University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Public Meeting of the Trust Board of Directors to be held on 21 December 2011 at 14:00 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 and Matters Arising from the Previous Meeting To consider the Minutes of a Public Trust Board meeting dated Monday 28 November 2011 for **approval.** All matters arising were noted as complete.	Chairman	1
4. Chief Executive's Report To receive this report to **note**.	Chief Executive	14
Quality, Performance and Compliance		
5. 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	18
6. Histopathology Action Plan Update To receive this report to **note**.	Chief Executive	80
Finance and Governance		
7. 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 19 December 2011, including the Report of the Finance Director b. Quality and Outcomes Committee dated 20 December 2011 c. Audit Committee dated 12 December 2011.	Committee Chairs	102
Strategy and Business Planning		
8. Partnership Programme Board Report To receive this report on the Partnership Programme Board dated 19 October 2011 to **note**.	Director of Strategic Development	119

Item	*Sponsor*	*Page*
Monitor Reports		
9. Report Results of Q2 Compliance Framework Monitoring Exercise To receive this report to **note**.	Chief Executive	122
Information and Other		
10. Any Other Business To consider any other relevant matters not on the Agenda.	Chairman	
11. Date of Next Meetings **Public Meeting of the Trust Board of Directors**, Thursday 26 January 2011 from 10:30 – 13:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	Chairman	

University Hospitals Bristol NHS
NHS Foundation Trust

Minutes of a Public Meeting of the Trust Board of Directors held on 28 November 2011 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Board Members Present	
• John Savage – Chairman • Robert Woolley – Chief Executive • Emma Woollett – Vice Chair • Lisa Gardner – Non-executive Director • John Moore – Non-executive Director • Paul May – Non-executive Director • Selby Knox – Non-executive Director • Kelvin Blake – Non-executive Director	• James Rimmer – Chief Operating Officer • Steve Aumayer – Director of Workforce and Organisational Development • Deborah Lee – Director of Strategic Development • Paul Mapson – Director of Finance • Alison Moon – Chief Nurse • Sean O'Kelly – Medical Director
Present or In Attendance	
• Elisabeth Kutt – Head of Division – Diagnostics and Therapies • Mike Nevin – Head of Division – Surgery Head and Neck • Mark Callaway – Head of Division - Medicine • 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 • Neil Auty – Governor • Joan Bayliss – Governor • Clive Hamilton – Governor • John Steeds – Patient Governor – Local • Florene Jordan – Staff Governor

Item	*Action*
1. Chairman's Introduction and Apologies The Chairman noted apologies from Iain Fairbairn – Senior Independent 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 Public Trust Board meeting held on Wednesday 26 October 2011 and **approved** them as an accurate record.	
4. Matters Arising All items on the Board Schedule of Matters Arising were noted as complete as reflected in the Schedule of Matters Arising.	
5. Chief Executive's Report 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:	

- A Contingency plan was in-place for the national day of industrial action on 30 November. The Chief Operating Officer, James Rimmer, was the 'lead' regarding planning, and he informed the Trust Board that services would be reduced, with an expectation that three-quarters of a usual day's elective activity would be provided. Cover was in-place for all areas, but there was a possible impact from Allied Health Professionals being unavailable to support clinics. Most training activities and discretionary leave had also been cancelled.
- The NHS Operating Framework for 2012 had been published. It set-out the principles in detail, including expected efficiency targets of 4%. In addition, there was a focus on Elderly and Dementia Services, and a need to understand mortality indicators in hospitals and emergency admissions.
- The Trust remained in contention for designation of its Paediatric Cardiac Surgical Services. The Joint Committee and Primary Care Trusts were appealing against The Brompton Hospital's challenge to the process.
- The first stage of the new Pharmacy system was implemented two weeks' ago, and the Pharmacy Team were striving to return to full capacity.
- The Royal United Hospital Bath NHS Trust had a fire in their Intensive Care Unit at the weekend. As a consequence of this, three patients had been transferred to the Bristol Royal Infirmary for intensive care. It was noted that the Hospital had formally thanked University Hospitals Bristol NHS Trust for taking the patients.

Discussion commenced:

- Following a query by Emma Woollett about the proportion of staff 'striking', James Rimmer responded that planning had been undertaken service-by-service, and approximately 80% of elective services would run. Staff had co-operated with the Trust about their plans for striking, but some groups remained undecided. A hotline had been provided for patients with concerns about the strike and the possible knock-on effect on their treatment and appointments.
- Following a request for clarification by John Moore, James Rimmer confirmed that a Risk Assessment of the industrial action had taken place, and training for covering staff would be provided where necessary. James added that a conference call was scheduled with Social Care Partners, to discuss the 'risk' element of the strike in greater detail.
- Paul May praised the professional and responsible line taken by James Rimmer, in his role as Chief Operating Officer.
- Selby Knox pointed out that many organisations deducted pay from striking staff. James Rimmer confirmed that the Trust also adhered to this policy, and this had been communicated throughout the Trust.
- James Rimmer informed the Trust Board that there might be further industrial action in the near future, and that a 'Log of Issues' would be maintained to note any matters arising from the imminent strike action.
- Following a request by Selby Knox, Sean O'Kelly confirmed that the Dr Foster report data on Mortality Rates for weekend stays at the Trust was not known, but clarified that the Trust was not amongst the nine Trusts who had been named as having higher than expected weekend Hospital Standardised

Mortality Ratios. Robert Woolley added that the Dr Foster figures were adjusted according to various weightings and factors, and that there was no access to the figures from day-to-day. Sean O'Kelly assured the Trust Board that Mortality rates are an area of increased focus.

- Mike Nevin commented that the emergency outcome data was critical, not the actual time of death.
- Robert Woolley confirmed that the Dr Foster report had commended the Trust in other areas of working. Alison Moon said that a detailed assessment of positive and negative outliers was being undertaken in response to the report.
- Paul May commented that the Hospital Standardised Mortality Ratio at the Trust remained considerably less than at other hospitals, and that this was a positive indicator of confidence in the safety of the Trust's hospitals.

*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 Trust remained 'Green' rated with Monitor, with an expectation of maintaining the position for Quarter 3. The key risk to this was performance of the '31-Day Cancer Standard', where some ground had been lost.

Two adverse areas were reported:

1. A Recovery Plan was in-place to address shortfalls in 'Recruitment into Trials'.
2. There had been a small deterioration in 'Patient Experience', which had gone from a 'Green' to an 'Amber' rating.

The 'Hospital Standardised Mortality Ratio' was noted to have returned to a 'Green' rating. Finance remained healthy, with the biggest challenges around Cash Releasing Efficiency Savings (currently delivering 72%).

b. Patient Experience

Alison Moon presented the Patient Experience Report, which related to Mr V, a patient who was admitted to the Bristol Royal Infirmary for an operation to remove a tumour from his left lung.

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

Divisional Learning

- Patients admitted via the Surgical Admissions Suite were not automatically allocated a ward, as this usually happened post-operatively. Due to this practice, a relationship with a ward and the staff had not been formed. One of the key contributing factors to this was the unsuitability of the current space in the Suite, which did not allow relatives to be present at any stage of Mr V's journey through the Suite.

- The Division had outgrown the current Surgical Admissions Suite and were putting in a fresh bid to the capital round for larger premises. Meanwhile, as a result of this complaint, a senior (Band 6) member of staff was now present during unit opening hours, in order to demonstrate good communication skills and leadership and provide continuity of care.
- Unfortunately, when Mr V died, his family did not receive the required level of support. A system had been put in-place and the staff in theatres now know to contact the Matron or Clinical Site Manager to arrange a viewing in the Chapel of Rest where appropriate.
- Referring to Mr V's 'rush' into theatre from the Surgical Admissions Suite, the staff were initially unable to proceed with his surgery as theatres were waiting on the availability of a High Dependency Unit bed. Surgical Admission Suite staff had been reminded that patients and relatives should always be dealt with in a calm manner, and that it was also important to explain what was to be expected on the day of surgery to patients at pre-operative assessment, and for this to be reinforced on the day of surgery.
- The Surgery, Head and Neck Division and medical staff met with Mr V's family, which proved extremely useful for them and enabled all of the relatives' questions and concerns to be addressed.
- The Division now encouraged meetings with concerned relatives, in order to provide them with a more comprehensive response.
- Learning from this complaint had enabled staff in the Surgical Admissions Suite, Pre-Operative Assessment Unit and Theatres, to reflect upon the importance of communication at all levels. It also highlighted the benefits of face-to-face meetings with complainants.

Organisational Learning

- Patients and relatives should always be dealt with calmly, to instil them with confidence in the care provided by the Trust.
- It was important to be clear about an individual's circumstances, so that subsequent actions by staff were appropriate.
- It was important to explain exactly what would happen to patients due to undergo treatment, and for this to be checked and reinforced, if required, at later opportunities.

Discussion commenced:

- Mike Nevin commented on the day-of-admission service, saying that it required an overhaul, as he felt it was not fit-for-purpose in its current form. He stressed that due to Mr V's added cardiovascular problems, he had an increased risk of a 'critical event' occurring. Mike added that the Surgery, Head and Neck Division had learnt from the incident.
- John Moore observed that Mike Nevin's response was from a more "technical" perspective. John had concerns about the need for more compassionate responses to families during devastating times. Robert Woolley emphasised that staff were expected to respond to people humanely, with candour, openness and transparently, but with recognition of the emotional circumstances of relatives.
- Robert Woolley said that the implementation of the Trust's

Transforming Care Programme in December would include training staff on the Trust Values, and this would include examples of learning from complaints. John Moore felt reassured by this approach.

- Kelvin Blake thanked the Executive for bringing this example to the Boardroom, and emphasised the importance of addressing difficult examples of patient and family dissatisfaction. He added that most cases seen recently had related to communication.

c. Quality

The Chief Nurse and Medical Director presented the Quality element of the Summary Quality and Performance Report.

The main points of relevance were:

The Chief Nurse, Alison Moon, referred to Commissioning for Quality and Innovation (CQUINs) targets, with regard to the levels of noise at night in the Children's Hospital. Bins had been replaced with quiet-closing lids, and the remaining noise levels were attributed to staff and patients. Alison had seen other methods of quietening wards utilised in other Trusts around the South-West region, and she was considering how these could be applied in our Organisation.

Incidences of Hospital acquired pressure ulcers were noted. It was also noted that Falls were decreasing, and a detailed report was scheduled to be brought to the Quality and Outcomes Committee for consideration.

Alison reported that there had been one case of breaching the Single-sex Accommodation standard this month, due to infection control issues, but measures were in-place to counter this on a daily basis.

Discussion commenced:

- Following a query by John Moore about data in arrears, both Alison Moon and Deborah Lee confirmed that only fully validated information was reported in the Board setting, but that they received unvalidated data, which gave insight, much sooner.
- Selby Knox was impressed by the trajectory for Length-of-Stay. He then referred to Antibiotic Prescribing Compliance, which had remained between 81% and 77% for several quarters, well below the 95% target. He asked if there were other Trusts who achieved this target and, if so, how they achieved it.
- At this point, it was noted that the Quality and Outcomes Committee had been actively scrutinising the matter, and the Board heard reports from the Chair of the Committee that the performance had been highlighted for focussed attention.
- Kelvin Blake asked if the patient who had experienced the Single-Sex Accommodation breach had commented on her experience. Alison Moon responded, saying that the Lady involved had not reported an unfavourable experience, but that this was a "negative measure", with the objective of avoiding breaches entirely. If such breaches did occur in the future, gaining the patients' view would form part of the breach report.
- Kelvin also asked about the Stroke Care Exception, and Mark Callaway confirmed that patients requiring thrombolysis received their treatment in a

timely way. Sean O'Kelly added that Dr Foster's Report had commended the Trust on low parameters of stroke mortality outcomes.

- After a request from Kelvin, Chris Perry described the difference between pressure ulcers and moisture lesions and the procedures for diagnosis. She added that thresholds were regularly reviewed with Matrons and Heads of Nursing. Chris informed the Trust Board that it was likely there would be national mandatory reporting on this in the New Year, and the definitions of reportable pressure ulcers was consistent with our approach at University Hospitals Bristol NHS Foundation Trust.
- Paul May referred to the 92 Serious Incidents logged in the last twelve months, and said that the Quality and Outcomes Committee had looked at assurance around the process. He added that although the number seemed low in the context of the scale of the Trust, every Incident was received and scrutinised by the Executive.
- The Chief Executive noted that there was not a rising trend, and confirmed that the objective of the Executive was not to reduce the number of reported incidents, but to ensure that the risks associated with them were effectively managed.
- John Moore requested assurance regarding Complaint Two (Page 71 of the report), and Alison Moon confirmed that significant changes had been made in the Womens' and Childrens' Division following key recommendations made at the working party.

d. 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:

- There had been a deterioration in fill-rates, following a move from weekly to monthly payment of wages. On-going reviews of fill rates would continue for the coming months, but this had now stabilised.
- John Moore asked whether seasonal data had been considered as attributing to the trend to payment changes. Steve Aumayer confirmed that the fundamental changes to bank usage over the past year made it very difficult to come to conclusions about year-on-year trends.
- Lisa Gardner noted and commended the appraisal rates of Junior Doctors.

e. Access

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

The main points of relevance were:

- Performance for the month had been good, except 31-Day Cancer. 4-Hour Performance was also noted to have 'dipped' in October. Incidences of Last-Minute Cancellations had increased to 0.9% and a focus remained on them in this regard.
- 28-day readmissions after Last-minute Cancellation of Surgery were at 100%.

- Regarding Reperfusion Call-to-Balloon Time – pressure was being sustained to maintain the performance rate, and the Specialised Services Division had taken steps to provide this service outside of working hours.
- Emma Woollett said that the Quality and Outcomes Committee had considered the Accident and Emergency 4-Hour Wait in a detailed report, which contained encouraging information about the steps being taken to maintain performance.
- Lisa Gardner asked how the Trust's Breastfeeding Rates compared to Southmead. Alison Moon would investigate this, and in doing so, planned to contact a Trust in London with successful breastfeeding rates.
- Clive Hamilton, a Governor who was present, asked about the predicted impact of "strike-day" on targets. James Rimmer confirmed that Primary Care and Accident and Emergency services would operate as normal. Union representatives had also offered to support urgent cases, to help achieve a good balance of patient care.

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

7. Hathaway Action Plan Update Report

The Board received and considered this report by the Chief Executive for **discussion**.

Robert Woolley presented the report, saying that it was a review completed in parallel with an audit of Divisional governance in the context of the Histopathology Inquiry.

The main points of relevance were:

- The report acknowledged that 'risk' and 'governance' were part of the language of the Organisation, and that sound systems were in-place in this regard. The report and action plan had been provided to Monitor and the Care Quality Commission (CQC) as part of their evidence gathering.
- Page 90 – 93 of the Report listed the outstanding actions, and Appendix 1 (page 94 onwards) gave all of the completed actions, which were:
    - A wide-ranging review of governance, with changes to Board and Executive structures.
    - Risk reporting changes
    - New Appraisal policies in Trust
    - Serious incident review panels established
    - Processes for individual appraisal revised

In addition to this, an external review of the Ulysses System had been commissioned, and found that the system was fit for purpose. The findings were taken to the Risk Management Group.

Discussion commenced:

- Kelvin Blake referred the Board to Recommendation 13 (page 108). He asked if Trust staff were involved in the selection and implementation of new systems. Robert Woolley replied that this was the case, particularly in respect of the new Medway system, where the Trust had done everything necessary

to involve staff and where good clinical engagement was evident.

- John Moore referred the Board to Recommendation 16 (page 109), with regard to the unhelpful wording used to describe the 'rejection' of email circulation lists. John highlighted that discussions at the recent Quality & Outcomes Committee had revealed that direct communication with Junior Doctors was a particular challenge, as they were not employees of the Trust, are here for a short period of time, and do not necessarily check their University Hospitals Bristol NHS Trust emails regularly. Given their important role within the Trust and their impact on patient care, the Quality and Outcomes Committee requested a review of current communication methods be made and improvements sought.
- Referring to Recommendation 10, it was questioned whether there was a Service Level Agreement between the Central Sterile Services Department and the departments it served. Robert Woolley confirmed there was not a Service Level Agreement, but performance was reported into Divisional Reviews and appropriately monitored.

