and agency usage in Full Time Equivalent (FTE) compared with targets set by Divisions for 2011/12

Performance in the period, including reasons for the exception:

Bank and agency usage for September 2011 is 14.8% above target. Usage increased by 35.8 FTE compared to August 2011. Divisions have set challenging targets to reduce bank and agency. However, compared with the same period a year ago, every Division except Estates and Facilities has reduced their bank and agency usage.

Bank and Agency (FTE)	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (excluding Estates & Facilities)	Estates & Facilities
Actual September 2010	484.7	28.1	116.7	47.1	91.8	97.3	74.5	29.2
Actual September 2011	395.0	19.3	104.1	35.2	76.0	76.9	29.1	54.4
Target September 2011	336.5	22.0	80.6	43.8	55.0	62.5	12.9	59.7

Recovery plan, including expected date performance will be restored:

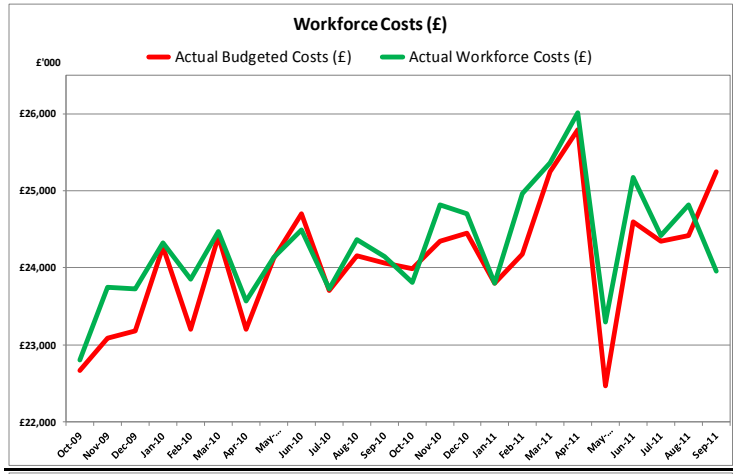
- For Women's & Children's Division, sickness and vacancies in Neo Natal Intensive Care Unit has resulted in increased bank usage, which will be addressed by 9 new staff starting over the next few weeks. In addition, there have been demand factors, such as a high birth rate, and increased requirement for one to one care, impacting on requirement for bank in midwifery and the Bristol Children's Hospital.
- For Medicine Division, high sickness in certain areas, combined with maternity leave, have offset the anticipated bank savings. An action plan to address sickness issue is now is now in place.
- Medicine Division will be revising again, the bank booking controls. Wards will staff against safe minimum staffing levels agreed by each ward. The guidelines have been refined for bank and agency usage, with authorisation only being granted via Matrons and the duty Matron.
- For Medicine and Surgery Divisions, bank and agency remains high because of the strategy in the Division to hold vacancies to be filled by staff displaced as a result of the ward changes and closures. Vacancy levels will reduce from November 2011, which should reduce bank and agency usage.
- New controls will be put in place to manage medical and admin and clerical locum spend at local level.

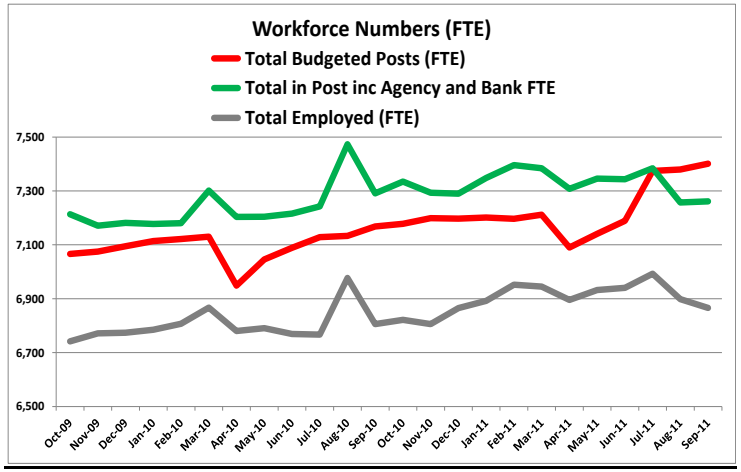
Progress against recovery plan: as above

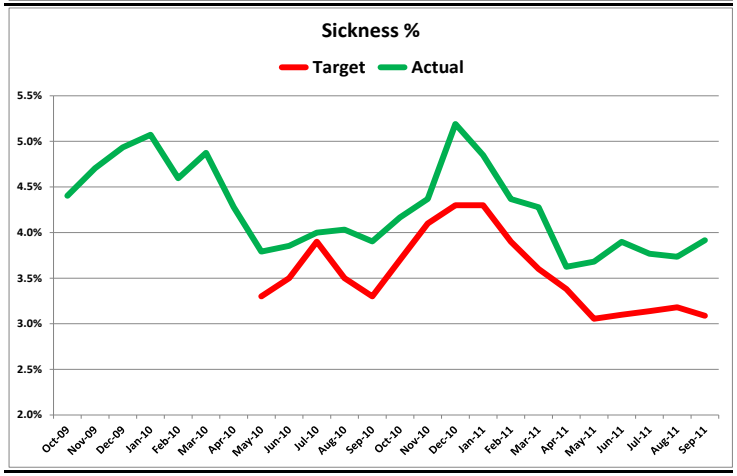
2.2 SUPPORTING INFORMATION

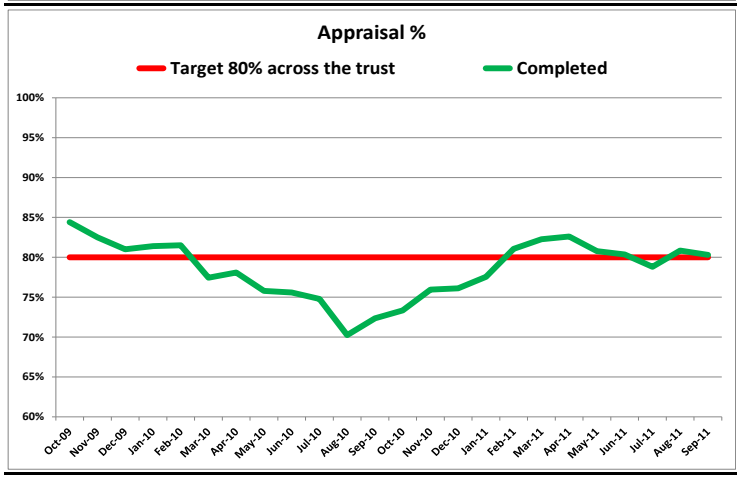
This report provides an outline of the Trust's position against key workforce standards for the month of September 2011 and year to date performance for 2011/12.

2.3.1 Summary





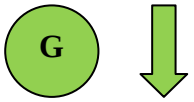
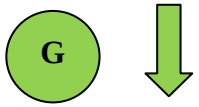
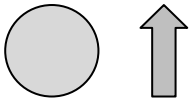
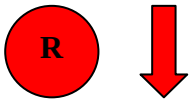
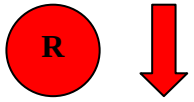
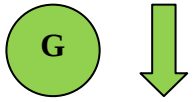




2.3.2 Changes in the period

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 reduced by 3.5% and workforce budget increased by 3.3% in September 2011, compared to last month`s report. September's costs were 5.1% below the budgeted workforce costs compared with 1.3% above budget in August.	See supporting information
Workforce Numbers		Workforce numbers increased by 0.1% compared with August 2011, 1.9% below the budgeted workforce numbers. This compares with August 2011 when workforce numbers were 1.7% below budget.	See supporting information
Turnover		Rolling voluntary turnover increased by 0.2% to 8.8%.	
Sickness		Sickness increased by 0.2 percentage points compared with August 2011 across the Trust, 0.8 percentage points above the monthly target for 2011/12.	See exception report
Bank/Agency		Bank and agency increased by 35.8 FTE compared with August 2011, 14.8% above monthly target for 2011/12.	See exception report
Appraisal		Appraisal rates reduced by 0.5 percentage points to 80.3% compared with August 2011.	See supporting information
European Working Time Directive		Monitoring of Junior Doctor hours commenced 2011 across all specialties in the Trust. Insufficient returns received for many areas, further exercise to start November 2011. Identified issues in Cardiology are fully supported by a rigorous action plan with anticipated resolution by December 2011. Derogated rotas identified in 2009 are now fully compliant through different measures. Green rated, subject to action plans being implemented.	

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	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Sep 11 Forecast
Budgeted Posts (FTE)	7167.9	7178.1	7198.8	7197.4	7201.0	7196.9	7211.5	7090.1	7140.7	7189.1	7374.1	7379.3	7401.1	
Total Employed (FTE)	6806.0	6821.6	6805.9	6865.4	6892.1	6951.8	6945.2	6895.7	6932.5	6940.7	6993.0	6898.2	6866.1	6917.9
Sickness Rate (%)	3.9%	4.2%	4.4%	5.2%	4.9%	4.4%	4.3%	3.6%	3.7%	3.9%	3.8%	3.7%	3.9%	3.1%
Bank (FTE) Admin & Clerical	92.6	85.6	84.3	78.9	81.5	80.1	89.1	73.6	73.0	77.8	79.2	80.9	78.7	73.9
Bank (FTE) Ancillary Staff	26.0	27.7	25.0	23.9	23.4	20.6	25.5	20.3	20.5	19.1	17.4	12.8	16.1	22.7
Bank (FTE) Nursing & Midwifery	249.6	263.0	245.9	212.9	239.8	214.8	232.4	231.5	233.1	230.8	239.7	193.9	220.7	157.5
Agency (FTE) Admin & Clerical	6.9	9.0	7.3	5.2	6.2	6.8	9.4	7.0	4.3	3.2	2.6	3.4	5.5	6.4
Agency (FTE) Ancillary Staff	48.2	52.4	43.1	41.7	28.5	32.1	35.2	31.1	34.7	34.3	18.1	34.1	37.7	35.3
Agency (FTE) Nursing & Midwifery	13.4	12.7	8.0	8.4	14.0	6.9	10.0	17.5	12.3	7.4	8.4	8.2	11.7	12.4
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	62.6
Appraisal (%) excluding Junior Doctors	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%
Appraisal (%) Junior Doctors												80.3%	88.3%	80.0%
Rolling Average Turnover (%)	15.5%	15.8%	15.6%	15.4%	15.3%	15.3%	15.4%	15.0%	14.9%	14.9%	14.7%	14.3%	14.9%	
Rolling Average Voluntary Turnover (%)	9.6%	9.9%	9.6%	9.6%	9.5%	9.3%	9.4%	9.1%	9.1%	9.0%	8.6%	8.6%	8.8%	
Vacancy Rate (%)	5.0%	5.0%	5.5%	4.6%	4.3%	3.4%	3.7%	2.7%	2.9%	3.5%	5.2%	6.5%	7.2%	

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 September 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 (14)	**Underachieving (2)**
- 31-day diagnosis to treatment cancer standard - *first* - 31-day diagnosis to treatment cancer standard – *all subsequent treatments* - 62-day referral to treatment cancer standard – *GP referred* - 2-week wait urgent GP referral cancer standard - Symptomatic breast patients (cancer not initially suspected) 2-week wait - Referral to Treatment Time for admitted patients (95th percentile) - Referral to Treatment Time for non-admitted patients (95th percentile) - Genito-Urinary Medicine (GUM) 48-hour access - A&E Time to Treatment - A&E Left without being seen rate - A&E Unplanned re-attendance - A&E Maximum waiting time (4-hours) - A&E Time to Initial Assessment (ambulance arrivals) (95th percentile) - Access to healthcare for patients with learning disabilities	- 62-day referral to treatment cancer standard – *Screening referred* - Last-minute cancelled operations
Failing (3)	**Not reported/scored (0)**
- 28-day readmission – *a date for re-admission within 28 days of cancellation* - Reperfusion times (call to balloon time of 150 minutes) - Infant health – breastfeeding rate	

Please note: the position shown above for the cancer standards includes the draft performance figures for September. Performance for these standards is reported by all trusts in the country two months in arrears. ***Indicators are shown as being failed where both 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

		Thresholds		2010/11	2011/12	Month												Quarterly Performance 2011/12			
	Target	Green	Red	to date	To Date	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Q1	Q2	Q3	Q4
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	88%	95.7%	95.5%	95.7%	95.9%	94.6%	91.9%	96.8%	96.9%	96.0%	95.4%	94.6%	95.4%	95.9%	Cancer standards report two months in arrears	95.4%	95.7%		
	Cancer - Symptomatic Breast (cancer not suspected) in Under 2 Weeks	93%	88%	87.9%	98.5%	95.5%	90.9%	100.0%	100.0%	100.0%	100.0%	100.0%	98.1%	98.6%	97.7%	97.0%		99.0%	97.4%		
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	93%	98.5%	97.4%	99.0%	100.0%	96.1%	96.0%	97.8%	98.0%	97.3%	96.8%	96.7%	96.7%	99.1%		97.1%	97.9%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	93%	99.6%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.1%	100.0%	100.0%	100.0%	100.0%		99.7%	100.0%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	89%	95.9%	97.1%	96.9%	95.7%	91.7%	92.3%	93.0%	98.0%	98.2%	100.0%	96.8%	97.8%	93.8%		98.2%	95.5%		
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	89%	Not applicable	99.8%	Standard not in effect			99.2%	100.0%	99.5%	100.0%	99.4%	100.0%	99.3%	100.0%		99.8%	99.7%		
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	80%	86.8%	85.1%	82.7%	89.9%	90.0%	79.3%	85.7%	91.2%	88.1%	85.7%	82.7%	84.2%	85.7%		85.1%	85.0%		
	Cancer 62 Day Referral To Treatment (Screenings)	90%	85%	94.0%	91.9%	93.8%	81.5%	100.0%	94.4%	70.8%	87.5%	96.8%	100.0%	95.3%	81.8%	86.1%		97.1%	84.1%		
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	99.1%	96.2%	81.0%	96.8%	92.5%	97.9%	100.0%	100.0%	100.0%	100.0%	88.9%	92.6%	100.0%		96.2%	96.2%		
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	80%	93.2%	92.1%	93.0%	92.6%	93.4%	94.0%	92.7%	91.5%	93.0%	92.4%	92.7%	91.8%	91.3%	91.9%	92.7%	91.7%		
	Referral To Treatment Non Admitted Under 18 Weeks	95%	85%	98.4%	98.1%	98.2%	98.5%	98.6%	98.4%	98.0%	98.0%	98.1%	98.7%	98.4%	98.0%	97.6%	97.7%	98.4%	97.7%		
	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	21.9	21.1	21.7		
	Referral to treatment time non-admitted patients (95th percentile - weeks)	18.3	18.3	Not applicable	14.4	Standard not in effect						13.6	13.7	14.0	15.0	15.1	15.3	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%	97.2%	97.8%	95.4%	95.9%	90.8%	89.5%	90.8%	94.2%	97.0%	98.8%	98.4%	97.7%	98.1%	97.1%	98.0%	97.6%		
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	Not applicable	13	Standard not in effect						85	53	15	15	12	13	55	13		
	A&E Time to treatment decision (median) - in minutes	60	60	Not applicable	16	Standard not in effect						24	20	20	18	15	18	20	16		
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	Not applicable	1.6%	Standard not in effect						2.1%	1.6%	1.1%	1.1%	1.8%	1.9%	1.6%	1.6%		
	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%	1.1%	1.0%		
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	1.01%	0.87%	0.90%	1.78%	1.69%	2.21%	1.44%	1.69%	0.97%	0.92%	1.01%	1.13%	0.89%	0.31%	0.97%	0.77%		
	28 Day Readmissions	95%	85%	94.6%	93.9%	95.3%	96.1%	88.2%	80.5%	91.1%	82.9%	94.1%	91.5%	95.8%	93.0%	93.2%	96.1%	93.9%	94.0%		
	GUM Offer Of Appointment Within 48 Hours	98%	95%	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%	100.0%		
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	Not applicable	83.6%	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%	76.4%	75.7%	76.9%	74.3%	77.9%	75.5%	75.1%	77.1%	72.3%	74.7%	78.4%	77.0%	78.1%	73.8%	75.1%	76.2%		

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 0.89% in August to 0.31% in September)
- 28-day readmission following a cancellation ↑ (up from 93.2% in August to 96.1% in September)
- 62-day referral to treatment cancer standard – GP referred ↑ (up from 84.2% in July to 85.7% in August)
- 62-day referral to treatment cancer standard – Screening referred ↑ (up from 81.8% in July to 86.1% in August)
- 31-day Subsequent surgery ↓ (down from 97.8% in July to 93.8% in August)

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

3.4 EXCEPTION REPORTS

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

1) 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 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 90% standard for patients referred from one of the three national screening programmes was not achieved in August, although performance was better than in July.

The breach reasons for August were as follows:

- 15.5 out of 18 (86.1%) patients were treated within 62 days during **August** (in accountability terms – with shared patients counting as 0.5) against the 90% standard
- There were 2.5 breaches of the 62-day standard (in accountability terms), all of which were internally managed patients:
    - 1.0 x medical deferral / patient choice to delay - breast
    - 1.0 x medical deferral - breast
    - 0.5 x elective capacity - bowel

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. These also include actions to support ongoing achievement of the 62-day GP referred standard. *Please note: actions completed in previous months have been removed from the following list*:

ACCESS STANDARDS

- Reduce wait for surgical diagnostics to 7 days (end September) – *on going, with escalation of individuals cases as required*
- Consultant job plans to be amended to enable further capacity to be provided for partial nephrectomies at North Bristol Trust (Action complete) – *additional operating capacity made available at North Bristol Trust from the start of October*
- 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*
- Achieve a 10-day request to report turn-around for radiological investigations for patients on a cancer pathway (end November)
- Reduce wait from request received to vetting of radiology requests to 2 days for patients on cancer pathways (end September) – 82% vetted within 2 days as of the 19th September (target 90%)
- Implement a 5-day turnaround for MRI scans for patients on a breast cancer pathway, to reduce delays for patients needing a sentinel node biopsy (end October)
- The Trust will seek Network-wide agreement for the reallocation of breaches when patients are referred late in the pathway (end December); *policy has been drafted and circulated to the local cancer network; North Bristol Trust to provide feedback and agree next version of the draft by the end of October; final ratification of policy with all cancer network providers scheduled for December, so deadline for completion of this action has been changed.*

Progress against the recovery plan:

Performance in September is expected to be confirmed as 94.1%, well above the 90% standard. However, the dip in the 62-day screening performance was such that the 90% standard could not be achieved for quarter 2 as a whole.

The 62-day standard for GP referred patients was achieved in August and September, and for the quarter as a whole.

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 was achieved in September. There were 17 last-minute cancellations of surgery in **September** (0.31% of operations). The main reasons for cancellations in the month were as follows:

- 35% of cancellations (6 cancellations) another more urgent patient was prioritised on the day
- 12% of cancellations (2 cancellations) the morning theatre list ran-over delaying the start of the afternoon session
- 12% of cancellations (2 cancellations) were due to surgeon availability

Of the 17 cancellations, 7 were day-cases and 10 were inpatients (41% day cases). On average, seventy percent (70%) of the Trust admissions in a month are day-cases.

96.1% of patients were re-admitted within 28 days of the cancellation of surgery at last-minute in September, which was above 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 reason for the two cardiology cases being cancelled in August due to equipment failure has been reviewed (Action complete); the two cancellations were unrelated (one cancelled due to x-ray equipment breakage, and one due to the Electrophysiology recording/assessment equipment not working)
- Compliance with the process for escalating potential last-minute cancelled operations to Divisional Managers, Heads of Nursing or Heads of Division will be audited (end 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; Phase 2 of the programme includes 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
- Norvirus action plan will be revised (Action complete)
- Christmas / New Year plan will be developed for elective services, to reduce the risk of cancellations as a result of peaks in emergency demand or staff availability (mid December)

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 consistently achieved by the end of March 2012.

Progress against the recovery plan:

In August NHS Bristol formally raised concerns regarding the levels of last-minute cancelled operations. The Primary Care Trust (PCT) was provided with the recovery plan. Performance since the start of the implementation of the recovery plan has been above the trajectory agreed with the PCT. October's performance is forecast to be 1.2%, due to the seasonal pattern of emergency admissions and bed pressures, which is above the national 0.8% standard. The Trust is currently on track to achieve the actions and performance trajectory agreed with the PCT for October.

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 was above the 2010/11 target level between June and August, but dipped in September. 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 Public Trust Board Meeting, to be held on 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 07 – Infection Control Report

Purpose

To provide the Board with a quarterly report on Infection Prevention and Control.

Abstract

Target reductions for MRSA and *C. difficile* were achieved in quarter 2 with *C. difficile* reducing by 40% on the same period in the previous year. The local target reduction for MSSA bacteraemias was not achieved and actions are in place to address targeted screening. Close scrutiny of decontamination processes and incidents continues with strengthened leadership across the Trust for this function. An overall rating of green was applied by Audit South West against the design and operation of controls in local decontamination processes. A reduction in training compliance was noted following a refresh and revalidation of data held on the Trust's training monitoring database. Compliance at the end of September is 80% (achieving the Trust standard) with actions in place to increase compliance to the 90% stretch target in quarter 3. Pending confirmation at the Infection Control Group meeting held 25 October 2011 compliance against Care Quality Commission outcome 8 (infection control/hygiene code) is declared compliant. There are no areas of concern with delivery of the infection control programme.

Recommendations

The Board is recommended to **Note** the report and the continued good progress in MRSA and *C. difficile* reductions.

Executive Report Sponsor or Other Author

- Executive Sponsor – The Chief Nurse, Alison Moon
- Author – The Director of Infection Prevention and Control, Christine Perry

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
					Infection Control Group

INFECTION CONTROL QUARTERLY REPORT

RESPONSIBLE DIRECTORS: Chief Nurse & Director Infection Prevention and Control

The quarterly report is provided in compliance with the Code of Practice for Health and Adult Social Care on the Prevention and Control of Infection and to provides Ward to Board assurance of infection prevention activities. This is a core duty of the Director of Infection Prevention and Control

Clostridium difficile:

- The Trust is currently achieving against the national and financial targets for 2011/12. There have been 16 cases from July to September 2011. This is one under the target for quarter 2.
- At the end of quarter 2, Medicine and Specialised Services Division are over target. All other Divisions are under target.
- From July to September there have been no deaths where *C. difficile* was stated on the death certificate.
- Figure 1 provides comparative regional and national data for Trust-apportioned cases by quarter as published by the Health Protection Agency. These data are published one quarter in arrears. For the reported quarter, the Trust rate was the same as the national rate and slightly higher than the regional rate.
- Figure 2 shows the improvements in numbers of *C. difficile* cases since 2008. In Quarter two there was 11 fewer cases than in the previous year; a 40% reduction.

Figure 1 – Rate of *Clostridium difficile* infection per 1,000 bed days

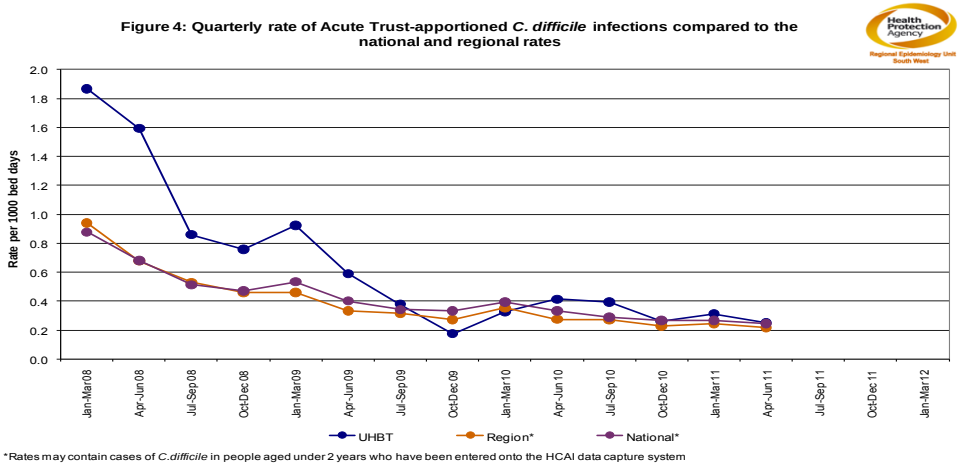
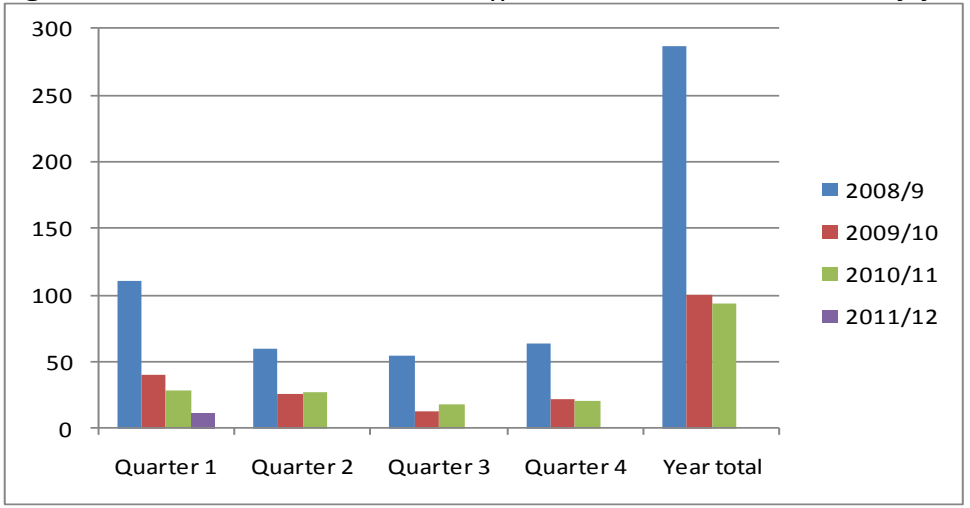


Figure 2 – Numbers of *Clostridium difficile* infection for UHBristol by year



MRSA/MSSA bacteraemias:

- The Trust over achieved against the national target for MRSA bacteraemias in Quarter 2 with no post-48 hour MRSA bacteraemias reported.
- From July to September 2011 there have been no reported deaths associated with MRSA.
- Monitoring of MRSA prevention practice continues through the Saving Lives dashboard (figure 3). The results of this monitoring and actions to address lower compliance are addressed directly with Divisions.
- Figure 4 provides comparative regional and national data for Trust-apportioned cases of MRSA by quarter as published by the Health Protection Agency. These data are also published a quarter in arrears. For the reported quarter the Trust was under both the national and regional rates.
- Figure 5 shows the reduction in MRSA bacteraemias from 2008/9 to 2011/12.
- Figure 6 shows the number of MSSA bacteraemias in 2011/12. For Quarter 2 the Trust is three cases over the local target agreed with NHS Bristol. Following root cause analysis of the increased cases in August and September targeted screening of some surgical patients for MSSA is being reviewed and compliance to current MSSA screening policy audited.
- Surgery Head and Neck and Specialised Services divisions are both over their reduction target at the end of quarter 2.

Figure 3 - Saving Lives Trust-wide compliance

	Jul 11	Aug 11	Sept 11
Central line insertion	100%	97%	99%
Central line ongoing care	94%	95%	92%
Peripheral line insertion	93%	95%	94%
Peripheral line ongoing care	95%	95%	94%
Surgical site infection pre-operative	97%	98%	100%
Surgical site infection peri-operative	90%	95%	94%
Ventilators observation	90%	95%	94%
Ventilators ongoing care	95%	100%	100%
Urinary catheters insertion	98%	98%	94%
Urinary catheters ongoing care	97%	97%	96%

Figure 4 - Rate of MRSA bacteraemia per 10,000 bed days

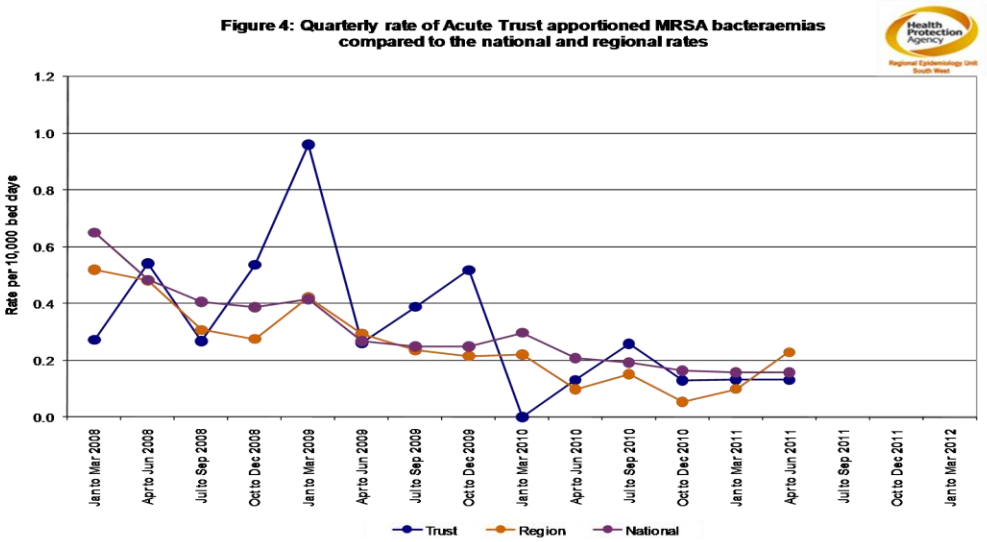


Figure 5 – Number of MRSA bacteraemias for UHBristol by year

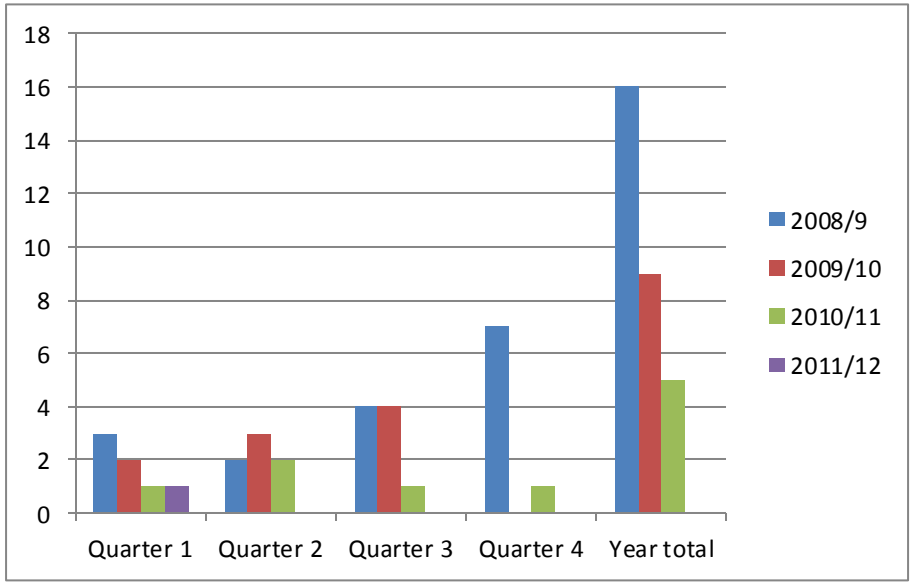
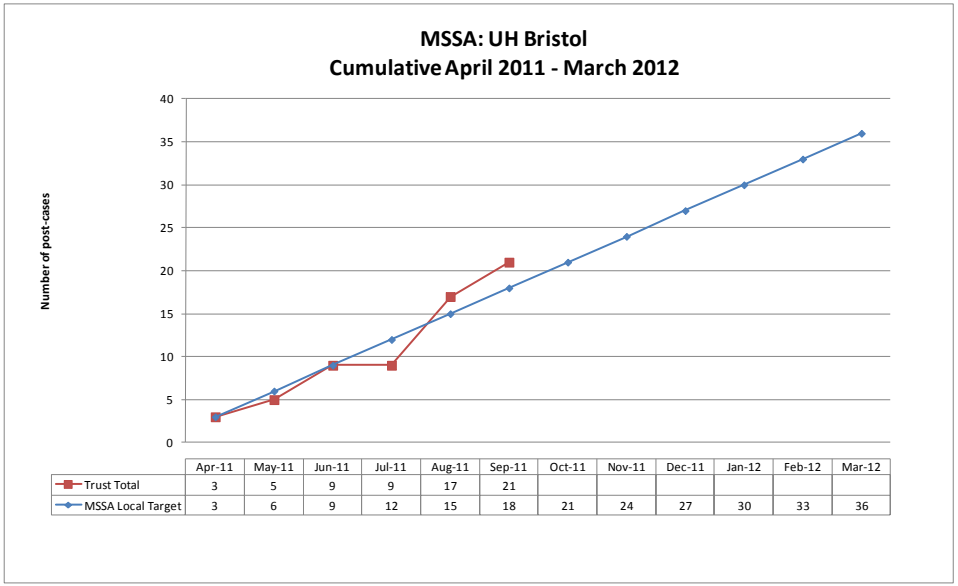


Figure 6 – MSSA bacteraemias UHBristol 2011/12



Cleanliness monitoring:

- The results of the Trust Monthly Cleaning Audits are in the table below. For the tenth successive month an overall score of 95% has been met or exceeded.

Risk Category	Jul	Aug	Sep
Very high	97	96	97
High	96	97	97
Significant	93	95	95
Low	95	92	93
Total	**95**	**95**	**96**

Average Hospital Scores	Jul	Aug	Sep
Bristol Royal Infirmary and Bristol Heart Institute	90	91	91
Bristol Royal Hospital for Children	95	97	96
St Michaels Hospital	97	97	98
Bristol Haematology and Oncology Centre	97	98	99
Bristol Eye Hospital	97	96	98
Bristol General Hospital	100	99	100
Bristol Dental Hospital	95	97	97
Central Health Clinic	93	93	98

- The overall Trust Cleanliness score was 96% in June and 95% for July and August, with the Very High Risk category areas achieving 96% or above.
- There are still some issues in the Bristol Royal Infirmary around some Very High Risk category areas, such as Heygroves Theatres, where the actual Theatres score highly but the "outside" areas, such as staff changing rooms and offices, score much lower. This has also been the case with the Queens Day Unit, where concentrated actions are being taken with the result that the scores have been rising consistently.
- There are sites in the Trust where consistently high scores are recorded of 96% and above across all risk categories. These are excellent results and demonstrate real commitment by all the staff teams involved.

Matrons quarterly report:

- The new linen contract will commence on the 30/11/11. A site visit to the laundry went well and the operation looks well organised with linen already purchased identified for this Trust. The current service continues to be variable and fluctuant with sheets having been a problem over the past couple of weeks. These are being escalated as and when necessary.
- The introduction of an electronic Estates helpdesk is planned to be trialled in the Bristol Heart Institute at the end of this year. Roll out to all areas will then follow once the trial is completed.
- Continued work for the phase 1 redevelopment has had some impact on the wards mainly at the back of the Queen's building with noise but staff are aware of the process to follow if the impact is detrimental to patients.

Antibiotic prescribing report:

- Work on antibiotic guidelines is ongoing with updates planned for those that have reached the review date.
- Antibiotic prescribing compliance has reduced below the 80% threshold in August and September 2011; the Medical Director continues to lead actions to make improvements as reported to the Trust Board in monthly exception reports.

Figure 7 – antibiotic prescribing compliance for Medicine

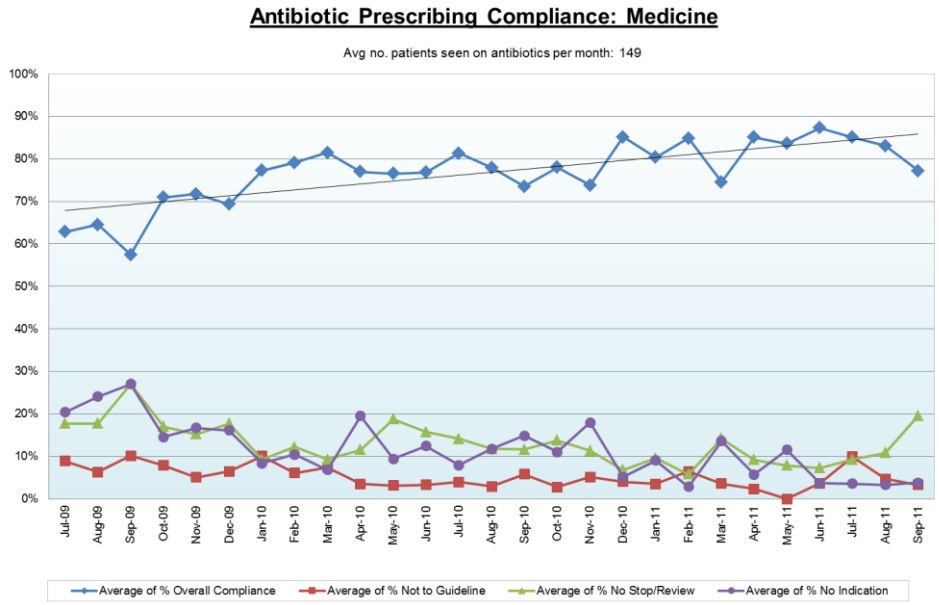


Figure 8 – Antibiotic prescribing compliance for Specialised Services

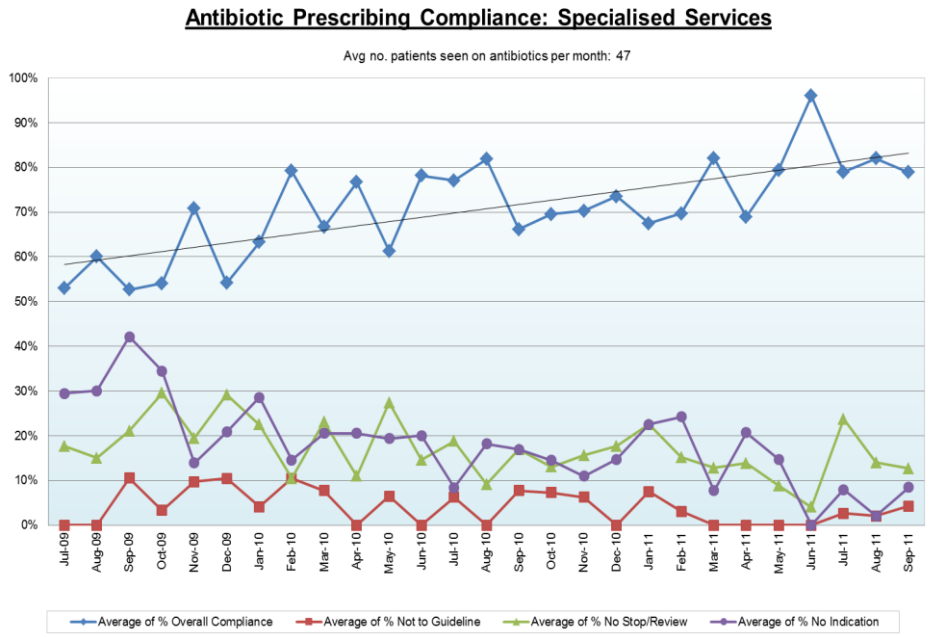


Figure 9 – Antibiotic prescribing compliance for Surgery Head and Neck

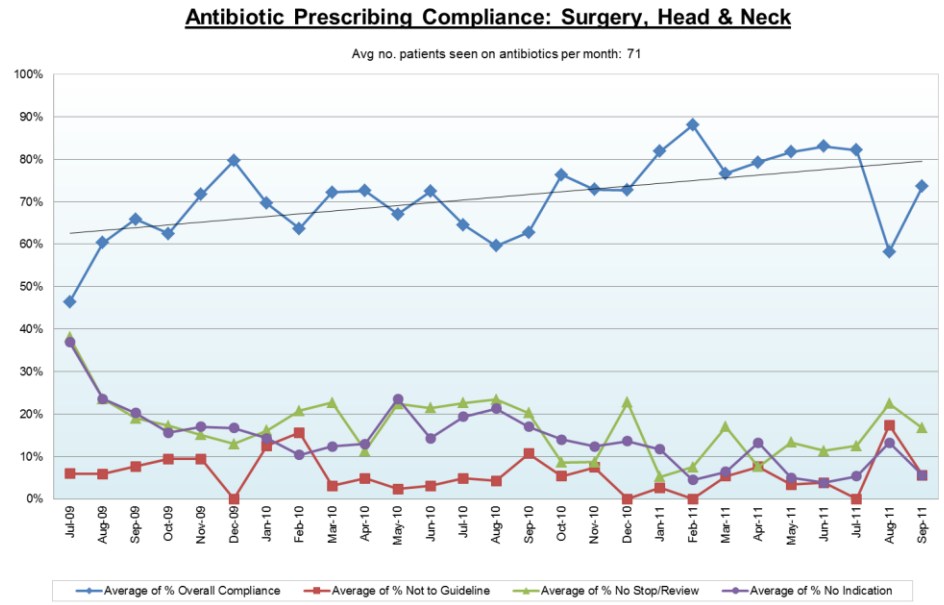
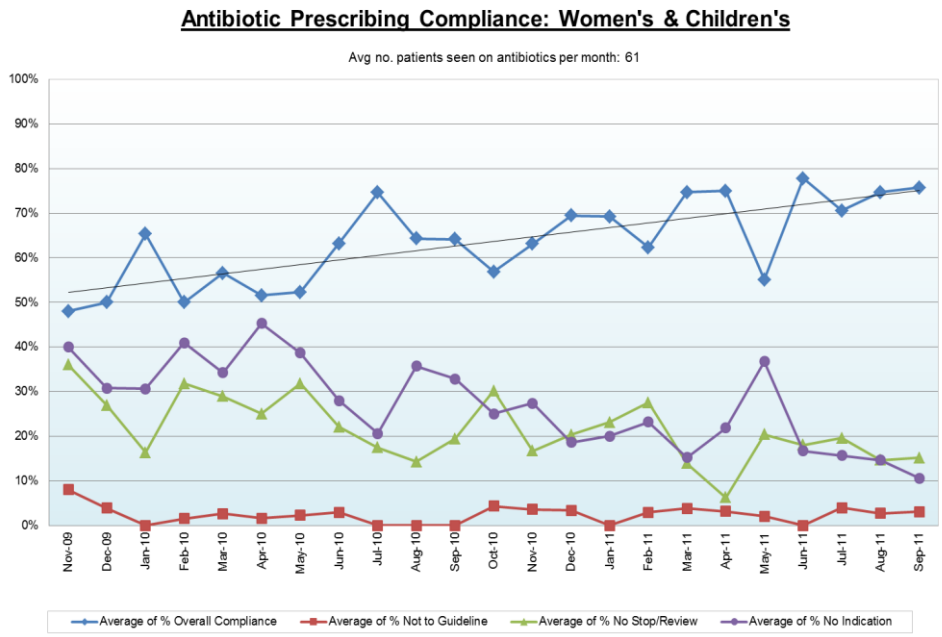


Figure 10 – Antibiotic prescribing compliance for Women and Children's



Decontamination:

Audit South West completed their audit and their findings were discussed at the Decontamination Board in September. The overall assurance opinion on the design and operation of controls is green. There were four recommendations made as follows:

- Formal annual review of the dissemination of decontamination policies at department level is undertaken
- The standard operating procedure for manual washing of clinical equipment is reviewed and disseminated throughout the Trust
- Decontamination user group consider the use of a standard staff training monitoring spreadsheet based upon Queen's Day Unit model, for use by all Named Lead Users
- Decontamination User Group to consider using the training package developed by the Queen's Day Unit for all other departments

The non-compliant washer-disinfector in the Children's Hospital Theatre was decommissioned 1st August 2011.

An exercise is being undertaken to understand the age and lifespan of decontamination equipment across the Trust. Items that are deemed to be approaching or beyond manufacturers recommended lifespan will be placed on the decontamination and divisional risk registers. This information will help inform requests for future capital monies in the interests of equipment replacement.

The service being delivered to end users by CSSD has improved in the last three months. Annette Giles has been appointed as Head of CCSSD and

Trust Decontamination Manager with a band 7 operations manager position to being recruited into with the aim of this person being in post early in 2012. Further restructuring of the department's whole team is underway.

The division of Surgery Head and Neck is in the process of developing a business case in terms of the future 'estate' for CSSD. The current building and facilities are over 20 years old and capacity is at a premium. In order to remain compliant and maintain accreditation a refit is necessary. Currently there is a capital allocation of £3 million provisionally planned to make the required improvements.

Clinical incidents forms that are completed with relation to CSSD are continually monitored and acted on. Collation of these reports continues to show the following themes:

- Holes in tray wrap
- Damaged instrumentation
- Contaminated set/instrument
- Wrong/missing/extra item on set
- Equipment unavailable when required.

Action plans are in place to address these problems. Key Performance Indicators have also been drawn up against which the department is being measured. In response to the continued issue of holes in tray wrap the feasibility of moving to sterilization containers as opposed to material wrap is being explored.

Outbreaks and untoward incidents:

- There have been no infection control related serious incident reports during quarter 2.
- There have been no ward closures due to confirmed Norovirus during quarter 2. Plans for outbreak prevention have been discussed at Service Delivery Group and will be implemented from this point onwards. These plans include a focus on assessment of admitted patients, use of appropriate cubicles for patients with suspected gastroenteritis and management of affected patients with ongoing symptoms in a cohort area.

Training compliance:

The training management database (At-Learning) was refreshed and revalidated during July 2011. As a result of this, overall training compliance has reduced to 80% in September 2011. Whilst this is lower than the internal stretch target of 90% compliance is at the 80% Trust agreed compliance standard. Divisions are actively identifying non-compliant individuals to ensure the 90% stretch compliance target is reached in quarter 3.

A breakdown of compliance by Division is shown in the table below.

Division	Percentage compliance
Diagnostics and Therapies	78%
Facilities and Estates	88%
Finance	85%
Human Resources	76%
Information Management and Technology	80%
Medicine	81%
Specialised Services	81%
Surgery Head and Neck S	82%
Trust Headquarters	61%
Trust Services	79%
Women's and Children's	78%
Grand Total	**80%**

Hygiene code and Care Quality Commission outcome 8 compliance:

The Infection Control Group received evidence against the compliance standards at its meeting on 25th October. The outcome of their assessment of compliance will be verbally reported at the Trust Board meeting.

Compliance against the standards is outlined below. Two standards have moved from minor concerns to compliant within the quarter.

Compliant	Minor concerns	Moderate concerns	Major concerns
66	**5**	**2**	**0**

Infection Control Programme 2011/12 exception reports:

The Infection Control Group received an update on progress with the infection control programme. The actions are RAG rated as follows.

On target to deliver objective or objective delivered	Minor delay to delivery of objective	Major delay to delivery of objective	Objective delivery date in the future
24	**4**	**0**	**2**

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 08 – Half-year Update on Corporate Quality Objectives

Purpose

To brief the Board on progress towards achieving the Trust's stated quality objectives for 2011/12.

Abstract

A set of corporate quality objectives was agreed as part of the development of the Trust's Quality Strategy 2011-14 and published in the Trust's Quality Report (Account) 2010/11.

Objectives are divided into the three core quality domains: patient experience, patient safety and clinical outcomes/effectiveness. The attached report describes mid-year progress towards achieving these objectives: RAG ratings have been applied to indicate progress to date and confidence of achievement by year end.

Recommendations

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

Executive Report Sponsor or Other Author

- Executive Sponsor – The Medical Director, Sean O'Kelly
- Author – The Assistant Director for Audit and Assurance, Chris Swonnell

Appendices

- Appendix A – Half year update on Corporate Quality Objectives

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	12 October 2011				

University Hospitals Bristol NHS
NHS Foundation Trust

Subject: **Half Year Update on Corporate Quality Objectives**

Report to: **Trust Board**

Author: **Chris Swonnell, Assistant Director for Audit and Assurance**

Date: **13 October 2011**

Introduction

In May 2011, the Board approved the Trust's Quality Report for 2010/11, which included a number of specific quality objectives for 2011/12. These same objectives also form part of the Trust's Quality Strategy, approved by the Board in June 2011.

Overview of half-year performance

The Trust's quality objectives for 2011/12 are summarised below with two RAG ratings: one indicating the amount of progress to date; the other indicating the current level of confidence of achieving the objective by the end of March 2012.

Patient Safety:		
We said we would:	**Progress to date**	**Confidence of achieving by year end**
Achieve sustained improvement (three months without sliding backwards) in process and outcome measures for pilot populations in all five work streams of the NHS South West Quality and Patient Safety Improvement Programme; also achieve spread - including testing, training, communication, etc. - of all key changes beyond the pilot populations of the same Programme.	R	R
Seek further improvements in the following areas which are within the scope of the SWQPSP:		
○ Hospital Acquired Thrombosis (VTE)	G	G
○ Medication errors	G	G
○ Inpatient falls	A	A
○ Pressure ulcers	R	A
Continue to implement the findings of the independent enquiry into our Histopathology services.	G	G

Patient Experience		
We said we would:	**Progress to date**	**Confidence of achieving by year end**
Persevere with our strategy for obtaining systematic feedback from inpatients and extend the core methodologies into Outpatient services (i.e. postal surveys, clinic-based surveys and comments cards)	G	G
Create a range of opportunities for carer feedback and engagement, with a particular focus on carers of patients with dementia	G	G
Achieve measurable reductions in patient-reported hospital noise at night	G	G
Ensure that patients who need assistance at mealtimes receive this	G	G
Review the provision of ward-based patient information ensuring that this meets our patients' needs	A	G
Develop customer care training for staff in response to what our patients tell us matters to them.	A	G

Clinical Effectiveness/Outcomes		
We said we would:	**Progress to date**	**Confidence of achieving by year end**
Maintain our 'lower than expected mortality' rating for headline HSMR[1]	G	G
Seek improvements in one year survival rates for colorectal, breast and lung cancer patients, in particular by implemented the recommendations of *Improving Outcomes: a strategy for cancer* (Department of Health, 2011)	R	A
Improve stroke care: establish a specialist stroke unit; ensure that 90% of patients who suffer a stroke spend 90% of their care in a specialist unit; achieve improved Dr Foster Hospital Guide ratings for stroke care	A	A
Increase the proportion of spontaneous vaginal births	R	G
Implement our dementia action plan	G	G

This report which follows describes progress made towards achieving these objectives in more detail.

[1] The HSMR will be replaced at some point during 2011/12 be a new measure called 'SHMI' – the Summary Hospital-level Mortality Indicator.

Patient Safety

The Trust is on target to achieve **some** of the agreed clinical effectiveness objectives for 2011/12.

South West Patient Safety and Quality Improvement Programme

The Trust is part way through the South West Patient Safety and Quality Improvement Programme (SWPSIP). The Programme is run as a South West Regional Initiative for all adult patients within acute trusts. It uses the improvement methodology of the Institute of Healthcare Improvement (IHI) which is for rapid tests of change (PDSA) to be carried out in local areas by clinical staff. When improvements are made following these rapid tests of change then the testing cycle begins in another area of the trust allowing the programme measures to spread to all relevant patients.

The overall aims of the programme are that by 2014 patient mortality will be reduced by 15% and adverse events reduced by 30%.

The programme is split in to 5 work streams: Leadership, Peri-Operative, General Ward, Medicines Management and Critical Care. Each work stream has a number of measures (see Appendix A to this paper) which are reported monthly, showing whether these have been tested in a pilot area, have tested successfully and are spreading work to other relevant areas in the Trust, or have completed spread to all relevant areas and are sustaining improvement by achieving 95% compliance (+/-5%) for at least 3 months.

In total, monthly monitoring covers 68 measures set by the IHI and South West Faculty and 5 additional measures set by the Trust. The Trust is not collecting data in relation to two of these measures:

- Surgical Patients with Appropriate Hair Removal – all razors were removed from theatres as part of the Safer Patient Initiative therefore it was not deemed necessary to collect data in relation to appropriate hair removal as there was no further improvement to be made.
- Anticoagulant Adverse Event Rate – this was an optional measure set by the South West Faculty and the Medicines Management Work Stream decided not to work on this measure until they had sustained improvement in the compulsory measures.

Therefore on a monthly basis the Trust reports data on 71 measures.

	Number of Measures showing sustained improvement for 3 months or more	Number of measures spread trust wide but not showing sustained improvement	Number of measures still in the pilot phase or data collection just began	Number of measures with no data collected and/or no testing taking place
Leadership	**5**	**0**	**0**	**0**
Peri Operative	**6**	**0**	**2**	**1**
General Ward	**10**	**8**	**10**	**0**
Medicines Management	**0**	**5**	**3**	**1**
Critical Care	**17**	**5**	**0**	**0**

The Trust is currently scored at 1.5 in the South West Faculty's Assessment Scale (see Appendix B to this report) and has been in this position since April 2010. The Chief Nurse and Medical Director have agreed that, with clear reporting lines for the programme and objectives for the work streams, the Trust will achieve an overall Programme Score of 2.5 out of a possible 5 within the South West Faculty Assessment Scale by the end of March 2012. The objective of achieving 3.5 will not be achieved by the end of 2011/12. Nonetheless, a score of 2.5 will represent significant progress and there is scope within the 5 year programme to recover the position by 2014. The next milestone will be to achieve the next target of 4.0 by the end of 2012.

In order to address the slippage on time scales, clearer status information will be provided to work stream leads and progress will be performance managed by the Medical Director and Chief Nurse. Dashboards will identify where improvements are required within each work stream. Delivery of objectives will be monitored at individual work stream meetings which take place on a monthly basis. The programme will also report monthly to the Patient Safety Group: where measures are not being met, exception reports will be provided by the work stream leads and steps to rectify any adverse position agreed.

The Programme Manager will continue to work closely with other project leads across the Trust to ensure there is no duplication of work for clinical staff and that all projects with similar measures are reporting the same improvements.

Hospital acquired thrombosis (VTE)
The CQUIN target is that 90% of patients will receive a VTE risk assessment (payment is made monthly based on an absolute standard). Performance in August (reported to September Trust Board) was 98.0%

Medication errors
The CQUIN target is, for Quarter 4 of 2011/12, to achieve of 3.1% of reported medication errors resulting in moderate or greater actual harm to (75% achievement of CQUIN) or 2.85% (for 100% achievement). Performance in June (reported to September Trust Board) was 0.85%.

Inpatient falls
The CQUIN targets agreed with NHS Bristol are as follows:
1. 95% of falls risk assessments are to be completed on patients 65 and over on admission from Q3.
2. 10% reduction in total number of falls reported incidents by Q4. Baseline measure to be Q2 2011-12.

The Trust is currently reporting 75% confidence of achieving the first target and 50% confidence of achieving the second. On 13th September, the Trust launched "Being the Best" which is a 90 day project designed to focus all staff on reducing and preventing falls and pressure ulcers for all our patients

Pressure ulcer prevention and management
The CQUIN target is to reduce the incidence of Grade 2 and above hospital acquired pressure ulcers by 25% compared to baseline. This equates to 6.51 pressure ulcers per 10,000 bed days in Q4. Data for July (reported to the Board in September) indicates a pressure ulcer rate of 13.61 per 10,000 bed days. The Trust is currently reporting 50% confidence of achieving this target.

Histopathology
The Board received an update of progress against the Histopathology Action Plan (v19) in September 2011 which demonstrated no exceptions to meeting implementation deadlines. The remaining key action: the formation of an integrated pathology service for Bristol going forward, which includes structure, location and workforce, is linked to the pan Bristol Pathology Services review. Significant

work has already taken place within existing arrangements to lay the foundations of a quality integrated service and this will be built on as part of the on-going development of the service when the Histopathology action plan is closed down. The focus is now on checking that all the evidence to demonstrate implementation of the action plan is complete and up to date and there are plans to take the final version to the Board in December 2011, having received more detailed non-executive scrutiny in the November Quality and Outcomes Committee.

Patient Experience

The Trust is on target to achieve **all** of the agreed patient experience objectives for 2011/12.

Systematic inpatient and outpatient feedback
Monthly inpatient surveys are continuing. These surveys achieve a consistent 50%+ response rate, providing the Trust with detailed feedback from around 1,000 patients every month. This feedback is used to identify improvement themes which are captured in Divisional Patient Experience Action Plans (PEAPs). A dashboard of PEAP indicators is monitored by the Patient Experience Group, including metrics relating the two local patient experience CQUINs for 2011/12 (see below). A half-year dashboard is currently being prepared for the October Trust Board meeting.

A first comprehensive survey of Outpatients has been completed: data has been received from our contractor, Patient Perspective, and is currently being analysed. A report is due to be received by the Patient Experience Group in November. A total of 2,125 patients have given us feedback (51% response rate).

Involving carers
A Carers Reference Group of different kinds of carers (including carers of Dementia) has been successfully running since March 2011. This has focused on areas such confidentiality and discharge and reported back to the Carers Strategy Group and the Discharge Group. A similar Group consisting solely of carers of people with Dementia has also been meeting. The Dementia Carers Reference Group offers an opportunity for carers of people with Dementia to share their perspectives and experiences of care at UH Bristol. The Group has recently been exploring how people are listened to whist they are in care, and how we listen to patients and carers and engage them more.

In the context of dementia care, carers have been involved in writing a Carers Charter which will be launched in the Trust this autumn and producing a Carers leaflet. A questionnaire for carers of patients with dementia is scheduled to be introduced by the end of October. LINks/Alzheimer's Society "Living with Dementia" listening exercises will also commence in October.

Reducing noise at night
Latest data (for July) indicates a trust-wide score of 82 points out of 100 (note: these scores are not percentages). The CQUIN itself will be measured on performance during Quarter 3 of 2011/12 (50% of CQUIN value will be achieved for a score of 80; 100% for a score of 81). We are confident of realising the full value of this CQUIN.

Helping patients at mealtimes
Latest data indicates a trust-wide score of 80 points. The CQUIN itself will be measured on performance during Quarter 3 of 2011/12 (50% achievement for a score of 74; 100% for a score of 76). We are confident of realising the full value of this CQUIN.

Review of ward-based information
The launch of a new "Welcome to the ward" patient information guide is being overseen by a working group formed for this purpose. Content will be finalised in October – production and design

decisions will then be made by the Communications Team. The guide will include a personalised generic ward leaflet and welcome letter; information about the routine of the ward; a guide to recognising different staff; information about support, visiting times, food choices, discharge, etc; and guidance about how to give feedback.

Customer care training
Following a trial in August, on October 4th the Trust will launch a new immersion and induction programme for all staff and new starters, which will draw on real patient compliments and complaints and enable staff to understand the role of the Trust's values and expected behaviours in improving patient care, across the organisation, making real changes to improve efficiencies and meet the Trust's savings target.

In the meantime, existing 'Treating People Well' workshops have been put on hold (the last workshops were held in September), pending the roll-out of the values-based training described above.

Clinical Effectiveness/Outcomes

The Trust is on target to achieve **some** of the agreed clinical effectiveness objectives for 2011/12.

Maintaining low HSMR
Headline HSMR is reported to the Board every month and remains below 100.

One year cancer survival
At the beginning of October, the Cancer Intelligence Service (CIS) at the South West Public Health Observatory provided the Trust with crude one year survival statistics for colorectal, breast and lung cancer patients. Further discussions are needed with lead consultants at UH Bristol to understand the reliability of this data before it is appropriate to release this for wider discussion (the quality of the data held by the Observatory will only reflect the quality of the Trust's data returns). Further dialogue is also needed with the CIS to understand whether data exists to enable the Trust to compare performance with peers. Nonetheless, progress has been made on this objective in the last quarter.

Note: by definition, one year survival statistics cannot be measured in-year. 2010 data should become available in early 2012.

Improving stroke care
A single ward (Ward 12) for hyperacute and acute stroke on BRI site opened on 4th August 2011. This is producing real focus on quality of care from the entire stoke team. There is a daily consultant presence on ward and board rounds. There are however some concerns over reduction in bed base of 10 beds, and the fact that beds are not protected: medical and other staff are working very hard at shortening length of stay, but frequently beds are filled with medical patients. Nursing staff have been amalgamated from parts of two clinical teams (Wards 17 and 25): this involves a learning curve for both teams with direct admissions, treatment and rapid turnover of hyperacute stroke including thrombolysis, plus management of very dependent rehabilitation patients and palliative patients.

A 15 bed stroke rehabilitation unit continues at BGH, potentially accessed by all admissions except North Somerset patients because of rehabilitation contract.

The Trust has a responsive and effective Early Supported Discharge Team for stroke patients, although this is only able to cover Bristol patients: patients are assessed on the same day following referral, and where appropriate are taken home within 24 hours. Delays result from need to access

social care for some patients. Our Accelerating Stroke Improvement measures target is 40% patients discharged with ESDT: the latest figure for Bristol PCT patients is 39% (averaged over 6 months)

Our agreed quality objective for stroke was to improve our published Dr Foster ratings. This is a difficult objective to report on because it is dependent upon two factors beyond our control: Dr Foster's choice of future published indicators and the performance of other NHS trusts. Since data was collected for this report, Dr Foster has released a definitive list of stroke indicators which will appear in its 2011 Hospital Guide, due to be published at the end of November. There will be **five** stroke indicators published for 2011, compared to the six used last year. Four of the 2011 indicators were used last year:

- Stroke – Mortality / Stroke standardised mortality ratio
- Stroke – Readmissions / Stroke standardised 28 day emergency readmission rate
- Stroke – Pneumonia / Stroke standardised rate of hospital acquired pneumonia due to swallowing difficulty
- Stroke – No discharge home / Stroke standardised rate of non-discharge to usual place of residence within 56 days of admission

One new indicator has been added:

- Stroke – LOS / Stroke standardised rate of long length of stay (above national upper quartile)

Two indicators appear to have been dropped by Dr Foster:

- Stroke – Performing brain scans the same or next day
- Stroke – Providing thrombolytic drugs within 24 hours

Taking the four indicators which are being retained from last year:

Indicator	**Q1**	**Q2**	**Dr Foster 2010 report**
In-hospital mortality	13%	8% (September data not yet available)	Cannot compare as DrF publishes a mortality index (against national average of 100 points, as per HSMR)
Stroke readmission within 28 days	1.67%	2.47%	Cannot compare as DrF publishes a readmission index (score out of 100)
Pneumonia due to dysphagia	4.17%	2.47%	UHB = 4.41% Best FT = 2.42%
Discharge to UPR within 56 days	93.67%	94.74%	UHB = 75.71% Best FT = 85.44%

In terms of the two indicators which have been dropped from the Dr Foster report:

Indicator	**Q1**	**Q2**	**Dr Foster 2010 report**
Brain scan within 24 hours of admission	92%	93%	UHB = 81.45% Best FT = 82.89%
Thrombolysis within 24 hours	4.4%	7.3%	UHB = 5.35% Best FT = 13.71%

In summary, there are some promising signs in the data, but we will not know whether our objective has been achieved until the Hospital Guide is published at the end of November.

Increasing the proportion of spontaneous vaginal births

The CQUIN target is to achieve a 1% improvement in the proportion of spontaneous vaginal deliveries compared to all vaginal deliveries. At the present time, this objective is not being achieved, however the Trust has approved the release of CQUIN pump-priming funds to enable the purchase of four telemetry units. Audit evidence shows that women needing continuous fetal monitoring are most at risk of instrumental births: the telemetry facility will enable women to mobilise up to 50 metres away from the machine and to use the birthing pool. With this equipment in place, there is a high degree of confidence of achieving the quality objective and related CQUIN.

Implementing our Dementia action plan

Specific goals in relation to this objective are covered by the South West standards which the Trust has signed up to. At the end of June, the Trust submitted an outline implementation plan to the SHA setting out how and when these standards would be achieved. Progress on key areas is as follows:

- Introduce "This is Me" document across the Trust:
  The plan to roll out "This is Me" is on track and has been implemented in key areas such as ED, MAU, T&O ward, Elderly Care wards
- Define and implement the Dementia Champion role across the Trust:
  A role description is due to finalised between NBT and UH Bristol. Awareness training for Champions is being held on 11th October, with a joint Trust day planned on 8 December. This objective is on target.
- Develop and implement a minimising ward move policy for patients with dementia:
  Transfer proformas now include key information on vulnerable people including people with dementia. The Transfer policy is in draft form and has been widely circulated for comment.
- Identify communal areas used by patients with dementia and ensure appropriate signage is in place:
  This is a level 2 requirement and will be completed in November 2011. Scott Rendall, the Estates Lead for dementia, is working on this aspect of the plan
- Install clocks and calendars in all ward areas:
  A bid to the WRVS was made in September with Executive approval. We are awaiting the outcome: initial feedback from the WRVS has been positive. Once approval is given, the clocks/calendars will be ordered. We are unlikely to meet our October deadline for this but aim to achieve this in November.
- Review current dementia training:
  A joint training plan and matrix is being developed by a joint NBT and UH Bristol sub-group. Level 1 awareness training has been approved and is starting to be rolled out. A Pilot to trial level 2 on line training is underway in UH Bristol. This objective is on target.

Appendix A

Measures recorded in NHS South West Quality and Patient Safety Improvement Programme

		Measure
OVERALL	AO1	Standardised Mortality Ratio
	AO2	Percent Unadjusted Hospital Mortality
	AO3	Adverse event rate per 1000 patient days
CRITICAL CARE	CC1	Percent ITU Mortality (includes HDU for combined units)
	CC2	Percent HDU Mortality
	CC3	ICU and HDU blood sugar results within range
	CC4	Central Line Infection rate
	CC5	days between a central line infection
	CC6	Compliance with central line bundle
	CC7	Ventilator acquired pneumonia rate
	CC8	Days between a ventilator acquired pneumonia
	CC9	Compliance with ventilator care bundle
	CC10	MRSA Bloodstream Infection rate - ITU
	CC11	Days between a MRSA bloodstream infection -ITU
	CC12	C. Difficile associated disease rate - ITU 7 HDU
	CC13	Days between a C. Difficile associated disease occurrence
	CC14	Compliance with Hand Hygiene - ITU
	CC15	Patients with completed VTE risk assessment on admission - ITU
	CC16	Patients receiving appropriate VTE prophylaxis - ITU
	CC17	Compliance with the Peripheral Vascular Catheter Insertion Bundle - ITU
	CC18	Compliance with the Peripheral vascular Catheter Ongoing Care Bundle -ITU
	CC19	Achievement of Multi-Disciplinary Rounds
	CC20	Achievement of Multi-Disciplinary Rounds and Daily Goals
	CC21	Average mechanical ventilation LOS
	CC22	ICU average LOS
Leadership	LD1	Number of walk rounds completed
	LD2	Actionable items identified during Walk Rounds completed
General Wards	GW1	MRSA Bloodstream Infection Rate - Wards
	GW2	days between an MRSA bloodstream infection - Wards
	GW3	C. Difficile associated disease rate - Wards
	GW4	Days between a C Difficile associated disease occurrence - Wards
	GW5	Percent Compliance with Hand Hygiene - Wards
	GW6	Percent Compliance with the Peripheral Vascular Catheter Insertion Bundle - Wards
	GW7	Percent Compliance with the Peripheral Vascular Catheter Ongoing Care Bundle - Wards
	GW8	Patients with completed VTE risk assessment on admission - Wards
	GW9	Patients receiving appropriate VTE prophylaxis - Wards
	GW10	Number of Cardiac Arrest Calls

		Measure Continued
General Wards Cont.	GW11	Number of Rapid response calls
	GW12	Percent compliance using Daily Safety Briefings
	GW13	Percent using SBAR (in selected communication strategy)
	GW14	Patients with observations complete
	GW15	Trigger patients receiving appropriate response
	PU1	Number of pressure ulcers newly acquired on the unit
	PU2	Days between diagnosis of hospital acquired pressure ulcers
	PU3	Compliance with Skin bundle
	PU4	Patients with completed risk assessment within 6 hours of admission
	F1	Number of falls resulting in harm
	F2	Days between falls resulting in harm
	F3	Compliance with falls risk assessment and identification
	F4	Compliance with comfort rounds
	IC1	Number of urinary catheters in situ
	IC2	Number of patients with catheters treated for UTI
	IC3	Percent compliance with catheter insertion bundle
	IC4	Compliance with catheter ongoing care bundle
	V3	Number of patients who have developed a VTE in hospital
Medicines Management	M1	Warfarin patients with INR results above 6
	M2	Anticoagulant adverse event rate
	M3	Patients with no medication reconciliation
	M4	RPN for FMEA on a high risk area core medication process
	M5 - trust	Cumulative % of medicines reconciliation completed within 24hours based on the day of the week
	M6 - trust	Warfarin Anticoagulation Services Patients with INR >8
	M7 - trust	Number of Warfarin Anticoagulant Service Patient with INR > 1 - INR unit below target
	M8 - trust	Number of Warfarin in patients with INR > 8
	M9 - trust	Patients without simple medicines reconciliation
Perioperative	P1	Surgical patients with SSI (selected population)
	P2	Antibiotics administered on time
	P3	Surgical patients with appropriate hair removal
	P4	Perioperative normothermia
	P5	Known diabetics with controlled glucose
	P6	Eligible surgical patients receiving DVT prophylaxis
	P7	Surgical patients on maintenance beta blockade continued on beta blockade
	P8	Compliance with WHO Surgical Safety Checklist
	P9	Compliance with Pre List Briefing

Appendix B

NHS South West Quality and Patient Safety Improvement Programme Assessment Scale

Score	Description	By when?
0.5	Pre-work completed by due date and pilot populations and teams have been identified for all five work streams.	Oct 09
1.0	Testing in all work streams is underway. Measurement system is being developed and at least half of the process and outcome measures are being collected and reported on the Extranet.	Jan 10
1.5	Results on all required outcome measures are being reported on the Extranet. In addition, all process measures relevant to the work currently underway are being reported on the Extranet. Improvement noted in process measures in pilot populations in at least two work streams.	Apr 10
2.0	Improvement noted (using run chart rules) in process and/or outcome measures for pilot populations in three or more work streams. Plans for spread within each hospital have been developed.	Oct 10
2.5	Improvement noted (using run chart rules) in process and/or outcome measures for pilot populations in all five work streams.	Jan 11
3.0	All key changes in all five work streams have been implemented in the pilot populations. Sustained improvement[1] noted (using run chart rules) in related process and outcome measures in one to three pilot populations.	Apr 11
3.5	Sustained improvement (three months without sliding backwards) is noted in process and outcome measures for pilot populations in all five work streams. Spread (including testing, training, communication, etc.) of all key changes is underway beyond the pilot populations.	Oct 11
4.0	Spread (including testing, training, communication, etc.) of all key changes has been achieved in one to three (breadth) work streams with at least 50% penetration (depth) into other applicable patient populations and areas.	Oct 12
4.5	Spread (including testing, training, communication, etc.) of all key changes has been achieved in all (breadth) work streams with at least 50% penetration (depth) into other applicable patient populations and areas.	Oct 13
5.0	Spread has been achieved in all five (breadth) work streams with 100% penetration (depth) into the applicable clinical areas and has been sustained (no backward slipping in the outcome measures) for a minimum of three months.	Oct 14

Sustained improvement is maintaining the new level of performance (with consideration for a little variation around the new level of improvement, i.e., +/- 5%) for 3 reporting periods (months) to be considered "*sustained*." If the improvement is followed by a return to the previous level of performance, the site will still get credit for the improvement but not for sustaining the improvement. It takes 3 months at the new level of performance in order to be considered a sustained measure.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 09 – Complaints Annual Report
Purpose
For the Board to receive the Complaints Annual Report.
Abstract
The 2010/11 Annual Complaints Report is provided.
Recommendations
The Board is asked to receive the report and **note** the 2011/12 work plan in Section 10.
Executive Report Sponsor or Other Author
• Executive Sponsor – The Chief Nurse, Alison Moon • Author – Patient Support and Complaints Manager, Karen Hurley

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	September 2011				Patient Experience Group September and October 2011.

University Hospitals Bristol NHS
NHS Foundation Trust

Complaints
Annual Report 2010/2011

Contents Page

Section

1. Introduction

The management of complaints at University Hospitals Bristol NHS Foundation Trust (UH Bristol) is undertaken in line with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the Parliamentary & Health Service Ombudsman (PHSO) Principles of Good Complaints Handling 2009, which are:-

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

The Trust's Complaints Policy has been reviewed and updated to reflect these principles and also supports the Trust in maintaining compliance with Care Quality Commission Registration Outcome 17 and NHSLA Risk Management Standard (Acute Trusts) 5.3.

The Patient Support & Complaints Team are responsible for the co-ordination, reporting and management of complaints. There is also divisional support for the management of complaints, with the investigation and resolution of written complaints largely taking place within divisions by the senior management and clinical teams with the support of Divisional Complaints Co-ordinators.

In May 2010 the corporate Patient Advice & Liaison Service (PALS) and Complaints Departments were merged together and rebranded as the Patient Support & Complaints Team. The combined team continue to provide the same services as the two previously separate departments, however the merging of the teams has enabled a review and streamlining of processes for the management and resolution of complaints at both divisional and corporate level, which are now managed in a more consistent and effective way.

In addition to complaints resolution, the Patient Support & Complaints Team also provide advice and information to patients, their relatives and the public regarding services provided at UH Bristol and support for patients who need additional help to access services at the Trust.

2. 2010/2011 Achievements and learning from complaints

University Hospitals Bristol NHS Foundation Trust aims to be a "learning organisation", that is one which listens to and acts on patient experience, complaints, feedback, etc. Our aim is to resolve complaints and concerns for patients and their relatives quickly and effectively; so wherever possible, complaints are resolved at local level by front line staff where this is within their control. For more complex complaints, clear structures are in place to support patients and to assist staff in the overall management and satisfactory resolution of complaints. This structure helps ensure that learning from complaints is understood and shared at an individual, divisional and organisational level and that actions are taken across the organisation to prevent the issue reoccurring.

During 2010/2011 more robust structures for learning from complaints at divisional and corporate level were put in place. Examples of learning are now sent to the Board each month and to the Patient Experience Group on a quarterly basis. The following are some examples of learning from the last 12 months:-

- Improved support and information is available to patients in the diabetic service. Specialist Diabetes Nurses provide the information and support to the administration team, which enables them to address general enquiries more effectively, improving the service for patients.

- White Boards were introduced to the outpatient clinic areas at Bristol Eye Hospital, to improve communication and to keep patients informed of any delays with their clinic appointment times.

- Improvements have been made to reduce the delays some patients experience in obtaining take home medication. Because a date of discharge is agreed for each patient, take home medication can be ordered the day before discharge. In addition, doctors complete discharge prescriptions electronically during a "one stop" ward round. This means that prescriptions are written up immediately, rather than waiting until the end of the ward round.

- Diagnostic follow up appointments have been set aside in one of the clinics in the Bristol Royal Infirmary for patients who are referred for diagnostic investigations following their outpatient appointments. This means that they do not experience any delays.

- Systems in some of the Children's Hospital clinics were reviewed and amended, to enable timescales for complex consultations and those for new patients to be managed more effectively.

- A formal escalation process for booking urgent CT scans under general anaesthetic was developed at Bristol Children's Hospital.

- Visitor toilets in the Bristol Royal Infirmary outpatient clinic were upgraded to address difficulties previously experienced by disabled patients.

- Bristol Eye Hospital has introduced new measures to reduce the number of outpatient appointments the hospital cancels. A new reporting system which highlights patients who have had their appointment cancelled has been implemented and a new policy introduced so that no patient can have more than one/two appointment cancelled.

- The cardiology department has introduced new performance targets and processes to reduce the time taken to type clinic letters and send these to GPs and patients. These improvements have contributed to a reduction in the time it takes for GPs and patients to receive letters from 40 days (at its longest) to 9 days (December 2010).

- Trends and issues raised through complaints have been used to influence training for ward and departmental teams. Real scenarios are used as part of the Trust-wide Treating People Well training programme.

In 2010/2011 we chose to merge our complaints and PALS teams at UH Bristol (rebranding as the Patient Support & Complaints Team) and restructure the processes and procedures for managing complaints at corporate and divisional level. This has been successfully achieved and the service is now delivered in a more streamline and effective way. The restructuring also included successfully reviewing the job roles and skill mix of staff, to ensure that a more responsive service is available for patients. A vacant part time Patient Support and Complaints Officer post was also successfully recruited to during the year.

Training also featured as one of our primary objectives for 2010/2011 and details are available under Section 9 of this report.

An external review of the Trust's complaints processes was commissioned by the Chief Nurse in January 2011, the outcome of which was reviewed in detail by the Chief Nurse and Patient Support & Complaints Team in July 2011. Actions were identified to improve systems, which have been formulated into a work plan to achieve our objectives for 2011/12. These are set out in Section 10 of this report.

3. Complaints received in 2010/2011

3.1 Number of complaints

The total number of complaints received by the Trust in 2010-2011 was 1532, averaging 127 per month. This is a decrease from 1942 reported in 2009/2010. There are no clear reasons for this decrease, although under reporting from Divisions of complaints resolved directly by front line staff may have contributed to the decrease this year. The full monthly breakdown of the number of complaints received is shown in Figure 1 below. Data by month is not available for locally managed complaints in 2009/2010 so a direct comparison is not possible.

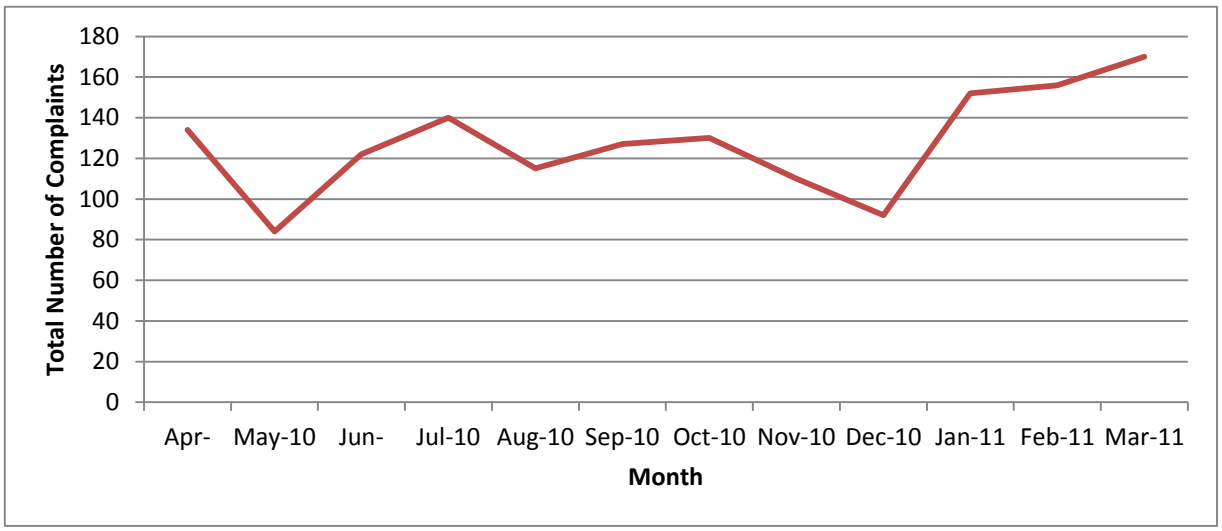


Figure 1: Total number of complaints received per month – April 2010 to March 2011

3.2 Activity Trends

The decrease in activity in May and December 2010 is a seasonal trend and consistent with previous years' activity. The increase in activity during January, February and March 2011 was largely attributable to ward closures and cancelled procedures and surgery, due to a norovirus outbreak at the Bristol Royal Infirmary during this period. Activity returned back to expected levels during April 2011. However lessons were learned from the issues raised from complaints about how services were managed during this time, particularly about the need to improve communication between services and the Patient Support & Complaints Team to ensure the Trust can respond quickly to complainants. This will be used to manage similar situations more effectively in the future.

3.3 Response Times

The Health & Social Care Complaints Regulations (England) 2009 require all complaints to be responded to in a proportionate manner, based upon their nature and complexity. Individually agreed response times are agreed with complainants before the investigation is started. The Trust's average response time is 25 working days (as required under the previous legislation). However less complex complaints are resolved within much shorter timescales (between 24 hours and 14 days) and longer timescales are negotiated for more complex complaints, particularly those covering more than one organisation.

UH Bristol has set an internal target that 98% of all complaints received should be responded to within their originally agreed timescale. During 2010/2011 the Trust's average was 95% over the whole 12 months. Figure 2 below shows performance against this target on a monthly basis:-

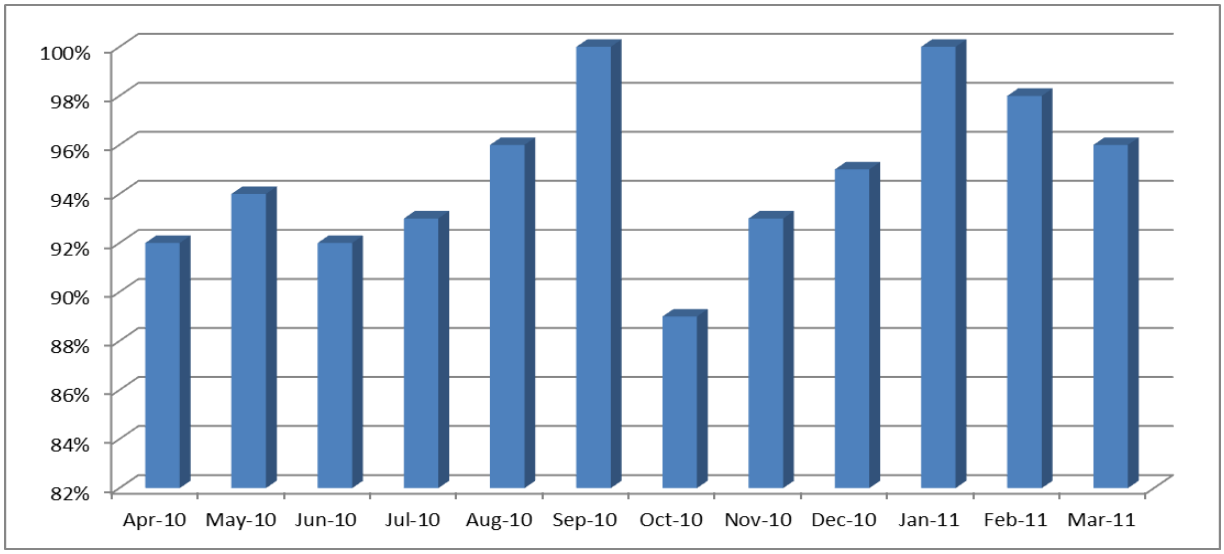


Figure 2: Percentage of complaints responded to within timescale agreed with complainant

The Trust is taking steps to improve response times during 2011/2012, which are highlighted at the end of this report.