*There being no further questions or discussions, the Board resolved to **note** the Hathaway Action Plan Update Report.*

Finance and Governance

8. Committee Chairs' Reports

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

a. Finance Committee dated 25 November 2011, including the Report of the Finance Director

The Chair of the Committee, Lisa Gardner, presented the report of the Finance Committee meeting in November:

1. The Trust had delivered a surplus of £3.626m for the seven months to 31 October. This was marginally better than the Annual Plan at this stage in the year. The Trust's Financial Risk Rating remained at 3 (actual = 3.45) – the Annual Plan gave a Financial Risk rating of 3 (actual 3.45) at this stage and over the rest of the year. The Trust's forecast outturn remained at £6m surplus.

2. The Committee noted the further deterioration in the Divisional financial position, with the cumulative overspending increasing by £0.479m in the month to £4.534m. Across the Trust there was a reported continuing improvement in the performance on pay budgets, with a small underspend noted for October of £90k (September £114k favourable). The requirement to make further progress on Cash Releasing Efficiency Savings schemes over the remainder of the year and for 2012/13, made it essential that recent progress on controlling pay costs were sustained. Non-pay budgets were overspent by £0.319m in October, with a significant adverse variance noted in the Specialised Services Division (£0.178m, of which £0.142m is non-recurrent). The Executive Team was in 'Board to Board' meetings with the Womens' and Childrens', Specialised Services and Surgery, Head and Neck Divisions to determine the measures required to bring each Division into financial balance.

3. Income from Activities showed an under performance of £0.432m for October (September activity reported a month in arrears). The cumulative position on Income from Activities showed a shortfall to date of £0.606m (net of the balance of the over performance for March 2011 (£0.81m), received in 2011/12). Operating income showed an in-month favourable variance of £0.182m, bringing the cumulative favourable variance to £0.375m to date. 4. The Committee considered the commentaries prepared by Finance Managers for each Division. Executive Directors provided updates on meetings held with Divisional teams and outlined the work that Divisions had been asked to complete in advance of scheduled meetings. The emphasis was on supporting Divisions to produce robust plans with a greater degree of granularity on the actions and outcomes of their plans to March 2012 and beyond. 5. Jan Bergman attended for the discussion on Cash Releasing Efficiency Savings and Service Transformation. He gave a progress report on the plans and achievement to date. The forecast savings for the year totalled £20.770m or 78% of the 2011/12 target of £26.636m. Jan presented a report on the Transformation Programme Workstreams, which was designed to show current performance of each Transformational Workstream, measured against four domains – Financial, Safety/Quality, Patient Experience and Staffing. A sample financial trajectory for Medical Staff Efficiencies showed financial performance from April 2011 with a forward-looking trajectory to the end of the financial year, and for 2012/13, had been developed – further Workstreams were to be completed for next month's meeting. There was an overarching summary linking the transformational themes and Workstreams. Information was continuing to be prepared to highlight blockages and actions being taken for Workstreams to achieve their targets, together with information on the interdependencies of Workstreams both internal and external to the Trust. The Committee noted the approach taken had identified the importance of engagement with clinical staff as being a key enabler in progressing Cash Releasing Efficiency Savings and transformation work in the Trust. 6. The Committee received and approved a proposal to introduce a differential Cash Releasing Efficiency Savings target in the range of 3.5 – 5% for 2012/13, to deliver an overall Cash Releasing Efficiency Savings programme of 4%. The Cash Releasing Efficiency Savings targets for next year took account of current information on service line profitability and Reference Cost Indices. Discussion commenced: • Paul Mapson added to Lisa's summary, saying that pay was under control, and income and activity was beginning to become an issue, but was being addressed in operating reviews. • Cash Releasing Efficiency Savings schemes were being reviewed for a 2012/13 position, in light of the Operating Framework, and once the tariff metrics were known in December and January. • John Moore referred to the Earnings before Interest, Taxes, Depreciation and Amortization (EBITDA) target being met, and added that in-year savings were being overlooked. There was a concern that Divisional positions should	

be reflected in organisational Earnings before Interest, Taxes, Depreciation and Amortization. Robert Woolley pointed out that there was an application of reserves, to maintain the position.

b. Quality and Outcomes Committee dated 25 November 2011

The Chair of the Committee, Paul May, gave a verbal report on the main issues discussed at the Quality and Outcomes Committee meeting for October:

- Paul praised the high quality of the reports being brought to the Committee.
- Additional issues for consideration at future meetings of the Quality and Outcomes Committee included an Outpatients' Survey and an overview of previously commissioned reports and actions taken.
- The Committee recommended that the Trust Board should receive a briefing regarding staff issues at a more detailed level than the current performance criteria show.
- The Committee sought further benchmarking information in the future, in order to judge the effectiveness of performance reports.
- A full review of the 62-Day Cancer Target had been undertaken. It was a good report, which had a clear patient focus. The Trust had consistently failed the target and the reasons for this had been explored. The outcomes related mainly to patient choice arising from national Bowel Cancer Screening, late referrals and workload planning in the Breast Screening Service. It was hoped that close, formal monitoring would ensure sustainability and achieve the predicted targets in Quarter 3.
- The Committee was presented with a full analysis of performance regarding Antibiotic Prescribing. It was noted that it required urgent attention and for the Heads of Divisions to accept accountability for deliverance of the target as a priority. Improvements had been made, but it remained non-compliant. Different practices existed within the Divisions and issues arose about how Junior Doctors received communication. The Medical Director was asked to review the rate of improvement and examine the timescale for electronic prescribing. This was to ensure that there would only be one prescribing form in use and to have full authority to prioritise further actions.
- The Patient Experience Survey and Action Report was a 'work in progress' that was expected to make a significant difference in the future. There was a plan to consult the Governors on the topics to be agreed for 2012/13.
- Peter Murphy, the Lead Clinician for Medicine, introduced his report about the Stroke Services of the Trust. He raised a key point regarding how to mitigate the dedicated ward for Stroke and Screening urgency, for both peaks and troughs of demand, plus how the service worked beyond the commissioned times. There was also a need to reinforce learning and awareness of Stroke symptoms in the Accident and Emergency Department.
- The Lead Nurse for Dementia Care, Helen Morgan, introduced the report on the Dementia Care Service. She noted that the Trust's progress had recently been peer reviewed. The "This is Me" initiative, clear leadership and joint working with North Bristol NHS Trust gave positive evidence of this.

- Regarding the Nutrition Report, it was noted that some concerns still existed regarding the consistency of results from the regular auditing that takes place. The Chief Nurse, Alison Moon, was treating this as an urgent issue and good progress had already been achieved in this regard.
- The Executives were congratulated for reviewing the Toft Report from 2007, which was commissioned following two Patient Safety Incidents at the Trust. The Report was also being brought to the Trust Board, and concerns had been raised, as around 25% of the recommendations had not yet been completed. The review of the Toft Report raised issues about the possibility of reviewing other significant historic reports.
- The Committee were briefed on plans to sustain performance against the 4-Hour Emergency Access Target in 2011/12. The purpose was to assure the Committee of the considerable improvements being made through the Transformation Programme, in optimising the use of beds, larger Medical Assessment Unit, dedicated Stroke Unit, discharge focus and clear management/community engagement. The Committee expressed caution regarding the likely winter pressures, as they would be the 'real test' of the plans in-place. In response to this, the Chief Operating Officer, James Rimmer, gave the Committee a level of assurance about winter Accident and Emergency planning performance.
- The Committee did not discuss the Quality and Performance Report at the meeting.

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

9. Annual Review of Standing Financial Instructions & Scheme of Delegation

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

Steve Aumayer explained that the Review had previously been approved by the Finance Committee in October, and required ratification by the Trust Board of Directors.

The review listed itemised changes on page 124.

*There being no further questions or discussions, the Board resolved to **approve** the Annual Review of Standing Financial Instructions and Scheme of Delegation.*

Strategy and Business Planning

10. Pathology Services Review

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

Deborah Lee introduced the report, explaining the findings and recommendations arising from the recent Pathology Advisory Panel. She sought support for the subsequent recommendations arising from the Trust Management Executive.

The main points of relevance were:

- The Trust was considering a different role for the future as a commissioner rather than provider of Pathology Services. North Bristol NHS Trust had put itself forward to provide the Service to University Hospitals Bristol NHS Foundation Trust and Weston, and it was being tested for its readiness to take on this role. The Panel had supported the vision and emerging clinical model being proposed for the new Pathology Service, however, they had noted that significant further work was now required to attain the levels of detail that would be required for the Business Case. The recommendation of the Panel was to support North Bristol NHS Trust to progress and undertake further feasibility testing for presentation to the second Panel event in March 2012.
- The Panel had noted that Weston, University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust had demonstrated good partnership working to date but that North Bristol NHS Trust now needed to provide a stronger leadership focus to the next phase of work.
- The Panel had supported North Bristol NHS Trust's recommendations around the consolidation of the majority of specialist testing.

Discussion commenced:

- Kelvin Blake noted that not all clinicians were in agreement about the model of service for the future, but stressed that getting to clinical consensus was less important than implementing a successful model for service delivery to the local population. He asked what the timescales were going forward, and Deborah Lee responded that these would be clarified as part of the next Panel, but said that a staff transfer was unlikely to take place before April 2013.
- Following a question by John Moore about the Financial Viability Assessment, Deborah Lee replied that this was an undeveloped element of the North Bristol NHS Trust proposal and testing this further would be a key element of the next stage of due diligence. At present, the North Bristol NHS Trust model did not demonstrate the level of savings aspired to. John Moore sought clarification around the strategic implications of the service change in considering future merger or competition with North Bristol NHS Trust. Deborah Lee responded that this had been considered by the Board when they had taken the decision not to bid to be the Lead Provider.
- Emma Woollett felt that considerable work was still required before a decision was made. Deborah Lee noted that the North Bristol NHS Trust project resourcing would be re-shaped to include recruitment of a full-time Project Director and part time Clinical Lead. The risk of the work not being completed on time was noted, but the Board agreed that doing it well was the most important thing.

There being no further questions or discussions, the Board resolved to support the Trust Management Executives recommendation to subject the proposed model for pathology to further feasibility testing.

Information and Other

11. Any Other Business

There was no other formal business of the Trust Board.

Members of the Trust Board of Directors responded to questions from Governors who had been observing the meeting.	
12. Date of Next Meeting **Public Meeting of the Trust Board of Directors**, Wednesday 21 December 2011 from 14:00 – 16:00 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 21 December 2011 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 04 – 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 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 – Trust Management Executive Report

APPENDIX A

TRUST MANAGEMENT EXECUTIVE

REPORT TO TRUST BOARD - DECEMBER 2011

1. INTRODUCTION

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

2. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** good performance against the compliance standards in Monitor's governance framework for Quarter 3 to date, with a requirement for continuing diligence in the management of cancer pathways, accident and emergency waiting times, referral to treatment times and last minute cancellations of surgery.

The group **noted** an initial report on the local impact of a national day of action by public services staff on 30 November. Thanks were due to staff who had worked normally or had undertaken different duties in order to support the continuing delivery of patient services. The group **agreed** that a formal report on lessons learned from the day should come to its next meeting.

The Trust Management Executive **noted** the latest reports of evidence providing assurance of compliance with Care Quality Commission Outcomes 11 (medical devices) and 21 (clinical record-keeping) by the end of the calendar year, as planned.

The group **noted** progress with a review of essential training requirements across the Trust (including statutory and mandatory training requirements), including setting of agreed priorities and formation of a steering group to oversee the review. The project plan indicated full delivery by September 2012 of the programme objectives, which encompass clarification of essential training requirements, establishment of a single point of access to essential training, use of competency-based assessment as the norm and further development of e-learning tools and induction processes. The Trust Management Executive **agreed** that early delivery of visible benefits for staff was a priority and that a further report on progress should be received in February 2012.

The group **noted** progress with delivery of the Histopathology Inquiry action plan prior to its consideration by the Trust Board. It was **noted** that the Independent Inquiry panel had been invited to review progress with the implementation of their recommendations.

The Trust Management Executive **approved** proposals for the re-organisation of central patient information services, with the intention of improving quality and reducing the costs of provision of patient leaflets across the Trust.

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

- the publication of the report, *Innovation, Health and Wealth, Accelerating Adoption and Diffusion in the NHS* which set out new national goals for the research, innovation, teaching and training in the health service
- new arrangements for the management of patient recruitment to clinical research trials and the imminent announcement of potential central infrastructure funding to support designated biomedical research facilities
- consideration by the Clinical Quality Group of the half-yearly progress of the Clinical Audit Programme
- engagement between Heads of Division and the new Clinical Commissioning Group chairs
- a further Trust-wide review of risk registers to support implementation of new risk reporting arrangements
- continuing progress with the development of the Transforming Care programme and the related the roll-out of a leadership development programme in the Trust.

3. STRATEGY AND BUSINESS PLANNING

The Trust Management Executive **approved** draft corporate guidance for the consideration of service disinvestment proposals, taking account of contractual and regulatory requirements, subject to a number of additions to the guidance.

The group received the comprehensive business case for the creation of a new Welcome Centre at the entrance to the Bristol Royal Infirmary Queen's Building and **approved** the recommendation to employ a Trust-funded development model for delivering the scheme.

The group received a report on the status of GP engagement and marketing activities and **agreed** that greater pace was needed to deliver the objectives of the plan.

The group **approved** a proposal from the Spiritual and Pastoral Care Team to apply the name, *The Sanctuary*, to chapels, quiet spaces and multi-faith facilities in the Trust.

4. RISK, FINANCE AND GOVERNANCE

The Trust Management Executive **approved** a recommendation to adopt pre-filled syringes for Potassium Chloride injection in the Trust's adult critical care facilities.

The Trust Management Executive **approved** final reports from the South West Internal Audit Consortium relating to Creditor Payments and Treasury Management.

The group **agreed** to adopt a new approach to the exception reporting of Divisional risks to the Risk Management Group and Trust Management Executive.

The group **noted** the current register of external agency visits, inspections and accreditations.

5. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
13 December 2011

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 21 December 2011 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 05 – Quality and Performance Report

Purpose

To brief the Board on the Trust's performance against Quality, Workforce and Access standards.

Abstract

The monthly Quality & Performance Report details the Trust's current performance against national frameworks, and against a range the Quality, Workforce and Access standards. Exception reports are provided, for areas requiring further attention, along with examples of learning and improvement from complaints, incidents and patient stories.

Recommendations

The Board is recommended to **note** the current performance of the Trust and to ratify the actions being taken to improve performance.

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
		20 Dec 2011			

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

December 2011

CONTENTS

PERFORMANCE OVERVIEW

SECTION A – Performance Overview

Summary

Overall, the 'health' of the organisation has deteriorated slightly relative to last month, with the number of GREEN rated indicators increasing by one, but the number of RED rated indicators increasing by three. This net change includes CRES (Cash Releasing Efficiency Savings) achievement and Same Sex Accommodation Breaches moving to a GREEN rating, and Hospital Standardised Mortality Ratio (HSMR) and 30-day Emergency Readmission rates moving to a RED rating.

Two of the three Patient Experience indicators are now GREEN rated, which follows improvements on both the Patient Climate Survey scores and achievement of the Same Sex Accommodation standard. Three of the four measures of Being Efficient retained their GREEN rating for a further month, including both Length of Stay indicators. The recent deterioration in both HSMR and 30-day Emergency Readmission rates is currently being investigated, to provide assurance that this does not reflect a deterioration in safety or quality of care. Financial performance has improved again, with all four measures now being GREEN rated in the month, and three of the four also being GREEN rated for the year to date. This is in addition to both measures of Delivering Our Contracts retaining their GREEN rating.

The Trust is forecast to achieve a GREEN rating against Monitor's Compliance Framework at the end of Q3, with the full achievement of all cancer standards expecting to be confirmed for November and December.

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)	73.9	76.2	N/A	Green: >= 74.4 Red: <72.4	↑	Current month is October 2011.
A02	Number of Patient Complaints	122	126	1002	Green: <120 Red: >=135	↑	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	10	0	65	Green: 0 Red> >0	↓	

Delivering High Quality Care

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
B01	Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4)	4	4	21	Green: 0 Red: > 1	→	No RAG rating for YTD. Current month is October 2011.
B02	Number of Inpatient Falls Per 1,000 Beddays	4.53	4.68	4.64	Green < 5.6 Red: >= 5.6	↑	Current month is October 2011.

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
C01	Number of Serious Incidents (SIs)	8	8	54		→	
C02	Number of C.Diff cases	5	4	42	Below Trajectory	↓	

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
D01	18 Weeks Admitted Pathways	91.2%	91.2%	91.9%	Green: >=90% Red: <85%	→	
D02	Number of Cancer Standards Failed	1	2	1	Green: 0 Red: >=2	↑	Previous is confirmed Quarter 2 2011/12. Current is Q3 to date (i.e. October only). YTD is Apr-Sep quarterly performance. Forecast is for achievement of all standards in Q3.
D03	A&E 4 Hour Standard	95.36%	97.06%	97.42%	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)	72.9	90.2		Green: <80 Red: >=90	↑	Previous and Current totals are June and July 2011.
E02	30 Day Emergency Readmissions	365	413	3058	Below 10/11 volumes	↑	

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
F01	Elective Length of Stay Reduction	3.27	3.42	3.57	Green: <= 3.64 Red: >= 3.83	↑	
F02	Emergency Length of Stay Reduction	4.78	4.66	5.01	Green: <= 5.07 Red: >= 5.34	↓	
F03	Theatre Productivity - Percentage of Sessions Used	94.8%	93.0%	94.5%	Green: >= 90% Red: < 90%	↓	
F04	Outpatient Follow-Up To New Ratio	2.01	2.04	2.08	Green: <2.03 Red: >=2.03	↑	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
G01	Workforce Costs	-0.1%	-0.2%	1.0%	current month and ytd budget	↓	current month below budget, ytd over budget, a reduction on previous ytd figure
G02	Staff Sickness	3.9%	4.3%	3.8%	See note	↑	Amber: Above Forecast (over 0.5% of target) [Parameters 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)	£2,294	£2,328	£2,328	Green:>Same Period Last Year Red:<Same Period Last Year		Previous is Apr-Oct cumulative total. Current (and YTD) is Apr-Nov cumulative total. Trend arrow is not applicable, as Current will always be higher than Previous.
H02	Weighted Patients Recruited Into NIHR Trials	2,202	1,996	14,776	Green: > YTD Last Year Red: < YTD Last Year	↓	Previous and Current are rolling 3 month totals Jul-Sep 2011 and Aug-Oct 2011 respectively). YTD is Apr-Oct 2011

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
J01	Monitor Governance Risk Rating	1	0	N/A	Green: < 1 Red: > = 4	➡	Previous now shows the confirmed Q2 reported position. Current shows forecast Q3 posiiton.

Delivering Our Contracts

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
K01	Financial Performance Against CQUINs (£millions)	£2.97	£2.89	£2.89	> 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)	-£0.01	-£0.09	£0.45	Green: Below Plan Red: Above Plan	⬇	Previous is Sept; Current is Oct; YTD is April to Oct. 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	3	3	Green: >3 Red: <3	➡	
L02	EBIDTA (Compared To Plan)	103%	103%	103%	Green: 100% Red: <95%	➡	
L03	CRES Achievement	77%	93%	75%	Green: >=90% Red: <75%	⬆	
L04	Liquidity (in Days)	34.9	33.6	33.6	Green: 25+ days Red: <=14 days	⬇	

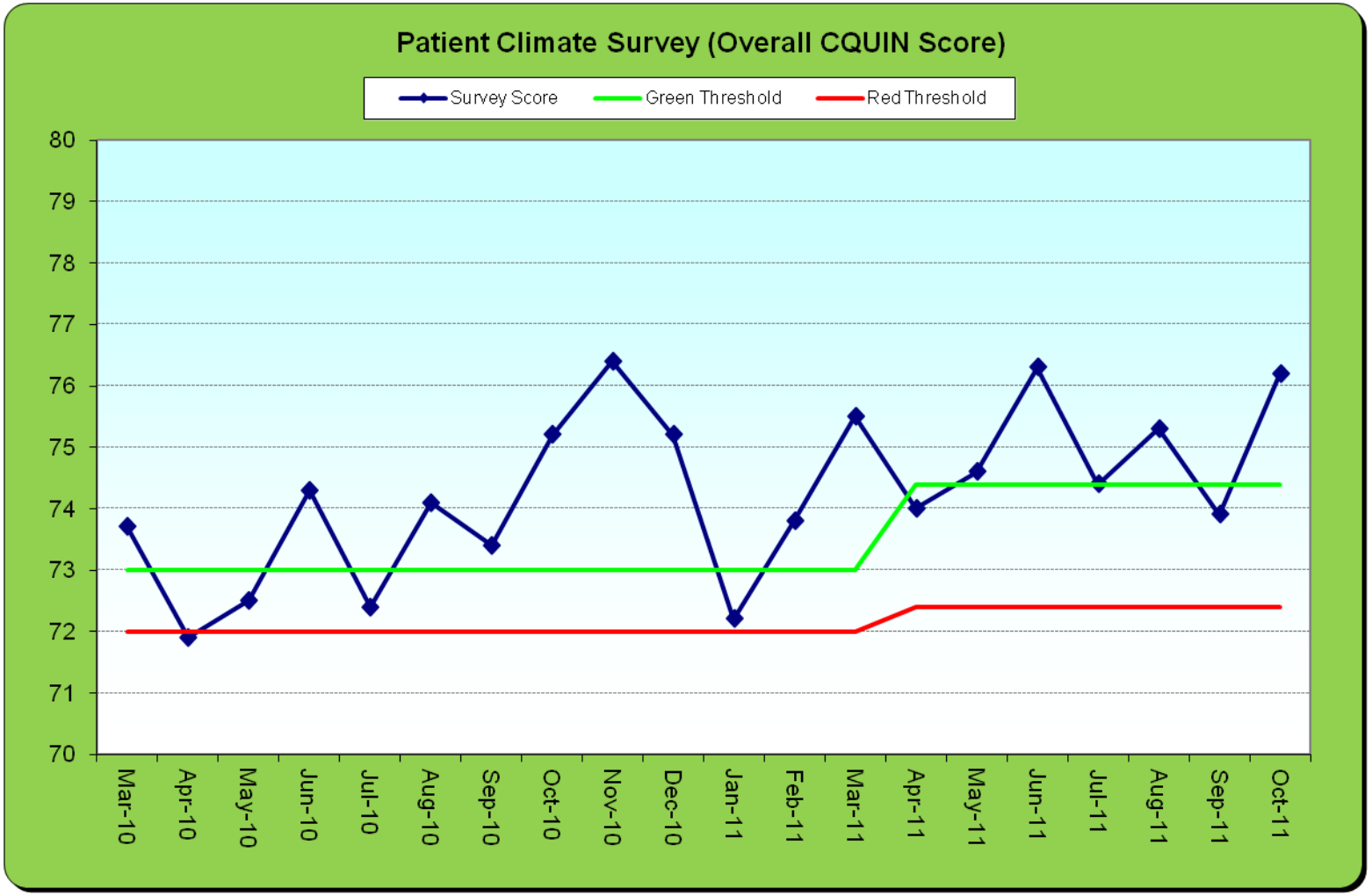
Notes

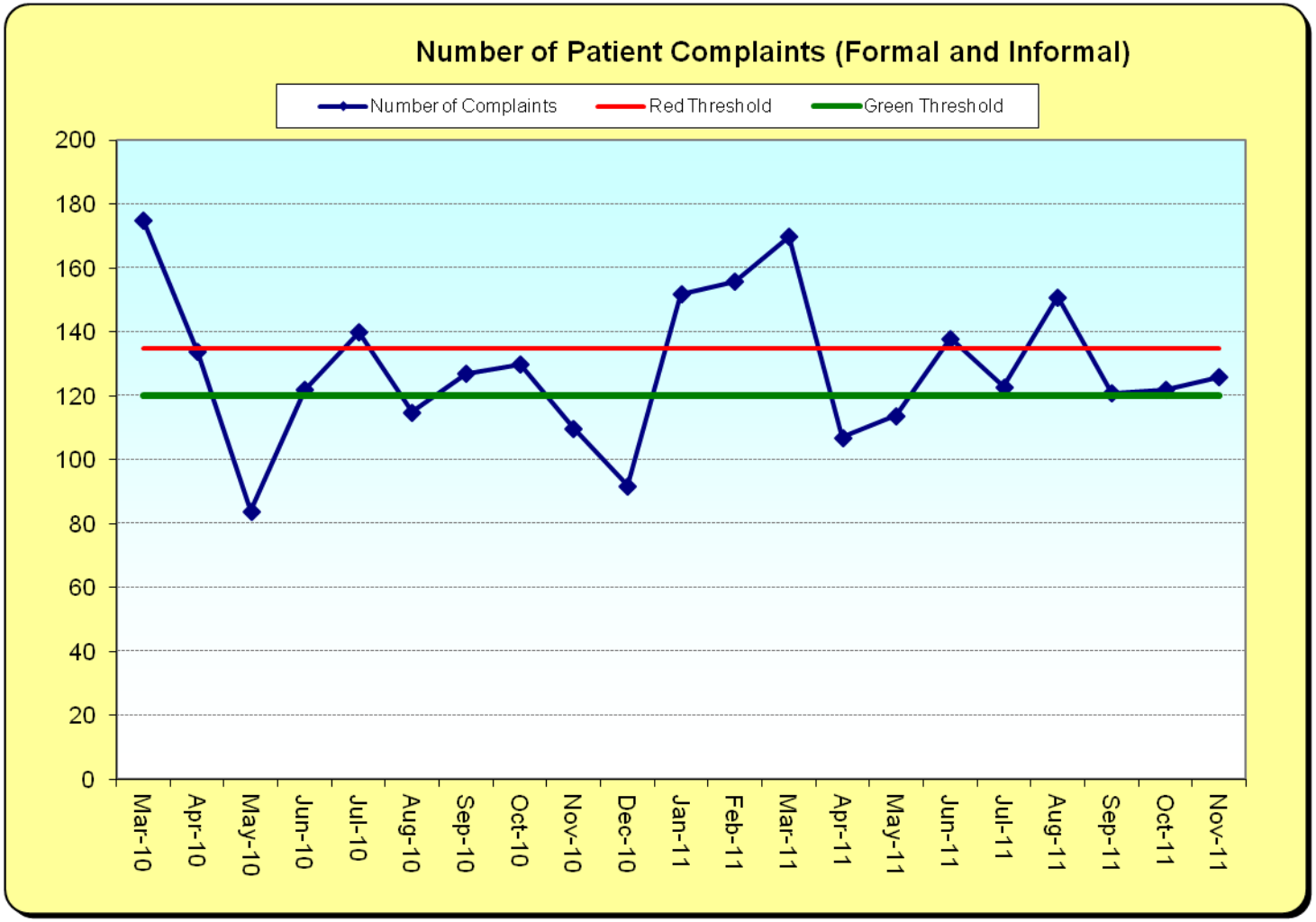
Unless otherwise stated, Previous is October 2011 and Current is November 2011

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
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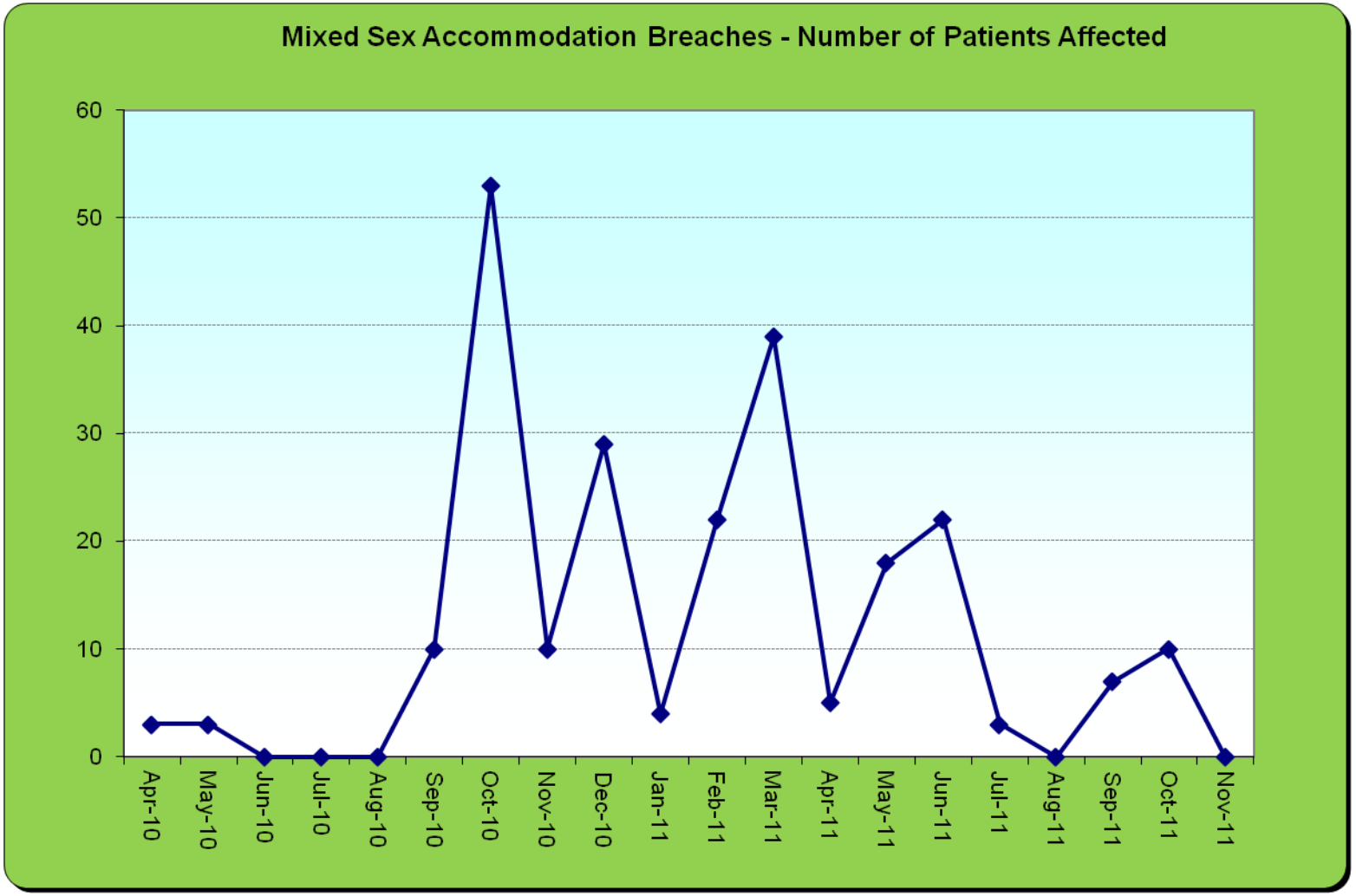
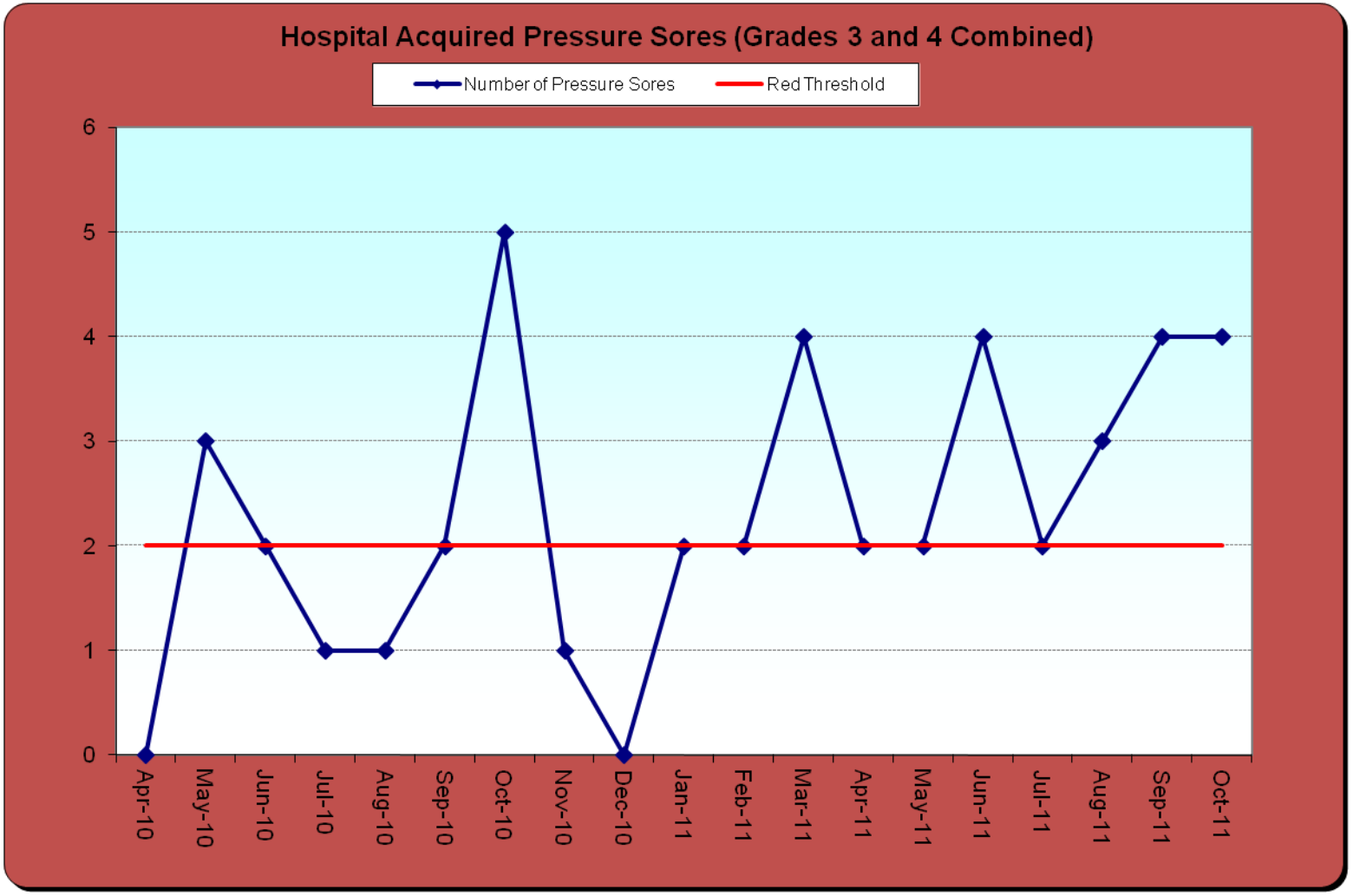
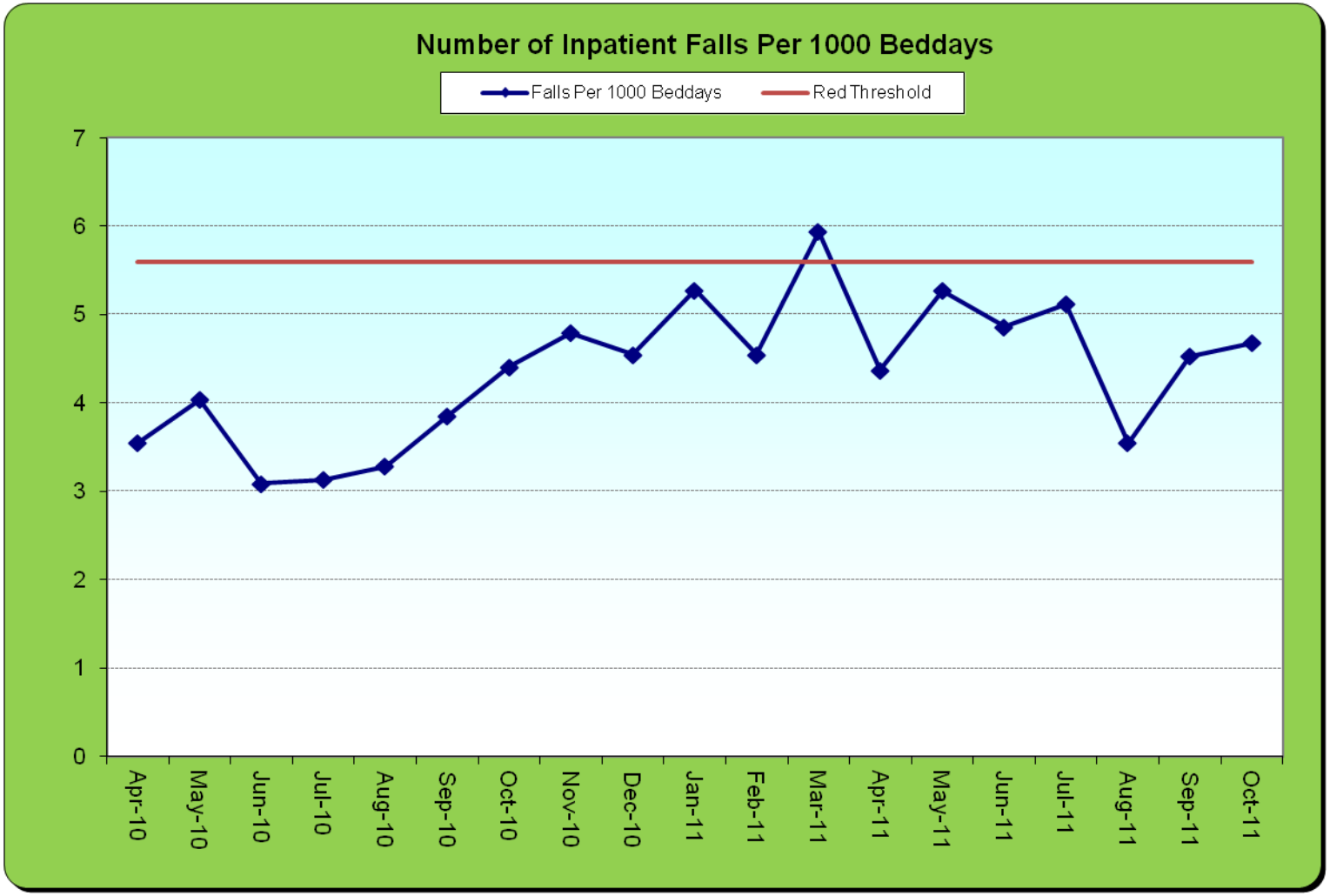
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11