3.4 Dissatisfied Complaints

The average number of complainants who remain dissatisfied with the response to their complaint was five per month. All of these complaints were reinvestigated by the Trust. In the majority of cases a re-investigation was required because the complainant raised further questions after receiving the Trust's response to their complaint. We are taking steps to reduce the number of dis-satisfied complainants by encouraging face-to-face resolution meetings to enable further questions to be answered as they arise. If they remain dis-satisfied, complainants have recourse to the Parliamentary & Health Service Ombudsman (PHSO) for consideration for independent review.

In 2010/11 fifteen complainants remained dis-satisfied with our response following attempts at local resolution and contacted the PHSO who has made recommendations to the Trust in relation to one complaint. One further complaint is still under investigation.

Number of complainants initially dis-satisfied following local resolution	Number who remained dis-satisfied and contacted the PHSO	Number of complaints with additional recommendations from PHSO	Number of complaints PHSO was satisfied with local resolution	Number of complaints still under review by PHSO
57	15	1	13	1

Table 1: Outcome of dis-satisfied complainants

4. Complaint Categories

Complaints are categorised according to issues raised, which help identify recurring themes which may need to be addressed. Some complaints relate to more than one issue and may be assigned more than one category; the total number of complaints shown in Table 2 below does not therefore correlate with the figures in paragraph 3.1.

Complaint Category	Number of complaints received 2010/2011
Clinical Care (Medical/Surgical)	147
Communication with Patient/Relative	122
Clinical Care (Nursing/Midwifery)	115
Delayed Appointment	102
Attitude of Medical Staff	68
Cancelled Appointment – Multiple	65
Delayed Operation	50
Information about Patient	48
Attitude of Nursing/Midwifery	46
Delayed Procedure/Investigation	33
Discharge Arrangements	32
Cancelled Appointment	30
Failure to Answer Phone	29
Personal Property	29
Cancelled Operation	26

Complaint Category	Number of complaints received 2010/2011
Waiting Time in Clinic	25
Lost/Misplaced/Delayed Test Results	23
Diagnosis Delayed	22
Attitude of Admin & Clerical Staff	22
Delayed Treatment	21
Cancelled Operation - Multiple	20
Diagnosis Missed	19
Communication – Administrative	19
Confidentiality	19
Premises - Environment	16
Service Not Available	16
Transport – Request For	15
Clinical Error	15
Service Denied	15
Failure to Respond	15
Communication Between Staff	14
Referral Errors	13
Clinical Care (Dental)	12
Diagnosis - Incorrect	12
Hospital Information Request	12
Car Parking	11
Delayed Response	10
Follow Up Treatment	10
Medication Incorrect	10
No Category Recorded*	10
Premises – Temperature	9
Attitude of Allied Health Professionals	8
Catering – Choice	8
Admissions Arrangements	7
Attitude of Security Staff	7
Cancelled Procedure – Multiple	7
Cancelled Procedure	7
Transport – Non Arrival	7
Cleanliness (Internal)	7
Discharge Premature	7
Complication During/After Procedure	6
Medication not Received	6
Premises – Access To	6
Choose & Book	6
Safety (Internal)	6
Discharge Delayed	6
Attitude of Dentist	5
Hygiene Facilities	5
Telecommunications	5
Bereavement Support	5

Complaint Category	Number of complaints received 2010/2011
Waiting Time for Pharmacy	4
Delayed Admission	4
Expenses Claim	4
Emotional Support	3
Safeguarding Children	3
Medical Equipment	3
Medical Records Requested	3
Premises – Unfit for Purpose	3
Waiting Time for Correspondence	3
A&E Wait	3
Signposting	3
Visiting Hours	2
Transport – Late	2
Transfer Arrangements	2
Infection Control	2
Benefits & Social Care Enquiries	2
Clinical Care (Allied Health Professionals)	2
Clinical Information Request	2
Freedom of Information Request	2
Transport – Inappropriate	2
Communication – equality of access	1
Consent To Treatment	1
Discrimination	1
Medical Records Not Available	1
Safety (External)	1
Smoking	1
Travel Arrangements	1
Pain Control	1
Aids & Appliances	1
Safeguarding Adults	1
Website	1

Table 2: Category of complaints received

***** *The 10 complaints with no recorded category relate to situations where someone has indicated they wish to make a complaint but a complaint has not subsequently been made following proactive attempts to follow up the initial enquiry.*

Complaints about clinical care have decreased this year but remain the highest category of complaint during 2010/2011. These complaints are about poor experiences of surgery or treatment undertaken at the Trust's hospitals. Key themes and trends are highlighted regularly through quarterly reports to divisional managers and clinical leads and trends about individual staff members are raised with the appropriate executive director for investigation and action where appropriate.

Complaints about communication and cancellation of appointments and surgery are also amongst the highest cause of complaint, although the number of complaints received about these issues has also decreased compared to the previous 12 months. Specifically, complaints

about the Bristol Eye Hospital appointment systems have decreased significantly during 2010/2011 following the implementation of new administrative systems and processes which has resulted in fewer cancelled and re-arranged appointment for patients.

5. Complaints by ethnic group of complainants

Ethnicity data is collected from the Trust's Patient Administration System when the patient's hospital number is known. However, for many of the complaints, the ethnicity of the patient is not requested at what is often a stressful time and therefore a high proportion is categorised as Not Known / Not Stated. For this reason comparisons with the ethnicity of our patient population are not be valid.

Ethnic Category	Number of complainants
African or British African	9
Any other Asian Background	4
Any other Ethnic Group	2
Any other Mixed Background	3
Any other White Background	19
Bangladeshi or British Bangladeshi	2
Caribbean or British Caribbean	6
Indian or British Indian	6
Not Known	640
Not Stated / Given	193
Pakistani or British Pakistani	2
White – British	631
White – Irish	6
White and Asian	1
White and Black African	1
White and Black Caribbean	7

Table 3. Ethnic category of complainants

6. Compliments

Figure 3 below details the number of compliments received per month during 2010/2011. However these numbers do not accurately represent the total number of compliments received as many compliments are sent directly to Trust staff and are not recorded through the reporting mechanisms available. The decreases shown in the above graph do not necessarily represent a decrease in satisfaction, but are likely to be attributable to a decrease in the numbers reported by Divisional staff during that particular month.

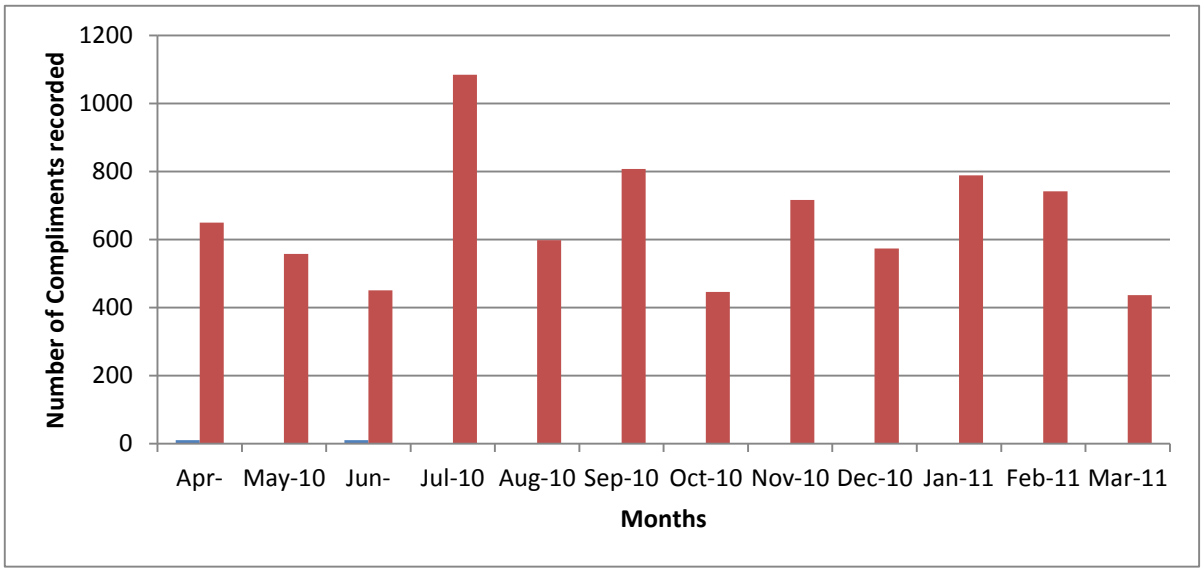


Figure 3: Number of compliments reported to the Patient Support & Complaints Team in 2010/2011

During 2010/2011, the Trust's Patient and Public Involvement Strategy focused on increasing the range of opportunities for patients to give constructive feedback about the services we provide. Comment cards have been introduced on all inpatient wards, the vast majority of inpatients receive a detailed post-discharge postal survey, and further targeted surveys are carried out on wards to explore patient care themes (e.g. dignity, compassion, etc.) in greater depth. Results from these surveys are reported to the Patient Experience Group and are summarised in the monthly 'dashboard' of quality indicators received by the Trust Board. This strategy is being expanded into Outpatient areas throughout 2011/12.

7. Information, Advice and Support

In addition to complaints management, the Patient Support & Complaints Team also assists with information, advice and support requests. The numbers of enquiries received during 2010/2011 are shown in Table 4.

Type of enquiry	Total Number
Request for information / advice	497
Request for support	96

Table 4: Type and total number of enquiries received (non complaints)

The types of information and advice requests relate to non clinical information and services which the Trust provides, advice about benefits, or sign posting to other local or voluntary services for support.

Requests for support include bereavement support for relatives who have lost a loved one in the hospital, but are not related to a complaint about their care. In many situations the family wish to meet with the staff involved with the patient's care again, to go through what has happened to enable them to move on with the grieving process.

Support is also provided for patients at outpatient clinic appointments with clinical staff and patients transferring from paediatric to adult services. The department also provides a liaison point and support for carers and patients who have additional support needs.

The service also provides a point of contact for families who arrive in Bristol with a patient but do not live locally and require local orientation and assistance to find somewhere to stay.

8. Training carried out during 2010/2011

The Patient Support & Complaints Team has continued to deliver complaints training as part of the Trust's Treating People well training. This training is aimed at front line administrative, security and nursing staff and takes place on average four times a month. The complaints session was evaluated, revised and extended in September 2010, to improve the quality of training and support provided to staff. The training now includes interactive work with participants and uses actual case work scenarios.

Complaints training has also taken place with senior managers and nursing staff in the Women's and Children's Division this year, to support improvements which have taken place to their internal complaints processes from May 2010.

Members of the Patient Support & Complaints Team and the LIAISE Team have delivered two sessions on self care within the Trust's Bereavement Support Training Programme. These sessions use real casework scenarios to support staff to develop skills in dealing with bereavement issues and supporting themselves, their colleagues and family members. Learning from these sessions has also been used to produce guidance for ward based for supporting themselves and other patients following a death on the ward.

9. Structure for the management of complaints

9.1 Corporate Team

The Assistant Director of Governance & Risk Management has overall responsibility for the management of complaints, on behalf of the Chief Nurse, as the named Executive lead. The Chief Executive has ultimate responsibility for complaints handling.

The Patient Support & Complaints Team comprises 4.5 whole time equivalent staff; a full time manager and deputy manager (both of whom carry a caseload), a full time and part time caseworker and two part time administrative assistants. The team are based over two sites at UH Bristol, an office at Trust Headquarters and a front facing base at the main entrance of the Bristol Royal Infirmary, offering a drop in service to patients and members of the public, Monday to Friday, 8:30am until 5:00pm.

9.2 Divisional Support

Each Division has a Complaints Co-ordinator who is responsible for the administration of the complaints process within their own Division. Senior management and nursing staff within each Division work closely with the corporate team in the resolution of complaints and lead the investigation and response of complaints which are managed through a formal investigation process.

As part of the restructuring of complaints management at Divisional level, the PALS service at Bristol Children's Hospital has been restructured and rebranded as LIAISE (Listening, Information, Advice, Involving, and Support & Experiences). The LIAISE service provides a local resolution service for parents and patients who attend Bristol Children's' and St Michael's Hospitals.

9.3 Cross-organisational working

A local South West Regional Network meeting of Complaints & PALS Managers in health and social care continued to meet during 2010/2011, of which the Patient Support & Complaints Manager at UH Bristol is a member. The network have worked closely together to support consistent ways of working across local organisations and to identify trends and themes for service improvement which cover the local area. The network also allows members to share best practice across organisations in the south west region.

Members of the group have links with the following networks:-

- National NHS Complaints and Customer Service Managers Group
- National Complaints Managers Group for Social Services
- Dorset VIAN Network (NHS and Social Care)
- Southwest Complaints Managers Group for Social Care
- South Gloucestershire LINKs network.

The LIAISE Officer at the Children's Hospital has also continued to attend the National Paediatric PALS Network Meetings and contributed to developments within paediatric services throughout the year.

10. Key objectives and service developments for 2011/2012

Objective	Action required	By when/who
Improve complaint response times to consistently reach the internal target of 98% of complaints responses being provided within the timescale agreed with the complainant.	Discuss timescales for more complex complaints with Divisional Co-ordinators / complaint leads before contacting complainants. Meet with divisions where there are particular issues with timely responses to explore remedies and share best practice from other divisions. Corporate Team to draft non clinical and less complex complaint responses, to allow the Divisional complaint leads to focus on more complex issues and ensure less complex complaints are responded to in a more timely manner.	July 2011 / Corporate Team September 2011/ Complaints Manager and relevant divisional leads. October 2011 / Corporate Team

Objective	Action required	By when/who
	Chief Nurse to designated authorised signatory for complaint response letters on behalf of the Chief Executive.	September 2011 / Chief Nurse
Reduce number of dis-satisfied complaints to consistently achieve internal target of less than 5 per month.	Corporate Team to routinely request divisions to provide further information for any responses which do not sufficiently address all issues raised. Training to be provided for complaint leads on drafting response letters and responding to verbal complaints. Develop use of conciliation meetings to resolve complaints as part of the local resolution process.	July 2011 / Corporate Team January 2012/ Corporate Team October 2011/Complaints Manager and Divisional Complaints Leads
Improve communication between Divisional and Corporate Teams and with complainants	Meeting to be arranged with Divisional complaint leads to review current arrangements and agree standard processes and ways of working for the future. Arrange for Divisional and Corporate staff to shadow each other, to gain a better understanding of each other's roles. Review administrative processes and formal paperwork used. Remove use of Local Resolution Plan.	October 2011 From September 2011 Sept 2011 / Corporate Team
Ensure that demonstrable learning and service improvement occurs through complaints management	Store all complaints files (corporate and division) electronically on the Ulysses Safeguard system including evidence of changes made as a result of a complaint where applicable. Corporate team to produce standardised quarterly reports for Divisional Complaint Leads, having agreed content with divisions which demonstrate learning within divisions and organisation-wide. Divisional Complaint Leads to produce cross organisational action plans, where appropriate, to ensure that learning across divisions occurs.	Dec 2011 / Divisional complaint leads Jan 2012 / Corporate Team September 2011 / Divisional Complaint Leads

Objective	Action required	By when/who
	Training to be provided to Divisional Complaint co-ordinators to enable them to produce their own locally specified complaint reports from Ulysses, to supplement information received from the corporate team. Expand to all divisions the existing good practice of using patient stories at Divisional Board meetings to support learning and service improvement.	January 2012 / Corporate Team September 2011 / Divisional Complaint Leads
Develop enhanced complaints training for staff and link to Trust values and behaviours	Complaints training to continue to be rolled out to front line staff, so that complaints are addressed quickly and not escalated unnecessarily. Trust values and behaviours to be incorporated into training programme. Refresh and re-launch expectations and responsibilities for all staff in the management of complaints in all divisions, linking to Trust's values and behaviour.	September 2011 / Corporate Team October 2011/Complaints Manager and Divisional Complaints leads
Review the ability of Trust to contribute to national complaints data collection and benchmarking.	Review data capture of complaints and consider whether alterations will enable the Trust to contribute to national data collection and benchmarking.	December 2011 Complaints Manager
Improve ethnicity data collection	Record ethnicity of all patients whose care is the subject of a complaint where they can be identified from the details provided.	Complaints Manager to instigate from November 2011.
Develop future accessibility of the service to patients.	Work with the Redevelopment Team towards the provision of new front line location for the integrated Patient Support and Complaints Team in the new Level 2 BRI Welcome Centre	Redevelopment Team. Complaints Manager. End 2012.

11. Risks to achievement and mitigation

There are no currently identified risks to the achievement of the 2011/2012 objectives as shown in section 10, as long as staffing can be maintained at current levels.

The Patient Support and Complaints Team is working with divisions to mitigate any risks to improving performance relating to dissatisfied or breached response times through the actions identified in section 10.

12. Conclusion

2010/2011 was the first year of operation for the newly merged team and the bedding down of the streamlined arrangements. The team and its structures, both corporately and divisionally, have been reviewed and are now more effective with further plans to develop systems further in 2011/12.

One of the main objectives for 2011/12 is to improve organisational learning and service development to address issues raised through complaints received and to improve performance relating to the management of complaints through supporting staff to address complaints locally and promptly, thus improving the experience of both our patients and their relatives.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 10 – Audit and Assurance Committee Annual Report

Purpose

To report to the Trust Board of Directors on the activities of the Audit and Assurance Committee for the period 01 April 2010 to 31 March 2011.

Abstract

The Audit and Assurance Committee reviewed the establishment and maintenance of an effective system of governance, risk management and internal control that supported the achievement of the Trust's objectives in the reporting period 2010-2011.

In particular, the committee reviewed the adequacy of:

- All risk- and control-related disclosure statements, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board,
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, the controls in place and the appropriateness of the disclosure statements,
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and,
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

By year-end, the Audit and Assurance Committee had fully discharged the duties set out in its Terms of Reference and had undertaken a formal review of its own performance.

Recommendations

The Trust Board of Directors is recommended to **Note** the report.

Executive Report Sponsor or Other Author

- Sponsor – Chair of the 2010-2011 Audit and Assurance Committee.

Appendices

- Appendix A – Audit and Assurance Committee Annual Report.

University Hospitals Bristol NHS
NHS Foundation Trust

Audit and Assurance Committee
Annual Report 2010 – 2011

Committee Chair's Introduction

The Audit and Assurance Committee, consisting of four Non-Executive Directors and chaired by the Vice-Chair of the Trust, reviewed the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

In particular, the committee reviewed the adequacy of:

- All risk- and control-related disclosure statements, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board,
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, the controls in place and the appropriateness of the disclosure statements,
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and,
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

The committee sought reports and assurances from Directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. In particular, the committee oversaw the development and improvement of the Board Assurance Framework.

The Committee met on four occasions in the reporting period and once in the month after the close of the year to ensure a full and effective handover to the newly established Audit Committee.

Membership of and attendance at meetings of the Audit and Assurance Committee are set out in the at Appendix A. The minutes of the Committee were submitted to the Board, and the Chair of the Committee submitted a report to the Board following each meeting, highlighting any issues requiring disclosure to the full Board.

By year-end, the Audit and Assurance Committee had fully discharged the duties set out in its Terms of Reference, which are publicly available, and the Committee had undertaken a formal review of its own performance.

Opinion

In support of the Chief Executive's responsibilities as Accountable Officer for the Trust, the Audit and Assurance Committee has examined the adequacy of governance, risk management and internal controls within the Trust.

From information supplied, we have formed the opinion:

- There is a generally adequate framework of control in place to provide reasonable assurance of the achievement of objectives and management of risk.
- Assurances received are sufficiently accurate, reliable and comprehensive to meet the Accountable Officer's needs and to provide reasonable assurance.

- Governance, risk management and internal control arrangements within the Trust include aspects of excellence as well as aspects in which ongoing attention to control improvement is required.
- Financial controls are adequate to provide reasonable assurance against material mis-statement or loss.
- The quality of both Internal Audit and External Audit over the past year has been satisfactory
- The organisation, activities and processes of the Audit and Assurance Committee were considered to be satisfactory although it was considered that the new governance arrangements, in particular the formation of both a new Audit Committee and a new Quality and Outcomes Committee, would result in greater effectiveness.

Work of the Committee

The Committee discharged its role through the year as follows:

- We reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the trust's activities (both clinical and non-clinical).
- We ensured that there was an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee. The committee reviewed and approved the internal audit strategy, ensuring that it was consistent with the audit needs of the organisation as identified by the Assurance Framework. We considered the major findings of internal audit's work (and management's response). The Head of Internal Audit had unrestricted access to the chair of the committee for confidential discussion.
- We reviewed the work and findings of the external auditor and considered the implications and management's response to their work. The external auditors had unrestricted access to the chair of the committee for confidential discussion.
- We reviewed the Annual Report and financial statements before submission to the Board.
- We ensured the Standing Financial Instructions and Standing Orders were maintained and kept up to date, with an annual review of instances where exceptions to the rules were made.
- We reviewed the findings of other significant assurance functions, both internal and external to the organisation, and considered the implications to the governance of the Trust. This included a regular report from the NHS Counter Fraud Service as well as a number of internal annual reports such as infection control, health and safety, complaints, information governance and clinical audit.

Specific areas considered by the Committee during the financial year 2010/11 were as follows:

- We undertook a review of the Board Assurance Framework and oversaw significant improvements in and development of this tool.
- We reviewed and approved a revised protocol explicitly requiring the application of the Trust's Standing Financial Instructions to the procurement of consultancy services. This had been reviewed by the Membership Council as part of its role in appointing the external auditor and was presented to the Committee for approval on the Trust's behalf.

- We reviewed the policy guidance and the register of benefits for the trust, and made recommendations to improve the consistency of returns across divisions.
- We reviewed the Quality Report before submission to the board. In their review of the 2009/10 Quality Account, our external auditors had suggested the formation of a Quality Committee to ensure sufficient scrutiny and challenge of this report, a suggestion which the trust has now implemented. The committee however took this role for the financial year 2010/11 and reviewed the draft account in some detail at the April meeting.
- We received quarterly reports from the CQC Committee. These covered both progress against the three outcomes we had declared to be non-compliant (Outcome 4, Supporting Workers, Outcome 5, Nutrition and Outcome 21 Records) as well as reviews of our current compliance across all outcomes.
- In our review of internal audit reports, we highlighted concerns about the management and administrative arrangements within Estates. This is an area of ongoing focus for the newly formed Audit Committee.
- The Committee continued to monitor progress on the External Audit report on consultant productivity and received assurance that the issue was being actively managed through the Trust Executive Group.
- We reviewed in detail and agreed with the proposed changes to Board governance arrangements, including the formation of new committees (including the Quality and Outcomes Committee) and the handover of the Audit and Assurance committee to the newly formed Audit Committee.

Appendix A – Membership and Attendance at the Audit and Assurance Committee

The table below shows the attendance of Directors at the Audit and Assurance Committee. Figures in brackets (3) indicate the number of meetings the individual could be expected to attend by virtue of their membership of the Board or Committee.

No. of Meetings in Reporting Period	**5**
Emma Woollett (Chair)	4(5)
Iain Fairbairn	4(5)
Lisa Gardner	4(5)
Paul May	5(5)

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11 – Patient Experience Action Plan Update (including Update on the Cancer Survey Action Plan)

Purpose

As requested by the Trust Board in May 2011, this paper provides a progress update on the Divisional patient experience action plan dashboard. It also includes an update on the Trust's National Cancer Survey Action Plan.

Abstract

Each clinical Division has set out a number of inpatient experience improvement objectives. Progress against these objectives is measured primarily via the Trust's monthly inpatient experience survey. This report provides a dashboard to show the current position against these improvement objectives. Since the Trust Board last saw this dashboard new objectives have been added for the Diagnostics & Therapies Division. In addition to the patient experience dashboard, a progress update is provided on the actions that arose from the 2010 National Cancer Survey.

Recommendations

This report is for the Trust Board to **note**.

Executive Report Sponsor or Other Author

- Executive Sponsor – The Chief Nurse, Alison Moon
- Authors – Paul Lewis, Patient Involvement Coordinator; Ruth Hendy, Lead Cancer Nurse

Appendices

- Appendix A –Inpatient Survey Action Plan: Update to the Trust Board

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
					The Patient Experience Group regularly reviews the dashboard and action plans provided in this report

Inpatient Survey Action Plan: Update to the Trust Board

Purpose of report

As requested by the Trust Board in May 2011, this paper provides a progress update on the Divisional patient experience action plan dashboard. An update on the Trust's National Cancer Survey Action Plan is also included.

Background

Patient Experience Action Plan Dashboard

Drawing on a range of patient feedback sources, each bed-holding Division has set inpatient experience objectives for improvement during the 2011/12 financial year. Progress against these objectives is measured via the Trust's monthly inpatient survey.[1] The targets are extremely challenging, based on quarterly improvement that culminates in Quarter 4 targets based on the highest performing trusts in the 2010 National Inpatient Survey.

Since the Trust Board last viewed this dashboard, improvement objectives for the Diagnostics & Therapies Division have been added. These objectives reflect the important role that the Diagnostics and Therapies Division has in supporting inpatient experience improvement, for example in ensuring patients can get help to eat meals and that clinicians receive test results and prescriptions as quickly as possible. As this contribution isn't easily measurable through the inpatient survey, management data is used to assess performance against the Diagnostics & Therapies targets.

The Trust has recently carried out a Divisional-level outpatient survey, the findings of which are in the process of being analysed and disseminated. It is anticipated that by January 2012 the patient experience action plan dashboard will have been extended to include outpatient improvement objectives for each clinical Division.

National Cancer Survey Action Plan

The 2010 National Cancer Survey highlighted a number of improvement opportunities for the Trust. An action plan was developed in response to the survey and a summary of progress is provided. The next National Cancer Survey is scheduled to take place in early 2012.

[1] Survey data is available six weeks after the end of month of discharge. Therefore the survey data presented for Quarter 2 in this report is provisional and the final score will be calculated in Mid-November.

University Hospitals Bristol NHS
NHS Foundation Trust

Patient Experience Action Plan Dashboard: Position as at October 2011

			2011-12 Financial Year					
		Q4 Jan-March	April-June (Q1)		Provisional Q2 (July + August)			
	All data are survey scores out of 100 (higher = better), except for the Diagnostics & Therapies Division	*Baseline*	*Final Q1 score*	*Target*	*Q2 to date*	*Target*	*Q2 - change from baseline**	
Specialised Services	**S1.** Reduce delays in the patient discharge process	64	67	71	70	77	+6	↑
	S2. Reduce noise from ward staff at night	77	81	81	81	84	+4	↑
	S3. Ensure patients have help to eat their meals	81	87	84	82	86	0	–
	S4. Told patient how they will feel after an op or procedure	78	75	80	75	81	-3	↓
	S5. Explain medication side effects at discharge	62	61	65	59	68	-3	↓
	S6. Patient can find staff to talk to about worries or fears	73	76	75	71	76	-2	↓
Surgery, Head & Neck	**SHN1.** Given choice of admission date	21	21	31	23	41	+2	↑
	SHN2. Privacy when discussing treatment and condition	85	85	86	88	87	+3	↑
	SHN3. Reduce noise from ward staff at night	80	84	83	85	85	+5	↑
	SHN4. Ensure patients have help to eat their meals	68	80	73	75	79	+7	↑
	SHN5. Explaining medication side effects at discharge	66	62	68	65	70	-1	–
Medicine	**M1.** Reduce delays in the patient discharge process	68	73	74	75	79	+7	↑
	M2. Reduce noise from ward staff at night	77	81	81	81	84	+4	↑
	M3. Explaining medication side effects at discharge	53	49	58	43	64	-10	↓
	M4. Ensuring patients get the help they need to eat meals	65	72	71	76	78	+11	↑

**Survey scores must move by more than one point to be marked as changed, as the data is not sufficiently accurate to measure changes within this margin. (This caveat has not been applied to the Diagnostics & Therapies results below, as these are not derived from survey data.)*

		Q4 Jan-March	April-June (Q1)		Provisional Q2 (July + August)			
		Baseline	*Final Q1*	*Target*	*Q2 to date*	*Target*	*Q2 - change from baseline*	
Women's & Children's	**W&C 1a.** Food quality at BRHC	54	55	60	56	65	+2	↑
	W&C 1b. Food quality on postnatal wards	42	49	50	47	59	+5	↑
	W&C 2b: Food availability at St Michael's	66	76	70	75	74	+9	↑
	W&C3a. Ensure BRHC patients have help to eat their meals	62	63	69	71	76	+9	↑
	W&C3b. Ensure W.78 patients have help to eat their meals	82	83	84	100	86	+18	↑
	W&C4. Kindness and understanding during postnatal stay	80	83	82	84	85	+4	↑
	W&C 7a. Reduce noise from BRHC ward staff at night	81	79	83	80	86	-1	→
	W&C 7b. Reduce noise from ward staff at night on W78	71	76	76	94	81	+22	↑
	W&C 8a. To improve the cleanliness of the wards at BRHC	87	88	89	89	91	+2	↑
	W&C 8b. To improve the cleanliness of postnatal wards	88	87	89	85	91	-3	↓
	W&C 9. Continuity of ante natal care	30	28	34	30	38	0	→
	W&C 10. Providing antenatal info about home birth	73	73	77	73	81	0	→
	W&C 11. One to one care during labour and birth	84	85	87	78	90	-6	↓
	W&C 12. Consistent postnatal advice about feeding baby	63	66	65	64	66	+1	→
	W&C 13. skin to skin contact after birth	93	95	95	98	97	+5	↑
Diagnostics & Therapies	**D1.** Dietetics to recruit volunteers to help patients eat meals (volunteer hours per month)	80	n/a	n/a	115	110	+35	↑
	D2. Pathology: 98% of blood test results available within 2 hours	95%	95%	98%	96%	98%	+1	↑
	D3. Pharmacy: 90% of TTA prescriptions available within 2 hours	76%	74%	90%	89%	90%	+13	↑

Summary of Patient Experience Plan Dashboard

The following table provides a summary of the Patient Experience Action Plan dashboard:

	Number of improvement objectives	Q2 (to date) target met	Improved from baseline	Improvement from Q1 to Q2
Specialised Services	6	0	2	1
Women's & Children's	15	4	9	5
Surgery, Head & Neck	5	2	4	3
Medicine	4	0	3	2
Diagnostics & Therapies	3	1	3	2
Total	**33**	**7**	**21**	**13**
%	**-**	**21%**	**64%**	**41%**

Further actions

The action plans underlying the patient experience dashboard are "live" in that each Division develops and co-ordinates actions to improve their scores on an ongoing basis. Learning and knowledge is shared between Divisions at the Trust's Patient Experience Group. The following extract from the action plans is provided to assure the Trust Board that objectives that have shown a decline from baseline in the main dashboard are the subject of ongoing attention and activity:

Objective	Division(s)	Examples of current actions
Ensure patients are told about potential medication side effects at discharge	Surgery, Head & Neck; Specialised Services; Medicine	Trialling "ticket to go" across the Trust; working with the Patients' Association to carry out qualitative work that will seek to further understand patient needs in this area; Liaising with top performing Trusts to identify learning opportunities
Tell patients how they can expect to feel after an operation or procedure	Specialised Services	Updated patient information booklets - currently assessing what impact this will have on the survey score
Patient can find staff to talk to about worries or fears	Specialised Services	Poster introduced to provide matron details / matron holds regular "surgeries" where issues can be addressed; Clinical Nurse Specialists working on the introduction of an alert system so that they can identify and visit inpatients they care for
Reducing noise at night from staff at the Children's Hospital	Women's & Children's	Bins have been adapted to reduce noise (currently assessing the survey data to check for improvement). Nurses also reminded about rules re: television and other noise from patients as this seems to be a linked issue.
To improve the cleanliness of postnatal wards	Women's & Children's (Maternity)	Requested action plan from Hotel Services for St Michael's; Flooring replaced and bathroom refurbishment is planned, as cleanliness audits suggest this is mainly an issue of perception.
One to one care during labour and birth	Women's & Children's (Maternity)	Trust Board recently approved increase in midwife numbers; Maternity review in progress; regular audits carried out on this issue.

National Cancer Survey Action Plan Update (provided by Ruth Hendy, Lead Cancer Nurse)

Aim	Work strand	Action	Lead(s)	When	Progress / comments
To raise the profile of cancer care around the Trust and ensure cancer care priorities are integrated into all appropriate Divisional work streams and developments	Communication and Information	Appointment of Trust Lead Cancer Nurse to lead on Patient and Public Involvement agenda for cancer / cancer nursing and allied health professionals' approach to cancer care delivery	Ruth Hendy	January 2011	Completed
		Lead Cancer Nurse to join the Trust Patient Public Involvement (PPI) Leads group to link in with the Heads of Nursing (as Divisional PPI Leads) to ensure that the Cancer agenda is integral to all other Trust and Divisional Patient Experience and PPI processes.	Ruth Hendy	March 2011	Completed
		Lead Cancer Nurse to meet with each Divisional PPI Lead (Head of Nursing) and discuss and agree their Divisional priorities (from the Survey results) and go to their Divisional PPI Meeting to discuss implementation of these Divisional actions	Ruth Hendy / Heads of Nursing	June 2011	Completed
		For these cancer survey results (and future results) to be reviewed and considered alongside all other Trust patient survey results (National Inpatient Survey, hand held surveys, patients comments cards) for cross-referencing and combined action-planning	Paul Lewis	May 2011	Completed
		For performance measures to be integrated into this action plan to enable the Cancer Services Board to monitor progress (detail to be added post Trust Board).	Mark Callaway Teresa Levy Ruth Hendy	May 2011	Discussed further and this aspect to be included in next survey action plan.
		To include lay representatives in Cancer Services discussions, decision making and developments (as discussed and agreed at Cancer Services Board, 18/04/11) • For UHBristol to engage with the existing Avon Somerset and Wiltshire Cancer Services (ASWCS) network user groups and Site Specific User representatives (enabling open dialogue on issues in a timely way). • Invite nominated representatives from these existing forums to sit on the Cancer Services Board.	Mark Callaway Claire Bullock (ASWCS)	June 2011	Completed. Users identified. Cancer Board attendance planned from 21/11/11
		In response to changes (April 2011) in the national Cancer Peer Review Programme (stating that site-specific teams, eg breast cancer, colo-rectal cancer etc, only need to self-assess their service against national measures, every other year now (instead of annually), UHBristol Cancer Services Board has agreed that all UHBristol teams will continue annual self assessment as a means of monitoring standards and progress.	Teresa Levy	May 2011	Completed

Aim	Work strand	Action:	Lead(s):	When	Progress / comments
For hospital staff to inform patients that they can get free prescriptions and how they can get financial help or benefits	Communication & Information	To discuss with all cancer Clinical Nurse Specialists (CNS) and Allied Health Professional (AHP) groups at Cancer CNS / AHP Forum	Ruth Hendy	26th April 2011	Completed
		To check availability and obtain leaflets / posters for display in Outpatients Departments (Bristol Haematology and Oncology Centre, Bristol Royal Infirmary, St Michaels) To expand access to patient information by installing satellite 'Information pods' in the Bristol Royal Infirmary and St Michael's Outpatients Departments	Ruth Hendy (Matrons, BHOC, BRI and St Michaels)	July 2011	Completed Grant application accepted by Macmillan. Infopods ordered. Should be in place by end of Nov'11.
		To discuss availability and access to Macmillan Citizens Advice personnel within Trust and the Information Centre in Bristol Haematology and Oncology Centre at Cancer Clinical Nurse Specialist and Allied Health Professional Forum	Ruth Hendy	26th April 2011	Completed
To make it easy for patients to contact their clinical nurse specialist	Clinical Nurse Specialists	For Clinical Nurse Specialists to ensure all patients have accurate contact details and have clear process for responding to calls / messages in a timely way	Ruth Hendy	May 2011	Completed
		Discuss the development of a Clinical Nurse Specialist service model to include a supportive / coordination post to act as a single point of entry for teams of Clinical Nurse Specialists to triage calls and filter enquiries, releasing Clinical Nurse Specialist time for direct patient care. Prepare and propose service model.	Ruth Hendy	August 2011	Ongoing discussion with Macmillan. UHBristol wishing to pilot Cancer Support Worker. Proposal for discussion Cancer Board 21/11/11
To ensure patients are given written information about their operation, pre-operatively To ensure patients receive clear written information about what to do after leaving hospital	Communication & Information	Individual Multidisciplinary Teams (MDTs) to review their own (cancer site specific) preoperative information and when and how it is given to patients. Feedback site specific actions into their MDT work plans and to the Cancer Advisory Group.	MDT Leads	June 2011	Completed
		The Trust will enrol in the National Cancer Action Team (NCAT) NHS Information Prescription Service. This will ensure all patients are provided with standardised, reliable and accurate information.	Ruth Hendy	**Awaiting date from NCAT, as to which wave UHB can apply for. End of 2011 / Spring 2012?**	**Agreed collaboration with NBT in Wave 1.** **Started Sept '11. Currently training staff and identifying cross-city teams to start roll out.**

Aim	Work strand	Action:	Lead(s):	When	Progress
Post-operatively, ensure staff explain how the operation went in a way the patient can understand	Communication & Information	To ensure that all Multi-disciplinary team core members with clinical contact attend the National Advanced Communication Skills Course, as per Peer Review recommendations (as guided by course availability)	Ruth Hendy Mark Callaway	Ongoing	Most core members have attended. Remaining staff are aw are. Dates made available.
To ensure patients feel they are treated as a whole person, rather than a set of symptoms. To ensure patients are given enough privacy when discussing their condition or treatment	Compassion, Dignity & Respect	As part of the Trust–wide ward based hand held survey schedule, Dec 2011 will be focused on asking patients if they are able to understand information / ask the questions they want to	Tony Watkin	December 2011	Still planned for Dec 11
		Survey results to be cascaded and discussed with all Trust Cancer Clinical Nurse Specialists / Allied Health Professionals (in the newly formed Trust Cancer CNS and AHP Forum) and to Heads of Nursing for cascade to Matrons/ Sister's for all cancer related inpatient and outpatient areas	Ruth Hendy	April 26th 2011	Completed
Those close to the patient to feel they had an opportunity to talk to a doctor	Communication & Information	To discuss with all Multidisciplinary Team Leads via Cancer Advisory Group and for the Leads to cascade into teams.	Mark Callaway	11th April 2011	Completed
		Survey results to be feedback and discussed with all the Trust Cancer Clinical Nurse Specialists /Allied Health Professionals at the Cancer CNS / AHP Forum. Monitor this question for cancer patients in the monthly inpatient survey.	Ruth Hendy/ Paul Lewis	April / Sept 2011.	Completed / results static = need further work

Aim	Work strand	Action:	Lead(s):	When	Progress / comments
To ensure patients and their supporters / carers get the information they need to continue care at home	Compassion, Dignity and Respect	To establish 'Living Well' clinics in Bristol Haematology and Oncology Centre (in collaboration with Penny Brohn Centre) for patients / supporters to attend at any time during or after treatment, to access support and signposting to additional resources available to them in the Community	Ruth Hendy (Helen Cooper)	Jan 2011	Completed
		To establish 'Living Well' courses (weekly 2hr sessions, x6 weeks) for patients /supporters to attend to learn strategies for living with and after cancer	(Helen Cooper)	July 2011	Completed
		To establish 'Moving Forward' days for Breast Cancer patients to attend at the end of treatment.	(Angie Nicholson)	November 2010	Completed
Enable different professionals to work together more effectively	Communication & Information	All Allied Health Professionals involved in Cancer care around the Trust (including therapeutic radiographers, physiotherapists, occupational therapists, psychologists, dieticians, speech and language therapists) will join together with Clinical Nurse Specialists regularly to discuss collaborative approach to care delivery. Consider Primary Care representative joining this forum.	Ruth Hendy	26th April 2011 and then bi-monthly	Completed
To improve the time that patients wait in Outpatients clinics	Compassion, Dignity and Respect	Following the Bristol Haematology and Oncology Centre Refresh programme, the Bristol Haematology and Oncology Centre Outpatients Department now has 12 consultations rooms (compared with 6 previously).	BHOC Team	Completed November 2010	Completed
		Monitor this through local Trust outpatient survey programme planned for 2011/12	Paul Lewis	August 2011	Completed

Aim	Work Strand	Action	Lead(s)	When	Progress / comments
To ensure that hospital staff do everything possible to control the side effects of chemotherapy and radiotherapy	Compassion, Dignity & Respect	To discuss and raise awareness of these concerns specifically with clinical groups in Bristol Haematology and Oncology Centre (Chemotherapy group, Radiotherapy Group) for dissemination to all clinical staff	Kate Love Steve Falk	May 2011	Completed
		The implementation and full integration of Bristol Haematology and Oncology Centre Acute Care model. This will enable a specifically appointed Speciality Doctor to respond to the urgent needs of patients with chemotherapy / radiotherapy side effects.	Fiona Jones	April 2010	Completed within BHOC
		To audit the current process and standard of chemotherapy information giving in the Chemotherapy Day Unit and on the wards in Bristol Haematology and Oncology Centre. To enable the clear identification of the areas where targeted intervention is required to improve this aspect of the service. (Work is already underway to review the nurse / patient ratio on ward 61 to enable a consistent and appropriate level of care delivery in all areas).	Fiona Jones (Jeremy Braybrooke and Rachael Herrington)	August 2011	Ongoing, awaiting detailed Feedback. Aiming for completion Nov '11
		To audit compliance to the radiotherapy on-treatment review protocol. To increase the effectiveness of on-treatment review clinics by moving to a model of radiographer-led review. Assess at next survey.	Kate Love	August 2011	Audit report due Dec'11. Additional resource identified & being recruited into. 2 further sessions will be available from Jan'12.
		A patient-held Chemotherapy alert card has been developed and will be piloted and evaluated. This will enable chemotherapy patients to show this card to any professional wherever they present for urgent / emergency treatment and it will identify what treatment they have had and where to contact for more information	Ruth Hendy (Hayley Long)	June 2011	100 cards being piloted. Discussions with A&B to fund further expansion
Enable professionals to work together more effectively	Communication & Information	Allied Health Professionals involved in Cancer care around the Trust (including therapeutic radiographers, physiotherapists, occupational therapists, psychologists, dieticians, speech and language therapists) will join together with Clinical Nurse Specialists regularly to discuss collaborative approach to care delivery. Consider Primary Care representative joining this forum.	Ruth Hendy	26th April 2011 and then bi-monthly	Completed

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 October 2011 at 10:30am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Committee Chairs' Reports - Item 12a– 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 £3.178m for the six months to 30th September 2011. This is marginally better than the Annual Plan projection for the first six months of the year. The Trust's Financial Risk Rating is now 4 (actual = 3.65) as performance on the Return on Capital Employed metric has improved this month. The projected outturn for the year remains a surplus of £6m with optimistic and pessimistic scenarios provided as part of the quarterly review. The Women's and Children's Division reports a significant overspend for the month. Slippage on the CRES continues of concern and a significant contributory factor to the reported divisional overspendings.

Recommendations

To note the financial position at 30th September 2011.

Report Sponsor

Director of Finance, Paul Mapson.

Other Author

Head of Finance, Paul Tanner

Appendices

- Appendix 1 – Summary Income and Expenditure Statement
- Appendix 2 – Divisional Income and Expenditure Statement
- Appendix 3 – Analysis of pay expenditure
- Appendix 4 – Executive Summary
- Appendix 5 – Financial Risk Matrix
- Appendix 6 – Financial Risk Ratings

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
			21/10/11		

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £3.178m for the six months to 30th September 2011. This is marginally better than the Annual Plan projection for this period. The operating surplus (EBITDA[1]) is £17.092m. This is £0.433m (or 2.6%) greater than Plan for the period. The Financial Risk Rating is 4 (actual 3.65), 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 September has seen an increase in the rate of delivery of CRES savings with £1.797m achieved. This equates to 79% of the Plan for the month. The September report reflects an adverse variance of £5.272m on the CRES programme. Actual savings of £8.046m represents slippage of £3.265m when compared with phased planned savings for the first six months of £11.311m. The adjustment to bring CRES plans on to a 1/12ths basis adds a further £2.007m to the reported non achieved CRES in the September report.

The latest CRES forecast is that savings of £20.553m, a small improvement on last month's forecast, will be achieved this year of which the non recurring element is £4.249m. This represents an under achievement of £6.083m 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 £21.282m. The Finance Committee received a more detailed report on CRES as a separate item on this month's agenda.

The table below shows that the in-month overspending against Divisional budgets totalled £0.565m in September. Within this total there is a reported overspend in the month for the Women's and Children's Division of £0.497m. The Division has recently agreed a plan with Executive Directors which delivers a balanced position. This included the receipt of additional funding of £0.5m. The adverse variance of £1.367m is against the revised plan and is therefore of concern.

Detailed information and commentary for each Division is to be considered by the Finance Committee. 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 August	Variance this month	Variance to 30th September	Memorandum CRES Variance
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(1,669)	114	(1,555)	(2,258)
Non Pay	(2,042)	(477)	(2,519)	(3,064)
Operating Income	142	51	193	(53)
Income from Activities	79	(253)	(174)	103
Totals	**(3,490)**	**(565)**	**(4,055)**	**(5,272)**

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 above to the extent that had the savings been achieved then a surplus would be reported on the pay and non pay headings.

[1] Earnings Before Interest Depreciation Taxation and Amortisation

After 5 months which have consistently seen pay costs incurred in excess of approved budgets it is encouraging to be able to report that, in total, pay budgets underspent in September. It is clearly too early to say that this is a trend and close monitoring of pay budgets will continue to support managers in their efforts to reduce pay costs. Further reductions in expenditure are essential if we are to see clear evidence that progress on CRES schemes, which includes a significant volume of pay related projects, are showing results on the bottom line.

Non pay budgets show a further overspending in September to a cumulative adverse variance of £2.519m. Slippage on CRES schemes of £3.064m is embedded within this position. The areas of particular concern are the overspendings recorded this month against the Surgery, Head and Neck Division (£0.159m) and the Women's and Children's Division (£0.245m).

Income from Activities shows an under performance of £0.253m for September (August activity reported a month in arrears). The cumulative position on Income from Activities shows a shortfall to date of £0.174m (net of the balance of the over performance for March 2011 (£0.81m), received in 2011/12). The underlying pattern that can be observed from activity and income so far this year is that capacity appears to be a real constraint on our ability to deliver contracted activity.

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

	£'000
Medical and Dental Education Levy funding	219
European Working Time Directive	140
MARS (Mutually Agreed Resignation Scheme)	138
Clinical Systems Implementation Programme	134
Energy inflation	97
Accommodation costs re Sam's House refurbishment	80

3. Income

For the year to date, contract income is £0.69m greater than plan. This position includes £0.81m related to 2010/11 activity; therefore 2011/12 contract income is less than plan by £0.12m. The majority of the over-performance is within BNSSG.

Clinical Income by Worktype	**Plan**	**Actual**	**Variance**
	£m	**£m**	**£m**
Accident & Emergency	4.50	4.66	0.16
Emergency Inpatients	30.29	30.91	0.62
Day Cases	13.93	14.48	0.55
Elective Inpatients	19.74	19.12	(0.62)
Non-Elective Inpatients	12.39	12.80	0.41
Excess Bed days	3.69	3.19	(0.50)
Outpatients	26.87	26.75	(0.12)
Bone Marrow Transplants	4.06	3.93	(0.13)
Critical Care Bed days	14.23	13.77	(0.46)
PbR Exclusions / NICE	15.36	14.19	(1.17)
Contract Penalties / Rewards	(2.87)	(3.42)	(0.55)
Other	19.43	21.12	1.69
Sub-Totals	**161.62**	**161.50**	**(0.12)**
2010/11 Estimate v Actual	-	0.81	0.81
Totals	**161.62**	**162.31**	**0.69**

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

(Penalties) / Rewards	Month 4 Year to Date £m	Current Month £m	Month 5 Year to Date £m
Clostridium Difficile	-	-	-
CQUINS	-	1.18	1.18
Emergency Readmissions	(0.60)	0.10	(0.50)
Emergency Marginal Tariff	0.09	(0.04)	0.05
First To Follow Up Ratio	-	-	-
Others	(0.08)	(0.02)	(0.10)
Totals	**(0.59)**	**1.22**	**0.63**

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**[2]	**South West Specialist Commissioner**	**Other Commissioners**	**Totals**
Over / (under) performance as at Month 5	4.12	(1.13)	(3.11)	(0.12)
QIPP	(4.41)	-	4.41	-
A&E / Emergencies	0.10	(0.05)	(0.52)	(0.47)
Residual Over (Under) performance	**(0.19)**	**(1.18)**	**0.78**	**(0.59)**

This demonstrates that, for example, of the £4.12m over-performance to date for BNSSG £4.31m is due to QIPP and A&E / Emergency activity. In total there is, therefore, a net residual under performance of £0.19m.

4. Expenditure

In total, Divisions are shown as overspent by £4.055m for the six month period to 30th September. 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 30th September Favourable / (Adverse)	Memorandum CRES Variance to 30th September	Variance to 30th September Favourable / (Adverse)	Memorandum CRES Variance to 30th September
	£'000	£'000	£'000	£'000
Diagnostic and Therapies	(92)	(365)	57	(216)
Medicine	(742)	(1,075)	(105)	(438)
Specialised Services	(973)	(688)	(716)	(431)
Surgery, Head and Neck	(726)	(1,893)	(163)	(1,330)
Women's and Children's	(1,367)	(775)	(1,074)	(482)
Facilities and Estates	(31)	(123)	51	(41)
Trust Services	(16)	(91)	10	(65)
Other Services	(108)	(262)	(108)	(262)
Totals	**(4,055)**	**(5,272)**	**(2,048)**	**(3,265)**

[2] Bristol, North Somerset and South Gloucestershire Commissioner

This shows that two Divisions – Women's and Children's and Specialised Services are not mitigating the under delivery of CRES i.e. other financial factors are contributing net to the adverse position to Month 6. This is particularly the case with Women's and Children's where CRES under-delivery is £0.775m but the Month 6 position is a £1.367m deficit.

The **Diagnostic and Therapies Division** reports a cumulative over spending of £92k – an underspending of £48k in the month. The Division has significant (greater than £100k) overspendings on non pay and operating income. These are partially offset by income from activities which is reported as favourable by £341k.

The **Division of Medicine** reports an adverse variance of £742k for the half year, an overspending of £45k in the month. To date, pay and non pay budgets are over spent by £426k and £578k with non achievement of CRES at £1.075m being a significant factor. Expenditure overspendings are partially offset by favourable income variances of £262k. The Division is projecting an overspending of £0.663m for the year.

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £973k, an overspending of £167k in September. There has been an improvement in the rate of overspending on pay budgets with the cumulative position increasing by 6k to £648k. The cumulative position is as a result of slippage on the CRES programme and overspendings on consultant pay of £136k and agency staff (£390k on cardiac surgery juniors and £45k covering physiologists). Income from Activities shows an adverse variance of £166k in the month and a cumulative adverse position of £0.38m. The Division's projection shows it expects to work to the control total overspending for the year of up to £0.85m.

The Surgery, Head and Neck Division reports an adverse variance on its income and expenditure position of £726k – an underspending of £92k in September. The favourable movement this month moves the Division's RAG scoring from Amber / Red to Amber / Green. Pay budgets have a cumulative overspending of £94k a reduction in the month of £74k. Non pay budgets are overspent by £791k to date with the principal cause being slippage on CRES at £969k. Income from Activities shows a favourable variance of £164k this month to bring the cumulative position in line with plan. Income from Operations budgets have a small favourable variance in September to bring the cumulative over achievement to £155k.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £1,367k – an overspending of £497k in September. Pay budgets are overspent by £605k – a small favourable movement in the month. Non pay budgets show a cumulative overspending of £502k against which the adverse variance of the CRES programme is £719k. Income budgets show an adverse variance of £260k to date.

The Facilities and Estates Division reports a cumulative overspending to date of £31k, an improvement of £1k in the month.

Trust Services report a cumulative overspending to date of £16k, an improvement of £47k in the month.

5. Financial Risk Rating

The Trust's overall financial risk rating, based on results to 30th September is 4. The improvement is as a result of the increase recorded on the Return on Capital Employed metric from 4.97% in August to 5.1% for the 6 months to 30th September. This is better than that assumed in the Trust's Annual Plan. The actual value for each of the 5 metrics is given in the table below together with the bandings for each metric.

Metric	30th September 2011		
	Metric Result	Metric Score	Weighted Average Score
EBITDA			
Margin	6.85	3	0.75
Plan achieved	102.6	5	0.50
Return on Capital Employed	5.1	4	0.80
I&E surplus margin	1.36	3	0.60
Liquidity ratio (days)	36.8	4	1.00
			3.65

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	**4**

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

6. Forecast Out-turn

The original financial plan for the year is still a £6m income and expenditure surplus. The forecast has been re-assessed at Month 6 (Quarter 2) as follows:

Surplus / (Deficit) For Year	Pessimistic £'000	Projection £'000	Optimistic £'000
Clinical Divisions			
– Diagnostics & Therapies	(300)	(150)	-
– Medicine	(1,500)	(1,000)	-
– Specialised Services	(1,500)	(850)	(850)
– Surgery, Head & Neck	(2,000)	(1,100)	(1,000)
– Women's & Children's	(2,000)	(1,500)	-
Sub Total	**(7,300)**	**(4,600)**	**(1,850)**
Corporate Divisions			
– Facilities & Estates	(100)	-	100
– Miscellaneous Support Services	(300)	(200)	(100)
– Research & Development	-	-	-
– Other Corporate Divisions	(300)	(200)	(150)
Sub Total	**(700)**	**(400)**	**(150)**

Reserves/Other Provisions			
– Skills for Health	-	-	-
– Contingency	200	700	800
– Inflation Reserve	1,400	1,400	1,400
– Transfer from Capital	(500)	(500)	(500)
– Corporate CRES	(1,260)	(1,260)	(1,260)
– Other Recurring Reserves	5,610	5,610	6,010
– Support to Divisions	(3,750)	(3,750)	(3,750)
– Non-recurring reserves/provisions	3,000	3,000	3,000
Sub Total	**4,700**	**5,200**	**5,700**
Financing Items			
– Fixed Asset Impairments	(200)	(200)	(200)
– Depreciation	-	-	-
– Interest payable	-	-	-
– PDC Dividend	-	-	-
Sub Total	**(200)**	**(200)**	**(200)**
Planned surplus for year	**6,000**	**6,000**	**6,000**
Forecast Surplus/(Deficit) for year	**2,500**	**6,000**	**9,500**

The forecast given above is based on six months expenditure data and five months activity. The revised forecast assumes that the Clostridium Difficile notification for the year will be within the tolerance allowed for in the Service Level Agreement.

The main drivers for the forecast surplus of £6m (as per the original plan) are as follows:

- The Clinical Divisions positions are subject to a re-assessment at Month 6 of their realistic out-turn. However, Divisions are still required under the accountability process to deliver either a break-even position or a control total overspend. Divisions are in receipt of £3.75m in non-recurring support which is included in the positions shown. So it needs to be made clear that the realistic positions are based on projections only and require mitigating actions to achieve the plans agreed with the Chief Executive.

- Capital Charges – the forecast for capital charges (depreciation and the dividend payable on Public Dividend Capital) has been made on the basis that building values will increase by 2% over the year. This is in line with both the assumption made at the time of preparing the Trust's Annual Plan and current estimates provided by the District Valuer. Further advice will be sought from the District Valuer, required for the beginning of January 2012, to firm up the indexation rate to apply to the Trust's building values for 31st March 2012. The Trust will discuss and agree the basis to be used with the Trust's External Auditor. The forecast for capital charges and impairments incorporates the estimated financial impact of the designation of the Bristol General Hospital being a non current asset held for sale given that disposal is planned within the next 12 months.

- Contingency – the variances represent the remaining funds left from the original £2m budget.

- Transfer from Capital – this is projected to be negative in 2011/12 due to costs funded in Capital being charged to Revenue (e.g. Bristol General Hospital decommissioning).

- Corporate CRES – this is a requirement in the original budget and is offset by savings elsewhere in Reserves.

- Other Recurring Reserves – these including the following:

  – MADEL/SIFT Reserve (pending rebasing) £0.9m
  – Strategic Reserve (from 10/11 activity changes) £3.7m
  – Slippage on other Reserves £0.8m

- Non recurring reserves/provisions – these include the balance of budgeted reserves in respect of change costs, service level agreement fines and balance sheet provisions.

- Support to Divisions – these are the funds allocated to Divisions in the Operating Plan as non-recurrent support. The sums to date include the following:

  – Surgery, Head & Neck £2.0m
  – Specialised Services £0.75m
  – Women's & Children's £1.0m

7. Capital Programme

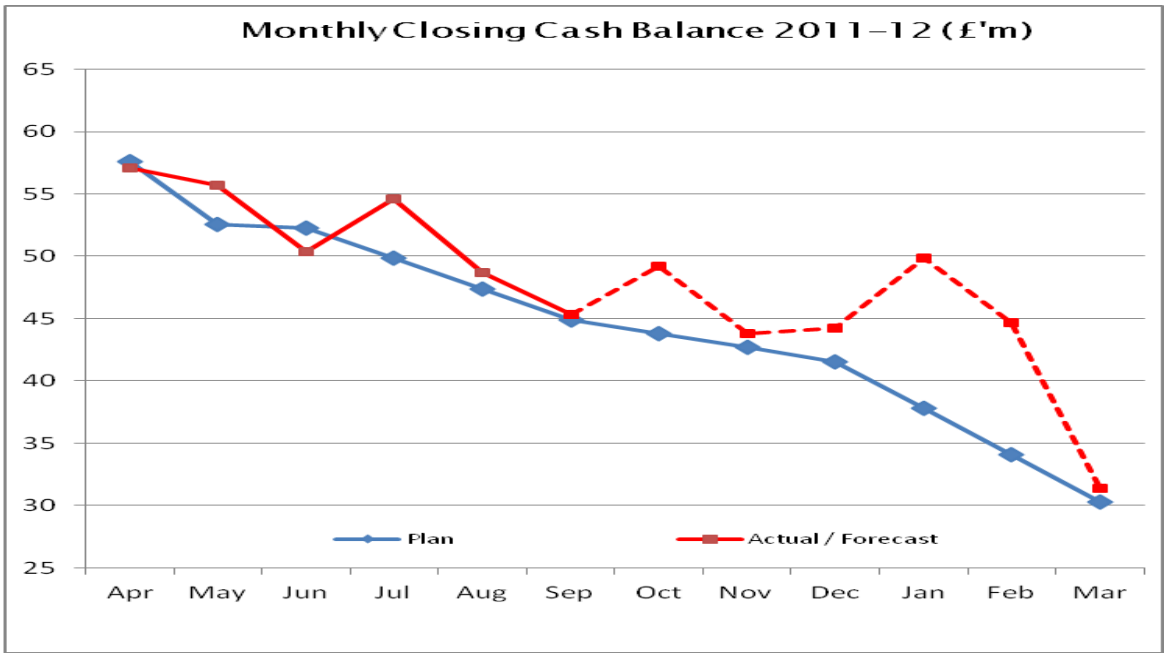
A summary of actual income and expenditure for the six months to 30th September is given in the table below.

Plan for Year		6 Months Ended 30th September 2011		
		Plan	Actual	Variance Favourable / (Adverse)
£'000		£'000	£'000	£'000
	Sources of Funding			
1,299	Donations	-	-	-
16,833	Retained Depreciation	8,327	8,491	164
1,500	Sale of Property	583	879	296
24,249	Cash balances	8,301	5,830	(2,471)
43,881	**Total Funding**	**17,211**	**15,200**	**(2,011)**
	Expenditure			
(21,224)	Strategic Schemes	(8,599)	(8,562)	37
(5,590)	Medical Equipment	(413)	(240)	173
(4,904)	Information Technology	(1,411)	(1,827)	(416)
(2,268)	Roll Over Schemes	(780)	(459)	321
(4,351)	Refurbishments	(2,294)	(1,348)	946
(10,174)	Operational / Other	(3,714)	(2,764)	950
4,630	Anticipated Slippage	-	-	-
(43,881)	**Total Expenditure**	**(17,211)**	**(15,200)**	**2,011**

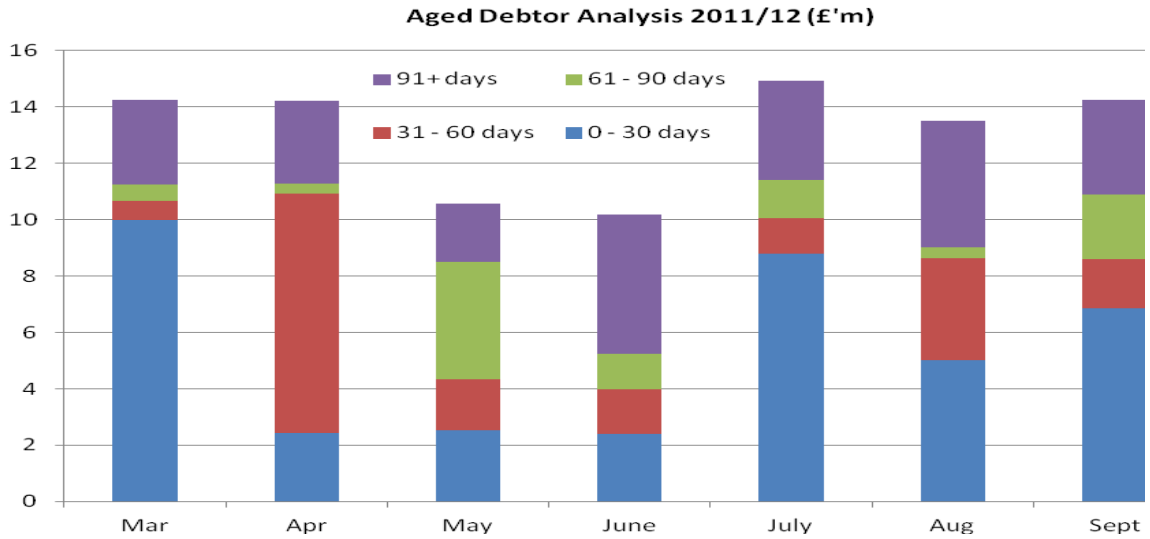
Expenditure for the six months to 30th September of £15.200m is £2m less than Plan. Progress on the Capital Programme will continue to be closely monitored as the Trust's plan shows further expenditure of some £37m over the second half of the year.

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

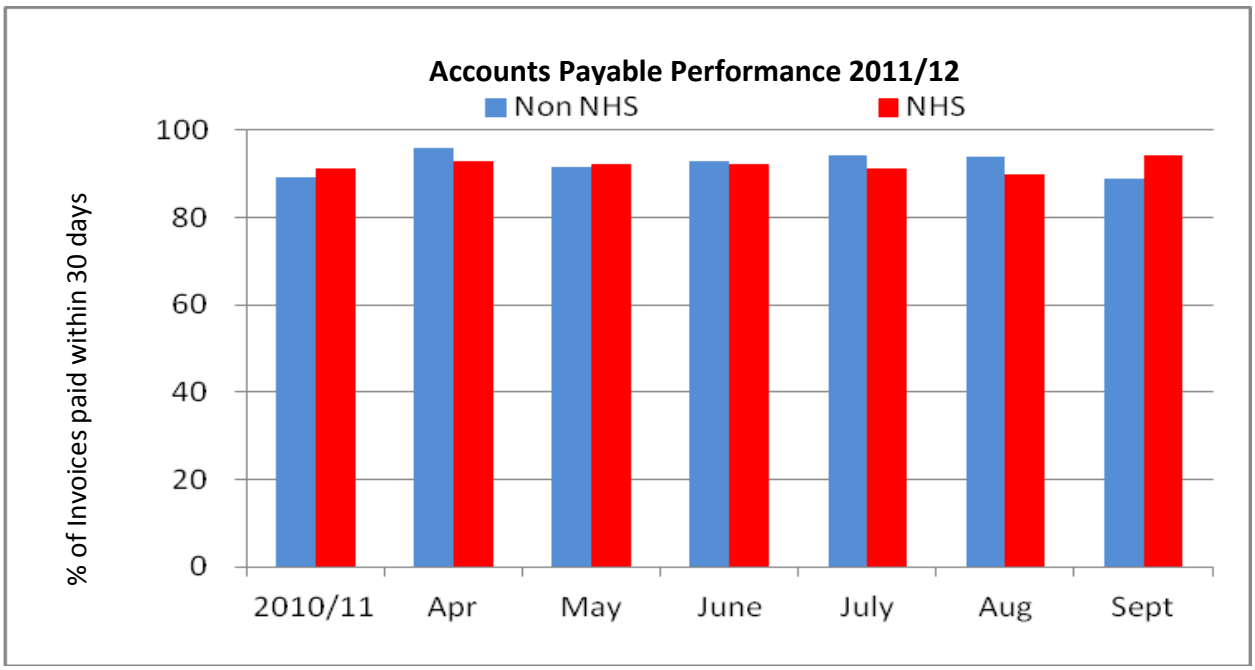
Cash - The Trust held a cash balance of £45.3m as at 30th September. The cash position is £0.4m higher than the forecast made at this point in the Annual Plan. The graph, shown below, sets out the current forecast for month end cash balances to March 2012.



Debtors - The total value of invoiced debtors has increased by £0.748m during September to a closing balance of £14.246m. The principal change relates to an invoice (£2.796m) raised on behalf of the Skills for Health service to the North West SHA for services provided in Quarters 1 and 2 of 2011/12. The debtor balance for the UHB segment reduced by £2m in September. The total amount owing is equivalent to 12.1 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In September the Trust achieved 94% and 89% 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

Appendix 1

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

Approved Budget / Plan 2011/12	Heading	Position as at 30th September: Plan	Actual	Variance Fav / (Adv)	Actual to 31st Aug	Forecast Outturn
£'000		£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)					
395,286	From Activities	196,875	196,720	(155)	162,684	396,905
105,019	Other Operating Income	52,485	52,631	146	43,482	104,497
500,304	Sub totals income	**249,360**	**249,351**	**(9)**	**206,166**	**501,402**
	Expenditure					
(306,780)	Staffing	(154,516)	(156,094)	(1,578)	(130,373)	(310,692)
(147,373)	Supplies and services	(73,646)	(76,165)	(2,519)	(61,935)	(157,134)
(454,153)	Sub totals expenditure	**(228,162)**	**(232,259)**	**(4,097)**	**(192,308)**	**(467,826)**
(12,524)	**Reserves** Reserves	(4,539)	–	4,539	–	–
(12,524)	Sub Total Reserves	**(4,539)**	–	4,539	–	**–**
33,627	**EBITDA**	**16,659**	**17,092**	**433**	**13,858**	**33,576**
6.72	**EBITDA Margin – %**		**6.85**		**6.72**	**6.70**
–	Profit / loss on asset disposals	–	–	–	–	–
(202)	Fixed asset impairments	(202)	(202)	–	(305)	(202)
(18,204)	Depreciation & Amortisation	(9,135)	(9,140)	(5)	(7,578)	(18,204)
357	Interest Receivable	187	188	1	157	350
(411)	Interest payable on loans & leases	(205)	(205)	–	(171)	(411)
(9,162)	PDC Dividend	(4,581)	(4,555)	26	(3,804)	(9,109)
6,006	**NET SURPLUS / (DEFICIT)**	**2,723**	**3,178**	**455**	**2,157**	**6,000**
1.20	**Net margin – %**		**1.27**		**1.05**	**1.20**

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

Approved Budget / Plan 2011/12	Division	Total Net Expenditure / Income to Date	Position as at 30th September [Favourable / (Adverse)] Pay	Non Pay	Operating Income	Income from Activities	Total Variance to date	Memorandum CRES Variance to Date	Cumulative Variance to 31st Aug	Forecast Outturn Variance
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements									
389,960	Service Agreements	193,767	–	–	(51)	53	2	–	–	–
(1,200)	Overheads	(1,234)	–	–	–	(34)	(34)	–	(59)	–
40,345	NHSE Income	20,255	–	–	–	–	–	–	–	–
429,105	**Sub Total Service Agreements**	**212,788**	**–**	–	**(51)**	**19**	**(32)**	**–**	**(59)**	**–**
	Clinical Divisions									
(42,336)	Diagnostic & Therapies	(20,873)	(87)	(180)	(166)	341	(92)	(365)	(140)	(32)
(54,704)	Medicine	(28,303)	(426)	(578)	136	126	(742)	(1,075)	(697)	(663)
(65,140)	Specialised Services	(32,705)	(648)	21	34	(380)	(973)	(688)	(806)	(850)
(86,859)	Surgery Head & Neck	(43,895)	(94)	(791)	155	4	(726)	(1,893)	(818)	(1,181)
(84,964)	Women's & Children's	(43,596)	(605)	(502)	(35)	(225)	(1,367)	(775)	(870)	(800)
(334,003)	**Sub Totals (1)**	**(169,372)**	**(1,860)**	**(2,030)**	**124**	**(134)**	**(3,900)**	**(4,796)**	**(3,331)**	**(3,526)**
	Corporate Services									
(1,212)	Trust Wide Accruals	(1,212)	–	–	–	–	–	–	–	–
(1,846)	Central Services	(1,009)	(28)	(67)	2	–	(93)	(65)	(81)	(140)
(52)	Community	(12)	–	14	–	–	14	(1)	11	27
(6,680)	Trust HQ	(3,480)	30	(77)	47	–	–	(1)	(40)	–
(5,240)	Human Resources	(2,507)	123	(56)	(31)	–	36	7	25	40
(5,326)	Information Technology	(2,709)	117	(96)	(17)	–	4	–	5	–
(5,066)	Finance	(2,469)	94	(33)	(24)	–	37	(32)	28	50
(25,898)	Facilities & Estates	(12,685)	97	(122)	16	(22)	(31)	(123)	(32)	–
(7,390)	Misc Support Services	(4,784)	(134)	(92)	82	(18)	(162)	(262)	(83)	(250)
8,416	Research and Development	3,874	6	19	(6)	–	19	–	8	329
(26,336)	Capital Charges	(13,248)	–	21	–	–	21	–	–	–
(76,630)	**Sub Totals (2)**	**(40,241)**	**305**	**(489)**	**69**	**(40)**	**(155)**	**(477)**	**(159)**	**56**
(410,633)	**Sub Totals (1) and (2)**	**(209,613)**	**(1,555)**	**(2,519)**	**193**	**(174)**	**(4,055)**	**(5,272)**	**(3,490)**	**(3,470)**
–	**Skills for Health**	3	(23)	22	4	–	3	–	1	
(410,633)	**Totals I & E**	**(209,610)**	**(1,578)**	**(2,497)**	**197**	**(174)**	**(4,052)**	**(5,272)**	**(3,489)**	**(3,470)**
	Reserves									
(12,466)	General	–	–	4,539	–	–	4,539	–	4,021	3,470
(12,466)	**Sub Total Reserves**	**–**	**–**	**4,539**	**–**	**–**	**4,539**	**–**	**4,021**	**3,470**
6,006	**TRUST TOTALS**	**3,178**	**(1,578)**	**2,042**	**146**	**(155)**	**455**	**(5,272)**	**473**	**0**

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	September £'000	Q2 £'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	5,564	16,716	33,354	5,559	5,238	5,491
	Bank	1,946	2,076	119	165	212	496	169	165	189	524	1,020	170	162	173
	Agency	370	654	39	88	55	182	40	59	29	128	310	52	31	55
	Waiting List initiative	502	304	26	25	22	73	16	24	2	42	115	19	42	25
	Overtime	90	91	4	5	5	14	5	3	3	11	25	4	8	8
	Other pay	61,039	62,798	5,401	5,447	5,371	16,219	5,372	5,577	5,325	16,274	32,493	5,415	5,087	5,233
	Total Pay expenditure	63,947	65,923	5,589	5,730	5,665	16,984	5,602	5,828	5,548	16,979	33,963	5,660	5,329	5,494
	Variance Fav / (Adverse)	(1,094)	(32)	(29)	(204)	(113)	(346)	(67)	(211)	16	(263)	(609)	(101)	(91)	(3)
Medicine	Pay budget	40,756	41,745	3,391	3,635	3,537	10,563	3,477	3,437	3,508	10,422	20,985	3,498	3,396	3,479
	Bank	3,763	3,434	220	260	326	806	222	269	250	741	1,547	258	314	286
	Agency	521	559	30	62	65	157	59	21	61	141	298	50	43	47
	Waiting List initiative	361	315	9	10	11	30	3	0	1	4	34	6	30	26
	Overtime	48	69	4	6	13	23	5	5	4	14	37	6	4	6
	Other pay	37,314	38,883	3,262	3,253	3,346	9,861	3,225	3,208	3,199	9,632	19,493	3,249	3,110	3,240
	Total Pay expenditure	42,007	43,260	3,525	3,591	3,761	10,877	3,514	3,503	3,514	10,532	21,409	3,568	3,501	3,605
	Variance Fav / (Adverse)	(1,251)	(1,515)	(134)	44	(224)	(314)	(37)	(66)	(6)	(109)	(423)	(71)	(104)	(126)
Surgery Head and Neck	Pay budget	62,265	66,148	5,541	5,245	5,630	16,416	5,607	5,605	5,735	16,947	33,363	5,560	5,189	5,512
	Bank	2,592	2,100	119	127	204	450	183	152	191	525	975	163	216	175
	Agency	1,730	1,206	41	69	11	121	(2)	53	44	95	216	36	144	101
	Waiting List initiative	2,158	1,209	98	127	79	304	16	27	7	50	354	59	180	101
	Overtime	276	152	7	7	8	22	15	8	12	35	57	9	23	13
	Other pay	58,271	61,071	5,143	5,327	5,314	15,784	5,337	5,352	5,406	16,096	31,880	5,313	4,856	5,089
	Total Pay expenditure	65,027	65,738	5,408	5,657	5,616	16,681	5,549	5,592	5,660	16,801	33,482	5,580	5,419	5,478
	Variance Fav / (Adverse)	(2,762)	410	133	(412)	14	(265)	58	13	75	146	(119)	(20)	(230)	34
Specialised Services	Pay budget	32,323	33,790	2,669	3,066	2,900	8,635	2,829	2,865	2,919	8,613	17,248	2,875	2,694	2,816
	Bank	1,025	1,049	61	74	95	230	87	93	85	265	495	83	85	87
	Agency	363	654	(69)	230	82	243	116	104	73	293	536	89	30	55
	Waiting List initiative	587	537	51	42	45	138	34	29	23	86	224	37	49	45
	Overtime	119	20	2	0	1	3	1	1	2	4	7	1	10	2
	Other pay	30,949	32,290	2,684	2,813	2,786	8,283	2,857	2,765	2,741	8,362	16,645	2,774	2,579	2,691
	Total Pay expenditure	33,043	34,550	2,729	3,159	3,009	8,897	3,095	2,992	2,924	9,011	17,908	2,985	2,754	2,879
	Variance Fav / (Adverse)	(720)	(760)	(60)	(93)	(109)	(262)	(266)	(127)	(6)	(398)	(660)	(110)	(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	September £'000	Q2 £'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	3,066	9,280	18,401	3,067	2,944	3,077
	Bank	537	544	46	50	48	144	35	43	29	108	252	42	45	45
	Agency	692	389	24	32	17	73	13	29	4	46	119	20	58	32
	Waiting List initiative	131	156	14	15	8	37	15	6	6	27	64	11	11	13
	Overtime	169	264	22	20	26	68	17	19	13	49	117	19	14	22
	Other pay	33,437	35,515	2,937	2,961	3,017	8,915	3,025	3,015	2,989	9,029	17,944	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	3,041	9,258	18,495	3,083	2,914	3,072
	Variance Fav / (Adverse)	361	61	2	(80)	(38)	(116)	(16)	13	24	22	(94)	(16)	30	5
Facilities & Estates	Pay budget	17,714	18,706	1,398	1,532	1,727	4,657	1,567	1,647	1,593	4,807	9,464	1,577	1,476	1,559
	Bank	572	483	29	29	35	93	26	22	27	75	168	28	48	40
	Agency	1,295	1,300	128	105	118	351	148	99	133	380	731	122	108	108
	Waiting List initiative	19	7	1	1	0	2	0	0	0	0	2	0	2	1
	Overtime	1,178	1,160	79	95	112	286	97	53	100	250	536	89	98	97
	Other pay	14,944	15,591	1,164	1,300	1,448	3,912	1,281	1,435	1,305	4,021	7,933	1,322	1,245	1,299
	Total Pay expenditure	18,008	18,541	1,401	1,530	1,713	4,644	1,552	1,609	1,565	4,726	9,370	1,562	1,501	1,545
	Variance Fav / (Adverse)	(294)	165	(3)	2	14	13	15	37	28	80	93	16	(25)	14
Trust Services	Pay budget	26,181	26,763	4,191	472	2,177	6,840	2,240	2,124	2,608	6,973	13,813	2,302	2,182	2,230
	Bank	619	609	54	34	66	154	52	75	47	174	328	55	52	51
	Agency	196	209	13	(4)	0	9	21	5	27	53	62	10	16	17
	Waiting List initiative	3	7	1	1	(3)	(1)	0	0	0	0	(1)	(0)	0	1
	Overtime	88	108	8	6	4	18	3	4	10	17	35	6	7	9
	Other pay	25,114	26,087	4,244	514	2,228	6,986	1,927	2,079	2,387	6,393	13,379	2,230	2,093	2,174
	Total Pay expenditure	26,020	27,020	4,320	551	2,295	7,166	2,003	2,163	2,471	6,637	13,803	2,301	2,168	2,252
	Variance Fav / (Adverse)	161	(257)	(129)	(79)	(118)	(326)	237	(39)	137	335	9	2	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	24,992	73,757	146,627	24,438	23,118	24,164
	Bank	11,054	10,295	648	739	986	2,373	774	819	819	2,413	4,786	798	921	858
	Agency	5,167	4,971	206	582	348	1,136	395	370	371	1,136	2,272	379	431	414
	Waiting List initiative	3,761	2,535	200	221	162	583	84	86	39	209	792	132	313	211
	Overtime	1,968	1,864	126	139	169	434	143	93	144	380	814	136	164	155
	Other pay	274,844	286,411	24,835	21,615	23,510	69,960	23,024	23,431	23,351	69,807	139,767	23,295	22,904	23,868
	Total Pay expenditure	283,018	291,900	26,015	23,296	25,175	74,486	24,420	24,800	24,724	73,944	148,430	24,738	23,585	24,325
	Variance Fav / (Adverse)	(5,599)	(1,928)	(220)	(822)	(574)	(1,616)	(76)	(379)	268	(187)	(1,803)	(300)	(467)	(161)

NOTE: Other Pay includes all employer's oncosts.

University Hospitals Bristol NHS
NHS Foundation Trust

Agenda Item 12a
Appendix 4

Key Issue	RAG	Executive Summary	Table
Service Level Agreement Income and Activity	G	For the year to date contract income is £0.69m greater 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 £0.05m favourable (last month £0.09m favourable) and SLA Contract Penalties / Rewards at a net reward of £0.58m (July cost £0.68m). A&E Attendances at 48,108 are 1,310 **higher** than planned. The average number of daily attendances is 314. Emergency activity at 15,665 is 1.3% or 206 spells **lower** than planned. Non Elective activity at 6,605 is 3.0% or 192 spells **higher** than planned. Elective activity at 5,826 is 6.5% or 406 spells **lower** than planned. Day case activity at 20,275 is 5.4% or 1,037 spells **higher** than planned. Outpatient Procedure activity at 11,188 is 6.8% or 715 attendances **higher** than planned. New Outpatients activity at 54,485 is 2.1% or 1,165 attendances **lower** than planned. Follow up Outpatient activity at 130,767 is 0.3% or 330 attendances **lower** than planned. An income analysis by commissioner is shown at Table INC 2. Information on clinical activity by Division, specialty and patient type is provided in table INC 3.	INC 1
Income and Expenditure	G	The reported surplus for the six months to 30th September is £3.178m. The EBITDA surplus of £17.092m equates to 102.6% of the Annual Plan target for the period. Total income to date £249.351m is in line with Plan. This includes £0.810m of residual over performance relating to 2010/11. Expenditure at £232.259m is greater than Plan by £4.097m, this reflects higher than planned expenditure in a number of areas and slippage to date on CRES plans. Financing costs are lower than plan by £22k.	I&E 1 I&E 2 I&E 3a I&E 3b
Cash Releasing Efficiency Savings	R	The 2011/12 CRES programme totals £26.636m. Actual savings achieved for the six months to 30th September total £8.046m compared with a target for the period of £11.311m, a shortfall of £3.265m (August cumulative shortfall £2.793m).	I&E 4a – 4b

Key Issue	RAG	Executive Summary	Table
Statement of Financial Position & Treasury Management	G	The cash balance on 30th September was £45.302m. The forecast cash balance for 31st March 2012 is £31.361m compares favourably with the Annual Plan forecast of £30.312m. The balance on Invoiced Debtors has increased by £0.748m in the month to £14.246m. The invoiced debtor balance equates to 12.1 debtor days. Creditors and accrual account balances total £61.142m although £13.308m relates to deferred income. Invoiced Creditors - payment performance for the six months to 30th September for Non NHS invoices and NHS invoices within 30 days was 94% and 90% respectively.	BS 1 BS 2 BS 3 BS 4
Capital	G	Expenditure for the six months to 30th September totals £15.2m - this is £2.011m less than profiled for the period. The principal areas of slippage to date are recorded against Operational capital schemes (£0.95m) and Refurbishment / Maintenance schemes (£0.946m).	Capital 1 Capital 2
Financial Risk Rating	G	The Trust's overall financial risk rating using the results for the six months to 30th September 2011 has been calculated to be 4 (actual score 3.65). This is an improvement on the Trust's Financial Risk Rating as a result of the increase in September in the Return on Capital Employed from 4.97% to 5.1%. The improvement above 5% moves the score on this metric from 3 to 4 and in turn improves the FRR by 0.2. 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 £1.343m 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

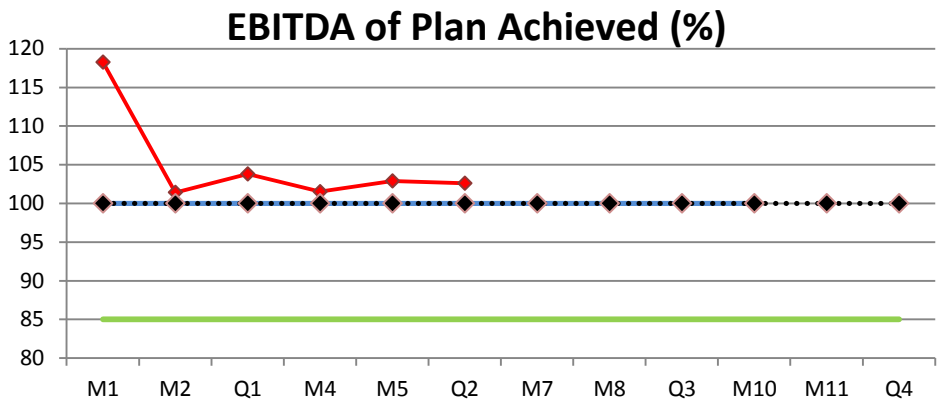
Finance Report September 2011 - Risk Matrix

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	-	
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	-	Private patient income @ 0.68% of patient related income remains well within the Trust's Cap of 1.1%.