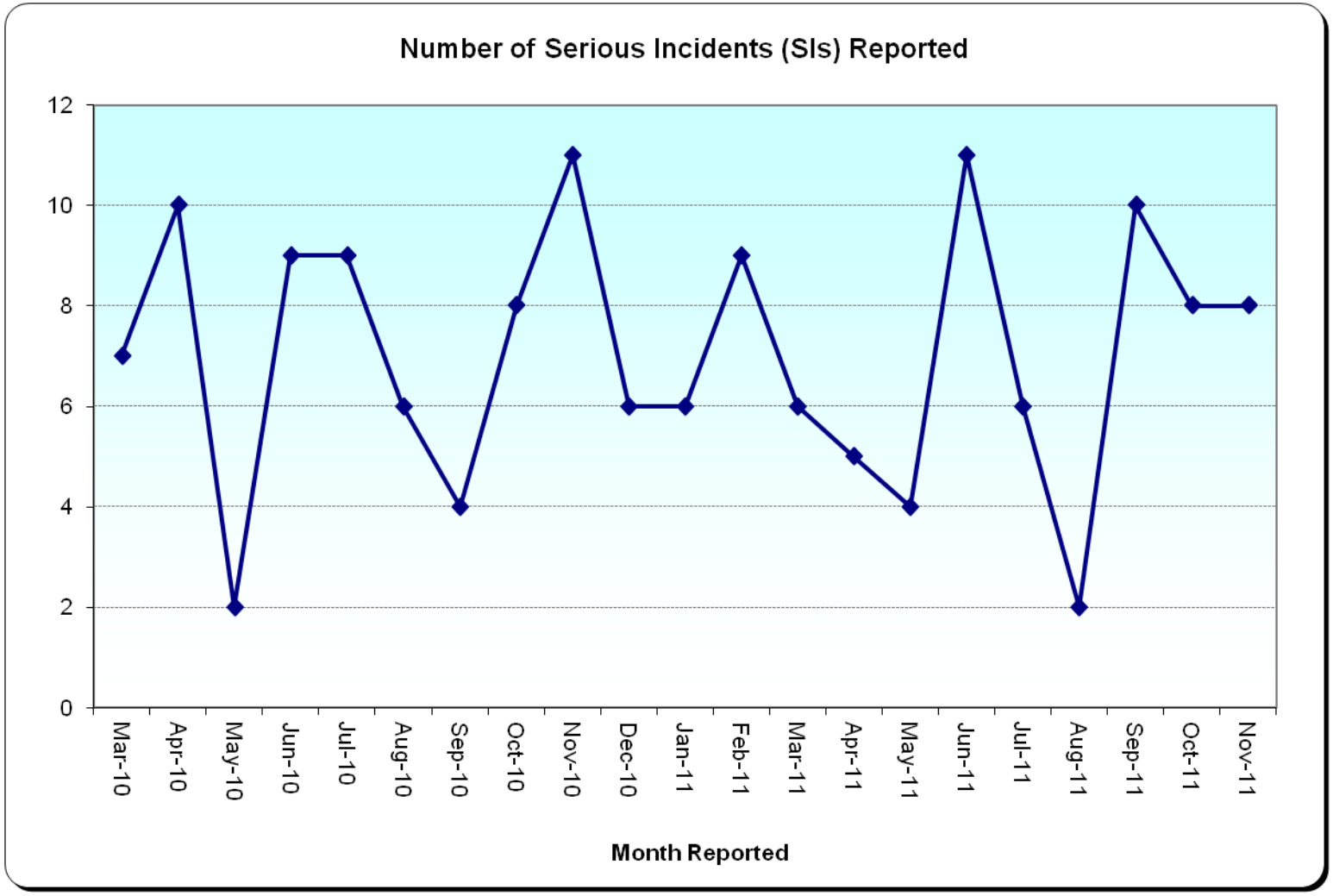

Mixed Sex Accommodation Breaches - Number of Patients Affected
60
50
40
30
20
10
0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11

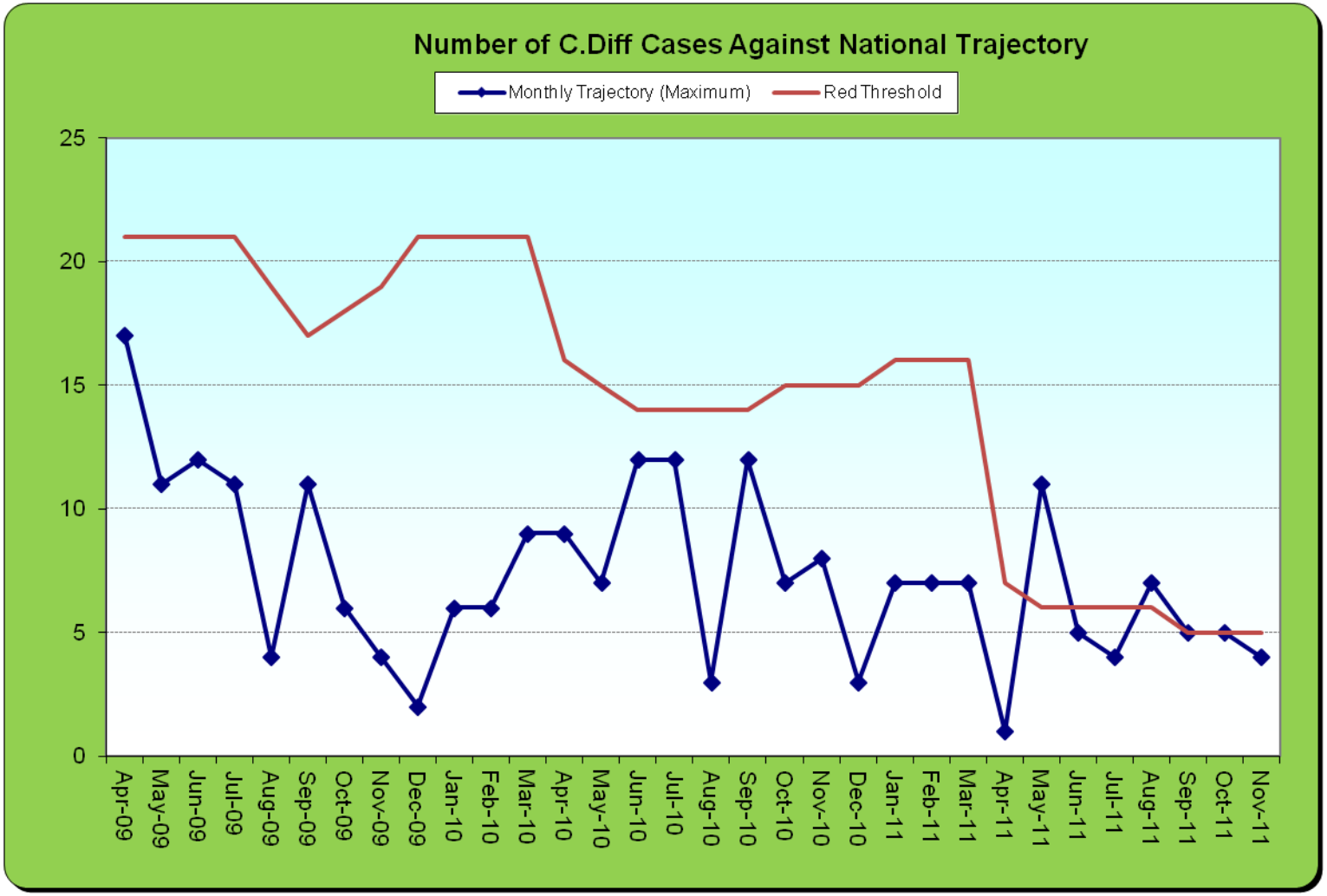
PERFORMANCE OVERVIEW



PERFORMANCE OVERVIEW




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
Oct-11
Nov-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
Oct-10
Nov-10
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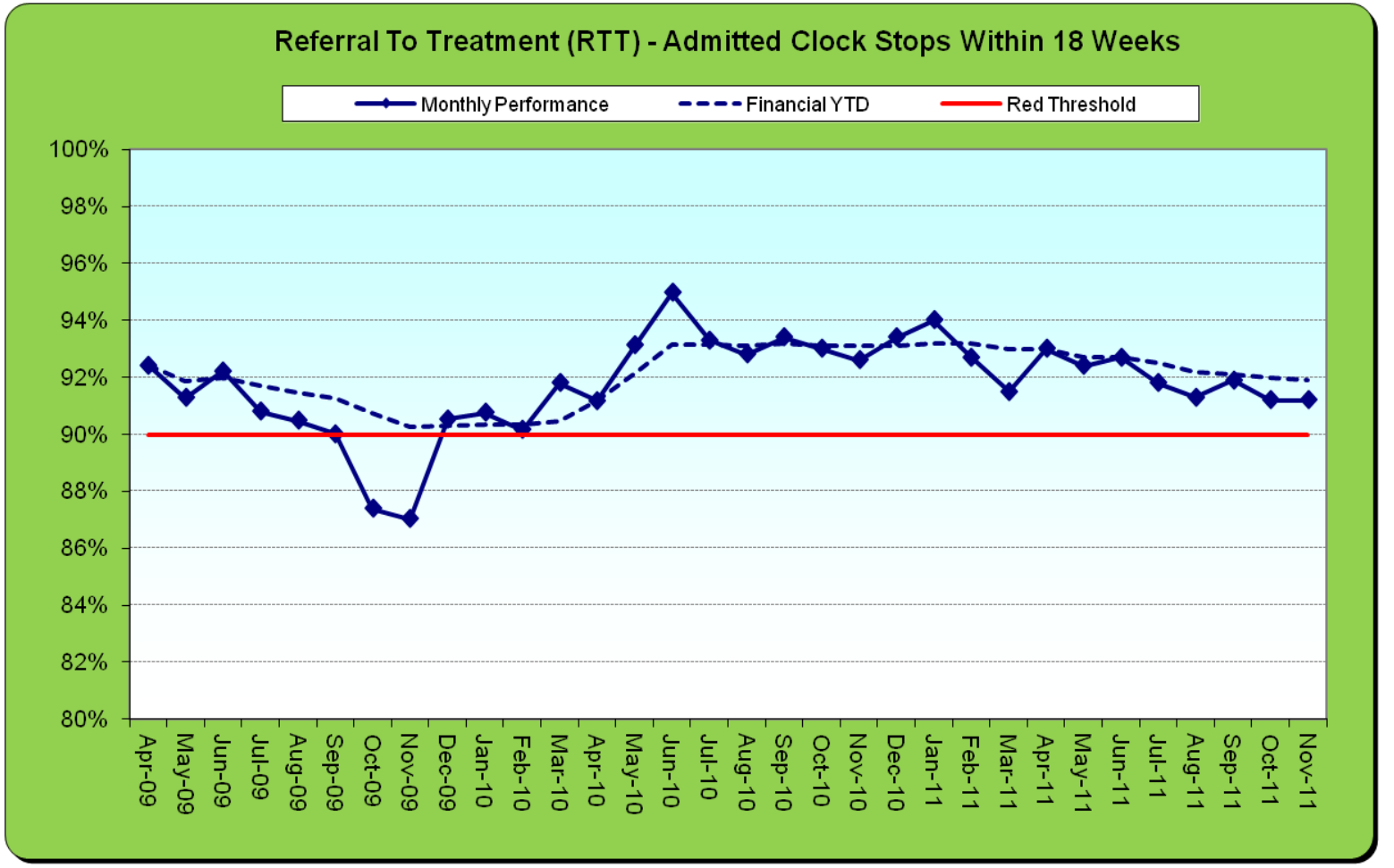
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11