Financial Risk Ratings – September 2011 Performance

1. Financial Risk Rating

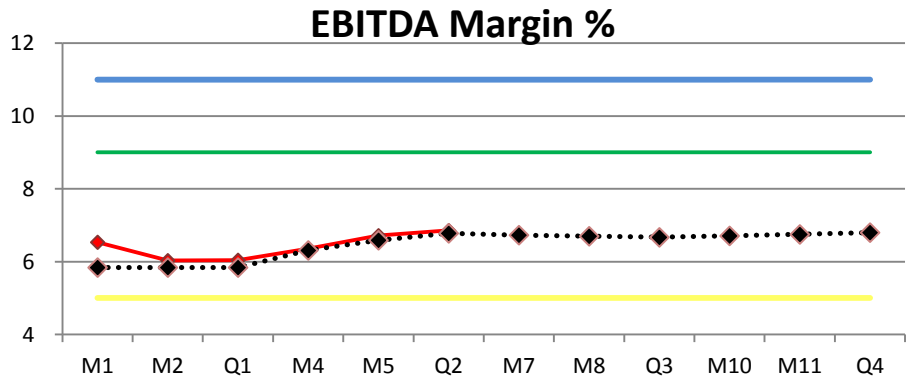
The following graphs will show performance against the 5 Financial Risk Rating metrics. The 2011/12 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 5 (blue line)**; **FRR 4 (green line)** and **FRR 3 (yellow line)**.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

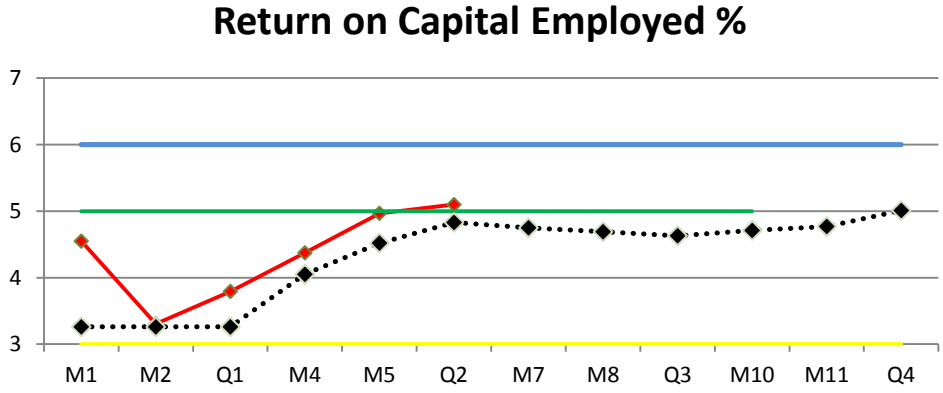


An EBITDA of £17.092m was achieved. This is 2.6% better than the proportion of the Annual Plan for the period value of £16.659m.

EBITDA Achievement of 102.6% of Plan earns a metric score of 5.

The EBITDA Margin of 6.85% for September achieves a metric score of 3. This is slightly better than the Annual Plan forecast of 6.78% to date.



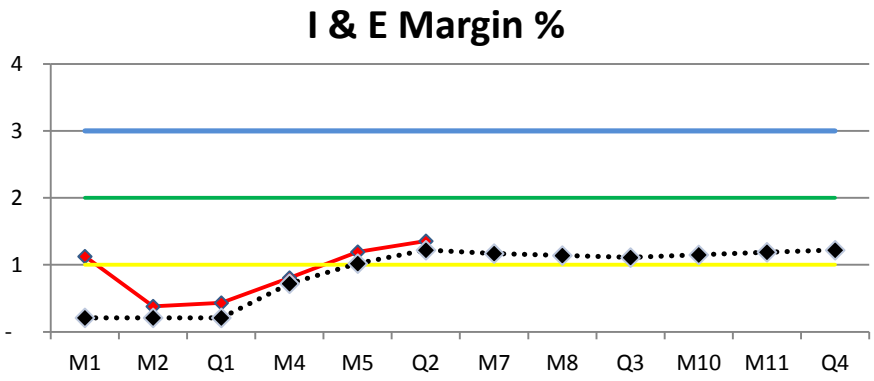


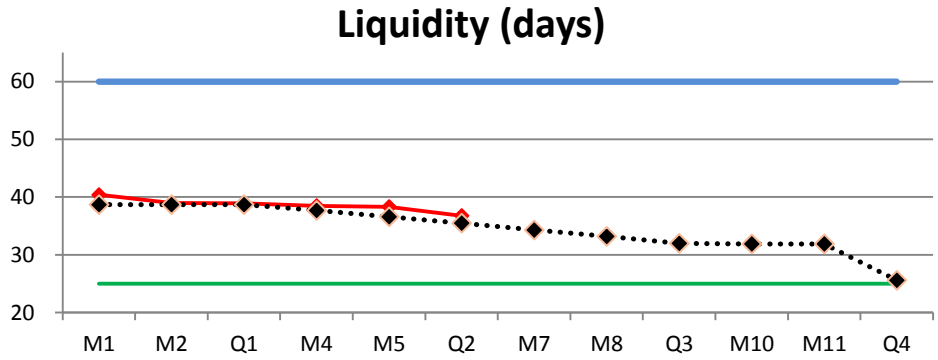
The planned Return on Capital Employed for the six months to September is 5.1%. The result earns a metric score of 4.

Annual Plan = 4.83%

2011/12 Annual Plan Income & Expenditure surplus margin is 1.22% for the six months to 30th September.

The Income and Expenditure surplus margin for the period is 1.36%, a metric score of 3.





2011/12 Annual Plan liquidity ratio is 35.5 days at 30th September.

The actual liquidity ratio for September is 36.8 days and remains 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 3.65 (August 3.45). The Trust has therefore achieved a Financial Risk Rating of 4 for the six months to 30th September 2011.

2. Prudential Borrowing Limit

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

Prudential Borrowing Limit Performance	Monitor Ratio Tier 1	30th September 2011
Minimum Dividend Cover	>1x	3.8x
Minimum Interest Cover	>3x	84x
Minimum Debt Service Cover	>2x	60x
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 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 13 –Teaching and Learning Strategy Progress Report
Purpose
To brief the Board on progress made against the Teaching and Learning Strategy
Abstract
The paper describes: • The Trust Mission for Teaching and Learning • The Strategic Priorities as described in the strategy • Progress against the strategy implementation plan • Other areas of progress – operational progress in addition to the deliverables within the strategic plan.
Recommendations
The Board is recommended to **Note** the report.
Executive Report Sponsor or Other Author
Director of Workforce and Organisational Development, Steve Aumayer

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	12 October 2011				

Teaching and Learning Strategy

Update to the Board - October 2011

1. Introduction

This paper provides an update to the Board on progress made since the Teaching and Learning Strategy was signed off on the 28th April 2011.

Activity is in line with plan with significant progress being made in some areas.

In order to provide context for progress, an overview of the key elements of the Teaching and Learning Strategy are described in the report.

This paper details:

- The Trust Mission for Teaching and Learning
- The Strategic Priorities as described in the strategy
- Progress against the strategy implementation plan
- Other areas of progress – operational progress in addition to the deliverables within the strategic plan

2. Trust Mission for Teaching and Learning

The Trust Mission for teaching and Learning is:

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

3. Strategic Priorities

As a part of the strategy formulation process, a number of Strategic Priorities were identified. These priorities underpin the implementation plans.

Strategic Priorities	
Strategy Integration	The Teaching and Learning Strategy will work in synergy with the Clinical Services Strategy and Research and Innovation Strategy, so that they are mutually supportive. The Teaching and Learning Strategy and workforce plans will enable the Trust to achieve internal and external quality and accreditation standards for service, research and teaching, as well as providing the skill levels required in our workforce, both now and in the future. The Teaching and Learning Strategy will support the further development of the Trust-wide transformation programme through the development and delivery of improved transformation capabilities. The Teaching and Learning Strategy will reflect the changes within the economic and political environment, ensuring the Trust retains the capability to deliver its services through a period of change.
Skilled and flexible workforce	The Teaching and Learning Strategy will develop a flexible skilled workforce using the widening participation agenda as the model and principle for delivery. The Teaching and Learning Strategy will provide opportunities for staff to grow and develop in a way which reflects our need for a flexible workforce and a new challenging skill mix
Leaders of the future	The Teaching and Learning Strategy will continue to develop our 'Top Leaders' with a focus on leading in a changing environment. The Teaching and Learning Strategy will develop a talent pool which will support effective talent management and succession planning ensuring we have the right people, with the right skills, at the right time for our business.

	The Teaching and Learning Strategy will ensure Leadership will be described through a common set of competencies and behaviours. The leadership behaviours will underpin our Trust values. The Teaching and Learning Strategy will ensure Leaders will be accountable for their performance and that of their teams. Performance management and appraisal will be at the heart of this.
Corporate and Professional Requirements	The Teaching and Learning Strategy will ensure a standardised approach which recognises and values consistency, where appropriate, however; is also flexible to support the development of specialisms within individual professions within the core teaching markets.
Partnership Working	The Teaching and Learning Strategy will support and lead in the development of cross community working to create an integrated Teaching and Learning approach that supports our wider partnership arrangements. The Teaching and Learning Strategy will enable us to provide services to other health community members creating income generation opportunities which will further develop the Teaching and Learning services.
Centre of Excellence	The Teaching and Learning Strategy will be delivered through an internally and externally accredited centre of excellence with a standardised approach to learning across all disciplines creating the flexible and high performing workforce needed for the future. All elements of Teaching and Learning will be directed through a single leadership structure, ensuring co-ordinated and consistent delivery of services alongside efficient and effective governance. This will ensure the best outcomes across all staff groups in the Trust in the most efficient way. The Teaching and Learning Strategy development solutions will be flexible to the needs of the learner and to developing Trust priorities. They will be delivered using the most appropriate media to ensure access for all, wherever possible at the time and place of need. Media may include e-learning, action learning, peer review/evaluation, mentoring and where appropriate traditional classroom style training.

4. Progress against implementation plan

Objective	Date	Progress	RAG
To ensure an efficient and externally responsive approach to the identification and delivery of teaching solutions and educational commissioning with a demonstrable return on investment that supports the Trust efficiency savings plan. This includes a full review of teaching and learning budgets and budget management across the Trust.	**With effect from March 2012**	Agreement to centralise appropriate budgets reached. Divisional Finance Managers working through divisional budgets to identify budget elements that should be centralised to facilitate bottom up budgeting and a fair bidding process going forwards - completed by the end of October. Budgeting process to be developed over remainder of 2011.	**Green**
Review the structures and procedures for all corporate teaching and learning teams to understand workflows and identify efficiency savings, ensuring clear corporate accountability for the Teaching and Learning agenda	**By June 2011**	Full review conducted using Spans and Layers methodology. Savings of 4.5% of paybill identified through simplification of processes and removal of duplication. Head of Teaching and Learning appointed - commences in role 31 October. Teaching and Learning team go into consultation on 07 November on identified changes.	**Green**
To ensure Teaching and Learning systems are developed appropriately to provide the platform for all training delivery including E-Learning and Continuous Personal Development (CPD) activity and the development of robust metrics for teaching and learning across the core	**By December 2011**	Full review of existing systems and options appraisal conducted to benchmark AT Learning with other learning management systems. Review process has identified additional issues	**Amber**

teaching markets.		raised requiring consideration, moving delivery date for report from September to October. Plan being reworked to take account of the delays. Appointment of Jane Bailey as Continuing Professional Development Lead to support delivery of new contract and to maximise E-Learning opportunities. Dementia pilot planned for wards 14 and 23 in October and project plan has been completed New CPD contract with SHA undergoing full risk analysis to identify areas where it does not deliver against Trust needs and mitigating actions required.	**Amber**
In response to the March 2011 customer questionnaire, improve customer satisfaction with Teaching and Learning, against a benchmark taken from the 2011 survey, demonstrated through a further survey in June 2012	**By June 2012**	Customer Survey conducted and the action plan being worked through by the Teaching and Learning teams.	**Green**
Deliver development support for leaders to ensure that they have the skills and capabilities to meet the requirements placed on them by the quality and cost challenges within the NHS.	**Commence development programme 10 October 2011**	Leadership programme commenced. 150 Senior leaders attending by end December 2011. Transformation project included within plan for every attendee to be tracked as part of the transforming care programme.	**Green**

5. Other areas of progress

In addition to the primary Teaching and Learning objectives, the past quarter has seen a major focus on the simplification of statutory and mandatory training and improved reporting.

Progress against each of these elements has been made, although it is recognised that each presents a range of potential and actual risks and issues to the Trust until they are fully developed and resolved. These areas are described further in the table below:

Area of focus	Plan Detail	Progress	Comments
Statutory and Mandatory training	Conduct a few review of statutory and Mandatory training - end October Present outcomes to TME with next steps – November Implement in line with plan – Nov onwards (NB it is expected that full roll out including the changes to solutions and methodologies will be a 12 month programme of work)	i) Multi-professional review underway. Statutory and Mandatory Steering Group formed, 3 full day events held with desired process, learning methodologies and priorities for action fully scoped ii) Identification of all statutory and mandatory training for all groups fully completed. Being reviewed to assess importance, method of delivery and frequency required	The range of Statutory and Mandatory training required has increased significantly over the past two years leading to a massive time burden for staff. Overall control of what constitutes statutory and mandatory training across the Trust has been weak with individual professional groups making decisions without appropriate centralised governance. In addition, the methodologies used often require personal attendance at face to face training when other methods might be more appropriate. The outcomes of this project

			will: i) ensure only essential training takes place ii) ensure it is only delivered to the people for who it is essential iii) deliver it in the best way at the right frequency iv) Place strict governance on any change in the process.
Systems and reporting	In addition to consideration of the platform for e-learning, there are a number of immediate issues to be sorted regarding the availability of reporting at a local level. A specific programme of work has been set up to: i) Better integrate @Learning (our system) with ESR – Oct 11 ii) Create single matrix for all needs – December 2011 iii) Deliver accurate time and place of need reporting – on going.	i) ESR changes being integrated into @Learning. Further automation being investigated with supplier (achievement at risk). ii) Fully linked to statutory and mandatory programme of work. iii) Reporting issues being progressed. All reports now accurate or issues known and being rectified – most data issues relate to changes in ESR.	The provision of accurate, timely data is core to maintaining compliance. Whilst the majority of reporting is now stable, there are a small number of programmes where further work needs to be done. These programmes are receiving attention from UH Bristol and AT Learning, our systems provider. Specific issues relate to changes made in ESR, the core NHS workforce system that have led to 3000 manual changes having to be applied to the Learning Management System (AT Learning)

There has been a continued focus on delivering new and improved training interventions over recent months. This has resulted in further development to, and delivery of enhanced solutions relating to:

- Skills for Life
- English as a Second Language
- Customer Service
- Values
- Vocational Qualifications in Healthcare
- Qualification Credit Framework Vocational Qualifications (ex NVQs) in healthcare, cleaning, business administration, team leadership and customer service
- Apprenticeships
- Management Development
- Individual facilitation sessions for leadership teams

6. Summary

The Teaching and Learning Strategy has given a solid foundation on which to build both capability and reputation moving forward.

Progress against the strategy implementation plan is on track. However, operational issues relating to statutory and mandatory training and reporting continue to present challenges. These areas are being actively managed and reporting on their progress will be maintained in Board updates until all actions are completed and issues resolved.

Whilst the delivery of the strategy implementation plan is critical, the ongoing delivery of programmes and support remains a priority. The additional solutions development and enhancement work in this area has led to further improvements to the training and support portfolio across the Trust.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 14 – Quarterly Capital Projects Status Report
Purpose
To update the Board on the current status of major capital development schemes.
Abstract
The purpose of this report is to update the Board on progress, issues and risks arising from the Trust's major capital developments. The update describes the achievement of the major programme milestone of agreeing the Guaranteed Maximum Price (GMP) for the BRI Re-development and Centralisation of Specialist paediatric schemes and the subsequent signing of contracts between ourselves and our P21 partner, Laing O'Rourke. There are no significant risks identified at this stage, where mitigation or contingency plans are not adequate.
Recommendations
The Board is recommended to Note the report.
Executive Report Sponsor
Director of Strategic Development, Deborah Lee.
Appendices
• Appendix A – Quarterly Status Update.

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
					Clinical Strategy Group Trust Management Executive

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT

1. Introduction

This status report provides a summary update for Quarter 2 of the Trusts Strategic Capital Schemes, all of which are managed through their respective Project Boards which in turn report to the Trust's Management Executive.

2. Project Updates

CENTRALISATION OF SPECIALIST PAEDIATRICS			
1	**Decisions required**	None.	
2	**Progress**	Target price agreed and contracts signed. Audiology development and service re-location successfully completed and extensions to structural frame complete.	
3	**Budget**	A capital allocation of £36.9m is in the capital programme including charitable funding support of £5.83m through The Grand Appeal. Scheme currently on budget though formal pledge regarding charitable support still outstanding from The Grand Appeal. Actions to address this are in hand.	
4	**Programme**	Project on programme.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Workforce plan cannot be implemented leading to failure to deliver models of care.	UH Bristol Human Resources reviewing strategies for training to ensure workforce is available, with required skills.
		Transfer of Adult BMT not achieved.	Full Business Case now being developed for March Board with significant progress made since Outline Business Case was received by Finance Committee.
		Charitable funding target not achieved.	Contingency plan developed which prioritises major equipment provision and phases non-critical investment as funds are secured.
		Additional revenue costs materialise as future designation standards and operational service models become clearer	All future costs will need to be accommodated within agreed FBC revenue envelope and investments re-prioritised to reflect any additional "must do" items.

BRISTOL ROYAL INFIRMARY PROJECT INCLUDING AIR AMBULANCE ACCESS			
1	**Decisions required**	None. The scheme now incorporates the Helipad and the Site Wide Generators.	
2	**Progress**	Target price agreed and contracts signed. Demolition, cycle store, orthotics and temporary main entrance complete. ED refurbishment and lift installation commenced. Site Wide Generators scheduled for completion June 2012.	
3	**Budget**	A capital allocation of £86.3m is in the capital programme including charitable funding support of £3m through Above and Beyond. Allocation of £86.3m includes funding for the Helipad and Site Wide Generators, which is now part of the target price agreement.	
4	**Programme**	Project on programme.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Delay to construction works and delayed cost certainty.	Constant monitoring and control of scope and cost plan.
		Logistics solution to allow disposal of Old Building not achievable. Retention of Old Building for non-clinical functions required.	Detailed enabling works and decant programme developed. Final approval of decant locations to be agreed at Strategic Estate Steering Group.
		Charitable funding target not achieved.	Contingency plan developed which prioritises single bed provision and phases non-critical investment as funds are secured.
		Construction and refurbishment stage proves problematic causing additional delays and cost.	Robust monitoring of programme.
		Delay to construction; increased cost and potential health and safety hazards.	Robust monitoring of programme.
WELCOME CENTRE			
1	**Decisions required**	None. <u>To note:</u> the Comprehensive Business Case (CBC) is to be submitted	

		in November and will evaluate both the Developer and Trust funded options.	
2	**Progress**	Market test initiated with retail sector. Pre application submitted to Bristol City Council. Public consultation with residents, local businesses, staff and physical impairment groups completed.	
3	**Budget**	Nothing to report.	
4	**Programme**	On programme.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Retail rentals not high enough to enable a successful scheme to be delivered	Aim to attract high profile anchor tenants. Market test underway to provide additional certainty for CBC.
BRISTOL HAEMATOLOGY & ONCOLOGY CENTRE			
1	**Decisions required**	None.	
2	**Progress**	Proceeding to Full Business Case scheduled to be submitted in March 2012. Capital gap at Outline Business Case stage now resolved, work to resolve revenue gap progressing well. Pre application submitted to Bristol City Council. Public consultation process to be implemented. Operational issues, such as maintaining public car parking being considered.	
3	**Budget**	Capital cost identified at £13.5m supported by £6.5m of charitable funding pledged by Above and Beyond, TCT and the Friends of BHOC.	
4	**Programme**	On track.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Unable to transfer Adult BMT beds out of BRHC.	Current operational work around is extended for a further period which would still enable the critical elements of CSP to be delivered to ensure Frenchay closure is not compromised.
		Business continuity during construction.	Ensure robust site logistic co-ordination through principle supply chain to provide

			continuity.
		Operational impact on radiotherapy service during Linac construction phase.	Robust construction logistic planning in place. Close working between operational and strategic development teams.

3. Conclusion

The Trust Board is requested to receive this report for information, noting the risks that have been identified and the mitigation / contingency plans that have been developed.

Date: 11 October 2011

Presented by: Deborah Lee – Director of Strategic Development
Prepared by: Andy Headdon – Strategic Development Programme Director

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 15 – Annual Business Planning Guidance 2012/13

Purpose

To seek Board approval for the proposed approach to Annual Business Planning for the 2012/13 period.

Abstract

The annual business planning process is the means through which the Trusts identifies it's forward priorities, develops its plans to ensure that it effectively manages any identified risks and sets its annual objectives for the coming year. This process culminates in the production of the Trust's Annual Plan, required for submission to Monitor, and the six Divisional Operating Plans which, if fully delivered, will in turn ensure delivery of the Trust's Annual Plan.

In response to significant discussion with Divisions and agreement through the Trust's Management executive, this guidance reflects a shift away from traditional approaches to Operating Plan development. This is in recognition of a changed financial climate and an acceptance that historical approaches to cost reduction will not achieve the levels of savings required if we are to preserve and continue to improve the quality of services offered.

Historical approaches to operating plan financial balance, where the primary contributors have been activity growth, transactional cost reduction and non-recurrent savings, will be replaced by a process that is driven by a requirement for service re-design and the subsequent re-modelling of the workforce.

Recommendations

The Board is asked to accept the Trust Management Executive's recommendation to **approve** this guidance.

Executive Report Sponsor or Other Author

- Executive Sponsor and Author – Director of Strategic Development, Deborah Lee.

Appendices

- Appendix A – Annual Medium-term Planning Guidance 2012/13 to 2014/15

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
05 October 2011	29 September 2011 12 October 2011				

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Management Executive
Date: 12 October 2011
Agenda Item: 15

Title

Annual Planning 2012/13 – Programme Context and Programme Plan

Summary

This paper sets out the context and programme plan for Divisional Operating Plans to be developed for 2012/13 onwards. Importantly, it notes the pivotal role that transformation initiatives must play in developing plans that are recurrently balanced.

It should be read in conjunction with the draft Trust-wide Annual Operating Plan, which sets out the overarching organisational approach to transformation, risk based management and workforce re-design.

This revised context signals a move away from historical approaches to operating plan balance, where the primary contributors to financially balanced plans have been activity growth, transactional CRES and non-recurrent initiatives. The new drivers to financial balance must be service re-design and workforce re-modelling.

Other key changes from previous years include the move away from a "bidding round" for internal cost pressures to one where unavoidable cost pressures are included within Operating Plans.

In response to feedback from Divisions, proposals for consideration of PCT funding will still be invited.

Recommendations

The Trust Management Executive is asked to approve the planning process.

Authors

Deborah Lee and Ben Hume

Presented by

Deborah Lee – Director of Strategic Development

Impact Assessed

No	

Annual Medium-Term Planning 2012/13 to 2014/15
Programme Context

1. Introduction

1.1 This paper sets out the wider context within which Divisional Operating Plans should be developed for 2012/13 and importantly notes the pivotal role that transformation initiatives must play in developing plans that are recurrently balanced.

1.2 It should be read in conjunction with the draft Trust-wide Annual Operating Plan, which sets out the overarching organisational approach to transformation, risk based management and workforce re-design.

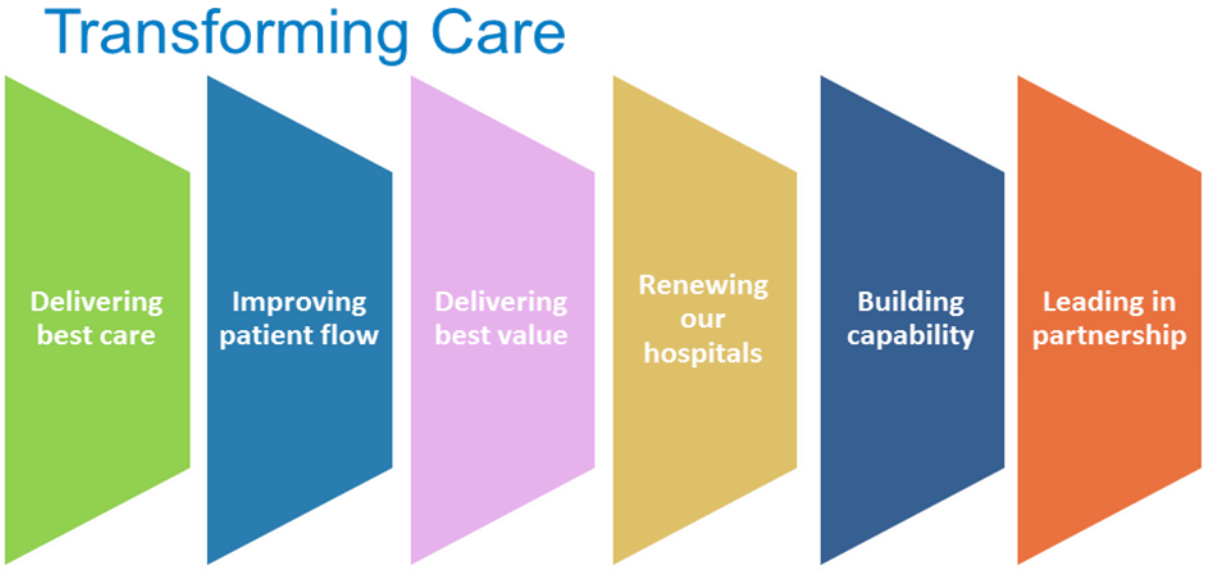
1.3 It is these three pillars of practice that will form the basis for Operating Plan development in 2012/13.

1.4 This revised context, therefore, signals a move away from historical approaches to operating plan balance where the primary contributors to financially balanced plans have been activity growth, transactional CRES and non-recurrent initiatives. The new drivers to financial balance must be service re-design and workforce re-modelling.

2. Transformation

2.1 *Transforming Care* sets out the framework for the Trust's approach to re-designing the way in which it delivers care to ensure that service quality is maintained at a time when unprecedented levels of cost reduction will be required.

2.2 The diagram below describes the six programmes that will drive our approach to transforming care and should, therefore, provide the framework for Divisional Operating Plan development.



3. Risk Based Management

3.1 Historically, the Annual Operating Plan has been the means through which risks have been identified and articulated within the business planning cycle. Going forward, identification and management of risk should be key drivers (inputs) to the operating plan as opposed to outputs arising from it.

3.2 The primary benefit that is expected to arise from this approach is the identification and prioritisation of risk at the outset of the planning process and thus operational, financial and workforce plans that are clearly aligned to the management and mitigation of these risks. This is in contrast to a "shopping list" of risk appearing at the end of a process which then requires funding.

3.3 Risk should be considered in the context of both the likelihood of occurrence and the impact should the risk arise. The following risk categories describe the different types of risk that may arise:

- Actual harm being caused to patients or staff;
- Regulatory or contractual non-compliance;
- The failure to deliver or support the delivery of the Trust's stated corporate objectives;
- The Trust suffering significant reputational damage;
- A significant deterioration in the Division's financial position.

4. Workforce Re-design

4.1 Operating cost reductions of the scale required in the next few years will not be achieved without significant reductions in workforce costs. This reduction in cost is expected to come from both reductions in the number of staff and a change in the profile of staff.

4.2 It is envisaged that 2012/13 Operating Plans will stand or fall by the strength of their workforce plans.

4.3 There are typically two major drivers to workforce re-design. The first being a remodelling of the workforce as a response to a re-designed service where the roles of staff and the requirement for staff change as a response to new, more efficient and effective models of care / service being developed.

4.4 Secondly, accepting that the major re-design of services will be a programme implemented over time, opportunities will continue to be sought to reduce the cost and/or volume of staff through the re-design of the workforce itself, i.e. the service may remain largely unchanged but the way in which staff are deployed to achieve the service aims changes. For example this might include the cessation of tasks / duties of low or limited value, or the revision of skill mix to deliver the same care at lower cost.

5. Summary

This narrative aims to signal a revised context in which Divisional Operating Plans will be developed for the three year period commencing 2012/13. It signals the importance of a risk based approach to management in a context of declining resources and a need to ensure service quality is maintained.

It defines the need to change the way in which we view cost reduction from one about spending less to doing things differently

Finally, it recognises that in an organisation where the single largest resource is staff, that a significant reduction in its cost base will only be achieved through a significant reduction in its expenditure on staff.

Programme Plan

1. Introduction

1.1 This Plan responds to the Programme Context and sets out practical arrangements for the annual planning round, based on feedback from Divisions. The planning process will take place between October 2011 and May 2012 and incorporates aspects of the budget setting process.

1.2 A core feature of the 2012/13 approach is that Divisions will prepare their plans through focusing on risk based management and transformative approaches to service delivery which support a re-modelling and reduction in the workforce. Plans will also be required to show how they to deliver the Trust's primary strategies and align with the NHS *Quality, Innovation, Productivity and Prevention* and commissioner agendas.

1.3 Future plans must also focus on the changes necessary to deliver major service moves and capital re-developments in the period to 2014/15 – and the transformations required to deliver them.

2. Mandate

2.1 The Programme Context makes clear that a risk-based approach will be used to identify priorities for the Trust's future planning.

2.2 Monitor considers that effective Foundation Trust planning must[1]:

- Focus beyond the immediate year;
- Describe credible cost savings;
- Work with commissioners on plans;
- Use transformative approaches to service provision.

2.3 These will be achieved by identifying the primary risks to the Trust and Divisions – and demonstrating that plans respond to these.

2.4 The planning round will also determine how key risks such as reduced tariff income and cost savings (CRES) can be mitigated to create balanced Operating Plans. The planning period will be 3 years, with a focus on the first (2012/13).

2.5 There will be a greater focus on understanding Trust operational capacity as part the Operating Plan process – and linking this with plans for service moves, safety and improved quality.

3. Responsibilities

3.1 The **Sponsor Group** is the Trust Board, who should advise and support the SRO. This document serves as the Programme Plan, which must be approved by the Trust Board prior to the programme commencing.

[1] Monitor briefing

3.2 The **Senior Responsible Officer** is the Director of Strategic Development. The SRO has overall responsibility for ensuring that the programme meets its objectives.

3.3 The **Programme Board** is the Trust Management Executive, which supports the SRO in delivering the programme. Members of the Programme Board are accountable to the SRO for their areas of responsibility – for example, Heads of Division and Divisional Managers.

3.4 The **Programme Manager** is the Head of Strategy & Business Planning. This role is responsible for the set-up, management and delivery of the programme.

3.5 The **Business Change Managers** are responsible for ensuring the delivery of the programme benefits (e.g. Operating Plans). These roles are usually held by Heads of Division or Divisional Managers for Operating Plans – and will also be allocated for the 3 Projects described below.

4. Projects and Timetable

Figure 1 (below) sets out the 3 Projects that will deliver the annual planning process. Each project will occur in sequence and be given overall direction by a Project Lead. A detailed timetable and schedule of outputs are contained in the Appendix.

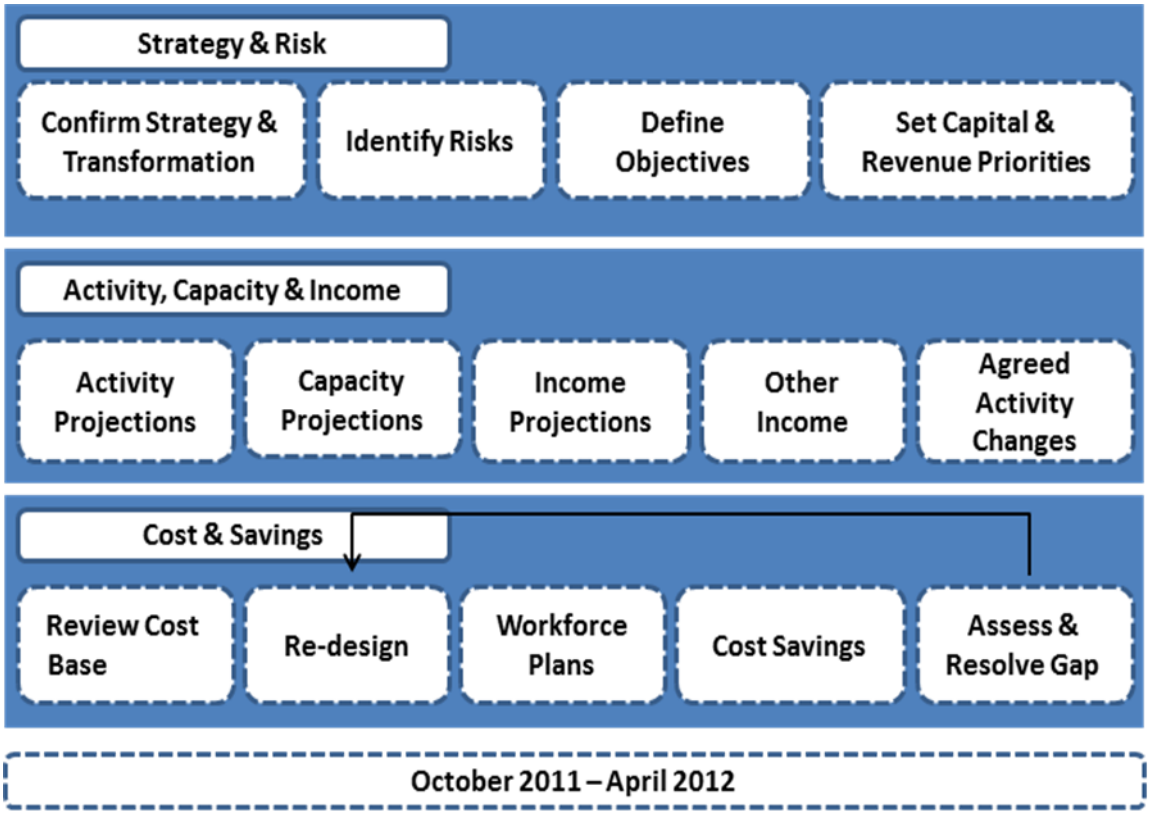


Figure 1: *Annual Planning Projects Overview*

4.1 The work of the 3 Projects will help Divisions create their Operating Plans and the Trust's Annual Plan. Key dependencies include the publication of commissioning priorities, the Department of Health Operating Framework and the national tariff.

4.2 For each Division, the final objective is to compile an annual Operating Plan, which is financially balanced and addresses the Divisional priorities and risk according to the timetable set out in the Appendix. Final Operating Plans are due for approval by the Trust Management Executive on **11 April 2012**. These will help generate the Trust's Budget and Monitor Annual Plan.

5. Projects

Three core Projects are at the heart of the planning process. These will be conducted in parallel and will influence each other through planned iterations of Operating Plans. A schedule of outputs from each Project in listed in Appendix 1.

5.1 Strategy & Risk

The aim of this Project is to set the overall direction for the Trust and Divisions. Objectives, revenue changes and capital priorities will be arrived at through a risk-based approach.

5.1.1 Strategy & Transformation

The Trust's three primary strategies for Clinical Services, Teaching & Learning and Research & Innovation were agreed by the Trust Board in May and June 2011. In addition, the *Transforming Care* programme has recently re-set the Trust's approach to managing change. The Trust's 3-5 year Corporate Objectives for remain unchanged but the annual milestones for 2012/13, will be developed as part of the planning process.

Questions to ask at this stage include:

- What do statements in the Strategies mean for us?
- What do the *Transforming Care* priorities mean for each Division?
- Where are we vulnerable to competition or demand reduction?
- What do commissioning plans (e.g. QIPP) mean for our services?
- Does the above present risks that are not documented on our risk registers?

5.1.2 Identify Risks

Divisions should begin by reviewing their risk register, updating it using the Trust's risk assessment tool where necessary. It is expected that a clear understanding of principal risks will emerge in this way, which will then be addressed through planning.

Risks will be used to a greater degree to inform Divisional and Trust priorities in this year's process – this will be reflected in Operating Plan templates. The following risk categories describe types of risk that may arise:

- Actual harm being caused to patients or staff;

- Regulatory or contractual non-compliance;
- The failure to deliver or support the delivery of the Trust's stated corporate objectives;
- The Trust suffering significant reputational damage;
- A significant deterioration in the Division's financial position.

5.1.3 Planning Assumptions

The results of your strategic and risk analyses should be a set of key assumptions on which you will base your Operating Plan. These assumptions should cover:

- Transformation priorities;
- Quality improvements;
- Workforce impacts;
- Activity levels and income sources;
- Cost reduction and efficiency priorities;
- Performance standards, including waiting time targets.

5.1.4 Objectives

Divisions will be asked to list key objectives for 2012/13, which respond to Corporate Objectives, the management of key risks and *Transforming Care*. These will be a key requirement of the Operating Plan templates, though it is recommended that work to understand Divisional objectives is undertaken before the templates are released.

5.1.5 Revenue and Spend-to-Save (see also 8.3)

There will be no central revenue prioritisation process this year. Instead, revenue cost pressures and core "Spend-to-Save" proposals will be managed in the first instance through Operating Plans. During the Draft stages of Operating Plans, those cost pressures and Spend-to-Save ideas that are deemed critical will receive scrutiny and guidance from Executives.

As a result of risk analysis and objective-setting, Divisions will have an idea of the priorities affecting future revenue budget positions. These should include:

- Income changes as a result of agreed activity or coding changes;
- New cost pressures;
- Potential disinvestments;
- Savings targets;
- Revenue consequences of proposed capital and service changes;
- Investments that save the Trust or commissioners more than they cost.

Further specific guidance will follow through the work of the Cost & Savings project.

5.1.6 Capital priorities (see also 8.2)

Through objective-setting, a review of your risk register and previous capital plans, you will also have an idea of capital investment priorities for 2012/13 – including equipment replacement.

The capital process beginning 2012/13 will have a 3-year focus and link to the BRI and paediatric redevelopment schemes, to avoid capital expenditure that might

achieve poor value for money over 2-3 years. Timings for the capital prioritisation process are contained in Appendix 2.

5.2 Activity, Capacity & Income

The objective of this project is to make an assessment of likely activity, capacity and income levels in 2012/13. This project has key interdependencies with the Costs & Savings Project.

5.2.1 Activity Projections

The Strategic Development and Finance teams will produce an activity data projection, based on predicted out-turn activity adjusted for one-off, in-year initiatives. This will form the basis for review workshops, to be conducted with clinical Divisions from late 2011 (see timetable in Appendix 2).