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
Oct-10
Nov-10
Dec-10
Jan-11
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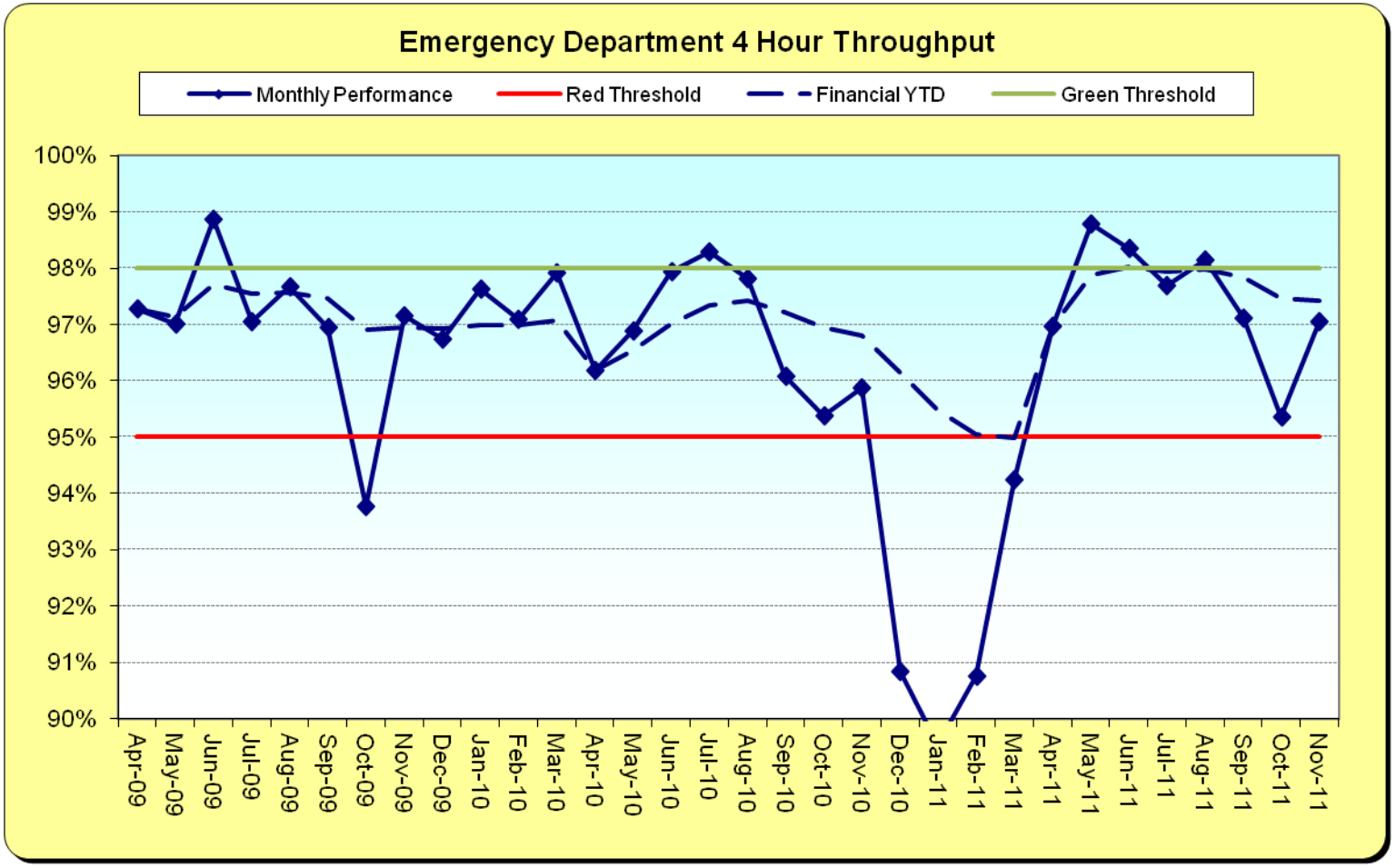
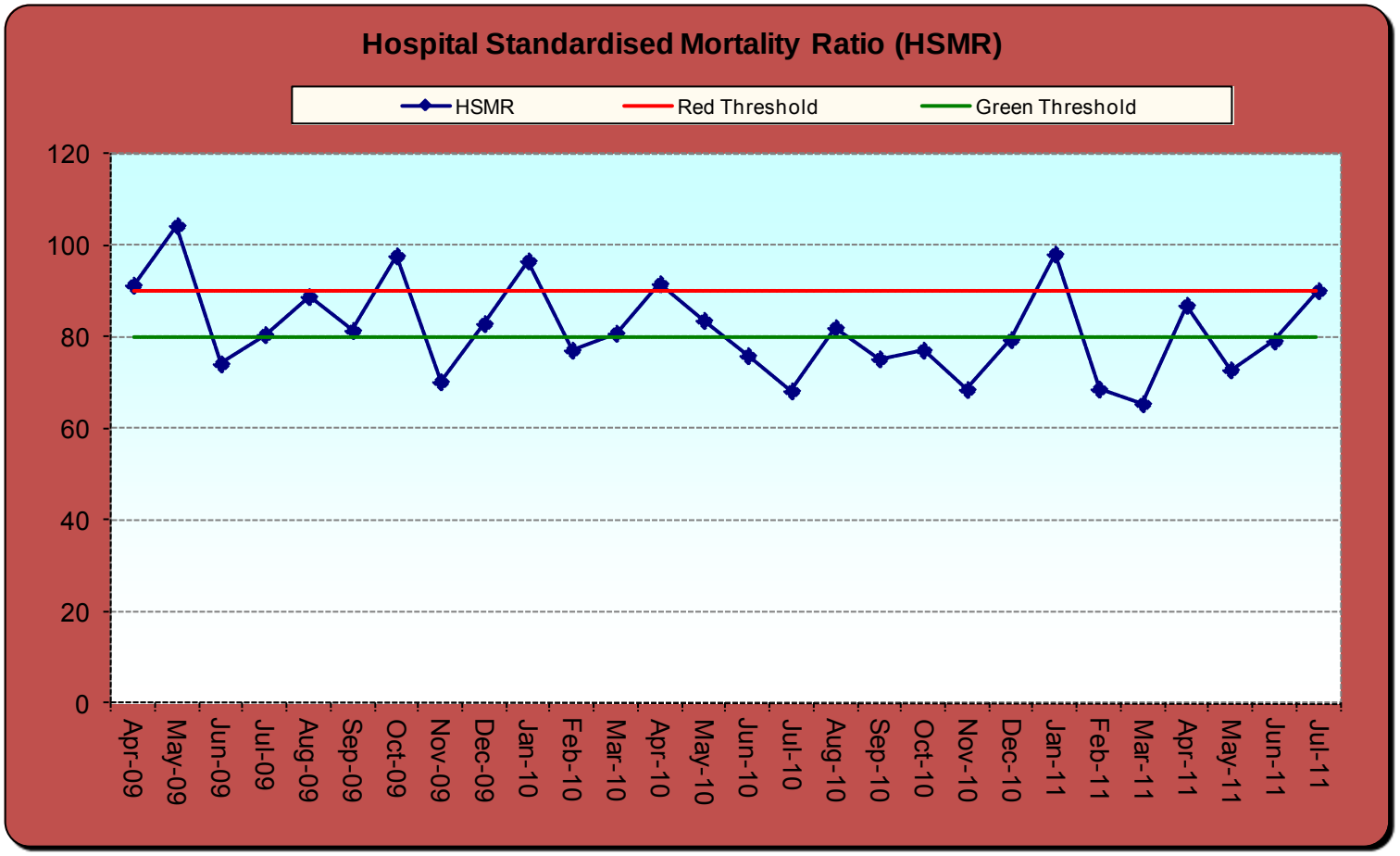
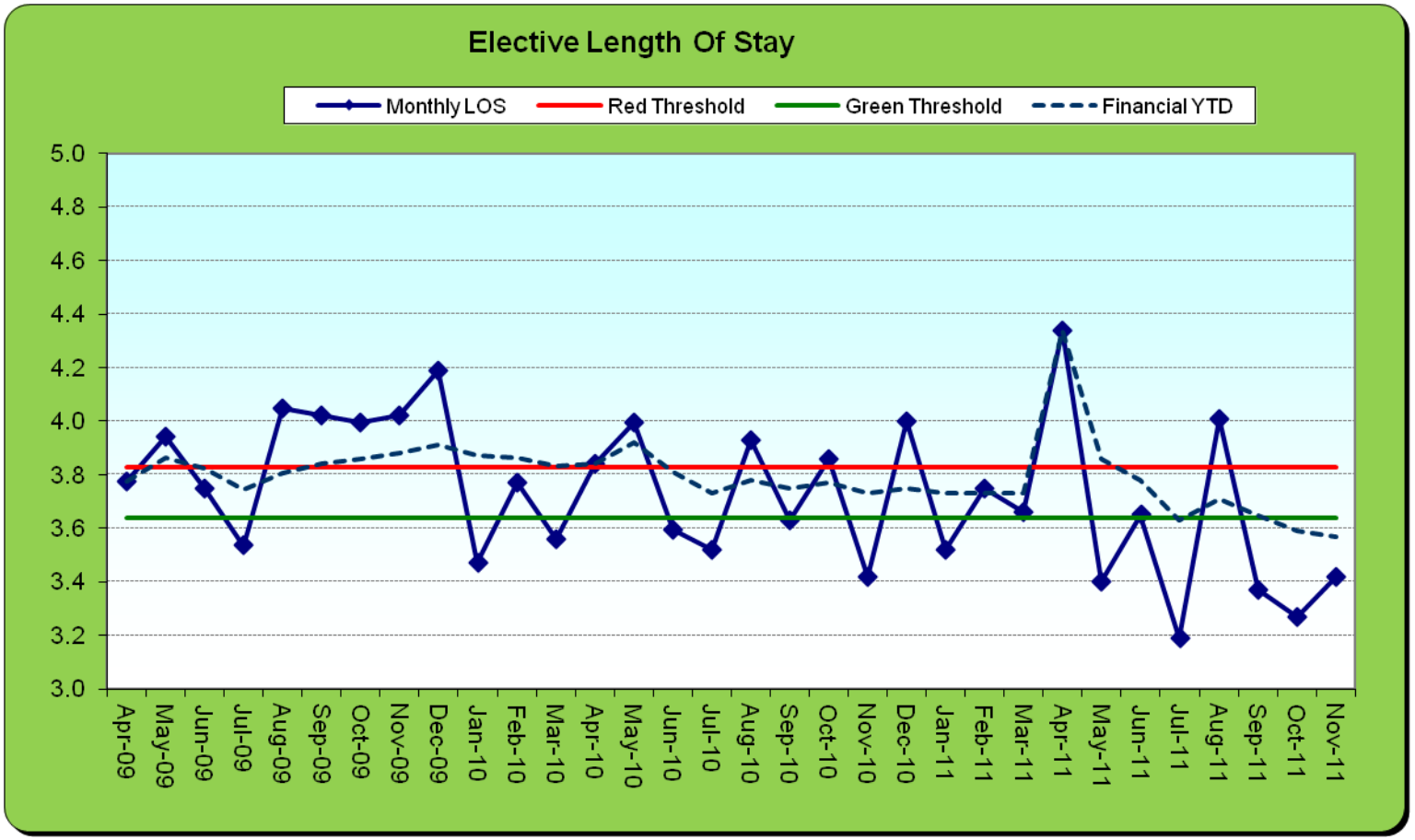
Aug-11
Sep-11
Oct-11
Nov-11

PERFORMANCE OVERVIEW




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
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

PERFORMANCE OVERVIEW



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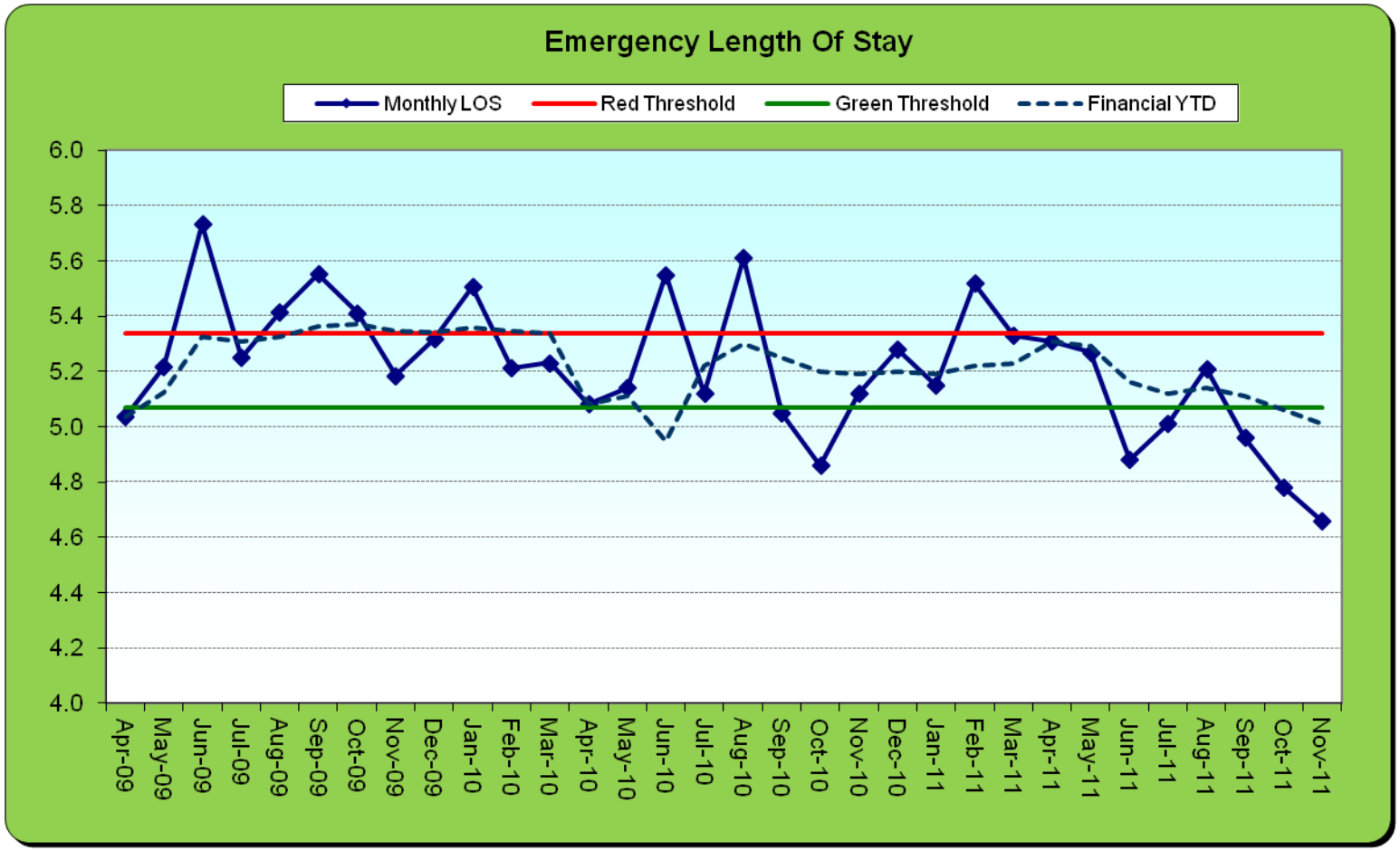
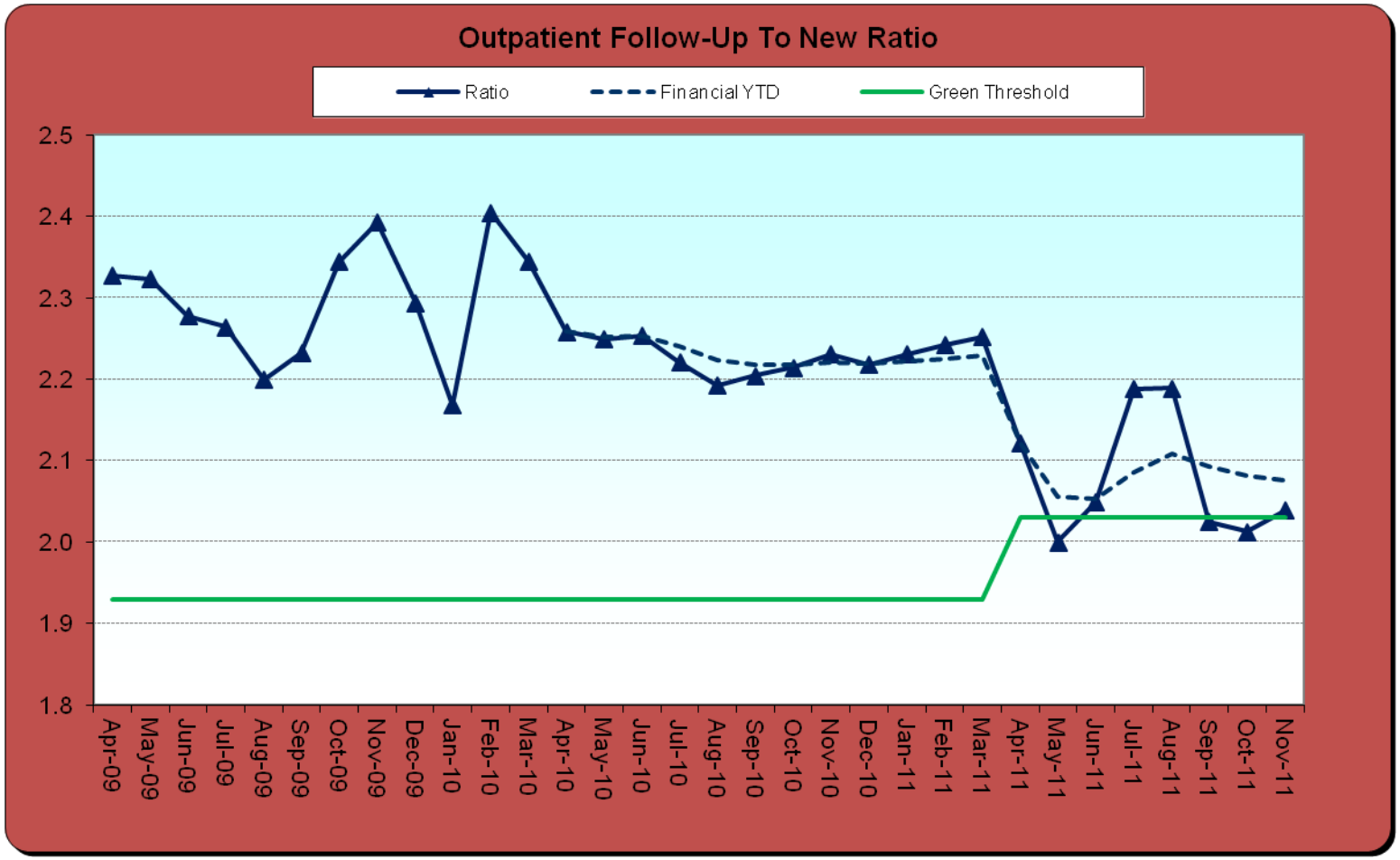