5.2.2 Capacity Projections

The Strategic Development and Information teams will work with clinical Divisions to produce and assess their capacity, expressed as facilities such as theatres, beds and outpatient rooms. This will help inform your assessment of costs and form part of the workshops referred to above.

5.2.3 Income Projections

Divisional Finance Managers should work with Corporate Finance to identify likely tariff income for 2012/13, based on the above activity analysis. The additional impact of commissioner-led service design and demand management schemes will impact on the analysis. Divisions will be informed of commissioner plans as part of this process, as soon as they are known.

5.2.4 Other Income

Divisions should plan on the basis that there will be no commissioner funding for acute service developments. However, where clear spend-to-save or critical proposals for commissioner (PCT or SCG) consideration are appropriate, a two-step process will be initiated:

1) High-level expressions of interest for Executive team review (November);
2) Invitation to work-up a full bid for Commissioner consideration, if appropriate.

Divisions are also asked to consider other potential funding sources, including:

- Private patients (where profitable);
- Commercial clients;
- Charitable funding bodies;
- Research and development.

5.2.5 Agreed Activity Changes

Activity changes as a result of agreed activity or coding / classification changes should be incorporated at this stage, including an assessment of income and capacity impacts.

5.3 Costs and Savings

The objective of this Project is to examine resource commitment for future years, taking account of the recurrent cost base, changes as a result of revenue and capital developments and the impact of savings plans.

5.3.1 Review Cost Base

The recurrent cost base is that required to deliver the services and activity levels identified in section 5.2.1. It is essential that a rigorous assessment of the position is made to ensure that the Operating Plan is robust.

5.3.2 Re-design

The impacts of transformational approaches to service provision should be accounted for, including any "pump-priming" costs that are outside the baseline budget. Expected savings benefits should be described briefly here, but also more fully in the Cost Savings sections of Operating Plan templates.

5.3.4 Workforce Plans

Templates will be developed to reflect further emphasis on workforce planning in this year's Operating Plans, allowing for clear links between transformative re-design solutions, "business as usual" and cost savings.

5.3.5 Cost Savings

As described further in Section 10.1, indicative cost saving (CRES) targets have been set for future years. These need to be refined into detailed savings plans as part of this work and will be described in detail in Operating Plan templates.

6. Supporting Themes

6.1 Resolving the "Gap"

All Divisional plans must demonstrate a minimum of a breakeven position throughout the planning period.

At the heart of the business planning process lies the need to assess the gap between planned costs, net of savings and planned income. The effectiveness of

each Division's Operating Plan will depend on the realism of this assessment and the measures adopted to turn an income gap into a balanced plan.

The possible responses to an identified gap are:

- Identify further re-design initiatives that reduce workforce and thus costs
- To reduce the recurrent cost base through additional non-pay savings;
- To withdraw or reduce planned developments, revenue or capital;
- To explore other potential funding income streams.

6.2 Workforce Planning

Templates will be developed to reflect further emphasis on workforce planning in this year's Operating Plans, allowing for clear links between transformative re-design solutions, "business as usual" and cost savings.

The outputs of Divisions' planning for 2012/13 will require an integrated workforce plan that considers:

- Workforce re-design
- Workforce reductions
- Job-plans
- Appointments
- Staff and skill mix required to deliver Operating Plans

6.3 Contingencies

There is an expectation that business planning outputs will be built on clear assessments of relevant risk, drawn from developed structures for identifying and recording all kinds of within Divisions or at a Trust level.

Where a predicted gap between cost and income is identified, measures to turn the identified gap into a surplus must be identified as part of core business planning. The outputs of business planning must also be supported by contingency plans that allow for unpredicted changes to planned assumptions, yet still address residual risks.

7. Divisional Operating and Monitor Annual Plans

Each clinical Division plus Facilities and Estates, Information Management and Technology and Trust Headquarters (incorporating Finance, HR, R&I and core services) will be expected to produce Operating Plans. This process will build on the outputs of the 3 core Projects – the timetable and requirements for Plans is indicated in Appendix 2, including a date for TME sign-off of **11 April 2012.**

The 3-year Trust Annual Plan for submission to Monitor in May 2012 will take account of and be based on Divisional plans.

8. Budget-Setting Assumptions for 2012/13

A review of the Trust's approach to resource allocation is expected to be presented to the Trust Management Executive and Finance Committee in October 2011. Options may include differential rates of CRES (building on service line reporting and reference cost data), with scheduled implementation from April 2012. If implemented, this approach would have considerable implications for the planning

assumptions of each Division, which would be subsequently reflected in Operating Plans.

8.1 Cash-Releasing Efficiency Savings

The expected national tariff CRES is 4% for 2012/13. In addition, there are likely to be other unavoidable external cost pressures as well as the risk of MPET and tariff deflation. Notwithstanding the expected resource allocation proposal, Divisions should plan on the basis of a 4.0% CRES requirement for 2012/13 plus any brought forward CRES from 11/12, for first cut operating plans . Given the clear need to reduce headcount significantly, it is important that plans for the three-year period are developed quickly to deliver the required financial savings for 2012/13 onwards.

8.2 Capital Budget

The process for prioritising Capital will have a 3-year focus from 2012/13. Priorities for 2012/13 and an outline programme for subsequent years will be agreed as follows:

Major Medical Equipment

The total budget is circa £5.0m for 2012/13 and will be subject to a similar prioritisation system as previous years. Prioritised Expressions of Interest will be reviewed by an expert panel to ensure that Programme is set appropriately, taking into account the need for replacement in 2012/13.

Strategic & Operational Capital

The combined allocation will be circa £5.0m for 2012/13. A multi-year programme of Strategic Capital will be agreed first, to ensure that schemes that are in-line with long-term plans attract a high priority. Once this is agreed, the budget for Operational Capital will be set and a prioritisation process will be conducted to ensure that priority capital requirements are funded.

8.3 Divisional Capital

The process for allocating minor capital is likely to be delegated to Divisions. This is to be used for Minor Medical equipment, bed replacement and patient environment schemes. It will be the judgement of the Divisions as to how this is spent. However, the expectation will be that operational needs will be met before other uses are agreed. The allocation will be circa £1.1m for 2012/13.

8.4 Revenue Budget

The cost of pay awards, non-pay inflation, CNST and incremental drift will be met corporately – insofar as funding allows. Any shortfall may be met by enhanced CRES targets.

Appendix 1 – Summary of Outputs

Project	Inputs / Components	Operating Plan outputs
Strategy & Risk	• Clinical Services Strategy • Regulatory standards • National and local priorities • Key business risks 2012-14 • Key planning assumptions • Key objectives	• Updated risk registers • Divisional objectives • Revenue and capital priorities
Capacity, Activity & Income	• Capacity analysis • Demand analysis • Projected tariff income • Other income sources • Trust-funded pressures	• Capacity, activity and income plans • List of proposals for relevant charitable partners • Potential proposals for PCT consideration (TBC)
Costs & Savings	• Review of cost base • Unavoidable cost pressures • Revenue consequences of capital • Savings plans	• Capacity plan • Cash-Releasing Efficiency Savings plans
Supporting Theme		
Gap Resolution	• Reduce the recurrent cost base through additional savings • Withdraw or reduce planned developments (revenue or capital) • Explore other potential funding streams	• Service improvement plans • Additional CRES
Workforce	• Assessment of Transformation and CRES impacts • Job-planning • Staff and skill mix requirements	• Workforce Plan
Risks & contingencies	• Risks to Operating Plan • Mitigation measures	• Contingency Plan

Appendix 2 – Outline Timetable Milestones

Version 1: Provisional summary, pending confirmation of assumed CRES, activity and commissioner deadlines

Month	Deliverables	Date
October	Commence fortnightly Core Group (Planning, Finance, HR)	1st October
	Feedback and evaluation seminar - 2011/12 process	6th October
	Annual Planning Programme Plan to Trust Management Executive	12th October
	Annual Planning Programme Plan to Trust Board	26th October
	CRES Plans - 1st Cut *Assumed*	28th October
November	Open Commissioner Schemes database (Expressions of Interest)	1st November
	Open Capital database (Expressions of Interest)	14th November
	Deadline for Commissioner Schemes Expressions of Interest	18th November
	Divisional Activity analysis (Step 1)	w/c 21st November
	Executive Team review of Commissioner Schemes EoI's	24th November
	CRES Plans - 2nd Cut *Assumed*	25th November
	Divisions invited to submit selected Commissioner Schemes bids	w/c 28th November
December	Deadline for Capital Expressions of Interest	16th December
	Deadline for selected Commissioner Schemes bids	16th December
	Capital EOIs to Capital Planners for review	21st December
	Capital EOIs to Estates, MEMO etc for review	21st December
January 2012	Divisional Operating Plan templates issued	9th January
	Activity & Capacity Planning workshops (Step 2)	w/c 16th January
	Estates, MEMO review of Capital EOIs complete	20th January
	PCT / Provider Review of Capacity & Activity	w/c 23rd January
	SDG Peer Prioritisation - Major Medical Capital EOIs	23rd January
	Provider-led Capacity Plan to PCT	End January
February	SDG Peer Prioritisation - Operational Capital EOIs	6th February

	Activity & Capacity Planning workshops (Step 3)	w/c 6th February
	Monitor Annual Plan responsibilities agreed	w/c 6th February
	Divisional Operating Plans - 1st Draft	10th February
	Executive feedback on 1st Draft Operating Plans (tabletop exercise)	w/c 13th February
	Issue Annual Plan responsibilities to nominated leads	20th February
	Provider-led Capacity Plan to PCT (including QIPP)	End February
March	TME Final Prioritisation - Capital EOIs	2nd March
	Divisional Operating Plans - 2nd Draft	9th March
	Executive feedback on 2nd Draft Operating Plans (face-to-face)	w/c 12th March
	Annual Plan - Template issues to Leads	12th March
	Final Capital EOI prioritisation to Capital Programme Steering Group	14th March
	Financial Resources Book (inc. Capital) to Finance Committee	22nd March
	Divisional Operating Plans - Final	23rd March
	Annual Plan - Draft 1 complete	23rd March
	Financial Resources Book to Trust Board	27th March
April	Final Divisional Operating Plans and Draft Annual Plan to TME	11th April
	Annual Plan update / Draft to Governors' Strategy Group	w/c 16th April
	Quarter 4 Divisional reviews (2012/13 Operating Plans)	w/c 23rd April
	Annual Plan update to Trust Board	28th April
May	Annual Plan update to Membership Council	2nd May
	Final Annual Plan circulated to Trust Board members	w/c 14th May
	Final Annual Plan to Finance Committee	25th May
	Final Annual Plan to Trust Board	31st May
	Submit Annual Plan to Monitor	31st May

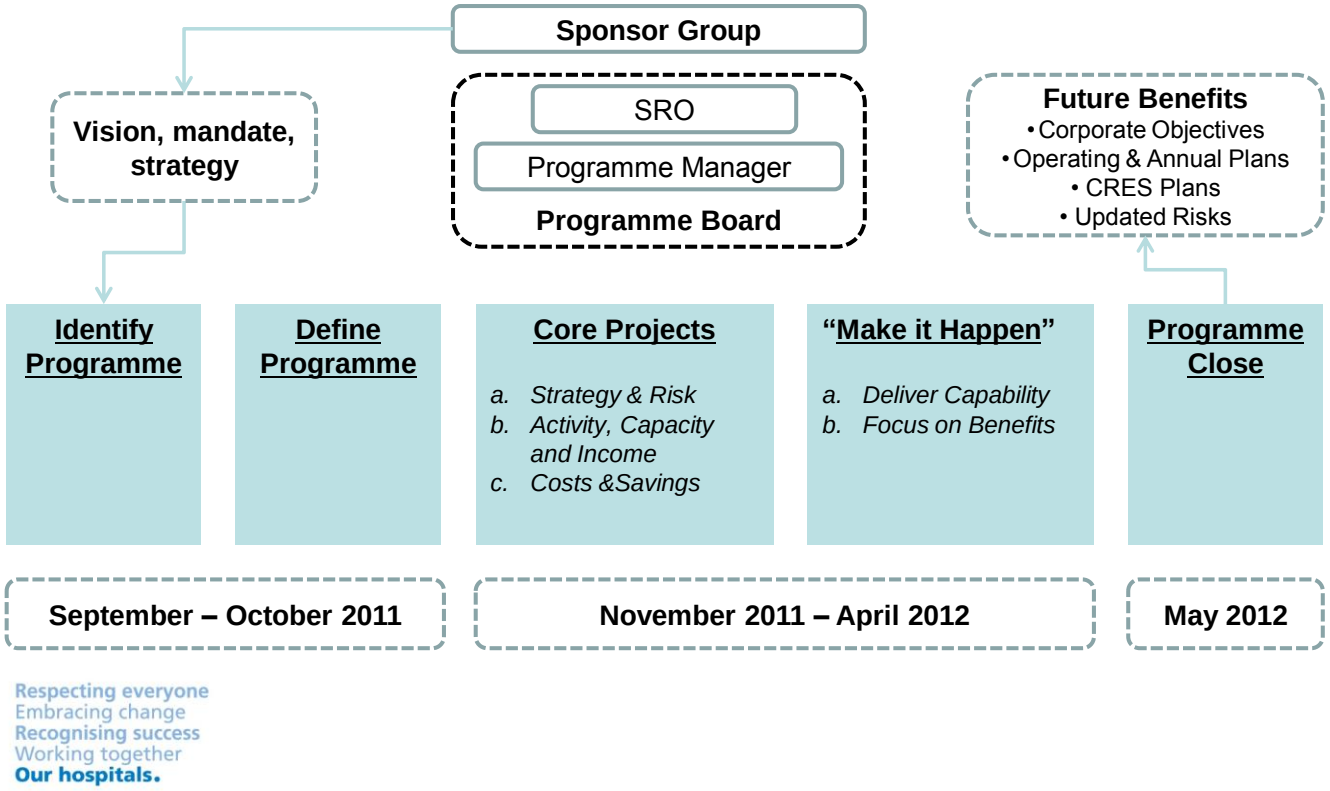
University Hospitals Bristol NHS
NHS Foundation Trust

Appendix 3

Overall Planning Programme Schematic

Programme Summary

University Hospitals Bristol NHS
NHS Foundation Trust



Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 October 2011 at 10:30am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 16 – Medium Term Indicative Capital Programme
Purpose
To seek Board approval on proposals for the Trust's Medium Term Indicative Capital Programme.
Abstract
Summarises key development proposals for the Trust's Medium Term Indicative Capital Programme to 2016/17. Proposed expenditure increases by £15.6m over the period – funded by donations and Trust cash. Proposals enable the Trust to maintain a liquidity metric of a minimum of 24 days throughout. The proposals are dependent on the 4 core assumptions set out in the report namely capital sources of funding, Operating Plans and CRES delivery, scheme costs and prioritisation of capital schemes.
Recommendation
To approve the Medium Term Indicative Capital Programme.
Executive Report Sponsor or Other Author
• Executive Sponsor and Author – Director of Finance, Paul Mapson.
Appendices
• Appendix 1 – Medium Term Indicative Capital Programme 2011/12 to 2016/17

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other (Capital Programme Steering Group)
	12/10/11		21/10/2011		12/10/11

Medium Term Indicative Capital Programme

2011/12 to 2016/17

1. Introduction

This paper summarises and describes the key developments in the Trust's Medium Term Capital Programme to 2016/17. The paper is structured so that it is read in conjunction with Appendix 1.

2. Overall impact of the proposed changes

The additional cash requirement from operating cash flows for the Capital Programme can be summarised as follows:

Cash Requirement	2010/11 £'m	2011/12 £'m	2012/13 £'m	2013/14 £'m	2014/15 £'m	2015/16 £'m	2016/17 £'m	**Total £'m**
Original	15.8	24.3	(6.2)	5.0	11.8	(3.9)	(6.9)	**39.9**
Proposed	15.8	31.6	(11.3)	14.4	5.7	(0.2)	(12.1)	**43.9**
Cum. Impact	-	7.3	2.2	11.6	5.5	9.2	4.0	

The net impact on the Trust's cash balances is a requirement for an additional £4.0m over the period. This is due to a planned additional cash requirement of £3.0m for the BHOC scheme and £1.0m for IM&T diagnostics. This additional cash requirement will be covered by the cash benefit from the deferment of the long term loan repayment until after loan is drawn down in full, in June 2015. Hence the changes are affordable within the Long Term Financial Plan (LTFP) with the financial risk rating unaffected.

The changes in the Medium Term Capital Programme expenditure are as follows:

	£m	
BHOC scheme	11.5	
BRI Redevelopment scheme	1.2	
CSP scheme	7.9	
SBCH equipping	1.4	
Subtotal – Strategic schemes	22.0	
Medical equipment	(2.6)	Linear accelerator transfer to BHOC scheme
Information Technology	1.0	PACS replacement
Roll over schemes	(0.9)	
Dental capital	(0.6)	£0.4m transfer to SBCH equipping
Operational capital	(3.9)	Transfer to BRI Redevelopment (Rheumatology)
Slippage reduction	0.6	
Total – additional expenditure	15.6	
Original capital expenditure	248.3	
Additional expenditure	15.6	
Proposed capital expenditure	**263.9**	

The main changes in the Medium Term Capital Programme sources of funding are as follows:

	£m
Donations	13.4
Reduction in disposal proceeds	(1.8)
Cash requirement	4.0
Total – additional funding	15.6
Original capital funding	248.3
Additional funding	15.6
Proposed capital funding	**263.9**

3. Sources of Capital

Sources of capital total £263.9 for the period to 2016/17. These are as follows:

3.1 Public Dividend Capital

The Capital Programme assumes Public Dividend Capital is not available to Trust as is usually the case for Foundation Trusts.

3.2 Revenue

No other transfers to or from revenue are assumed at this time.

3.3 New Systems Funding

The two principal sources of funding for the programme are depreciation of £118.4m and prudential borrowing from the Foundation Trust Financing Facility (FTFF) of £70.0m.

3.4 Donations

Substantial donations are assumed at £16.8m over the period, an increase of £13.4m relating to the following schemes

	£m
BHOC	6.5
BRI Redevelopment	3.0
CSP	5.8
NICU expansion	1.0
Other	0.5
Total	16.8

Three charities have pledged funding of £6.5m in support of the BHOC scheme: £2.0m Above & Beyond; £2.0m Friends of BHOC; and £2.5m Teenage Cancer Trust (TCT). Commitments, in writing, have been received from Above & Beyond and TCT and work to secure the same from the Friends of BHOC is progressing well.

The BRI Redevelopment scheme includes confirmed charitable funding of £3.0m from Above & Beyond.

The Grand Appeal has yet to confirm funding of the £5.8m capital requirement in support of the CSP scheme though work to progress this is actively in train.

3.5 Disposals

Disposals proceeds arising from the sale of the Trust's existing estate contribute £14.25m as a source of capital funding, a reduction of £1.8m. The reduction is due to the lower than anticipated sale receipt of £6.15m for the Bristol General Hospital. The revised forecast proceeds for the BRI Old Building is £5.0m compared with £6.0m previously.

3.6 Capital Grant

The Trust has secured a capital grant of £0.6m from NHS Bristol as a contribution towards equipping expenditure for the community dental provision at South Bristol Community Hospital (SBCH).

3.7 Cash Balances

Critically, the programme assumes either a cash requirement or surplus in each year. The use of cash balances are a source of funds in addition to the items list above and are predicated on delivery of Income & Expenditure surpluses in each year, in line with the Trust's LTFP.

The use of cash for capital purposes impacts upon the Trust's ability to meet its ongoing revenue obligations arising from the Trust's day to day operating activities. However, the cash implications of the Capital Programme upon the Trust's liquidity have been modelled and throughout the period and is summarised in the table below:

Liquidity	2012/13	2013/14	2014/15	2015/16	2016/17
Original - Days	35.6	36.1	28.7	34.3	43.1
Original - Metric	4	4	4	4	4
Proposed - Days	33.7	26.0	24.0	26.3	39.5
Proposed - Metric	4	4	3	4	4

Liquidity Metric	Liquidity Equal to or greater than
5	60 days
4	25 days
3	15 days
2	10 days
1	Less than 10 days

The liquidity metric is one of five metrics used by Monitor to calculate the Trust's Financial Risk Rating. The modelling shows the Trust exceeds the minimum requirement of 15 days necessary for a liquidity metric score of 3.

This underlines the importance of delivering balanced Divisional Operating Plans and CRES in each year over the period. If these are not achieved, then the cash available as a source of funding is reduced and capital programme expenditure must be scaled back or alternative external sources of funding identified.

4. Application of Funds

The applications of capital funding total £263.9m for the period to 2016/17. These are as follows:

4.1 Major Strategic Schemes

These schemes are the principal application of capital funding at £152.9m over the period of the programme, an increase of £22.0m. The increase is mainly due to the inclusion of the BHOC scheme £11.5m and additional CSP scheme expenditure of £7.9m.

GMP has been agreed with Laing O'Rourke for the BRI Redevelopment and CSP schemes at £123.3m.

The BHOC scheme totals £15.5m and includes provision for one linear accelerator at £2.0m. The equipping of SBCH for UH Bristol's dental, day surgery, imaging and outpatient services is estimated at £4.3m.

4.2 Medical Equipment

A total of £28.9m is allocated over the period of the programme with £2.4m for Emergency allocation, £20.9m for annual allocation through the Trust's capital prioritisation process (for items over £15k) and a further £5.7m for the replacement of Linear Accelerators. Work continues on Linear Accelerators replacement costs and this may lead to revision of the Capital Programme at a future point.

4.3 Information Technology

Schemes totalling £16.8m are identified, mainly £8.1m for the implementation of a new Patient Administration System, £3.75m for the replacement of personal computers over the period and £3.3m allocated as a provision for general IM&T and data storage purposes. In addition, the requirement to replace or renew the Trust's PACS system (at the end of the NPFiT contract) has been recognised with an initial allowance of £1.0m.

4.4 Roll Over Schemes

The principal call on this allocation of £15.1m is the Works Replacement programme of £12.2m for the period.

4.5 Refurbishments

Specific schemes totalling £11.3m are detailed in appendix 1, including a sum of £1.5m in each year for strategic refurbishment schemes. The 2011/12 funding is fully committed. Any requirement for strategic refurbishment capital above £1.5m per year will impact on applications elsewhere in the programme; notably Operational Capital.

4.6 Miscellaneous

Provisions for the Dental Programme of £2.15m and Divisional Capital of £6.65m are included. Divisional Capital is assumed at £1.0m in each year – the process for the allocation of these monies for equipment over £5k is generally at the discretion of Divisions and based on an apportionment of funds to Divisions.

4.7 Operational Capital

The application of the £32.3m for the period includes specific schemes of £10.3m, notably decontamination compliance of £3.7m, radiopharmacy of £2.0m, NICU expansion of £1.7m and the reprovision of Rheumatology at £2.9m. General Operational Capital is available at £18.3m. Operational Capital is allocated in each year through the Trust's capital prioritisation process.

4.8 Scheme Slippage

An assumption of programme slippage at 15% is applied to the total of capital expenditure excluding the BRI Redevelopment, CSP and BHOC schemes. Slippage is carried forward into the following year and is regarded as a prudent assumption based on past experience. The slippage assumed in 2011/12 is £3.2m.

5. Implications

The programme outlined in this paper is dependent on several core assumptions, including:

- Capital sources – these include but are not limited to the FTFF loan that has recently been approved, significant donations from charitable sources, depreciation and cash. The attainment of each source is essential to the programme. The most significant risk is the increased charitable funding assumed at £15.3m for the BHOC, BRI Redevelopment and CSP schemes;
- Operating Plans and CRES – delivery of plans for income, expenditure and cost savings in line with the Trust's LTFP will have an impact on the Trust's liquidity and therefore the availability of cash for the Medium Term Capital Programme. This is an essential link between the Trust's Capital Programme and its annual financial performance;
- Scheme costs – changes or further slippage may result in revisions to the capital programme aligning applications of funding with sources;
- Prioritisation of capital – annual processes are established and continue to be developed for the allocation of Major Medical and Operational Capital, with an outstanding need to identify priorities for Strategic Refurbishment capital. Changes to the overall amounts required for these schemes will impact on other parts of the programme.

6. Conclusion

This paper summarises the latest position in respect of capital schemes in the period to 2016/17. Key issues include the relationship between the capital programme and the Trust's annual Operating Plans and CRES achievement along with the confirmation of the charitable funding for the strategic schemes.

7. Recommendation

To approve the Medium Term Indicative Capital Programme.

University Hospitals Bristol NHS Foundation Trust

Medium Term Capital Programme 2011/12 to 2016/17

Appendix 1

	Budget Manager	Prior years	2011/12 Plan			Forward Plan					Grand Totals
			2010-11 slippage	2011-12	Total	2012-13	2013-14	2014- 15	2015 - 16	2016 - 17	
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	**£'000**
SOURCE OF FUNDS											
A. Public Dividend Capital											
Sub-Total		-	-	-	-	-	-	-	-	-	-
B. Revenue											
Other transfers to/from Revenue		-	-	-	-	-	-	-	-	-	-
Sub-Total		-			-	-	-	-	-	-	-
C. New System Funding											
Depreciation From Long Term Plan	P Tanner		-	16,833	16,833	18,147	18,390	19,924	22,173	22,963	**118,430**
Prudential Borrowing	P Tanner	-	-		-	50,000	20,000		-	-	**70,000**
Sub-Total		-	-	16,833	16,833	68,147	38,390	19,924	22,173	22,963	**188,430**
D. Donations											
BEH CRU/ Paediatrics expansion	S Nadin		288	-	288	-	-	-	-	-	**288**
BHOC Upgrade - Above & Beyond	F Jones		138	-	138						**138**
NICU	I Barrington		1,000	-	1,000	-	-	-	-	-	**1,000**
BHOC Upgrade - Above & Beyond	D Lee		-	-	-	-	2,000	-	-	-	**2,000**
BHOC Upgrade - Friends of BHOC	D Lee		-	-	-	-	-	2,000			**2,000**
BHOC Upgrade - Teenage Cancer Trust	D Lee		-	-	-	-	2,500				**2,500**
BRI Redevelopment - Above & Beyond	D Lee		-	-	-	-		1,500	500	-	**2,000**
BRI Redevelopment - TBC	D Lee								1,000		**1,000**
CSP - Grand Appeal	D Lee		-	-	-		1,838	4,000	-		**5,838**
Sub-Total		-	1,426	-	1,426	-	6,338	7,500	1,500	-	**16,764**
E. Disposals											
Sale of BGH	B Pepper	-	-	308	308	5,845	-	-	-	-	**6,153**
Sale of BRI Old Building	B Pepper	-	-	-	-	-	-	-	-	5,000	**5,000**
Sale of Brentry site	B Pepper	-	-		-	-	1,600	-	-	-	**1,600**
Sale of Residences	B Pepper	-	-	1,500	1,500	-	-	-	-	-	**1,500**
Sub-Total		-	-	1,808	1,808	5,845	1,600	-	-	5,000	**14,253**
F. Capital Grant											
South Bristol Community Hospital Dental Grant	J Rimmer	-	-	600	600	-	-	-	-	-	**600**
Sub-Total		-	-	600	600	-	-	-	-	-	**600**
G. Cash Balances											
Cash Balances b/fwd	P Tanner	15,817	16,303	15,264	31,567	(11,285)	14,359	5,702	(239)	(12,078)	**43,843**
Sub-Total		15,817	16,303	15,264	31,567	(11,285)	14,359	5,702	(239)	(12,078)	**43,843**
TOTAL - SOURCES OF FUNDS		**15,817**	**17,729**	**34,505**	**52,234**	**62,707**	**60,687**	**33,126**	**23,434**	**15,885**	**263,890**
APPLICATION OF FUNDS											
Committed Schemes											
A. Major Strategic Schemes											
BRI Redevelopment (Phase 3&4, HV and Air Amb)	A Headdon	7,269	4,589	7,193	11,782	28,958	24,548	10,937	2,853	-	**86,347**
Centralisation of Specialist Paediatrics	A Headdon	2,051	597	8,426	9,023	9,838	11,608	4,414	-	-	**36,934**
Other Strategic Schemes											-
BHOC Strategy inc Adult BMT	A Headdon		-	633	633	6,109	6,258	-	500	-	**13,500**
Linear Accelerator	A Headdon		-	-	-	-	-	2,000	-	-	**2,000**
St Michaels CSP transfer scheme	A Headdon			166	166	-	-	-	-	-	**166**
BHOC Residual scheme	B Pepper	2,153	11	-	11	-	-	-	-	-	**2,164**
BRI Phase 1 - BRI Redevelopment	B Pepper	3,854	642	-	642	-	-	-	-	-	**4,496**
BGH Re-provision / decommissioning	B Pepper	224	458	800	1,258	267	-	-	-	-	**1,749**
Bristol Heart Institute	A Headdon	-	30	-	30	-	-	-	-	-	**30**
Old Building re-routing of services	N Phillips	-	-	-	-	-	-	-	1,200	-	**1,200**
South Bristol Community Hospital	J Rimmer	266	110	2,769	2,879	-	-	-	-	-	**3,145**
South Bristol Community Hospital - Dental	J Rimmer	-	-	1,155	1,155	-	-	-	-	-	**1,155**
Sub-Total - Major Strategic Schemes		15,817	6,437	21,142	27,579	45,172	42,414	17,351	4,553	-	**152,886**
B. Medical Equipment											
Emergency medical equipment	CPSG	-	582	300	882	300	300	300	300	300	**2,382**
Major Medical Programme	DMs	-	610	3,237	3,847	3,067	4,800	2,124	4,800	2,220	**20,858**
Major Medical Programme - Linear Accelerators	K Love			1,458	1,458	1,733				2,500	**5,691**
Sub-Total		-	1,192	4,995	6,187	5,100	5,100	2,424	5,100	5,020	**28,931**
C. Information Technology											
Electronic Discharge System	Whittaker	-	24	-	24	-	-	-	-	-	**24**
HP Swift	A Hooper	-	42	-	42	-	-	-	-	-	**42**
IM&T - General & Data warehouse	A Hooper	-	40	500	540	500	500	600	600	600	**3,340**
IM&T - CSIP	A Hooper	-	942	2,809	3,751	2,112	1,395	600	250	-	**8,108**
Oncology System	D Watteau	-	60	-	60	-	-	-	-	-	**60**
Diagnostics	D Watteau	-	68	-	68	-	-	1,000	-	-	**1,068**
PC Replacement	C Cookson	-	-	600	600	600	600	650	650	650	**3,750**
Blood Tracking	L Galvani	-	275	-	275	-	-	-	-	-	**275**
SEMS System	P Smithson	-	24	-	24	-	-	-	-	-	**24**
VPLS Replacement server	A Hooper	-	118	-	118	-	-	-	-	-	**118**
Sub-Total		-	1,593	3,909	5,502	3,212	2,495	2,850	1,500	1,250	**16,809**

University Hospitals Bristol NHS Foundation Trust

Medium Term Capital Programme 2011/12 to 2016/17

Appendix 1

	Budget Manager	Prior years	2011/12 Plan			Forward Plan					Grand Totals
			2010-11 slippage	2011-12	Total	2012-13	2013-14	2014- 15	2015 - 16	2016 - 17	
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	**£'000**
D. Roll Over Schemes											
Compliance with Lease Obligations	B Pepper	-	5	100	105	100	100	100	100	100	**605**
Feasibility Fees	B Pepper	-	42	100	142	100	100	100	100	100	**642**
Fire Precautions compliance	B Pepper	-	(110)	150	40	150	150	150	150	150	**790**
Health & Safety	M Fewkes	-	8	50	58	50	50	50	50	50	**308**
Vehicle Replacement	D Ponsford	-	-	75	75	75	75	75	75	75	**450**
Works Replacement	N Phillips	-	180	1,700	1,880	1,700	1,900	2,200	2,200	2,300	**12,180**
Works Replacement - BGH	B Pepper	-	97	-	97	-	-	-	-	-	**97**
Sub-Total		-	222	2,175	2,397	2,175	2,375	2,675	2,675	2,775	**15,072**
E. Refurbishments											
BDH Waiting room	B Pepper	-	105	-	105	-	-	-	-	-	**105**
Bed Store KE building	N Phillips	-	131	-	131	-	-	-	-	-	**131**
CHC - Digitisation Project	L Galvani	-	161	-	161	-	-	-	-	-	**161**
Dental Lifts	B Pepper	-	82	-	82	-	-	-	-	-	**82**
Fire improvement	B Pepper	-	280	-	280	-	-	-	-	-	**280**
ITU	B Pepper	-	1,003	-	1,003	-	-	-	-	-	**1,003**
Level 6 decant KEB	B Pepper	-	23	-	23	-	-	-	-	-	**23**
Other	B Pepper	-	134	-	134	-	-	-	-	-	**134**
NICU 4 bed expansion and Parent Accommodation	B Pepper	-	1,227	-	1,227	-	-	-	-	-	**1,227**
Strategic Refurbishment	D Lee			-	-	1,500	1,500	1,500	1,500	1,500	**7,500**
Surgical Reconfiguration	S Nadin	-	-	500	500	-	-	-	-	-	**500**
Other	C Thompson	-	-	150	150	-	-	-	-	-	**150**
Sub-Total		-	3,146	650	3,796	1,500	1,500	1,500	1,500	1,500	**11,296**
F. Miscellaneous											
Dental Capital Programme	M Wheeler	-	-	400	400	200	200	450	450	450	**2,150**
Divisional Capital	DMs	-	650	1,000	1,650	1,000	1,000	1,000	1,000	1,000	**6,650**
Sub-Total		-	650	1,400	2,050	1,200	1,200	1,450	1,450	1,450	**8,800**
G. Operational Capital											
2009/10 Operational Capital											
Enabling Core Lab L8 Queens	B Pepper	-	5	-	5	-	-	-	-	-	**5**
Bristol Eye Hospital Development	B Pepper	-	754	-	754	-	-	-	-	-	**754**
Other 2009/10 Operational Capital	B Pepper	-	99	-	99	-	-	-	-	-	**99**
2010/11 Operational Capital											
Spend to save	DMs	-	1,231	-	1,231	-	-	-	-	-	**1,231**
Schemes <£300k - 2010/11	DMs	-	490	-	490	-	-	-	-	-	**490**
Decontamination Compliance	S Nadin	-	738	-	738	-	-	-	3,000	-	**3,738**
Respiratory Minimum Standards	B Pepper	-	553	-	553	-	-	-	-	-	**553**
Additional Allocation 2010/11	DMs	-	446	-	446	-	-	-	-	-	**446**
Contingency funds	CPSG	-	173	-	173	-	-	-	-	-	**173**
NICU Expansion per guidelines	B Pepper	-	-	850	850	850					**1,700**
Strategic & General Operational Capital	DMs	-	-	2,605	2,605	2,850	3,800	3,000	3,000	3,000	**18,255**
Rheumatology	CPSG	-	-	-	-	-	-	1,400	1,500	-	**2,900**
Radiopharmacy	L Galvani	-	-	-	-	-	2,000	-	-	-	**2,000**
Sub Total		-	4,489	3,455	7,944	3,700	5,800	4,400	7,500	3,000	**32,344**
Total Committed Schemes		**15,817**	**17,729**	**37,726**	**55,455**	**62,059**	**60,884**	**32,650**	**24,278**	**14,995**	266,138
H. Scheme Slippage @15%											
In year slippage		-	-	(3,221)	(3,221)	(2,573)	(2,771)	(2,295)	(3,139)	(2,249)	**(16,248)**
Slippage from prior year		-	-	-	-	3,221	2,573	2,771	2,295	3,139	**13,998**
Sub Total		-	-	(3,221)	(3,221)	648	(197)	476	(844)	890	**(2,249)**
TOTAL - APPLICATION OF FUNDS		**15,817**	**17,729**	**34,505**	**52,234**	**62,707**	**60,687**	**33,126**	**23,434**	**15,885**	**263,890**

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 17 – Quarter 2 Compliance Framework Monitoring and Declaration Report

Purpose

To consider the quarterly governance, quality, and finance self-certification to Monitor for Quarter 2 of 2011-2012.

Abstract

Background

The Trust is required to make its Quarter 2 declaration of compliance with the 2011-2012 Monitor Compliance Framework by 31 October 2011. Since the Trust's Quarter 1 declaration, Monitor has made the following changes to the Compliance Framework:

- Accident and Emergency Total visit time 4 hours – weighting of 1.0 from Q2 onwards
- Accident and Emergency Clinical Quality Indicators (removed from the framework)

The scoring remains the same:

Score less than 1 = GREEN

Score 1 or 1.5 = AMBER-GREEN

Score 2 to 3.5 = AMBER-RED

Score 4 or more = RED

Governance risk rating declaration

In Quarter 1 Monitor advised the Trust that it would be making an amendment to the Trust's score against the Compliance Framework following the publication of the Care Quality Commission's report on the Nutrition Standard (Outcome 5). The Care Quality Commission report noted 'Moderate Concerns' and recorded the requirement for Compliance Actions to be taken to ensure prompt achievement of the Nutrition standard. Monitor applies a score of 2.0 for any Compliance Action outstanding during the period of declaration.

As planned the Trust implemented in full the actions arising from the Care Quality Commission Nutrition report. Based upon the Trust's declaration of compliance and the evidence submitted to the Care Quality Commission at the beginning of October, Monitor has confirmed that the Compliance Actions and 'Moderate Concerns' are no longer considered to be in effect for the Quarter 2 declaration.

The Trust Management Executive Group has reviewed performance in Quarter 2 against the remaining standards in Monitor's Compliance Framework (see Appendix A). One standard was not met for the quarter, which was the 62-day cancer standard for Screening referred patients. This standard was last failed in Quarter 4 2010-2011. The combined 62-day GP/Screening referred cancer standard has a weighting of 1.0 in Monitor's Compliance Framework.

This gives the Trust a draft declaration of AMBER-GREEN for Quarter 2 of 2011-2012.

In making the quarterly Governance Risk Rating declaration the Trust has to also take account of

prospective performance risks. Any such risks, if additional to performance issues already declared in the quarter being reported on, should be declared as an 'over-ride' to the Governance Risk Rating.

As part of the review of performance, the Trust Management Executive also considered the risks to achievement of the performance standards in Quarter 3. The risk assessment for Quarter 3, as detailed in Appendix A, describes the 62-day Cancer Standard as having a 'High' residual risk.

This reflects the lack of consistency in achieving this standard every quarter and the fact that the 62-day cancer action plan is not due for implementation in full until the end of Quarter 3. In the Annual Plan, Governance Declaration risks were recorded in the areas of Clostridium Difficile reduction, reflecting the significant year on year reduction required (32%) and Accident and Emergency, reflecting risks to achieving the 4-hour standard during the winter.

In both cases the required standards were met in Quarter 2 but remain at risk going in to the Quarter 3, due to the seasonal pressures, and are therefore shown as having medium residual risk.

Finance risk rating declaration – forthcoming twelve months

The Director of Finance will provide assurances to the Trust Board of Directors that the Trust expects to maintain a financial risk rating of at least 3 over the next 12 months. This position is supported by the provision of a written report to the Finance Committee on 21 October 2011, attached at Appendix B "Quarter 2 Financial Performance Commentary for Monitor Return".

Quality declaration

Monitor's Compliance Framework for 2011-2012 includes a requirement for declaration regarding the governance of quality as follows:

"The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS Foundation Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients."

The Board established two new functions at the beginning of the 2011-2012 reporting (financial) year for ensuring the quality of services provided to patients and other stakeholders; both the non-executive Quality and Outcomes Committee, and the executive Clinical Quality Group were set up for the purpose of meeting the Board's expectations in this regard.

The Clinical Quality Group continues to maintain a set of sub-groups that report to it on specialised functions for managing quality and outcomes.

The Quality and Outcomes Committee extends the Board's monitoring and scrutiny function, and has a standing remit to assess 'quality governance' on the Board's behalf. The Committee will provide the Board with a formal assessment of the Trust's quality governance provisions after its November 2011 meeting. This review is not expected to identify any significant gaps in relation to the governance of quality. However, actions will be taken to address any concerns identified by the Committee expediently.

Recommendations

The Board is recommended by the Trust Management Executive to:

Approve the declaration of an AMBER-GREEN ***governance risk rating*** for Quarter 2, 2011-12

(declaration 1).

Approve the declaration that the Board anticipates that the Trust will continue to maintain a ***financial risk rating*** of at least 3 over the next 12 months (declaration 1).