PERFORMANCE OVERVIEW



Please note: *The baseline measurement of the Follow-up to New ratio was re-calculated in November. The data has been back-dated based upon this new calculation. The adjustment was made because of data reclassification and service changes which were giving a false picture of the underlying follow-up rates.*

PERFORMANCE OVERVIEW

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Incidence of Hospital Acquired Pressure Sores	In the *Quality* section of this report	
Number of Cancer Standards Failed	In the *Access* section of this report	Forecasting full achievement of all cancer standards for the quarter as a whole.
Hospital Standardised Mortality Ratio (HSMR)	In the *Quality* section of this report	
30 Day Emergency Readmission Rates	In the *Quality* section of this report	
Outpatient Follow-up to New Ratio	See additional information	The baseline measurement of the Follow-up to New ratio was re-calculated in November. The data has been back-dated based upon this new calculation. The adjustment was made because of data reclassification and service changes which were giving a false picture of the underlying follow-up rates. The target is currently flagged as RED, with a deterioration in the month from a ratio of 2.01 follow-ups to one new, to 2.04, against a target of 2.03. Work continues to understand where we are under-performing and what action can be taken to reduce un-necessary follow-ups where clinically appropriate.
Weighted Patients Recruited into NHIR Trials	See additional information	Recruitment into National Institute for Health Research (NIHR) studies remains off target year to date. 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.

SECTION C – Monitor's Compliance Framework

At the end of November the Trust is on track to achieve all of the targets in Monitor's Compliance Framework during quarter 3. As the 31-day subsequent surgery cancer waiting times standard is currently reported as not being met for the year to date, an exception report has been provided in the *Access* section of this report.

The Trust therefore has a forecast score of zero against Monitor's Compliance Framework and a GREEN Governance Risk Rating. This is the lowest rating out of four.

Monitor's Compliance Framework - dashboard

	Number	Target	Weighting	Target threshold	Year To Date	Q4 10/11	Q1 11/12	Q2 11/12	*Q3 to date	Q3 Forecast	Notes	Forecast Q3 Governance rating
Monitor Compliance Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	42	✓	✓	✓	9	✓	Trajectory: Q1 19; Q2 17; Q3 13; Q4 15	Achieved
	2	Infection Control - MRSA Bloodstream Cases Against Trajectory	1.0	< or = trajectory	2	✓	✓	✓	1	✓	Trajectory: Q1 1; Q2 2; Q3 1; Q4 2	Achieved
	3a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	99.9%	✓	✓	✓	100.0%	✓	December figures 100%, with no further breaches expected. On track to achieve 95.5% for the quarter as a whole.	Achieved
	3b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	96.9%	✓	✓	✓	93.9%	✓		
	3c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	99.5%	✓	✓	✓	99.2%	✓		
	4a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85.0%	86.0%	✓	✓	✓	86.3%	✓		Achieved
	4b	Cancer 62 Day Referral To Treatment (Screenings)		90.0%	92.2%	✖	✓	✖	93.3%	✓		
	5	Referral to treatment time for admitted patients (95th percentile) - in weeks	1.0	23	Achieved each month		Achieved each month	Achieved each month	22.6	Achieved each month		Achieved
	6	Referral to treatment time for non-admitted patients (95th percentile) - in weeks	1.0	18	Achieved each month		Achieved each month	Achieved each month	15.6	Achieved each month		Achieved
	7	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	0.5	96%	97.8%	✓	✓	✓	97.8%	✓		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	0.5	93%	95.1%	✓	✓	✓	95.5%	✓		Achieved
	8b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	98.0%	✓	✓	✓	94.6%	✓		
	9	A&E Total time in A&E 4 hours (95th percentile)	1.0	5%	97.4%	✓	✓	✓	96.2%	✓		Achieved
	10	Stroke indicators - to be confirmed	0.5	To be confirmed (TBC)	Not applicable					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		Achieved
		CQC standards or over-rides applied	Varies	Agreed standards met	CQC Actions completed	Hisopathology inquiry over-ride	CQC Compliance actions	CQC Actions completed	Not applicable	Not applicable		Achieved
					rating	AMBER-RED	AMBER-RED	AMBER-GREEN	AMBER-GREEN	GREEN		0.0 GREEN

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

***Q3 to date cancer figures based upon confirmed figures for October and draft figures for November.**

QUALITY

1.1 PATIENT EXPERIENCE

Usually this section of the report contains an example of a patient experience which was not of the standard we expect. It identifies what went wrong, what we have learned and what preventative action we have taken. On this occasion we have provided an example of a positive patient experience and the sharing of learning which is important from best practice.

Miss W wrote to the Chief Executive to share her very positive experience of her treatment at the Bristol Heart Institute. She has given permission for her story to be shared with the Trust Board, stating that it has changed not only her life, but the lives of those around her.

Miss W has Postural Orthostatic Tachycardia Syndrome (POTS), where her autonomic nervous system does not control her blood pressure or heart rate properly, causing multiple disabling symptoms related to reduced oxygen to her brain.

For most of the last six years, Miss W explained that her life has been extremely difficult. She identified that slurred speech, the inability to think, shaking, loss of co-ordination and altered levels of consciousness were all a normal part of her life. Her heart rate could reach 180 beats per minute just from standing up. She was medically retired in 2010 at the age of just 28, on grounds of permanent ill health, after deteriorating for five years, despite treatment at a specialist centre in London. Miss W reports that the effort of eating a meal would knock her out for several hours and she was rarely able to hold even a short conversation sitting up. In Miss W's words, she was "surviving but not truly living". Her life consisted of forcing herself to do the bare essentials and then lying semi-conscious as her body struggled to recover.

This all started to change when Miss W first saw her consultant at the Bristol Heart Institute in September 2010. Miss W now receives medication, which she reports made an immediate difference to her symptoms, and inpatient physiotherapy. She has also had access to on-going advice from the Bristol Heart Institute for her local physiotherapists, and phone and email advice from the arrhythmia nurses which provide her with an avenue to resolve anything that concerns her. Miss W described the very positive impact this has had on how she manages her condition. She also has access to an internet blog where she can get advice and support from other patients at the Bristol Heart Institute with the same condition, as well as from her consultant and the arrhythmia nurses, without needing to use up a valuable appointment time and resources.

Miss W reports that under the care of her consultant and his team, her progress has been amazing and that now, just over a year later, she is living independently. She can do her own shopping, make her own meals and go out for coffee with friends. She works as an author and illustrator, publishing four books in the past year, giving talks and holding book signings. She also works as a maths tutor, has joined a dance group and says she feels "truly alive".

Miss W states that in the space of a year, the team at Bristol Heart Institute have achieved more than the specialist centre in London did in five years. She would be extremely happy if the Bristol Heart Institute could further develop its interest in, and treatment of POTS, and has suggested becoming an internationally recognised centre of excellence, carrying out pioneering research into the management and treatment of POTS.

Miss W explained that whilst she still has symptoms of POTS, thanks to the Bristol Heart Institute she is in control and knows how to deal with these symptoms and can now do the physiotherapy she needs to manage her other underlying medical issues. She is still disabled but is now working, is independent, has a social life and is no longer just surviving.

Organisational Learning

- The importance of clear communication, access to advice and working in partnership with patients to enable them to manage their long term conditions can work extremely well.

- A team approach to patient care, both within the Trust and provision of expert advice to more general community services, has worked well in this particular situation. This example demonstrates the benefit for patients of having specialist expertise contained within a specialist centre but being able to link in with local service provision.

- The use of technology (e-mails/blogs) and nurse specialists to provide advice and support patients need without them having to attend Outpatients is better for patients as they do not need to travel and is more efficient for the Trust as it frees up appointments for others who need to be seen in person.

1.2 QUALITY DASHBOARD

		ID	Title	Green Threshold	Year To Date	Monthly Totals												Quarterly Totals			
						Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Q4	Q1	Q2	Q3
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%	93.0%	80.6%	90.4%	92.0%	91.7%	91.5%	93.3%	92.5%	92.7%	93.1%	93.2%	93.4%	94.1%	91.3%	92.4%	93.0%	93.7%
		PS-A3	Hand Hygiene Audit Compliance	95%	97.4%	95.3%	96.1%	96.0%	97.3%	97.8%	95.0%	98.3%	99.1%	98.8%	97.3%	97.2%	96.2%	96.4%	97.0%	98.4%	96.7%
		PS-A4	Antibiotic Compliance	95%	80.2%	78.6%	77.5%	79.4%	76.5%	81.5%	78.4%	84.1%	80.1%	76.3%	76.7%	81.5%	83.7%	77.7%	81.4%	77.4%	82.8%
		PS-A5	Matron's Checklist	95%	94.2%	94.4%	94.8%	94.8%	93.7%	94.8%	93.1%	93.7%	94.2%	93.8%	94.5%	95.2%	94.9%	94.4%	93.8%	94.2%	95.0%
		PS-A6	Cleanliness Monitoring - Overall Score	95%		96%	96%	95%	95%	95%	96%	96%	95%	95%	96%	95%	96%				
		PS-A7	Cleanliness Monitoring - Very High Risk Areas	95%		97%	97%	97%	97%	97%	97%	97%	97%	96%	97%	97%	96%				
		PS-A8	Cleanliness Monitoring - High Risk Areas	95%		99%	97%	96%	96%	96%	96%	96%	96%	97%	97%	96%	97%				
		PS-A9	Number of GRE Bacteraemias	<=2	5	0	3	1	1	1	0	0	0	3	1	0		5	1	4	0
		PS-A10	Infection Control - C.Diff Infections Against National Trajectory	<Traj.	42	3	7	7	7	1	11	5	4	7	5	5	4	21	17	16	9
		PS-A11	MSSA Cases Against Trajectory	<Traj.	28					3	2	4	0	8	4	5	2		9	12	7
	Incidents	PS-B1	Number of Serious Incidents (SIs) Reported		54	6	6	9	6	5	4	11	6	2	10	8	8	21	20	18	16
		PS-B2	Serious Incidents Reported Within 48 Hours	80% (Q3)	74%					60%	100%	91%	83%	100%	50%	62%	75%		85%	67%	69%
		PS-B3	Percentage of Serious Incident (SI) Investigations Completed Within Timescale	80% (Q3)	100%							100%	100%	100%	100%	100%	100%		100%	100%	100%
		PS-B4	Total Never Events	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0
		PS-B5	Total Number of Patient Safety Incidents Reported		5093	704	862	748	860	645	790	740	710	681	688	839		2470	2175	2079	839
	Falls	PS-C1	Number of Inpatient Falls Per 1,000 Beddays	<5.6	4.64	4.55	5.28	4.55	5.94	4.37	5.27	4.86	5.12	3.55	4.53	4.68		5.28	4.83	4.42	4.68
		PS-C2	Repeat Inpatient Falls		23.7%	21.7%	21.2%	26.9%	20.0%	31.9%	15.4%	31.8%	21.7%	20.3%	13.4%	28.6%					
		PS-C3	Number of Inpatient Falls - Patients Aged 65 And Over		593	92	100	88	132	79	104	88	94	63	78	87		320	271	235	87
		PS-C4	Number of Inpatient Falls - Patients With Cognitive Impairment		299		28	41	73	40	53	45	43	26	44	48		142	138	113	48
	Pressure Ulcers	PS-D1	Total Pressure Ulcer Incidence per 10,000 Bed Days	6.51	13.88	5.06	7.06	9.84	9.84	7.16	14.15	14.37	13.61	12.70	13.97	21.21		8.89	11.88	13.43	21.21
		PS-D2	Percentage of Hospital Acquired Pressure Ulcers Not Graded	<5%	0.0%	0.0%	0.0%	4.2%	14.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		7.1%	0.0%	0.0%	0.0%
		PS-D3	Number of Hospital Acquired Grade 2 Pressure Ulcers	<83 yr	218	13	17	21	19	16	34	31	32	27	29	49		57	81	88	49
		PS-D4	Number of Hospital Acquired Grade 3 Pressure Ulcers	<1	21	0	2	2	3	2	2	4	2	3	4	4		7	8	9	4
		PS-D5	Number of Hospital Acquired Grade 4 Pressure Ulcers	<1	0	0	0	0	1	0	0	0	0	0	0	0		1	0	0	0
	Venous Thrombo-embolism (VTE)	PS-E1	Adult Inpatients who Received a VTE Risk Assessment	90%	96.9%	69.3%	82.4%	84.4%	91.6%	94.2%	95.1%	97.0%	97.5%	98.0%	97.6%	97.5%	98.0%	86.8%	95.5%	97.7%	97.7%
		PS-E2	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	90%	91.9%								87.5%	93.3%	89.6%	97.5%	89.7%			90.4%	93.7%
	Nutrition	PS-F1	Patients who Received Fully Completed Nutritional Screening Within 24 Hours	90%	78.5%	76.6%			76.1%			66.2%			92.0%			76.1%	66.2%	92.0%	
	Safety	PS-G1	WHO Surgical Checklist Compliance	98%	94.6%	97.8%	97.7%	98.7%	98.0%	98.6%	92.6%	90.2%	87.3%	96.8%	97.7%	97.0%	97.3%	98.1%	93.5%	93.9%	97.1%
		PS-G2	Reduction in Medication Errors	<2.84%	1.20%	3.39%	3.73%	5.10%	5.93%	2.08%	0.79%	0.85%	0.85%	1.77%	1.05%			4.86%	1.17%	1.23%	
	Leadership	PS-H1	Number of Executive Director Patient Safety Walk-arounds	>=6	62	7	5	5	5	7	11	9	6	5	10	9	5	15	27	21	14
		PS-H4	Percentage of Non-Estates Actions Completed Within 2 Months	80%	89%	29%	100%	80%	67%	100%	100%	77%	95%	75%	91%	100%	86%	75%	89%	88%	90%

Please see next page for part 2 of the Quality Tracker.

QUALITY

		ID	Title	Green Threshold	Year To Date	Monthly Totals												Quarterly Totals			
						Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Q4	Q1	Q2	Q3
Clinical Effectiveness	Mortality	CE-A1	Hospital Standardised Mortality Ratio (HSMR)	<=80		79.5	98.1	68.8	65.5	87	72.9	79.2	90.2								
	Length of Stay	CE-C1	Average Length Of Stay - Elective	<=3.64	3.57	4.00	3.52	3.75	3.66	4.34	3.40	3.65	3.19	4.01	3.37	3.27	3.42	3.64	3.78	3.53	3.34
		CE-C2	Average Length Of Stay - Emergency	<=5.07	5.01	5.28	5.15	5.52	5.33	5.31	5.27	4.88	5.01	5.21	4.96	4.78	4.66	5.33	5.16	5.06	4.72
	Learning Disability	CE-D1	Risk Assessment of Patients with Known Learning Disability within 48 Hours	90%	63.1%					50.0%	37.5%	60.0%	33.3%	42.9%	87.5%	85.7%	81.8%		51.7%	61.1%	83.3%
	Readmissions	CE-E1	Emergency Readmissions Within 30 Days	<412 mth	3058					431	404	405	398	350	292	365	413		1240	1040	778
	Maternity	CE-G1	Percentage of Spontaneous Deliveries Compared to All Births	64.4%	62.76%	59.63%	64.67%	62.34%	65.04%	63.83%	65.01%	63.53%	64.88%	61.22%	57.79%	63.84%	61.97%	64.05%	64.13%	61.32%	62.92%
	Fracture NoF	CE-H1	Fracture Neck of Femur Patients Treated Within 36 Hours		57.9%					61.1%	51.9%	58.3%	65.4%	58.3%	53.8%				56.5%	59.2%	
		CE-H2	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72hours		40.0%					22.2%	11.1%	12.5%	38.5%	66.7%	84.6%				14.5%	63.2%	
		CE-H3	Fracture Neck of Femur Patients Achieving Best Practice Tariff		23.4%					11.1%	3.7%	8.3%	30.8%	37.5%	46.2%				7.2%	38.2%	
	Stroke Care	CE-J1	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	50%	29.2%	32.5%	20.0%	30.0%	39.4%	25.7%	23.1%	25.0%	42.9%	28.6%	37.9%	28.6%	24.3%	29.5%	24.7%	35.9%	26.2%
		CE-J2	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	80%	85.9%	89.8%	82.1%	62.9%	80.6%	81.4%	86.5%	82.9%	81.8%	85.4%	97.1%	85.7%	87.8%	75.5%	83.5%	87.9%	86.8%
		CE-J3	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	65.29%	63.16%	78.95%	52.38%	74.07%	70.00%	75.00%	42.86%	50.00%	63.16%	77.78%	75.00%	64.29%	68.66%	63.04%	65.31%	69.23%
	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	5.5	3.5				
Patient Experience	Single Sex Accom.	PE-A1	Same Sex Accommodation Breaches - Number of Patients	0	65	29	4	22	39	5	18	22	3	0	7	10	0	65	45	10	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	73.9	76.2			75	75	76.2
		PE-B2	Monthly Patient Survey - Noise At Night	81						83	83	81	82	83	80	83			82	82	83
		PE-B3	Monthly Patient Survey - Help To Eat Meals	76						77	81	80	80	76	76	80			79	77	80
		PE-B4	Monthly Patient Survey - Patients Who Would Recommend The Trust	92%						96%	96%	96%	97%	96%	96%	95%			96%	96%	95%
		PE-B5	Monthly Patient Survey - Local Score	83						87	87	89	86	88	86	88			88	87	88
	Complaints/Compliments	PE-C1	Number of Patient Complaints	<=120	1002	92	152	156	170	107	114	138	123	151	121	122	126	478	359	395	248
		PE-C3	Percentage of Complaints Resolved Within Timeframe (Formal Complaints)	98%	91.8%	95.5%	100.0%	98.7%	98.4%	88.9%	92.2%	89.5%	97.4%	92.7%	92.6%	90.2%	90.9%	99.1%	90.4%	93.9%	90.5%
		PE-C4	Number of Complainants Disatisfied with Response	0-5 mth	62	5	4	6	9	3	4	14	10	8	4	7	12	19	21	22	19
		PE-C6	Complainants Disatisfied with Response (Not Responded In Full)		7											6	1				7
		PE-C7	Complainants Disatisfied with Response (Additional Information Requested)		12											1	11				12

1.3 SUMMARY

This month the quality report shows some key improvements in MSSA (Meticillin Sensitive *Staphylococcus aureus*) cases against trajectory, same sex accommodation breaches and length of stay for lobectomy patients.

An increase in Hospital Standardised Mortality Ratio is also noted and will be reviewed via the Quality Intelligence Group.

In response to a request by Divisions, the total number of dissatisfied complainants has been separated out to show where complainants have come back with new issues or questions in relation to their complaint and where, upon review, it has been identified the original complaint response did not fully address the complainant's concerns. The threshold of a maximum of 5 dissatisfied complainants per month has now been applied to the latter type of dissatisfaction, however the actual threshold will be reviewed for 2012/13.

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

Achieving set threshold (29)	**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 - Glycopeptide Resistant Enterococci (GRE) Bacteraemias - MSSA (Meticillin Sensitive *Staphylococcus aureus*) cases against 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	- Antibiotic prescribing compliance - Matrons checklist (*C. difficile* dashboard) - Percentage adult in-patients who received thrombo-prophylaxis - WHO surgical checklist compliance - Total number of complaints - Percentage of complaints resolved within formal timescale

QUALITY

- Reduction in medication errors - Percentage of all actions completed with 2 months of patient safety walk round - Reduction in average elective length of stay - Reduction in average emergency length of stay overall - 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 - Number of breaches of the same sex accommodation standard - 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 (9)	**Quality metrics with thresholds not yet finalised 10)**
- 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 - Number of executive director patient safety walk rounds - Hospital Standardised Mortality Ratio - Percentage of spontaneous deliveries compared to all births - 30 day emergency re-admissions - Stroke care: percentage receiving brain imaging within 1 hour	**Metrics for quarterly reporting** - Risk assessment of patients with known learning disability within 48 hours **Thresholds not yet applicable** - Fractured neck of femur patients treated with 36 hours - Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours - Fractured neck of femur patients achieving best practice tariff **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 98% in November against the monthly target of 90%.
- Spontaneous vaginal births. Performance of 61.97% in November against a target of 64.4%
- Patient Experience overall score relating to the discharge survey. Score for October 76.2 against target of 74.4.
- Patient Experience: reducing noise at night. Score for October 83 against target of 81.
- Patient Experience: assistance at mealtimes. Score for October 80 against a target of 76.
- Reduction in medication errors of 15% on 2010/11 outturn of 3.5%. Performance of 1.05 % in September 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 3.5 days in November against a target of 5 days.

1.4 CHANGES IN THE PERIOD

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

- Antibiotic prescribing compliance up ↑ from 81.5% in October to 83.5% in November.
- MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory down ↓ from 5 in October to 2 in November.
- Lung lobectomy median length of stay down ↓ from 5.5 days in October to 3.5 days in November.
- Number of dissatisfied complainants down ↓ from 6 in October to 1 in November.
- Single sex accommodation breaches down ↓ from 10 in October to 0 in November.
- 30 day readmissions up ↑ from 365 in October to 413 in November.
- Number of executive director patient safety walk rounds down ↓ from 9 in October to 5 in November.

1.5 EXCEPTION REPORTS

Exception reports are provided for ten (10) indicators in total, nine (9) which are red rated and a further one* (1) which is amber rated and has been of particular interest to the Board:

1. Antibiotic prescribing compliance*
2. Serious Incidents reported with 48 hours
3. Total pressure ulcer incidence per 10,000 bed days
4. Number of hospital acquired grade 2 pressure ulcers
5. Number of hospital acquired grade 3 pressure ulcers
6. Number of executive director patient safety walk rounds
7. Hospital Standardised Mortality Ratio
8. Percentage of spontaneous deliveries compared to all births
9. 30 day emergency re-admissions
10. Stroke care: percentage receiving brain imaging within 1 hour

QUALITY

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

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

The overall percentage compliance increased to 83.4% in November (from 81% in October).
Compliance increased in:

- Medicine (84.6%, up from 83% in October)
- Surgery, Head & Neck (83.5%, up from 81% in October)
- Women and Children (86.3%, up from 77% in October)

Compliance fell in Specialised Services (73.5%, down from 80% in October)

Recovery plan, including expected date performance will be restored:

- Actions as detailed in the report submitted to the Quality & Outcomes Committee and Clinical Quality Group continue.
- A monthly letter is now sent to all Heads of Division highlighting the importance of the antimicrobial prescribing compliance target, with a recommendation to examine the reasons why any sub-Division is achieving less than 80% prescribing compliance within any one month.
- Trust communications are involved in the proposed advertising campaign which will take the format of a multi media campaign aimed at prescribers to improve prescribing of antimicrobials.
- A new antibiotic prescribing policy has been launched in line with the "start smart – then focus" guidance from the Department of Health.
- Antibiotic review rounds continue with opportunities taken to educate junior doctors on antibiotic prescribing where non-compliant prescriptions are identified.

QUALITY

Q2. 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. The targets for Quarters 3 and 4 is 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 eight serious incidents reported in November, two were reported outside of the 48 working hour deadline = 75%, which is an improvement on the previous month. Q3 to date is at 69%. Of the two incidents not reported with 48 hours:

- One was a grade 3 pressure ulcer which occurred in August, for which the division correctly undertook a root cause analysis investigation but overlooked the need to report it as an incident. The oversight was identified when the investigation report was received centrally in November.
- One was a pressure ulcer originally risk assessed as low risk by the reporter and was subsequently identified as a grade 3 pressure ulcer.

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 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 revisited the covering arrangements for the processing of serious incidents in Trust Headquarters in the absence of key personnel.
- All divisional managers have been also been written to requesting they raise awareness of timeliness of incident reporting. Divisions have access to incident information identifying the areas in which delays are occurring so they can target specific areas.
- 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. To rectify this in our own systems we have:
    - Looked at triggers in our systems for grade 3 pressure ulcers to feed into the serious incident process and have introduced a new arrangement for the Tissue Viability Team to report Grade 3 and 4 pressure ulcers where they have been made aware and have identified the incident has not already been reported by the clinical area. This does rely on the person identifying the pressure ulcer to have graded it correctly which is being assisted by the "Being the Best" programme. Further work is in progress with the Tissue Viability Team to look at strengthening systems.

QUALITY

- We have re-introduced a system for all divisions to view their reported incidents each working day to identify possible serious incidents which have not been initially assessed as high risk.

Accurate prediction of whether quarterly targets will be met is difficult to achieve due to the monthly variation in small numbers of serious incidents. We are aiming for 100% compliance in December, but no serious incidents have been reported for December at the time of writing, therefore opportunities for recovering the Q3 position are limited.

QUALITY

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

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

The rate of hospital acquired pressure ulcers grade 2 and above was 21.21 per 10,000 bed days in October and 18.81 per 10,000 bed days in November 2011. Divisional rates are shown in the table below:

Division	September 2011	October 2011	November 2011
Medicine	17.50	30.94	23.32
Specialised Services	19.53	11.50	28.14
Surgery Head and Neck	20.86	37.45	20.02
Women and Children's	1.49	2.92	6.15

There were no category 4 pressure ulcers reported in October and November 2011. There were four category 3 pressure ulcers reported in October and five category 3 pressure ulcers reported in November. In all cases a root cause analysis is undertaken and results of this are formally reported through the Patient Safety Group, and learning from these incidents is shared across the Trust through the weekly tissue viability operational meeting.

A Trust-wide Pressure Ulcer Prevalence survey was repeated in October 2011, which the Tissue Viability Team facilitate currently every 6 months. The audit results are disseminated throughout the Trust via the Heads of Nursing. The overall prevalence rate in October 2011 was 10.93 % which is a decrease from (14.88%) July 2010. The rate of hospital acquired pressure ulcers (excluding category 1) is below the national average at 2.1% (national average 3.4%). In reality, 39 patients out of 750 audited had hospital acquired pressure damage, category 1 and 2 on the day. There were NO deep tissue injuries (category 3 or 4) identified on the day.

The 'Being the Best' programme has moved into the embedding phase. Monitoring of practice is embedded and this shows that pressure ulcer risk assessments were completed for 98% of patients, 99% of patients were on the correct pressure relieving surface and 79% of patients had intentional rounding carried out correctly; this is an area for continued focus.

QUALITY

Recovery plan, including expected date performance will be restored:

The focus on assurance of practice standards will continue through the 'Being the Best' programme with the programme moving into review and embedding in practice.

Following a benchmarking exercise, the process for reporting pressure ulcers has been reviewed. In line with national guidance and other Trusts skin damage that is assessed as being due to moisture as opposed to pressure, shear or friction, by tissue viability or senior nursing staff, will continue to be reported as incidents but will be recorded separately as moisture rather than pressure lesions.

Timeliness of reporting pressure ulcers has now improved such that from December, the month delay in presenting data will be removed and the Board will receive the previous month's data from this point onwards.

There is also a focus on information giving to patients and staff, and following a short consultation period, posters and patient information leaflets will be updated and disseminated by the New Year.

QUALITY

Q6. EXCEPTION REPORT: Number of executive director patient safety walk rounds	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

Number of Executive Director Patient Safety Walk Rounds

Number of walk rounds due to be carried out in November = 7

Number of walk rounds actually carried out in November = 5

Number of walk rounds cancelled in November = 2

Details of Walk Rounds cancelled =

Occupational Therapy, cancelled by James Rimmer: rescheduled for 1st December 2011

Clinical Investigation Unit, cancelled by Paul Mapson: rescheduled for 1st December 2011

Recovery plan, including expected date performance will be restored:

Reminder to all involved to avoid cancelling executive walk rounds if at all possible, and to rearrange within the same month where this is unavoidable.

QUALITY

Q7. EXCEPTION REPORT: Hospital Standardised Mortality Ratio (HSMR)	RESPONSIBLE DIRECTOR: Medical Director

Description of how the standard is measured:

The Hospital Standardised Mortality Ratio (HSMR) calculation is derived from data provided by the Strategic Health Authority which is monitoring all acute Trusts following the Mid-Staffordshire NHS Foundation Trust Inquiry. The reported months figures are two months in arrears. An HSMR of **above** 100 is below average performance for an NHS acute Trust and UH Bristol has set a stretch target aim of maintaining a figure below 80 throughout the year.

Performance in the period, including reasons for the exception:

During 2011/12 the Trust has had a consistently low HSMR with the majority of monthly figures being below 80. The last previous 'blip' in the HSMR occurred in January 2011. The latest figure shows an increase from the previous month's figure of 79.2 to 90.2. The reason for this increase is not clear at this stage, although this is being investigated. It is known that the number of deaths in the month did not change from the monthly average, but the number of calculated 'expected' deaths, which is based upon case-mix, dropped in July. Further analysis will include a break-down of the Trust ratio to a specialty and treatment level.

July's ratio of 90 is still well below the national average of 100. This means that we are still preventing 10% of 'expected' deaths within our patient population. August's provisional ratio is known to be back down to close to our local stretch target of 80.

Recovery plan, including expected date performance will be restored:

The Quality Intelligence Group will consider what work is required to establish further detail of possible reasons for the increase. In the near future, the Trust will move to reporting the new measurement of mortality, the Summary Hospital Mortality Indicator (SHMI) and we are currently working with our intelligence provider to be able to drill down to a range of detailed levels of information to better understand where there may be areas for improvement.

QUALITY

Q8. EXCEPTION REPORT: 30-day emergency readmissions	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the standard is measured:

The number of patients readmitted as an emergency within 30 days of their discharge from hospital, following either a previous emergency readmission or an elective readmission, compared with the baseline figures for 2010/11.