Approve the declaration for ***Quality*** that the Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS Foundation Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

Report Sponsor

- Chief Executive, Robert Woolley

Other Authors

- Deborah Lee, Director of Strategic Development
- Xanthe Whittaker, Head of Performance Assurance & Business Intelligence and Deputy Director of Strategic Development
- Paul Tanner, Head of Finance
- Charlie Helps, Trust Secretary

Appendices

The following appendices are included in this report:

- Appendix A – Risk assessment against targets and indicators in the 2011-2012 Compliance Framework
- Appendix B – Targets and Indicators Q2
- Appendix C – Quarter 2 Financial Performance Commentary

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	12/10/2011				

APPENDIX A - Risk assessment against targets and indicators in the 2011/12 Compliance Framework

Measure	Threshold	Performance in Q2	Risks	Risk	Mitigation of risks	Residual risk
Clostridium difficile	64 cases per annum 19 cases for Q1 17 cases for Q2 13 cases for Q3	16 cases against a target of 17. This represents a 31% reduction on Q2 2010/11	32% reduction on 2010/11 out-turn required	High	Improvement plan developed and implemented; target could in part be achieved by eliminating repeat / inappropriate testing alone. However, robust systems are already in place, and the remaining margin for improvement may be relatively small. A prolonged outbreak of norovirus, with more testing, may be sufficient for us to breach our annual target. So mitigation also includes action to limit the likelihood and extent of a norovirus outbreak. Testing regimen to be changed to a 2-stage, which will reduce false positives.	Medium
MRSA [1]	6 cases per annum Q1 – 1 case Q2 – 2 cases Q3 – 1 case	0 case in Q2 2011/12 2 case in Q2 2010/11	Although the required standard of performance has previously been achieved, the annual objective of six cases gives no margin for error.	Medium	Zero tolerance to MRSA bacteraemia cases adopted. Continued focus on good clinical practice.	Low
Cancer: 31-day wait for subsequent treatment	Surgery – 94% Drug therapy – 98% Radiotherapy – 94%	Achieved all standards in Q1 and Q2 2011/12. Achieved all standards in	Performance is not impacted by other providers and therefore should be able to be managed internally. The main cause of	Medium	Adult Intensive Therapy Unit (ITU) expansion. Prospective planning of	Low

[1] Monitor Compliance Framework states in schedule B – 'Where an NHS foundation trust has an annual MRSA objective of six cases or fewer (the *de minimis* limit) and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of Monitor's Compliance Framework. If an NHS foundation trusts with an annual objective of six cases or fewer declares a risk of exceeding the *de minimis* level *and* its annual objective in-year, but has not yet done so, it will be required to [provide, and then] report monthly against an MRSA action plan until the risk has been satisfactorily addressed.'

Measure	Threshold	Performance in Q2	Risks	Risk	Mitigation of risks	Residual risk
		all quarters of 2010/11.	breaches has been around a shortage of adult ITU beds which has been improved during 2011/12		subsequent treatments. Tight management of cancer pathways to continue.	
Cancer: 62-day wait for first treatment	GP referred – 85%	GP referred standard achieved in all quarters in 2010/11 and in Q1 & Q2 2011/12.	Significant proportion of breaches wholly attributable to late receipt from another provider; this risk is more difficult to mitigate. Internal risks are focussed predominantly in diagnostic and surgical elements of pathway. However, the standard was achieved throughout 2010/11.	High	Refreshed action plan focusing on eliminating avoidable delays in internal pathways, notably theatre capacity and delays between diagnostic tests and Multi Disciplinary Team meetings. Action plan tracked via Service Delivery Group (SDG) and due for completion by the end of quarter 3. Network-wide policy for re-allocation of breaches due to late referral by other providers has been developed and is currently under discussion within the network. The revised breast screening pathway has been reviewed and steps taken to ensure it can be completed within 62 days. Bowel screening pathway continues to be reviewed, and local changes adopted. Patient choice to delay diagnostics, staging and certain types of treatments remains an unmitigated risk, which is why	High
	Screening referred - 90%	Screening referred standard achieved in Q1 but not Q2 2011/12. Achieved in all quarters of 2010/11 except Q4.	The number of breast screening breaches increased significantly in Q2 due to changes to the clinical pathway and a shortfall of capacity. The screening standard would have been achieved without the increase in breast breaches. The nationally prescribed bowel screening pathway is difficult to complete within 62 days. Any delays can result in a breach and these delays can also be outside of the control of the Trust (e.g. patient choice; late tertiary			

Measure	Threshold	Performance in Q2	Risks	Risk	Mitigation of risks	Residual risk
			referrals)		the residual risk would be medium if all other risks had been fully mitigated via the current action plan.	
18-week Referral to Treatment Time (95th percentile) – admitted patients	23 weeks	Achieved in all months except April 10 and March 2011 (when previously cancelled patients were booked-in, in high volumes). Achieved in Q1 and Q2. But same specialties continue to under achieve (Cardiology, Paediatric ENT, Colorectal, Upper GI)	Backlog of over 23 week waiters remains high. Tight management of booking of breached patient remains critical. Clinical concerns remain about "managing" volumes of breached patients to achieve target.	Medium	Risk to non achievement can be managed by robust monitoring and escalation to optimise the number of long waiters booked each month, within the constraints of the contract. Cross Divisional approach to "breach quota" to support whole Trust achievement.	Low
18-week Referral to Treatment Time (95th percentile) – non-admitted patients	18.3 weeks	Achieved every month in 2009/10 and 2010/11. Achieved to date in 2011/12.	No significant risks to ongoing achievement	Low	Routine management of 18-week non-admitted pathways to continue.	Low
Cancer: 31-day wait for first treatment	96%	Achieved in all quarters	Lower risk than some of the other cancer standards as not impacted by tertiary referrals.	Low	Routine management of cancer pathways/performance to continue.	Low
Cancer: 2-week wait for urgent suspected and symptomatic breast referrals	93%	Urgent suspected – achieved in all quarters. Symptomatic breast – achieved Q2 to Q4 (100% in Q4). Achieved above 98% in Q1 and Q2 2011/12.	Short-term capacity problems for breast 2-week wait represent the greatest risk.	Low	Robust escalation process in place to ensure any capacity problems are addressed before they impact on performance.	Low

Measure	Threshold	Performance in Q2	Risks	Risk	Mitigation of risks	Residual risk
A&E Total visit time (95th percentile)[2]	4 hours	Achieved in excess of 98% in Q1 and just below 98% in Q2 2011/12.	Key risk remains unpredicted growth in emergency admissions or significant deterioration in level of patient discharges.	High	Patient Flow action plan, including work to reduce delayed discharges and long lengths of stay. Larger adult Medical Assessment Unit (MAU) from 1st August. However, the Trust has failed the 98% and 95% standards in at least one winter quarter each year since the standards came into effect. Growth in emergency demand is also outside of the Trust's control, and could impact upon target achievement, as could a prolonged outbreak of norovirus.	Medium
Stroke care	To be confirmed	To be confirmed	Depends upon which standards are selected.	To be confirmed	To be confirmed	To be confirmed once Monitor finalises the indicators
Access to healthcare for patients with a learning disability	Achievement of standards	Standards were met and continue to be met	None	Low	Monitoring of standards to continue.	Low

Appendix B – Targets and Indicators draft Q2 2011/12 submission to Monitor

Declaration of performance against healthcare targets and indicators for BRISTOL as at Q2 2011/12

These targets and indicators are set out in the 2011-12 Compliance Framewor

Definitions can be found in the "2011/12 Compliance Framework"

Key: must complete

may be asked to complete

YTD = Year to date

Target or Indicator (per 2011-12 Compliance Framework)	Threshold/ agreed target YTD	Weighting	Annual Plan At Risk or Not	Quarter 2 Achieved / Not Met	explanation	Actual
Clostridium Difficile -meeting the C.Diff objective	36	1.0	Yes	Achieved	Q2 target 17; total cases YTD 33	16
MRSA - meeting the MRSA objective	3	1.0	No	Achieved	Q2 target 2; total cases YTD 1	0
Cancer 31 day wait for second or subsequent treatment - surgery	>94%	1.0	No	Achieved	Figures subject to final confirmation	96.4%
Cancer 31 day wait for second or subsequent treatment - drug treatments	>98%	1.0	No	Achieved	Figures subject to final confirmation	100.0%
Cancer 31 day wait for second or subsequent treatment - radiotherapy	>94%	1.0	No	Achieved	Figures subject to final confirmation	99.4%
Cancer 62 Day Waits for first treatment (from urgent GP referral)	>85%	1.0	No	Achieved	Figures subject to final confirmation	85.5%
Cancer 62 Day Waits for first treatment (from Consultant led screening se	>90%	1.0	No	Failed to Meet	Figures subject to final confirmation	87.6%
Referral to treatment time, 95th percentile, admitted patients	<23Wks	1.0	No	Achieved	Standard met each month	21.7
Referral to treatment time, 95th percentile, non-admitted patients	<18.3Wks	1.0	No	Achieved	Standard met each month	15.0
Cancer 31 day wait from diagnosis to first treatment	>96%	0.5	No	Achieved	Figures subject to final confirmation	98.0%
Cancer 2 week (all cancers)	>93%	0.5	No	Achieved	Figures subject to final confirmation	94.9%
Cancer 2 week (breast symptoms)	>93%	0.5	No	Achieved	Figures subject to final confirmation	98.1%
A&E Clinical Quality- Total Time in A&E (was 95th percentile now 95%)	<4Hrs	0.5	Yes	Achieved		97.6%
A&E Clinical Quality- Time to Initial Assessment (95th percentile)	< 15 Mins	0.5	No	Not relevant		
A&E Clinical Quality- Time to Treatment Decision (median)	< 60 Mins	0.5	No	Not relevant		
A&E Clinical Quality- Unplanned Re-attendance Rate	<5%	0.5	No	Not relevant		
A&E Clinical Quality- Left Without Being Seen Rate	<5%	0.5	No	Not relevant		
Stroke Indicator (TBC)	TBC	0.5	No	Not relevant		
Stroke Indicator (TBC)	TBC	0.5	No	Not relevant		
Care Programme Approach (CPA) follow up within 7 days of discharge	>95%	1.0	No	Not relevant		
Care Programme Approach (CPA) formal review within 12 months	>95%	1.0	No	Not relevant		
Minimising delayed transfers of care	<=7.5%	1.0	No	Not relevant		
Admissions had access to crisis resolution home treatment teams	>90%	1.0	No	Not relevant		
Meeting commitment to serve new psychosis cases by early intervention	>95%	0.5	No	Not relevant		
Data completeness: identifiers	>99%	0.5	No	Not relevant		
Data completeness: outcomes	>50%	0.5	No	Not relevant		
Ambulance Category A 8 Minute Response Time	>75%	1.0	No	Not relevant		
Ambulance Category A 19 Minute Transportation Time	>95%	1.0	No	Not relevant		
Compliance with requirements regarding access to healthcare for people	N/A	0.5	No	Achieved		Standards met

Risk of, or actual, failure to deliver mandatory services	Yes/No	4.0	No	No	
CQC compliance action outstanding	Yes/No	2.0	No	No	
CQC enforcement notice currently in effect	Yes/No	4.0	No	No	
Moderate CQC concerns regarding the safety of healthcare provision	Yes/No	1.0	No	No	
Major CQC concerns regarding the safety of healthcare provision	Yes/No	2.0	No	No	
Unable to maintain, or certify, a minimum published CNST level of 1.0 or	Yes/No	2.0	No	No	
		Results left to complete	0	0	
		Total Score	1.5	1.0	
		Overide Rating			If overridden please comment here
		Indicative Governance risk rating	AMBER-GREEN	AMBER-GREEN	

University Hospitals Bristol NHS
NHS Foundation Trust

For consideration and approval by
Finance Committee — 21st October 2011 – Agenda Item 7

To be Received by
Trust Board — 26th October 2011 – Agenda Item 17
Membership Council — 2nd November 2011 – Agenda Item

QUARTER 2 PERFORMANCE COMMENTARY FOR MONITOR RETURN

Director of Finance
October 2011

1. EXECUTIVE SUMMARY

This commentary covers the results for the six months to 30th September 2011.

The Trust reports an EBITDA[1] surplus for the half year of £17.092m. This is £0.433m higher than the Annual Plan for the period of £16.659m. EBITDA is at 102.6% of Plan. The summary income and expenditure statement shows a surplus for the half year of £3.178m (EBITDA and financing costs). The financial risk rating is 4. This is better than shown in the Trust's Annual Plan as the Return on Capital Employed at 5.1% takes performance on that metric to a higher band (4).

	Weighting	30th September 2011	5	4	3	2	1
EBITDA							
Margin %	25	6.85%	11	9	**5**	1	<1
Achievement of Plan	10	102.6%	**100**	85	70	50	<50
Return on Capital Employed	20	5.1%	6	**5**	3	-2	<-2
I&E surplus margin	20	1.36%	3	2	**1**	-2	<-2
Liquid ratio (days)	25	36.8 days	60	**25**	15	10	<-10
Overall rating				**4 (actual weighted score = 3.65)**			

A summary of the Trust's performance against the Prudential Borrowing Limit is given in the table below.

Prudential Borrowing Limit Performance	**Monitor Ratio Tier 1**	**30th September 2011**
Minimum Dividend Cover	>1x	3.8x
Minimum Interest Cover	>3x	84x
Minimum Debt Service Cover	>2x	60x
Maximum Debt Service to Revenue	<2.5%	0.1%

[1] Earnings Before Interest Taxation Depreciation and Amortisation

2. CLINICAL INCOME

Clinical income is £0.478m higher than the Monitor Annual Plan, standing at £196.720m for the year to date. Clinical income includes income from NHS commissioners, territorial bodies, and non-NHS clinical income.

The variance for the first quarter is explained in table 1 below:

Table 1 – Clinical Income – Quarter 1 - Variance from Plan

	£m
Monitor Plan	196.242
Other Changes To The Plan	0.633
Current Plan	196.875
Under Performance (See Table 2 Below)	(0.155)
Quarter To Date Income	196.720

Activity and Income by Worktype

Performance against the current plan for the year is summarised below by worktype.

i. Elective Inpatients

Overall Elective Inpatients are £0.902m behind plan. The under-performance is across a number of specialties particularly Paediatric Cardiac Surgery, Paediatric Medical Oncology and Cardiac Surgery.

ii. Non-Elective / Emergency Inpatients

Non-Elective Inpatients are £1.660m ahead of plan for the year. The key areas of over-performance are Cardiac Surgery, Colorectal Surgery, Obstetrics and Geriatric. This position excludes the impact of contract penalties which are included in Other NHS activity below.

iii. Day Cases

Day Cases are £0.723m ahead of plan for the year. The key areas of over-performance are Clinical Oncology, Paediatric Surgery and Gastroenterology.

iv. Outpatients

Outpatient activity is under-performing by £0.894m; the key areas of over-performance are Medical Oncology, Ophthalmology and Paediatric Respiratory Medicine.

v. Accident and Emergency

A&E is over-performing by £0.295m.

vi. Other NHS

Other NHS activity includes Direct Access, Radiotherapy, Critical Care, PbR Excluded Drugs & Devices, Contract Penalties and specialised services such as Bone Marrow Transplants.

vii. Private Patient Revenue

Private Patient Revenue is under-performing by £0.027m.

viii. Other Clinical Revenue

Other Clinical Revenue is under-performing by 0.226m.

Table 2 – Clinical Income by Worktype

Worktype	Plan £m	Actual £m	Variance £m
Elective Inpatient	24.077	23.175	(0.902)
Non-Elective Inpatient	51.051	52.711	1.660
Day Case	16.903	17.626	0.723
Outpatient	34.341	33.447	(0.894)
Accident & Emergency	5.382	5.677	0.295
Other NHS	63.090	62.306	(0.784)
Private Patient Revenue	1.227	1.200	(0.027)
Other Clinical Revenue	0.804	0.578	(0.226)
Grand Total	196.875	196.720	(0.155)

Over Performance by Commissioner

During the Local Delivery Plan process the Trust agreed to reduce Service Level Agreement values for demand management schemes put forward by Primary Care Trusts that the Trust believed were over optimistic. Because the Trust did not expect these activity reductions to materialise the clinical income budgets were not reduced, and an income budget was created for a dummy commissioner -Variable Estimates. Table 3 below shows the cumulative income variances by commissioner and how the Variable Estimates income target then adjusts this for the overall position.

Table 3 Over Performance by Commissioner

Commissioner	Variance £'m	Variance %
NHS Bristol	1.909	2%
NHS North Somerset	1.368	6%
NHS South Gloucestershire	0.844	5%
NHS Wiltshire	0.202	6%
South West Specialised Commissioning	(1.130)	(3%)
NHS Somerset	0.033	0%
NHS Gloucestershire	0.788	18%
Prior Year Income	0.809	N/A
Variable Estimates	(4.777)	N/A
Other (including Exceptional Funding)	(0.201)	N/A
Total	(0.155)	0%

3. OTHER OPERATING INCOME

Overall other income is £3.142m higher than planned for the year to date. The main reasons are:

- Higher than planned levels of Education and Training income of £0.374m due to changes in the contracts for SIFT and MADEL.
- Higher than planned levels of Research and Development income due to changes in the CLRN contract £0.688m.
- Additional CRES schemes not in the original plan £0.781m.
- Lower than planned other income £0.534m.
- Lower than planned Patient Transport Services Income £0.238m
- Higher than planned Skills for Health income £2.070m.

4. EXPENDITURE

Overall operating costs of £232.259m for the year to date are £3.185m higher than plan. Trust pay costs are £2.752.m greater than plan and non pay costs are £0.433m higher than plan.

4.1 Pay Costs

Pay costs for the year to date were £2.752m, higher than plan. The main reasons for this are an underachievement against the planned CIP savings target, higher than planned spend within Skills for Health and redundancy costs not in the original plan offset by underspending on various staff groups including scientific and technical staff and other clinical staff.

4.2 Drugs

Drug costs for the quarter were £0.006m lower than plan.

4.3 Clinical supplies and services

Clinical supplies and services costs for the quarter were £1.856m lower than plan this includes lower than planned spend in Cardiac Services due to lower than planned activity levels. CRES achievement was higher than planned by £0.243m and spend on Blood and Blood products was £0.425m lower than planned.

4.4 Other Costs

Other costs for the quarter were £2.196m higher than plan. This is due mainly to lower than expected CRES delivery £0.731m and other smaller overspends including external staffing and consultancy costs £0.250m, CNST contributions £0.374m and training costs £0.194m.

4.5 Non Operating Expenses

The principal variances within this section are the higher than planned depreciation charges on purchased assets in quarter 1 (£153k). The updated medium term capital programme (subject to approval by the Trust Board) also provides for a higher level of capital expenditure than originally included in the Annual Plan with expenditure on strategic schemes being brought forward from 2012/13.

The September report provides for the net cost of asset impairments and the partial reversal of historical impairment losses (£202k).

5. CAPITAL

Actual expenditure for the 6 months to 30th September totals £15.2m. This represents expenditure at 84% when compared with the Annual Plan assumption of £18.034m for the half year.

There have been a number of approved changes to the Trust's Capital Programme since the submission of the Annual Plan in May. These are reflected in the summary table below. It can be seen that expenditure for the six month period is less than plan. For 2011/12 it is anticipated that slippage on capital schemes will be less than the £4.63m built into the current programme and that the resulting forecast outturn will now be £46.1m. This will continue to be closely monitored over the remainder of the financial year.

Plan for Year		6 months to 30th September 2011		
		Plan for Period	Actual for Period	Variance
£'000		£'000	£'000	£'000
	Sources of Funding			
1,299	Donations	-	-	-
16,833	Retained Depreciation	8,327	8,491	164
1,500	Asset Disposals	583	879	296
24,249	Cash balances	8,301	5,830	(2,471)
43,881	**Total Funding**	**17,211**	**15,200**	**(2,011)**
	Expenditure			
(21,224)	Strategic Schemes	(8,599)	(8,562)	37
(5,590)	Medical Equipment	(413)	(240)	173
(4,904)	Information Technology	(1,411)	(1,827)	(416)
(2,268)	Roll Over Schemes	(780)	(459)	321
(4,351)	Refurbishments	(2,294)	(1,348)	946
(10,174)	Operational / Other	(3,714)	(2,764)	950
4,630	Anticipated Slippage	-	-	-
(43,881)	**Total Expenditure**	**(17,211)**	**(15,200)**	**2,011**

6. STATEMENT OF FINANCIAL POSITION (Balance Sheet)

The significant balance movements and variances are explained below.

6.1 Non Current Assets

The balance of £298.210m at the end of September is £4.794m lower than the planned £303.004m. This mainly reflects the reclassification of the Bristol General Hospital site as a Non-current asset held for sale.

6.2 Inventories (formerly referred to as Stock)

At the end of September the value of inventories held totalled £7.466m. This is broadly in line with plan of £7.129m.

6.3 Trade and Other Receivables (Including Other Financial Assets)

The balance at the end of September is £23.388m, which is £5.557m above plan of £17.831m. This is mainly due to an increase in NHS Trade Receivables (£6.970m) offset by a decrease in Non-NHS Trade Receivables (£1.413m).

6.4 Prepayment

The prepayment balance at the end of September is £1.877m. This is mainly due to payments for maintenance contracts for servicing of equipment. This is broadly in line with the plan of £1.601m.

6.5 Non Current Assets held for Sale

This item relates to the expected sale proceeds relating to the disposal of the Bristol General Hospital site and residential houses and adjoining land in Horfield Road. The Trust plans to complete disposal of these assets within the next 12 months.

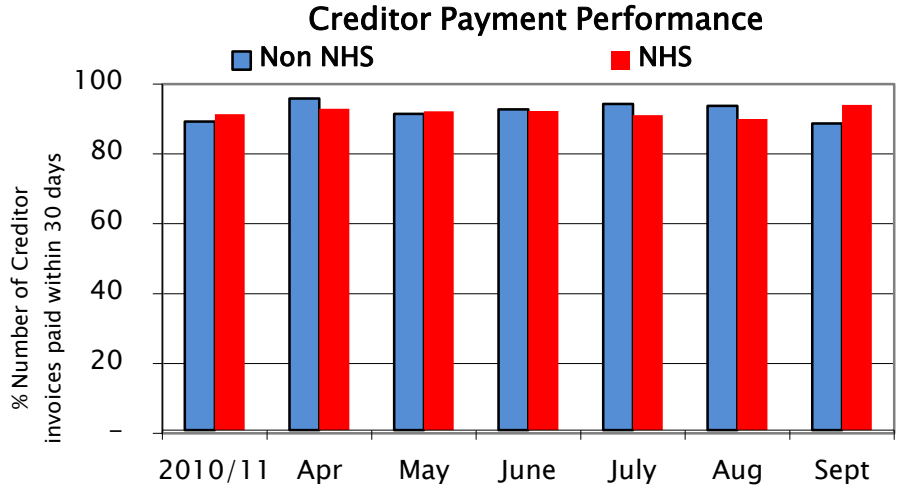
6.6 Deferred Income

Deferred income of £11.308m is £0.820m higher than the plan of £10.488m. The current figure includes balances relating to Skills for Health (£4.314m) and Research fund balances (£2.996m) and £0.308m in respect of Bristol General Hospital sale deposit monies received.

6.7 Trade Creditors / Other Creditors / Capital Creditors

Trade Creditors and Other Creditors which total £19.348m are £4.532m lower than the planned position of £23.699m. This is due to the Trust paying invoices promptly in accordance with its policy.

The Trust aims to pay at least 90% of undisputed invoices within 30 days. In the six months to September the Trust achieved 92% and 93% compliance against the Better Payment Practice Code for NHS and Non NHS creditors.



The improvement in payment performance in 2011/12 reflects the benefits of making better use of information and functionality offered by the accounts payable system introduced in 2010. This is now being supplemented by a systematic review of processes in order to provide a better service to clinicians and managers and provide scope to further improve payment performance.

6.8 Other Financial Liabilities

The balance of £18.079m is £7.646m higher than the planned value of £10.433m most of which relates to expenditure accruals. This is mainly due to increases for drug purchases (£1.565m), Skills for Health (£3.473m) and other supplies and services (£1.473m). It is difficult to plan for the dates that expenditure invoices are received from suppliers so these could be classified as either Trade creditors or Accruals depending on whether or not an invoice has been received by the month end date.

6. 9 Summary Statement of Financial Position

A summary statement is given below showing the balances as at 30th September together with comparative information taken from the Trust's Annual Plan.

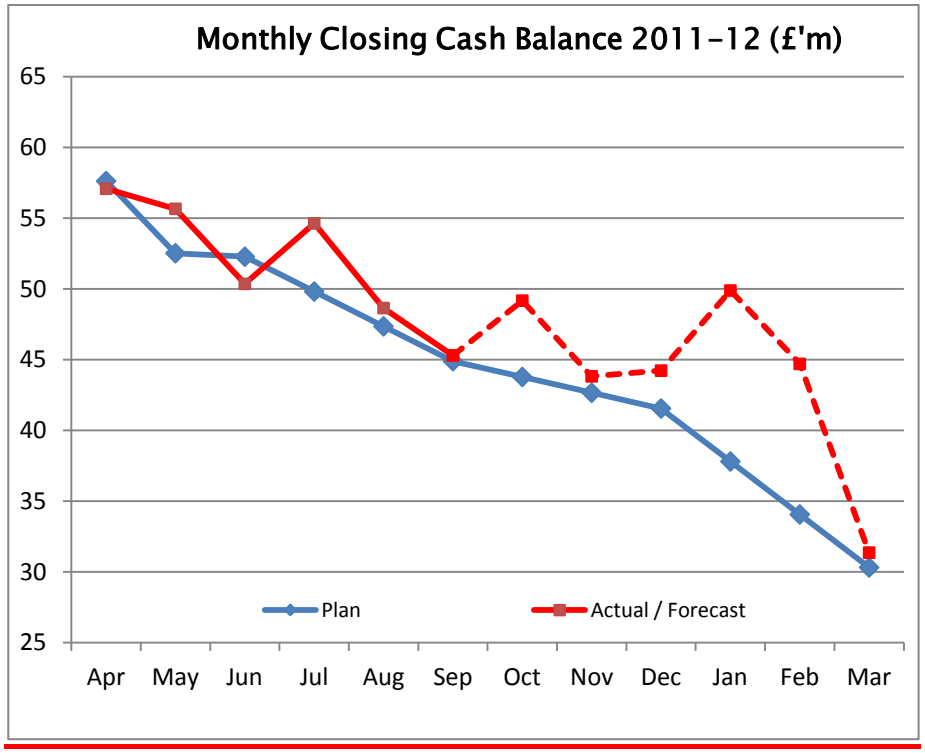
Summary Statement of Financial Position (Balance Sheet)

	Position as at 30th September 2011		
	Plan	Actual	Variance Fav/ (Adv)
	£'000	£'000	£'000
Non Current Assets			
Intangible	2,833	4,137	1,304
Property, Plant and Equipment	300,171	294,073	(6,098)
	303,004	**298,210**	**(4,794)**
Current Assets			
Inventories	7,129	7,466	337
Current Tax Receivables	549	218	(331)
Trade and Other Receivables	17,831	23,388	5,557
Other Financial Assets	516	642	(126)
Prepayments	1,601	1,877	276
Cash & Cash Equivalents	44,894	45,302	408
Non Current Assets held for sale	889	6,442	5,553
Assets Current Totals	**73,409**	**85,335**	**11,927**
ASSETS TOTALS	**376,413**	**383,545**	**7,132**
Current Liabilities			
Deferred Income	(10,488)	(11,308)	(820)
Provisions	(780)	(382)	398
Current Tax Payables	(6,918)	(6,602)	316
Trade and Other Payables	(23,699)	(19,348)	4,352
Other Financial Liabilities	(10,433)	(18,079)	(7,646)
Other Liabilities	(5,401)	(5,423)	(22)
Liabilities Current Totals	**(57,719)**	**(61,141)**	**(3,423)**
NET CURRENT ASSETS/(LIABILITIES)	**15,690**	**24,194**	**8,504**

	Position as at 30th September 2011		
	Plan	Actual	Variance Fav/ (Adv)
	£'000	£'000	£'000
Liabilities Non Current			
Provisions	(258)	(257)	1
Finance Leases	(6,061)	(6,060)	1
Liabilities Non Current Totals	**(6,319)**	**(6,317)**	**2**
TOTAL ASSETS EMPLOYED	**312,375**	**316,087**	**3,712**
Taxpayers' and Others' Equity			
Public Dividend Capital	191,011	191,011	-
Retained Earnings	38,414	39,883	1,469
Donated Asset Reserve	12,782	12,335	(447)
Revaluation Reserve	70,083	72,773	2,690
Other Reserves	85	85	-
TAXPAYERS' EQUITY TOTALS	**312,375**	**316,087**	**3,712**

7. Cash and Cash Flow

The Trust held cash balances at the end of September of £45.302m. This is £0.408m more than the plan to date of £44.894m. The graph shown below provides a comparison of actual compared with planned month-end cash balances for 2011/12.



The Trust has a working capital facility of £37.5m. This has been agreed with Barclays Bank for an initial period of 2 years from 1st September 2010.

8. Potential Financial Risk Indicators

Monitor has identified 10 potential financial risk indicators. The Trust's position against each of these is summarised below.

8.1 Unplanned decrease in quarterly EBITDA margin in two consecutive quarters.

The EBITDA achieved for the six months to 30th September at £17.092m is 2.6% better than Plan. The EBITDA margin of 6.85% compares favourably with the Plan for the period of 6.78%.

8.2 Quarterly self-certification by the Trust that the Financial Risk Rating may be less than 3 in the next 12 months.

UH Bristol = The Board anticipates that the Trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.

8.3 Financial Risk Rating 2 (or less) for any one quarter.

UH Bristol = Not applicable.

8.4 Working capital facility agreement includes default clause.

UH Bristol = The following default events are specified: failure to pay on the due date any amount payable pursuant to the facility; any representation made that proves to be misleading in any material respect; the borrower is unable to pay its debts; value of assets is less than its liabilities; the borrower ceases or threatens to cease operations or its operations become

unlawful; any legislation or regulation or official directive that materially affect the Bank's ability to recover the Loan.

8.5 Debtors over 90 days past due account for more than 5% of total debtor balances.

UH Bristol = 22% of the Trust's total debtor balances exceed 90 days, of which 8% relates to the NHS Injury Recovery Unit. A provision has been made for all potential bad or doubtful debts as at 30th September. The Trust has made good progress in resolving a number of long standing debtors. Further progress is anticipated in the coming months to minimise debtor balances over 90 days.

The Trust is aware that this metric has been triggered for the sixth consecutive quarter (it is understood that around 50% of all NHS Foundation Trusts are in a similar position). Whilst every effort is being made to reduce debtor balances it is unlikely that debtors over 90 days will be less than 5% of total debtors at any time over the remainder of this financial year.

8.6 Creditors greater than 90 days past due account for more than 5% of total creditor balances.

UH Bristol =Not applicable.

8.7 Two or more changes in Finance Director in a twelve month period.

UH Bristol = Not applicable.

8.8 Interim Finance Director in place over more than one quarter end.

UH Bristol = Not applicable.

8.9 Quarter end cash balance less than 10 days of annualised operating expenses.

UH Bristol = Not applicable.

8.10 Capital expenditure outside the range 75 – 125% of Plan for the year to date.

UH Bristol = The Trust's capital expenditure for the first two quarters of £15.200m is equivalent to 84% of the Annual Plan forecast for the period. The Trust's current plans indicate that expenditure will be greater than that projected in the Annual Plan but will remain within the range 75 – 125% tolerance for this risk indicator.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 October 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 18 – Board Assurance Framework Report (including Strategic, Corporate and Compliance Objectives Status Report)

Purpose

To provide the Board with the quarterly update on progress against the Trusts objectives at the end of Quarter 2 and to provide associated assurance of the control of any associated risks to delivery.

Abstract

Context

This reporting format brings together the former Board Assurance Framework and the report on Corporate Objectives into a single monitoring and assurance framework.

The purpose of the Framework is to track progress against the Trust's stated medium term objectives and specifically tracks progress against the 2011/12 milestones which were derived as part of the 2011/12 Annual Planning programme. The framework also describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks to ensure delivery is not compromised.

Any inherent risk rating that is high or extreme (RED rated) is also captured within the Trust's Corporate Risk Register to ensure appropriate executive oversight through the Risk Management Group.

Quarter 2 Position

There are 5 objectives where the risk to delivery is considered High (RED), four of these are de-escalated to AMBER or GREEN through the application of effective controls but one risk (recruitment to NIHR trials) remains RED rated even after actions to mitigate and it is unlikely that this objective will be achieved for 2011/12. Improvement of performance in this area has recently been reviewed at Trust Management Executive and the Research Committee is very actively managing actions to minimise the level of non-delivery.

Recommendations

The Board is asked to **Note** the report.

Executive Report Sponsor or Other Author

- Executive Sponsor – Chief Executive, Robert Woolley
- Authors – Director of Strategic Development, Deborah Lee.

Appendices

- Appendix A – Board Assurance Framework

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
20 October 2011					

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2011-2012	Progress Towards Achievement %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk Rating	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
1	T&L	1.1	We will develop and implement a teaching and learning Strategy that is fully integrated with all other strategies in order to support the Trust's mission.	Improved Teaching and Learning provision within the Trust. Improved recognition externally of UH Bristol as a Teaching Hospital	Strategy developed and signed off	75% to 100%	Strategy signed off at Board	Nil / strategy completed	Amber	Strategy completed	n/a	Green		Dir W&OD	Teaching and Learning Group
					New Teaching and Learning Structure identified and delivered	75% to 100%	Head of Teaching and Learning appointed (starts 31 Oct). Consultation on structure change commences 7 November.	Consultation identifies new issues.		Full consultation plan in place	Teaching and Learning Group	Green			
					Teaching and Learning systems in place to enable delivery of volume e-learning and Continuing Professional Development	50% to 75%	Systems in place - technical issues identified and solutions under testing Systems issues not resolved and require significant capital spend			Systems specification being confirmed for future PCs. Performance issues being investigated.		Amber			Teaching and Learning Group; IM&T Committee
1	R&I	1.2	We will focus on and foster our priority areas of high quality translational and applied health services research and innovation where we are, or have the potential to be world leading		Goals, priorities and investment agreed for each identified priority group Developmental groups identified	50% to 75%	Research Priorities agreed and illustrated in the BRIG-H diagram of research strengths. Strategies in place for each area. Investments yet to be agreed. Developmental groups of Nutrition and Obesity identified	Nil	Green	Nil	n/a	Green		Dir Med	Research Group
1	R&I	1.3	We will develop a culture in which research and innovation are embedded in routine clinical services leading to improvements in clinical care		Transparency within Divisions of research funding achieved; Divisional governance structures for research in place. Agreed goals and research plan for each division in place	50% to 75%	Transparency exists with regard to Delivery funding in the Divisions. Divisional governance structures in place for Divisions. All Divisions have targets for recruitment and income.	Nil	Green	Nil	n/a	Green		Dir Med	Research Group
1	R&I	1.4	We will demonstrate our undertaking to improve patient health through our excellence in world-class translational and applied health services research and our culture of innovation by increasing participation in NIHR trials		Increase in the number of patients entering NIHR trials by 15% over previous year.	0% to 25%	We are off target for increasing the number of patients recruited. There is a detailed action plan in place to address the known barriers to recruitment. We Have now appointed to key research support positions. Discussions with WCLRN have been positive with regard to the actions taken.	we have an unbalanced portfolio of research, concentrating on complex, low participant number projects led by our clinical academics. There is a lack of engagement of 'non research' clinicians with research.	Red	Progress against recruitment action plan monitored weekly and reported to TME monthly		Red		Dir Med	Research Group
1	CSS	1.5	We will consolidate and expand our specialist services portfolio through designation of target services and repatriation of work from outside the South West	An increase in income from specialised services and a greater proportion of Trust income coming from the specialist portfolio.	Achieve designation for cardiac paediatric surgery and Teenage and Young Adults Scope the opportunity, by speciality, work type and finance for work that could be repatriated Agree priorities for repatriation activities and develop plans to effect the change.	50% to 75%	UH Bristol designated for TYA. Consultation for Paediatric Cardiac Safe & Sustainable concluded with UH Bristol in all 4 options under consideration. Scoping of opportunities and priorities for repatriation of specialist work completed in Adult BMT with commissioner support. Launch meeting for SW Repatriation Project planned for October 2011.	Risk of change to national designation process or recommended options for paediatric cardiac surgery. Repatriation of specialist activity contingent in large part to success of Specialised Commissioning Group Repatriation Project.	Amber	Engagement with emerging and confirmed processes for designation and other commissioner processes. Risks are monitored and actions developed at Division and Trust-level groups.	Clinical Strategy Group; Commissioning & Planning Group	Amber		Dir SD	Clinical Strategy Group
1	CSS	1.6	We will work with our partners to ensure the optimal configuration for acute services across the City	Single strategy for acute services developed and agreed between NBT and UHB and endorsed by commissioners. Reduction in the number of specialities duplicated across the City, fewer opportunities for competition between acute Trusts.	Develop and agree, with NBT and commissioners, a plan for acute services configuration Agree priorities for service change, if requirement identified as part of Acute Services Configuration work. Achieve Monitor Review and Board sign off for CSP and BRI Full Business Cases . Conclude Pathology Services Review and agree configuration of pathology services for BNSSG	25% to 50%	Monitor Review and Board sign-off now gained for CSP and BRI Full Business Cases. Collaborative work in train with NBT, under auspice of Partnership Programme, to develop scenarios for further service change in support of the optimal City wide configuration of acute services. UH Bristol has declared "support in principle" for the development of NBT as the Lead Provider for Bristol, North Somerset and South Gloucestershire Pathology services.	These are complex and sensitive projects with multiple stakeholders - often outside of this organisation - with attendant risks to project delivery and agreement of solutions. Potential financial impact of scenarios on Long Term Financial Model for this Trust.	Green	Participation of senior Trust representatives in Bristol health community programmes such as Healthy Futures, to influence work plans, objectives and outcomes in our favour.	Clinical Strategy Group; Commissioning & Planning Group	Green		Dir SD	Clinical Strategy Group
1	CSS	1.7	We will undertake a feasibility study of the opportunities and models for increasing Private Patient Services and Income	Options for private patient services scoped and model for UH Bristol agreed and progressed	Undertake market analysis of business opportunity Undertake option appraisal (if market opportunity is confirmed) for expanding private patient provision.	0% to 25%	Brief for Private Patient Market Opportunity Assessment developed in draft with view to identifying a partner to take work forward in Q3.	Management capacity to progress scoping work	Green	Risks will be monitored and actions developed Trust Executive Management Group and Clinical Strategy Group.	Trust Management Executive Group; Clinical Strategy Group	Green		Dir SD	Clinical Strategy Group
1	CSS	1.8	Grow the non-clinical income base through exploiting greater commercial opportunities for income generation	Increase in the number of third party providers to whom UH Bristol provides its services. Increase in non-clinical income	Undertake a feasibility study for expanding the footprint of the BRI Redevelopment to incorporate a greater level of income generating patient and staff facilities Identify further opportunities for commercial developments / partnerships	50% to 75%	Market test has confirmed potential for Retail Based Welcome Centre. Comprehensive Business Case in development for presentation to November Board appraising both third party developer and Trust led scheme.	Unable to financially stack up retail centre in terms of acceptable Return on Investment against capital required.	Green	Robust market test of opportunity. Maximising retail space to promote strong ROI. Exploring Trust led scheme which can support lower ROI.	BRI Redevelopment Board; Trust Management Executive Group	Green		Dir SD	BRI Redevelopment Board

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2011-2012	Progress Towards Achievement %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk Rating	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
1	CES	1.9	Fully embed the Trust's values in everything we do and say and establish them as the behaviours that drive the way we do things around here.	Improvements in staff survey questions which pertain to morale and positive work place. Reduction in number of staff experiencing bullying and harassment. Achieve place in top 20% of Trusts for UH Bristol being a "good place to work". Reduction in staff sickness and turnover	Every member of staff has a values based objective set in their appraisal and cascaded down through divisions/teams. Loud & Clear research provides base line data to inform Communications strategy for 2011-14. Key Performance Indicators monitored by TEG and board. Staff, inpatient and outpatient surveys triangulated to provide cross reference information relating to behaviours.	50% to 75%	Strategy approved by TME and Board in June 2011. Living the Values programme launched October 2011.	Staff resistance to adopting values. Leadership focus inadequate.	Green	Executive Leadership. Trust-wide programme of staff engagement.	Reports to Transformation Programme Board/TME oversight.	Green	n/a	CE	Trust Management Executive
2	CSS	2.1	We will further refine our strategic intentions and operational role in community service provision	Clear position statement on the provision of community services by UH Bristol. Direction of travel agreed for community services currently provided by UH Bristol.	Conclude strategic analysis and option appraisal in relation to any future vertical integration and community provision. Agree target areas for community service expansion or retrenchment.	25% to 50%	Board strategy seminar convened for September 2011 to establish Board position on vertical integration.	Unforeseen developments may test or go against previously stated intentions regarding community services provision. Economic case for future developments unclear.	Green	Active identification of opportunities, responses and governance of decision-making for community services developments. Dialogue with Bristol Community Health commenced to explore merits of a more formal partnership agreement.	Clinical Strategy Group	Green		Dir SD	Clinical Strategy Group
2	CSS	2.2	We will confirm our intentions with regard to major strategic opportunities that are likely to arise in the medium term including our role on the provision of services to the Weston community, our role in the running of SBCH and the organisational model through which we will work with North Bristol Trust.	Decision and if applicable timeline for merger with NBT agreed. UH Bristol position in relation to SBCH and Weston formulated and agreed by Board.	Develop Strategic Outline Case for Change for models of working with NBT and agree preferred way forward. Clarify opportunities regarding Weston and undertake strategic analysis and option appraisal in relation to any future role for UH Bristol Clarify opportunities regarding SBCH and undertake strategic analysis and option appraisal in relation to future role for UH Bristol	50% to 75%	Partnerships Programme over seeing on-going work in relation to UHB / NBT service configurations. Successful strategy seminar undertaken in September with clear strategic position on DGH / community integration established.. Due diligence work on an extended role for UHB at SBCH in train to concluded and presented to PCT - decision expected October 2011	Potential for options to face clinical, public or business case challenges.	Green	Engagement with NBT, commissioners and stakeholders - e.g. NBT and UH Bristol Partnership Board and NHS Bristol Healthy Futures Programme Board. Internally, through Trust groups and Board discussions.	Clinical Strategy Group	Green		Dir SD	Clinical Strategy Group
2	T&L	2.3	Partnership Working - We will further develop our academic partnerships and relationships with the wider health community both locally and nationally to broaden our teaching hospital reputation beyond the south west region	UH Bristol will be recognised as a top Teaching Trust and will be a provider of choice for the wider health community	Relationships fully scoped and stakeholder maps / development plans created Business plan developed and approved for the provision of services	0% to 25%	Work on track - stakeholders identified	None	Green	Not applicable	Not applicable	Green		Dir W&OD	Teaching and Learning Group
						25% to 50%	High level plan developed - full financial analysis underway. This includes a review of where budgets will be held going forward to ensure best value spend.	None		Not applicable	Not applicable	Green			
2	R&I	2.4	Partnership Working – we will work with our Bristol Research and Innovation Group for Health and regional partners to align our research and clinical strengths leading to the establishment of a Bristol Academic Health Sciences Centre.	Academic Health Sciences Centre operating across health partners with demonstrable increase in research activity as a result.	Programme director and chair of Academic Health Sciences Centre programme Board appointed; agreed model of Academic Health Science Centre in place	50% to 75%	Leadership group agreed on AHSC model for wider consultation.	Divergent views of partner organisations. Leadership priority business case.	Green	Executive Leadership. Partnership Working.	Partner feedback.	Green	n/a	CE	Bristol Research and Innovation Group for Health
3	T&L	3.1	Learning and Development Centre of Excellence - We will create a recognised Academy that delivers high quality learning and development which is aligned with trust strategies and culture.	The trust will have a Training Academy that delivers quality assured solutions to its staff and the wider community	Teaching and Learning brought together into one cohesive unit under a single leadership. Academy framework document developed.	50% to 75%	Head of Teaching and Learning appointed. Structures and relationships identified and fully mapped. Stage 1 consultation commences 07/11/11.	Discussions with Divisions on structure takes longer than planned.	Amber	Tight project management of process.	Teaching and Learning Group	Green		Dir W&OD	Teaching and Learning Group
						0% to 25%	Planned for later in year								
3	T&L	3.2	Skilled and flexible workforce - We will ensure that learning and career pathways are developed based on Trust priorities, are flexible and responsive to changes in service and are supported by effective development solutions	All training is based on Trust requirements, linked to required competencies and provides career development for individuals.	KSFs established for all roles.	75% to 100%	Knowledge and Skills Framework in place for all roles with multiple staff in them	Managers of non "bulk" roles do not agree KSFs	Green	Communications plan to engage leaders	Teaching and Learning Group	Green		Dir W&OD	Teaching and Learning Group
					Learning solutions in place for KSF development	50% to 75%	Significant solutions in place - others under development	Nil		Not applicable	Not applicable	Green			
					A common set of management and leadership competencies is in place	75% to 100%	LQF agreed for management staff - Links to supervisory roles under development. Incorporated into leadership development programme.	Nil		Not applicable	Not applicable	Green			
					Learning linked to corporate requirements	50% to 75%	being reviewed alongside performance management. New performance management process	Training plans not aligned to actual business needs		Training needs analysis process being reviewed	Not applicable	Green			

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2011-2012	Progress Towards Achievement %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk Rating	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
3	CSS	3.3	To be recognised by our patients and their families for the consistently high quality of the care they receive whilst in our care	By 2013/14, we will achieve a Top 5 ranking amongst peer trusts for at least 50% of patient experience measures (as measured as the 2013 National Inpatient Survey).	We will extend our patient experience strategy to include Outpatients and carers, learn from feedback and improve scores in measures of satisfaction.	25% to 50%	Contract placed for Outpatient survey - questionnaire design agreed. Other aspects of outpatient roll-out (comments boxes, ward-based surveys) to be approached collaboratively through Transformation. Inpatient ratings show that local patient experience indicators (for patient-reported noise at night, and support at mealtimes), measured in Q3, are already being achieved by Divisions.	Low risk associated with Outpatient aspects. Also low risk associated with achievement of local Commissioning for Quality and Innovation, based on current progress. Achievement of national patient experience CQUIN is unpredictable: based on results of 2011 National Inpatient Survey (approximately 450 patients seen in July 2011 - results available April 2012).	Green	This objective is being achieved. Patient experience strategy is being rolled out into Outpatients (first major survey of outpatients has commenced); inpatient patient experience CQUIN targets are being achieved.	Not applicable	Green	N/A	Chief Nurse	Patient and Public Involvement Leads Group, reporting in future to the Clinical Quality Group
3	CSS	3.4	We will strive to eliminate all incidents of unintended harm to patients and be recognised nationally for the safety of the services we offer.	The spread of all key changes relating to the NHS South West Quality and Patient Safety Improvement Programme will have been achieved in all work streams with at least 50% penetration into other applicable patient populations and areas. We will achieve zero 'Never' events. We will learn from the findings of the Inquiry into Histopathology services.	• We will achieve sustained improvement (three months without sliding backwards) in process and outcome measures for pilot populations in all five work streams of the NHS South West Quality and Patient Safety Improvement Programme*. • We will also achieve spread - including testing, training, communication, etc. - of all key changes beyond the pilot populations of the same Programme. • We will achieve zero 'Never' events • We will focus specifically on seeking improvements in hospital acquired thrombosis (VTE), medication errors, inpatient falls and pressure ulcer prevention and management. Success criteria will be defined via the CQUIN framework • We will fully implement the agreed action plan following the Inquiry into Histopathology services.	25% to 50%	There have been no further Never Events since Q1. Venous Thromboembolism risk assessments are at 98% for August 2011. Reduction in medication error figures for June 2011 are within target at 0.85%. Falls incidence for July 2011 is below the benchmarked average of 5.16 per 1,000 bed days and CQUIN measures are in place for Q2. Pressure ulcer incidence is significantly above the target at 13.61 per 10,000 bed days for June 2011. Numbers of Grade 2 and Grade 3 pressure ulcers have both breached CQUIN target for April and May 2011. The Histopathology Action Plan is on target to be implemented by the agreed dates.	Never Event objective cannot be reversed. Risk to achieving a reduction in pressure ulcers remain until action plan is fully implemented and embedded in practice. Current risk to South West Quality and Patient Safety Improvement Programme we will not achieve the objective as described by March 2012, but we will have opportunity to recover progress by 2014.	Amber	Refocusing of NHS South West Quality and Patient Safety Improvement Programme underway. Launch of Being the Best rapid improvement programme September 2011. Robust pressure ulcer and falls action plans in place.	Quality dashboards scrutinised by Quality and Outcomes Committee. Monitoring of Risks by Clinical Quality Group. External Pressure Ulcer prevalence audits.	Amber	Pressure Ulcers 1755 Falls 1705	Chief Nurse	Patient Safety Group reporting in to the Clinical Quality Group
3	CSS	3.5	To be recognised for the excellent clinical outcomes we achieve for our patients across all areas of service.	We will achieve clinical outcomes that are consistently in the upper quartile of comparable Trusts' performance, including a relevant measure of hospital mortality.	• We will maintain our Dr Foster "Lower than expected mortality" status for Hospital Standardised Mortality Ratios and Mortality in high-risk conditions. The Trust will implement a new Quality Intelligence Group to ensure early detection of and response to statistical outliers, supported by strengthened M&M review in Divisions • In line with the NHS Outcomes Framework, the Trust will seek to achieve year-on-year improvements in one year survival rates for colorectal, breast and lung cancer. Actions will include: review of respiratory Multi Disciplinary Team by Division of Medicine to improve outcomes for lung cancer patients; on-going focus on patient access times; implementation of the policy is Improving Outcomes: a Strategy for Cancer (DH, January 2011) • We will achieve improved Dr Foster ratings (measured by comparison with peer trusts) in at least 5 out of 7 stroke-related indicators. The Division of Medicine will create a dedicated stroke unit on the BRI site to improve • We will implement the action plan resulting from a local gap analysis of the NICE Quality Standard for Dementia, and agreed standards of dementia care developed by the South West Expert Reference Group. • We will seek to increase the proportion of spontaneous vaginal births. Will we do this by actively promoting home births and vaginal delivery after C Section; ensuring 1-1 care in labour; introducing staff study for normal births	0% to 25%	• HSMR on track - monitored by Board • Progress during last quarter re. extracting one year cancer outcomes data, but further work required to determine robustness of data and peer comparison - on-going discussions with SW Observatory • Achievement of stroke objective is difficult to predict as performance will be measured relative to other providers. Data provided by the lead stroke consultant indicates that Trust performance against majority of Dr Foster indicators has improved. Stroke report to CQG in October. Dr Foster Hospital Guide published November. • Dementia action plan agreed • No recent improvement in % of spontaneous vaginal births - however CQUIN pump priming funding has now been agreed	We continue to have an HSMR at 'lower than expected' levels and have successfully initiated the Trust's Quality Intelligence Group to examine quality performance information available from external and internal sources. There is an inherent risk of not achieving any objectives which are based upon our achievements relative to other trusts. It us unclear whether the Trust currently has the data/information capacity to monitor one year cancer survival outcomes.	Amber	Active discussions with SW Observatory re. availability and robustness of cancer survival data	All outcomes/ effectiveness objectives are monitored by Clinical Quality Group - reported to TME and Board.	Amber	n/a	Dir Med	Quality Intelligence Group reporting to the Clinical Quality Group
3	R&I	3.6	We will achieve compliance as far as is reasonably practicable with all Health & Safety regulations		Annual external audit undertaken against the HSG 65 Model of Successful Health & Safety management. Whole audit compliance scores provided for 5 clinical Divisions and 3 specific areas in Trust Services - Estates & Facilities - IM&T and rest of Trust Services	50% to 75%	Plans in place for all areas to achieve required standards. Audit outcomes presented to Executives.	Divisional plans not fully implemented	Green	Progress under on-going review	Trust Health and Safety Committee	Green		Dir W&OD	Risk Management Group
4	CSS / CES	4.1	We will play a greater role in shaping the health system in Bristol and the Southwest through our early and constructive engagement with future influencers. We will improve our reputation with our commissioners by understanding their needs better and rapidly responding to the issues they raise.	Established and productive relationships with PCT Clusters, GP Consortia and National Commissioning Board with evidence of UH Bristol leading, not reacting to, change. GPs will report improved levels of satisfaction with UH Bristol's response to their commissioning intentions and ad hoc issues (evidenced through formal market surveying)	Develop and agree a GP engagement strategy and action plan. Agree and establish revised ways of working between Trust Executive, Heads of Division, Consultant body and emerging GP commissioners Re-structure roles and responsibilities of Commissioning and Planning Team to support new commissioning models Co-lead with NBT the development of an Acute Services Configuration Plan for the City.	50% to 75%	The GP Engagement Strategy and Action Plan is agreed and in the process of being implemented. The Commissioning and Planning team is, as of 1st August, at its full complement and workflow/team responsibilities are currently being allocated in order to support the new commissioning models. NHS Bristol has now completed its elections to its Clinical Commissioning Groups (CCG) and liaison meetings have been established. CCG Leads have been invited to join UH Bristol Clinical Strategy Group on tri-annual basis for primary care focussed strategy debate.	Potential for emerging commissioning structures to change. Difficulty in accessing key primary care decision makers in new structures. Measuring the impact of productive relationships.	Green	Close liaison with commissioner colleagues and agreement of joint priorities for action. Establishment of regular meetings with key primary care influencers.	Commissioning & Planning Group; Clinical Strategy Group	Green		Dir SD	Clinical Strategy Group
4	CSS	4.2	We will strengthen our approach to marketing our services to both GPs and consultant referrers with a view to maintaining or growing market share in our target areas	No service losing market share except where as a response to a Trust business decision.	Develop and agree a GP Marketing and Communications plan Identify early priorities for implementation and embed key changes during 2011 / 12.	75% to 100%	Plan agreed and approved at TME. Liaison between Director of Strategic Development and GP Commissioning Leads underway.	GP priorities. System change.	Green	Progress reporting to TME.	None at present	Green	n/a	CE	Trust Management Executive

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4	CES	4.3	Agree the nature and form of our future relationships with our major fundraising partners. Agree our priorities for charitable funding and develop cases for support in partnership with charitable leads	Fundraising target for major appeals achieved. Positive working relationships in place with all major charitable partners.	Establish Memorandum of Agreement with each of our major charitable partners Agree model for fundraising for major capital developments in 2014/15 Undertake market analysis to confirm fundraising potential. Agree fundraising targets and priorities with each of our key partners	50% to 75%	External report on opportunities for development of charitable relationships and funding sources received. Charities: Above and Beyond have provide a funding strategy for BRI , target £3m The Grand Appeal have to get trustees support for £5.83m for CSP meeting in Sept to confirm. Above and Beyond confirmed £2m for BHOC TCT indicate £2.5m £2m support now secured from Friends of BHOC	Risk that fundraising targets are missed and therefore need review of schemes or alternative funding.	Green	Continued close working and representation at Charitable Boards.	Regular updates to TME and involvement of Trust Lead Executive with each of Trustee Boards	Green		Dir SD	Trust Management Executive
4	T&L	4.4	Leaders of the future - We will create leadership and talent pools who are equipped with the skills, knowledge and behaviours required to lead the Trust both now and in the future.	We will have leaders who are fully effective and are able to embrace and deliver change is a safe and sustainable way	A common set of management and leadership competencies is in place	75% to 100%	LQF agreed for leaders - supervisory competencies under development	Minimal Risk	Green	Not applicable	Not applicable	Green		Dir W&OD	Teaching and Learning Group
					Talent pool identified for future leaders at all levels	75% to 100%	Talent pool identified and used to nominate for new transformational leadership programme.	Minimal Risk		Not applicable	Not applicable				
					Formal leadership and talent development programmes launched to meet development needs of talent pool and leaders	75% to 100%	Leadership Forums commenced July. Full development programme launched. 10 sessions booked through December 2011 with 150 attendees.	Leadership development does not meet future business needs		Sign off of content by appropriate leaders. Contents reviewed for each cohort to ensure remains relevant.	Teaching and Learning Group				
4	CES	4.5	We will continue to work with our media partners locally, regionally and nationally to ensure UH Bristol positions itself as a trustworthy and notable commentator on health issues and is recognised as a successful organisation, through case studies of our staff and patients in relation to Research & Innovation, Teaching & Learning and patient care.	Positive to negative media about UH Bristol increases. All proactive media about UH Bristol is balanced; the Trust is consistently featured aligned to its core values and brand through media coverage. The Trust is known for its commentators	Positive to negative media about UH Bristol increases. All proactive media about UH Bristol is balanced; the Trust is consistently featured aligned to its core values and brand through media coverage.	50% to 75%	Coverage for quarter 1: Positive 381; Negative: 61; Neutral: 162. The Trust has strong proactive relationships with the regional media and relationships are being built with the trade media. The communications department actively promotes positive stories about Appendix A – Summary Quality & Performance Report	Risk that operational issues result in negative media coverage. Continuing adverse publicity following Histopathology Inquiry.	Green	The Communications department maintains close relationships with all Divisions to ensure that it receives early notification of communications issues and can work in partnership with Divisions. The department's working relationships with the media help to ensure that coverage is balanced. Performance reporting of positive and negative coverage.	SHA analysis. Feedback from media organisations.	Green	1467	CE	Trust Management Executive
4	CES	4.6	The Trust embraces all appropriate methods of communication, with staff, patients, members and the wider public to involve them in the strategic developments of the Trust.	Staff survey shows improvements in staff perception of communication with respect to capital developments All KPIs being achieved to required standards. Minimal patient complaints about negative impact of construction works	Establishment of Communications steering group for the capital redevelopment projects. Agree objectives and KPIs for that group, monitored by the Trust Capital Steering Group. Implement a coordinated approach across all communications associated with major strategic initiatives. Embed new internet from June 2011 with greater interactivity.	50% to 75%	Communications Steering Group established. Feedback regular to develop KPIs. Coordination involving internet launched and operational	Failure to effectively engage staff and patients on our redevelopments	Green	Active management of communications agenda through Steering Group and regular review of learning if we get it wrong	Trust Management Executive	Green		CE	Capital Programme Board
5	ES	5.1	An Estates Strategy exists which is agreed by the Board, covering the period up to 2020. Approved Site Development Control Plan exits	Develop a 10 year Estates Strategy and secure Board approval Develop a three year rolling capital planning programme to support Estates Strategy. Develop a Site Development Control Plan	Develop options for the disposal or re-development of the BRI Old Building Agree the detail of Redevelopment Phase 4 – reconfiguration of the King Edward Building to house services displaced from the old Building Review year 1 of the 3-year rolling capital programme to reflect progress made and changing operational requirements	0% to 25%	The layouts for the use of the KEB will be progressed after the business cases for the Welcome Centre and the Bristol Haematology and Oncology Centre expansion have been through the Trust Board in August. A Tracker tool has been developed to track different elements - wards, theatres, outpatients, non-clinical etc. year by year from today through to completion in 2015. This will be worked up and used to intelligently inform the capital programme in the interim years. A plan for development of the strategy will be drawn up in Quarter 3.	There is a risk that the forthcoming Estates and Facilities Review will take the .... Estates Strategy delivery.	Green	Range of Redevelopment Project related groups, boards etc. to progress aspects of development. Continual review by groups identified in next column. Use of external; consultants for Estates and Facilities Review.	Capital Programme Steering Group Strategic Estates Steering Group	Green		COO	Trust Management Executive

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5	ES	5.2	Ensure on-going compliance with all annual fire and safety audits.	Avon Fire & Rescue Service issue no Improvement Notices. Health & Safety Executive issue no improvement notices. Care Quality Commission Outcome 10 (Safety and Suitability of Premises) remains compliant. Willis Risk Management Audit shows no major unmitigated risks.	Annual external surveys undertaken for fire, legionella, asbestos, windows, water quality, disabled access, security. Whole environment scores provided routinely to Divisions for discussion within quarterly reviews Three year rolling programme of improvements agreed by TEG and funded within capital programme and first year of implementation Annual Willis Risk Assessment undertaken, reviewed against preceding action plan and updated.	25% to 50%	Review of Health Technical Memorandum compliance being reviewed by Divisional Board. Fire Risk assessments to be taken to SDG in September to measure completeness across the Trust. Programme of external reviews for key services being finalised. DDA compliance programme for 2011/12 year investment being progressed - prioritised on Disability Discrimination Act public toilets. Willis Health and Safety review being presented to Exec team August 2011 and to divisions subsequently. New benchmark being established by this.	Lack of delivery can lead to real (safety) or potential (reputational) risks.	Green	Audit of Risk Assessments. Increased incidence of fire training to annual from 2-yearly. Training for risk assessors and fire wardens.	Health and Safety Committee Infection Control Committee Decontamination Group Facilities & Estates Divisional Board Service Delivery Group	Green		COO	Service Delivery Group
5	ES	5.3	To strengthen our approach to business continuity with the aim of ensuring patient safety and minimising operational disruption during times of incident.	UH Bristol viewed as a beacon Trust in the Avon Health Emergency Response Group area. Outcome of test exercises identifies no major shortcomings in Trust arrangements	Conclude a review of back up generation requirements and implementation of short term plan. Review of current arrangements and responsibilities for business continuity re-assessing the balance of corporate and divisional responsibility Review of suitability of existing Business Continuity Plans	75% to 100%	Standard operating procedures are in place for areas identified as not covered by back up generation. Future generator requirements have been identified and business cases presented and accepted. Current business continuity planning arrangements have been reviewed and a business continuity management strategy devised and put in place. All identified trust individual business continuity plans have been reviewed and updated as necessary.	In the event of a power failure there are some areas of Trust premises that are not covered by back up generation or UPS. The risk remains that trust business continuity plans will not be reviewed and updated on a regular, timely basis	Amber	Standard operating procedures are in place for affected clinical areas. Business Continuity management should now sit on all divisional management boards and this feeds into the Business continuity Planning Group. Trust Business Continuity plans being entered onto the Trust Safeguard system which will allow for timely reminder of review management	Recent Trust internal audit 2011, Standard operating procedures, Emergency planning Trust Board report	Amber		COO	Civil Contingencies Committee
5	ES	5.4	Improvement trust wide satisfaction with the services provided by the Estates Function Development of KPIs and systems of feedback from Divisions to ensure improvements in responsiveness	User surveys indicate an 80% level of compliance with Service Level Agreement Key Performance Indicators User surveys show 80% return being good or excellent	Set standards for estates and facilities services, including response times. Develop a set of KPIs to monitor achievement of standards and report at divisional level Agree key performance requirements with Divisions annually and introduce an annual Division to Division review of estates performance Introduce customer feedback mechanisms to enable estates to pick up concerns over responsiveness or quality routinely	25% to 50%	Project evolving through placement of contract for new estates helpdesk IT system. Opportunity confirmed with Transformation Team to carry out exercise with the estates team for modernisation / greater effectiveness / customer focus. KPIs and dashboard being developed for discussion with the Service Delivery Group and Trust Management Executive.	Risk that new IT system will not deliver intended benefits.	Amber	Progress to be monitored through Divisional Board.	Health and Safety Committee Infection Control Committee Decontamination Group Facilities & Estates Divisional Board Service Delivery Group	Amber		COO	Service Delivery Group
5	ES	5.5	Ensure estates practice contributes fully to infection control objectives	Internal and external Assurances / Audits indicate no major shortcomings in key safety related areas. All improvements to process identified through assurances and audits are fully implemented. Compliance with HTMs 1 -7 Assured regularly (at least once every 2 years) Increased percentage of single rooms available year on year.	Review Asset Base and Project Portfolio Management requirement of that base. Implement review of PPM delivery / completion against pre-agreed KPIs. Produce annual report for Infection Control Committee on Legionella Compliance Implement year 2 of 3-year ward upgrade improvements	50% to 75%	Asset base being reviewed as part of helpdesk project and internal audit action plan. Good progress being made towards completion in October which is a revised completion date. External annual and quarterly testing contract put in place with Audere. New External Authorised Person contract in place. Annual report for Infection Control Committee achieved 19 July 2011. HTM compliance review included on Divisional Board work plan for review. Cost pressure for external review etc. of specialist ventilation still to be resolved. Single room review incorporated into Redevelopment "Tracker" tool (see 5.1 above). Update given to SDG.	There is considerable mitigation in place to manage the risks to Legionella and to Hospital acquired infections through the Cleaning regimes.	Green	Planned preventative maintenance. External Audits. Authorised Persons and testing.	Annual & Quarterly reports to Infection Control Committee. Monthly exception reports to Decontamination Committee.	Green		COO	Service Delivery Group
5	ES	5.6	Reduce further our carbon footprint	Carbon footprint is reduced by 5% per annum over next 3 years	Achieve annual reduction in energy consumption of 5% per annum over next three years. Implement annual milestones of three year energy strategy and Big Green Scheme Big Green Scheme to be reviewed by Board of Directors and for appropriate new three year plan developed.	50% to 75%	Progress on 5/6 of the energy saving projects proceeding to plan. All of these due to be complete by January 2012. Summer boiler project reprogrammed due to its interdependency with the site-wide HV generator project. Big Green Scheme progressing awareness and green champions to be involved in identifying additional areas for thermostatic radiator valve heat control installation.	Local uncontrolled energy usage (lights & computers etc) not switched off when not required.	Green	Active monitoring by Energy Manager. The Big Green Scheme. Energy saving invest-to-save programme.	Periodic reports to SDG, TME and Finance Cttee.	Green		COO	Service Delivery Group
6	T&L	6.1	Implement revised performance management processes to better align individual performance with trust goals	Performance management will fully support the achievement of Trust goals	Performance management timetable changed to align corporate and individual objective setting	75% to 100%	New performance management process signed off by SDG and goes live October 2011.	Risk relates to new process having impact rather than its delivery	Amber	Detailed communications and training for appraisers and appraisees.	Trust Management Executive Group	Amber	To be reviewed during process launch	Dir W&OD	Teaching and Learning Group

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					Managers trained in delivering quality performance management process	25% to 50%	Training fully integrated into plans for roll out.								
6	LTFP	6.2	Deliver an annual Cost Reduction Programme (CRP) in line with the requirements of the Long Term Financial Plan	The Trust achieves a balanced plan for the next three years	Deliver a programme management approach to Transformation/CRP delivery including review of corporate and divisional roles, responsibilities and leadership Establish Executive Cost Reduction Plan Leadership group to retain oversight of whole trust CRP Review role and focus of transformation team to ensure they are targeted at supporting both divisional and corporate CRPs Sign off and hold to account for delivery a range of Cost Improvement Plans that deliver a balanced plan in year.	50% to 75%	Transformation Director in post July 2011. Outline of accountability agreed. Programme Steering Group refocused. CIP plans all signed off. Transformation half days established. Mid-year review established. Trust on track to deliver 77% of CRES target.	Divisions not delivering to plan. Corporate work streams behind plan	Amber	Two Divisions placed in escalation with Board to Board meetings and recovery plans. All corporate work streams have clearer accountability structures for delivery.	Dates for meetings booked. Work stream levels held to account at Programme Steering Group	Amber		COO	Programme Steering Group
6	CSS	6.3	Delivery of significant improvement in outpatients by 2014.	The Outpatients function is transformed and is upper quartile nationally on a range of indicators including new to follow-up appointments, Do Not Attends and Cancelled appointments. Clinical Administration is streamlined by using technology, the new Patient Administration System is used to best effect and saved Consultant PAs have been redistributed/eliminated.	Implement Phase 2 of Outpatient Booking Project to include centralisation of bookings, reduction in cancellations, standardisation of outpatient processes, review of helpline. Introduce Digital Dictation and Voice Recognition across the Trust resulting in Clinical Administration savings. Identify consultant PAs that can be reduced by better Outpatient clinic utilisation.	25% to 50%	Commenced Year 1 of the Productive Outpatients Programme includes programme set up and governance, monitoring and delivery. Progressing projects to improve Clinic Scheduling, Booking Process, Clinic Process, the Patient Pathway and to agree and implement an improved booking model for the Trust. Projects will ensure we use our existing capacity to full effect therefore eliminate/minimise the use of Waiting list initiatives through better use of our existing clinic capacity and will identify consultant PAs, and workforce if appropriate, that can be reduced by better outpatient clinic utilisation and processes. Performance monitoring system being developed. Presentations to TME Strategy Group.	Risk that programme deliverables will not be achieved as delivery relies on improvement being coordinated, monitored and delivered within the Divisions. Resources will be required in each division to progress the project.	Amber	All Divisions have been alerted to the programme plan, governance and key deliverables with an awareness of resource requirements so they can enable resources to be released when required. Close monitoring of progress against plan for each area and escalation of issues to the Productive Outpatients Steering Group as required.	Productive Outpatients Risk and Issues log established and reviewed by Divisional/Hospital Site Productive Outpatient working groups fortnightly as well as the Productive Outpatients Steering Group every 6 weeks for escalated risks and issues	Amber		COO	Transformation Programme Board
6	CSS	6.4	Delivery of significant improvement in theatre productivity by 2014.	Theatre processes have been fully re-engineered and have released significant savings.	Implement Year 2 of the Productive Theatre Programme. Eliminate the use of Waiting list initiatives through better Theatre scheduling and utilisation. Eliminate last minute cancellations for theatre reasons, A short notice protocol for DNA patients (Eye Hospital) and staggered admissions on the day is introduced.	75% to 100%	A number of the key actions from the year plan of the POT are being implemented successfully. There are on-going improvements in the lists starting on time work and the BEH has now fully implemented the short notice protocol, which is functioning well. WLI savings are above trajectory, with month 3 seeing £40k spent on WLI, with £70k standing as the maximum spend per quarter to make the required savings. Work is also progressing on the non-pay savings elements with anaesthetic drugs providing a focus. Escalation process for LMCs established; target achieved in September 2011.	Increasing demand on emergency and elective workloads and requirement to achieve key access targets, mean that there is an on-going demand for WLI in some areas.	Amber	High level authorisation of the use of WLI and management of the cancer and 18 week waiting lists to ensure WLI are only used in extreme situations	Active monitoring of waiting lists and performance targets through 4 PTL meetings a week and increasing demand managed through regular contract monitoring and commissioning and planning meetings. Monthly production of WLI figures and monitoring through Divisional Board.	Green		COO	Transformation Programme Board
6	CSS	6.5	Delivery of improvement to upper quartile for Average Length of Stay (ALOS) and associated bed productivity by 2014.	The Trust's Average Length of Stay (ALOS) is Upper quartile for the majority of HRGs.	Improve discharge processes for routine, more complex and highly complex patients. Reduce the number of non-elective medical patients with a Length of Stay of more than 14 days to 40. These initiatives will enable the permanent closure of beds – in Medicine the current projection is two wards. Move towards upper quartile ALOS for the majority of HRGs. Implement revised urgent care pathways and reduce medical admissions, close flex beds except in times of peak pressure.	50% to 75%	The key priority for 2011/12 is to enable closure of beds through reductions in long length of stay & improvement in discharge processes. The creation of a new operations centre in the BRI and a revamp of bed management processes have delivered in this regard. The daily reviews of 'red list' patients awaiting discharge has resulted in a dramatic reduction in the average number of (particularly medical non-elective) patients staying >14 days (from a peak average >90 in February 2011 to <50 in Q1 2011/12) and a reduction in average length of stay which has enabled the closure of 40 medical beds. Plan to enable flexi beds over 2011/12 Winter.	Unforeseen increases in emergency demand or changes in case mix which could negatively impact on performance	Amber	Daily focus on indicators of patient flow through revised ops centre in BRI. More strategically there is proactive planning internally (flex capacity) & with community partners, to minimise impact of peaks in demand (e.g. winter pressures / 'flu)	Active monitoring of 'predictor' KPIs using patient flow dashboard at service delivery group fortnightly. Oversight of performance (on amber - trajectory in Q2) at monthly bed optimisation steering group, & review of divisional performance on LOS at monthly operational & finance reviews with exec directors. These should all allow early warning of deviation from plans and remedial action to be taken.	Amber		COO	Transformation Programme Board
7	LTFP	7.1	Develop and implement an engagement programme that ensures staff are fully involved in the work and development of the trust, are able to contribute to its further development and go the extra mile to ensure its success..		Programme defined and developed	75% to 100%	Programme fully defined and implementation plan in place. Leadership development, performance management, recognition, comms, values roll out and commence Oct/Nov.	Implementation seen as a series of unconnected events leading to loss of impact and key messages	Green	Programme includes full communications plan and overall branding to draw into single programme	Transformation Board and the Trust Management Executive Group	Green		Dir W&OD	Trust Management Executive

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7	R&I	7.2	We will train, mentor and support research-active staff to deliver high quality translational and applied health services research of direct patient benefit in our priority areas of research		100% research staff aligned with a Divisional research unit. Research staff training and learning needs identified and managed in line with Trust-wide learning and development strategy	25% to 50%	SH&N, Medicine and SS's all have staff in Divisional Research Units: Work underway with W&C. Survey of training needs undertaken. To be implemented in line with T&L strategy	No update	Green	Not stated	Not stated	Green		Dir Med	Research Group
8	IT	8.1	Implement modern clinical information systems in the Trust	Modern clinical information systems are in use in the Trust	Information Management &Technology Strategy moving to Implementation Phase	75% to 100%	Implementation Phase 1 March 2012	Operational engagement. System failure	Amber	Active project management	CSIP Board and IM&T Committee	Amber		DoF	Information Management and Technology Board
					Implementation Teams established.	75% to 100%									
					Complete Procurement	75% to 100%									
					Core systems Implementation commences	50% to 75%									
8	IT	8.2	Review and deliver fit for purpose clinical admin support processes	Fit for purpose clinical admin process in place	Agree Terms of Reference of review and establish review team and processes	75% to 100%	Report October 2011	Changes proposed and timescale for implication	Amber	Project Group	Project Group	Amber		DoF	Clinical Systems Implementation Programme Board
8	IT	8.3	Improve our ability to manage our business through the production of robust and timely business intelligence to both head quarters and divisional staff	20% reduction in analyst time spent on routine report preparation. Improved Divisional satisfaction with information format and flow	Agree and implement model for Business Intelligence Function Procure and install business intelligence software Train all divisional analysts Develop consultant level quality and productivity dashboards	50% to 75%	Business Intelligence software (QlikView) has been procured. Divisional analysts have been trained. Work is underway to establish the data flows from the various Trust data sources (e.g. Patient Administration System; Electronic Staff Record; Ulysses etc.), to enable dashboards to be set-up. The first Access and Finance (Service Line Reporting) dashboards were demonstrated to the Service Delivery Group in early September with agreements on priorities and next steps reached.	No significant risks noted at present	Green	Not applicable	Not applicable	Green		Dir SD	Trust Management Executive
8	LTFP	8.4	Develop better understanding of service profitability using Service Line Reporting	Better resource allocation in the Trust	SLR development and benchmarking with other Trusts	75% to 100%	AUKUH benchmarking data collated. Report to TME and Finance Committee		Red	Continued development of SLR with Clinicians and managers	Finance Committee	Amber	962	DoF	Finance Committee
9	T&L	9.1	Deliver a full Trust review of structures using the "spans and layers" approach	Structures will have appropriate spans of control and the number of layers between senior leaders and patients will be minimised	Spans and Layers process agreed and pilot division completed	75% to 100%	Pilot completed and reports being finalised - savings identified	Complete	Amber	Not applicable	Not applicable	Green		Dir W&OD	Trust Management Executive
					Full plan developed with targets	50% to 75%	Pilot outcomes presented to TME. Approach being offered as consulting intervention. Currently being used in Physio, finance, THQ and Estates. Requests will be prioritised based on ROI.	Divisions do not commit to the process		Full communications plan developed to engage with all stakeholders	Programme Steering Group	Amber			
					"light" process delivered across the Trust	0% to 25%	Programmed for later in year. Train local facilitators to support basic process.	Divisions do not commit to the process				Amber			
10	LTFP	10.1	Deliver minimum normalised surplus	As per objective	Achieve full delivery of annual CRES programme and positive contract settlement with BNSSG and SCG commissioners	25% to 50%	Year 1 of 4 per LTFM	CRES delivery	Red	In year financial management	Finance Committee	Green	962	DoF	Finance Committee
10	LTFP	10.2	Deliver minimum cash balance	As per objective	Maintain liquidity ratio of at least 3 and cash balance of no less than £20m.	75% to 100%	Currently year end £30m	I&E surplus delivery and capital programme	Green	Treasury management policy	Finance Committee	Green	962	DoF	Finance Committee
10	LTFP	10.3	This is a duplicate of Objective 6.2												
11	LTFP	11.1	Maintain Monitor Financial Risk Rating of 3 or above	As per objective	Achieve Earnings Before Tax, Depreciation Amortisation, Return on Assets, Net Surplus Margin and Liquidity ratio in line with plan	75% to 100%	Delivered by 10.1 and 10.2 above	As per 10.1 and 10.2	Green	In year financial controls	Finance Committee	Green	962	DoF	Finance Committee
11	T&L	11.2	Achieve Compliance with EU Working Time Directors for Medical Staff	All staff will be working appropriate hours, ensuring a safe workplace for patients and staff	Ensure all derogated rotas are compliant before expiry of derogation in August 2011	75% to 100%	All rotas now technically compliant. In monitoring period to confirm compliant in practice.	Work hours do not reflect planned hours.	Amber	Maintain communication with job holders concerning hours worked.	Not stated	Amber	1406	Dir W&OD	Trust Management Executive
11	CSS	11.3	Maintain 'compliance without conditions' with the Care Quality Commission		Compliance with Outcomes 5 and 14 and 21 is due to be achieved by the end of 2010/11. In 2011/12, we will therefore focus on maintaining compliance with these, and all other, CQC Outcomes. We will continue to foster an open and collaborative relationship with the CQC, including prompt responses to any requests for Planned Reviews and to any issues highlighted during, or as a result of, inspection. (Note: the Trust has further declared non-compliance with Outcomes 7 and 11 in-year)	25% to 50%	• Outcome 5 - compliance declared to CQC in early October • Outcome 7 - final push required to deliver adult safeguarding compliance by 31st October • Outcome 11 - Divisional equipment records are compliant; however urgent action required to ensure medical device training compliance by 31st December • Outcome 14 - compliance pending achievement of Outcome 7 and maintaining 80% appraisal compliance • Outcome 21 - action plans to be implemented following recent record keeping audits	• limited confidence in achieving Outcome 11 compliance by 31st December 2011	Red	Revised action plan to be issued by 18th October setting our clear practical steps which Divisions must follow to achieve compliance	Monitoring of all CQC Outcomes via designated lead groups, CQC Group, Clinical Quality Group, TME, Board.	Amber	Outcome 7 is 1483 on corporate risk register; Outcome 5 is 1703 on BRHC rr. Outcome 11 is 732 on BRI rr.	Chief Nurse	Risk Management Group

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2011-2012	Progress Towards Achievement %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk Rating	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
11	CSS	11.4	Maintaining a Green Governance Risk Rating Clostridium Difficile infections (CDI)		Ensure continued adherence to Norovirus prevention best practice in 2011 / 12 only. The number of side rooms increased as part of the 2011/12 ward refurbishment schemes Increase proportion of single rooms in new BRI development Bed store with hydrogen peroxide cleaning facility available	25% to 50%	Over achievement against quarter two target with 16 cases reported against a target of 17. Position for year to date is 33 cases against a target of 36.	Limited number of single rooms with reductions due to ward movements Current testing regime that can identify false positive cases will continue until December 2011. Continuing risk of Norovirus outbreaks that would impact on specimen sending and number of colonised cases identified Failure of staff to consistently follow best practice	Amber	Use of cubicle tracker and infection control nurse input to isolation decisions Diagnostic and Therapy Division have received agreement for funding for change to testing regime Proactive risk assessment of all patients admitted to detect possible Norovirus Monitoring of practice through the infection control dashboard audits	Monthly monitoring of isolation target through infection control dashboard Weekly operational meetings that review all C diff cases and identify any failures in practice Monitoring of risk assessment completion through Nursing Quality in Care tool	Green		Chief Nurse	Infection Control Committee and then to Clinical Quality Group
11	CSS	11.4.1	Ensure compliance with the revised Accident and Emergency Department access targets.	Compliance is achieved with all Emergency Access Targets in a sustainable way.	Deliver a full programme of work that addresses Patient Flow issues from the 'front door' to discharge in a sustainable way. Key elements o this work stream include: - Delivery of an effective Ambulatory Care Unit that prevents unnecessary admissions - Delivery of an expanded Medical Assessment Unit (MAU) to aid patient assessment and flow - Delivery of a Control Centre and real time reporting so that decisions to expedite flow and discharge can be taken without delay. - Delivery of a new Discharge Lounge to free up beds early in the day.	50% to 75%	Patient Flow included in bed optimisation programme. New MAU opened on 1st August 2011. Operations Centre opened on 4th July 2011. National standard achieved for 4/5 areas. Outstanding area is 15 minute assessment	Admission avoidance does not deliver. Delayed discharges / 'red' patients increase.	Amber	Activity monitoring for meeting with PCT. Length of Stay escalation process.	Regular meetings with PCT. Review at 1/12 Ops and finance meetings.	Amber		COO	Emergency Access Steering Group
11	CSS	11.4.2	Ensure compliance with the Cancer Access Targets and ensure improvement against the first National Cancer Patient Experience Survey.	Compliance is achieved with all Cancer Access Targets in a sustainable way and quantifiable improvements are seen in the National Cancer Patient Experience Survey.	Set appropriate priorities for the Cancer Board ensuring that comprehensive plans are in place to meet the cancer standards taking appropriate account of patient choice, stages of diagnosis and treatment and winter and other service pressures. In addition create an action plan to address issues requiring improvement identified in the first National Patient Cancer Survey.	25% to 50%	Q1 62 day cancer target on the line. Tighter monitoring process established.	Delivery of 62 day cancer targets. Failure to improve Cancer Survey results.	Red	Weekly 62 day cancer target meeting. Cancer nurse assigned as lead for delivery.	Weekly 62 day target meeting. Overview of survey issues at Cancer Board	Amber	1412	COO	Cancer Board onto Trust Management Executive