Performance in the period, including reasons for the exception:

The number of 30-day emergency readmissions in November was two cases above the baseline of 2010/11 (413 against a 'target' baseline of less than 412 readmissions per month). Year-to date the volume of emergency readmissions is below the 10/11 baseline levels. However, due to the different costs of cases and variation against plan at a specialty level, the Trust is still currently expecting additional financial penalties to be incurred above plan.

The only Division to be in exception this month was Specialised Services. The Division consistently has a higher number of emergency readmissions than the 2010/11 baseline. This is mainly due to higher levels of emergency readmissions in clinical/medical oncology and haematology than last year. Many of the readmissions relate to neutropoenic sepsis of patients undergoing active treatment, and are a consequence of cancer patients' condition deteriorating. Comparative data is being sourced, to confirm whether our complication rates are higher than the 'expected' levels nationally.

Although the national guidance says that readmissions related to cancer care should be excluded, some cancer-related haematological conditions still appear to count as readmissions even when the national exemptions are applied. This is because the way the readmission is clinically coded, the cancer condition does not feature in the primary diagnosis code for the spell. The clinical coding of these cases has been verified, and the national rule-set re-checked.

Recovery plan, including expected date performance will be restored:

Clinical Divisions are continuing to undertake clinical reviews of readmissions across all specialties where readmission levels are above the baseline. This is, firstly, to understand the clinical reasons why patients have needed to return to hospital following their recent inpatient stay, and whether changes are needed to clinical practice to help prevent readmissions in the future. But it is also to validate our recording of readmissions, so that we are confident that we are correctly applying the national rules regarding financial reimbursement for these readmission cases.

Performance against the 2010/11 baseline levels continues to be closely monitored through the monthly Divisional Finance and Performance Review meetings.

QUALITY

Q9. 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 has improved to 63.8% for October 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 consultant 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:

- A normal birth working party has been set up 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). They 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 the home births, going out as the second midwife to the community midwife and covering the clinics in the community when the community midwife has been up at night.

QUALITY

- All maternity pathways are being reviewed as part of a service review and is putting in an expression of interest as part of next year's operating plan for more midwives and a capital spend to enable the formation of a triage area and a midwifery led unit. This would allow fewer non labouring women to be present on the delivery suite and reduce the risk of intervention for low risk women by accommodating them on a separate unit. This will promote normality and improve normal birth rates. If successful, this is not expected to impact until 2012/13.

QUALITY

Q10. EXCEPTION REPORT: Stroke care – percentage receiving brain imaging within an hour	RESPONSIBLE DIRECTOR: MEDICAL DIRECTOR

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 hospital. 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 varies month on month, but has remains broadly unchanged at around 30%. November's results are 24.3%

There are two potential areas where delays in the pathway can occur. Firstly a delay in requesting the CT scan, and secondly a delay in processing the request and undertaking the scan. At present any grade of doctor can see an acute stroke patient arriving in the Emergency Department, GP Support Unit or Medical Assessment Unit. This has made it more challenging to ensure everyone has the understanding of the clinical urgency for scans, as well as ensuring there are no delays in the request for a scan being made.

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*:

- Acute Stroke pathway established on ICE Order Comms system, so that CTs for acute stroke patients can now bypass the Radiologist, thus reducing delays (Action complete)
- 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 taken place between the Stroke Team, Emergency Department, Radiology and Management team to review resource implications and what can be changed to ensure the scans for these patients are requested more quickly. A plan is being put in place including more rapid assessment of stroke patients in ED, along with a dedicated stroke specialist nurse being available Monday – Friday 9am - 5pm to help speed up the ED assessment if there is likely to be delay.
- Different practice has been identified in other trusts around the requesting of CTs by nurses with extended roles; the Stroke Navigator role may be able to do this with additional training. This is being looked into with regard to IRMER (Ionising Radiation Medical Exposure Regulations) training. Additional clinical training is likely to take more than 6 months. However it would speed-up the requesting of the tests, as well as

direct admission to a stroke unit and rapid specialist assessment.

- General awareness raising of the importance of early scanning for at risk patients, via the clinical teams and Newsbeat

Progress against the recovery plan:

Performance remains below the required standard. The clinical team is continuing to review what additional action can be taken to ensure compliance with this standard.

1.6 SUPPORTING INFORMATION

1.6.1 Examples of Learning from Recent Complaints

Summary of Complaint

The Patient Support & Complaints Team was contacted by a patient's daughter following her admission to Ward 54 in the Bristol Heart Institute.

In her complaint the patient's daughter described how her mother, a 74 year old lady, had been exhibiting signs of considerably agitated movement whilst sleeping. However, on one occasion, the bed rails on the sides of her bed were not properly secured and her mother fell out of bed, striking her head on a chair and then on the floor. Her mother suffered a bad cut to her head, heavy bleeding and severe facial bruising.

The patient's daughter went on to describe how, following the fall, her mother was given a head scan, a chest x-ray and hourly observations throughout the night. However, the following day, neither she nor any other relatives were made aware of the incident by staff and her daughter found out only when she visited and saw her mother's condition. Also the patient daughter explained that shortly after the fall, her mother was discharged, despite still being severely bruised, having a high temperature, a chest infection; and with continued pain from her fall.

Moreover, her mother's discharge summary did not mention the fall she had sustained and since being discharged home her mother had started to have regular nosebleeds, something she had never suffered with before.

Investigation

The investigation found that:

- The patient fell during a shift change over and, following the fall, the ward staff were concentrating on ensuring the patient was safely assisted back into bed and caring for her immediate needs. By the time they had done this, they felt it was too late at night to contact the family. The night nurse intended to contact the family in the morning but failed to do so;
- The clinical management of the patient post-fall was appropriate;
- The Falls Care Plan did not contain the outcome of any bed rails assessment, therefore it was not possible to confirm from the care plan if an appropriate assessment of the need for bed rails was completed;
- On reviewing the patient's notes there was no documentation of attempts to make contact with her family. Details of the patient's son as next of kin were recorded.
- The fall was recorded as an incident and as the impact was initially assessed as minor, this assessment was subsequently confirmed on review by the Ward Manager. Further information about the circumstances surrounding the fall was only partially completed on the electronic incident reporting system.

QUALITY

An initial review of the incident was carried out by the Assistant Chief Nurse, who visited the patient and her daughter on the ward on the day that the complaint was received. An apology was immediately offered and the Assistant Chief Nurse checked that the patients' needs had been properly assessed and her care was being appropriately managed. The patient's family were provided with contact details for the Head of Nursing and the Ward Matron so they can contact them directly should the patient need to be admitted again.

A full investigation was then carried out via the complaints process and a meeting held with the patient, her daughter, Head of Nursing and the Ward Sister.

Organisational Learning

- The Falls Lead (Assistant Chief Nurse) was informed of the incident and has followed this up further as a case study with the Falls Prevention Group
- The Trust is undertaking improvement works to reduce the number of patients who fall in hospital. The nursing staff now use a new assessment tool to identify people at risk of falling.
- There is a new falls care plan in place and the first action on the care plan is to undertake a bed rails assessment.
- Signs are now placed above patients' beds to identify if they are at risk of falling

Departmental Learning

- Personalised signs can now be placed above patients' beds reminding staff that bed rails should be kept in place for unattended patients where this is an assessed requirement.
- The nursing handover sheet has been adapted to include a message in large print, about the requirement to have bed rails up at all times for certain patients
- The issue of the patient's fall not being recorded in the Discharge Summary sent to the GP has been raised at the junior doctors' meeting

Individual Learning

The nurse who omitted to contact the patient's family the morning after the fall has been reminded of the importance of keeping families informed of such incidents.

WORKFORCE

2.1 SUMMARY

The Trust has selected a range of key workforce indicators. Targets for workforce costs, workforce numbers, bank and agency usage, statutory and mandatory training and appraisal were achieved in November 2011. Sickness absence was below target this month.

 **Achieving (5)**	 **Underachieving (0)**
- Workforce costs – *compared with budget* - Workforce numbers – *compared with budget* - Bank and agency usage - *compared with target* - Appraisal compliance - *compared with target* - Statutory and mandatory training – *compared with target*	
 **Failing (1)**	 **Not reported/scored (1)**
- Sickness absence - *compared with target*	- Turnover *(no target)*

2.2 EXCEPTION REPORTS

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

1) Sickness absence – 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 FTEs (full time equivalents) absent

Performance in the period, including reasons for the exception: Absence has increased from 3.9% in October to 4.3% in November 2011. All Divisions are above monthly target, except Diagnostic & Therapies and Estates & Facilities.

	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Estates & Facilities)	Estates & Facilities
Target November 2011	3.5%	3.0%	3.4%	3.5%	3.6%	3.1%	3.3%	4.8%
Absence November 2011	4.3%	2.5%	5.1%	3.7%	4.2%	5.1%	4.3%	4.7%
Cumulative absence November 2011	3.8%	2.4%	4.5%	3.4%	3.7%	4.2%	3.7%	5.0%
Absence November 2010	4.4%	3.1%	4.7%	4.2%	5.0%	3.7%	4.0%	6.2%

Recovery plan, including expected date performance will be restored:

Employee Services has produced a report that highlights all staff in each Division who are on long term sick to ensure that they are being supported back to work and Employee Services is aware of their case. This report was piloted last month and will be available a few days after the Board Report this month. Once the long-term sick staff have been identified we can turn our attention to those who are about to go over 4 weeks and short term sickness. Taking this systematic approach will enable us to ensure that all absent staff are being supported back to work.

The Women's & Children's and Medicine Divisions have funding to pilot a Sickness Absence Case Management pilot in conjunction with Occupational Health where staff who are absent due to sickness are contacted as particular times to support them and aid their return to work. This is expected to go live in April 2012, with the preparatory working beginning in March 2012. The pilot will also involve North Bristol Trust.
The Employee Services team continue to support managers to apply the Supporting Attendance policy robustly and consistently, and working with Occupational Health to ensure that the focus is on achieving return to work.

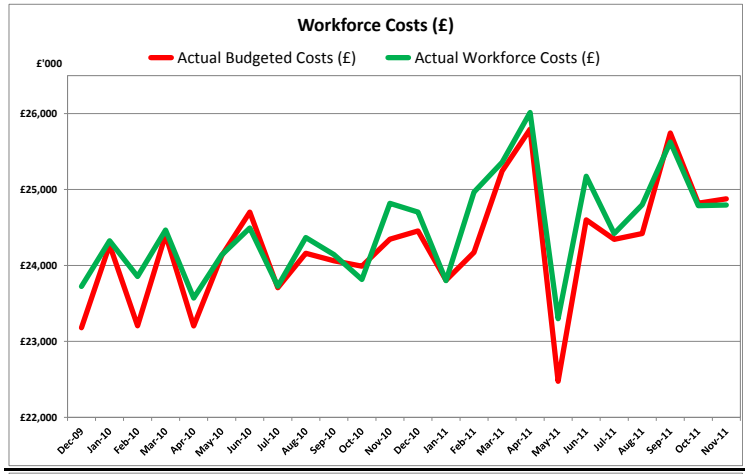
Progress against recovery plan: See above**.**

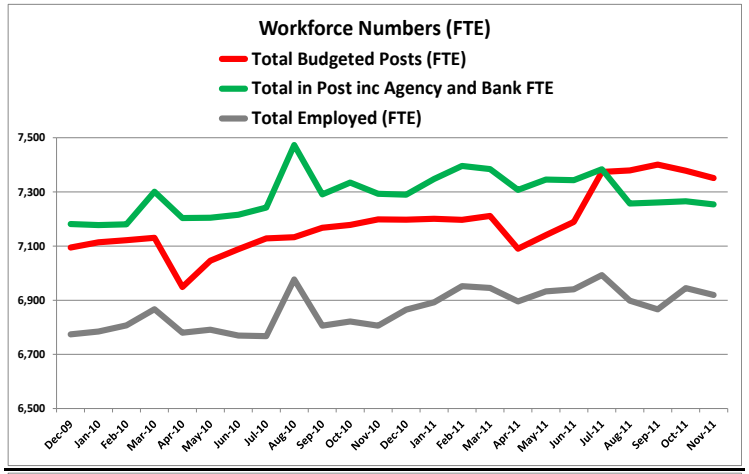
WORKFORCE

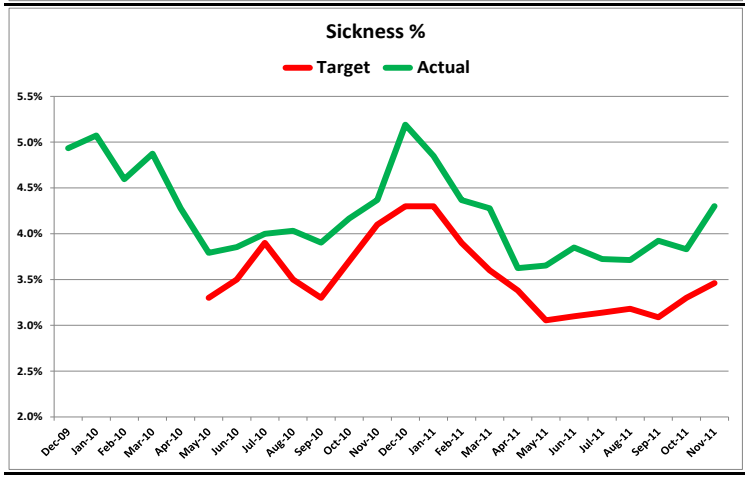
2.3 SUPPORTING INFORMATION

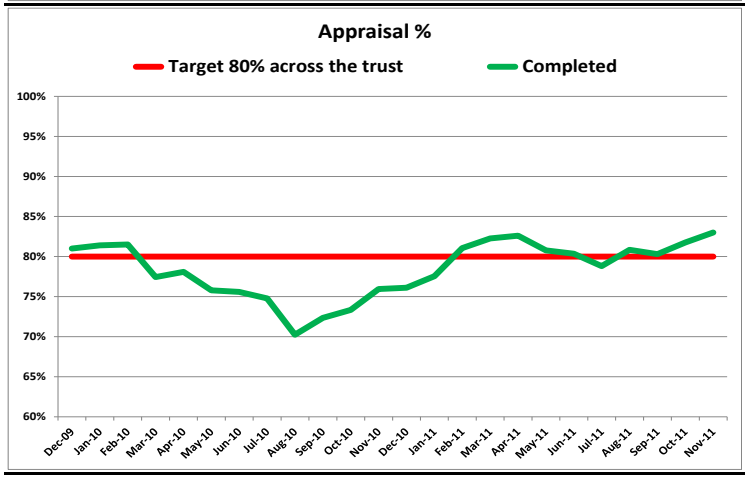
This report provides an outline of the Trust's position against key workforce standards for the month of November 2011 and year to date performance for 2011/12.

2.3.1 Summary









2.3.1a Statutory and mandatory training

Statutory and mandatory training compliance percentage for the key topic areas are shown below for the period April 2011 to December 2011.

Statutory and Mandatory	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Dec 11 Movement
Induction	84%	86%	88%	89%	82%	85%	90%	89%	87%	↓
Health & Safety	89%	89%	90%	90%	86%	86%	87%	85%	83%	↓
Infection Control	93%	94%	94%	94%	82%	83%	81%	80%	80%	↔
Manual Handling	78%	78%	78%	79%	79%	77%	78%	78%	76%	↓
Fire Safety Training	85%	84%	86%	44%	45%	45%	46%	48%	51%	↑
Violence & Aggression L2	86%	87%	88%	90%	91%	91%	91%	90%	90%	↔
Child Protection, Level 1	85%	86%	87%	88%	88%	88%	88%	89%	89%	↔
Child Protection, Level 2	61%	65%	75%	79%	78%	79%	79%	83%	84%	↑
Child Protection, Level 3	66%	67%	76%	81%	82%	82%	82%	82%	83%	↑
Child Protection, Level 4	91%	91%	91%	92%	92%	90%	93%	92%	92%	↔
Safeguarding Adults Level 1		44%	42%	46%	52%	56%	71%	81%	81%	↔
Safeguarding Adults Level 2		14%	6%	17%	31%	46%	50%	91%	91%	↔
Safeguarding Adults Level 3		29%	27%	42%	58%	60%	72%	100%	100%	↔

The direction of the arrow shows the change from last month.

WORKFORCE

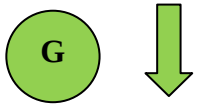
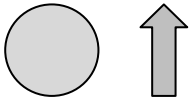
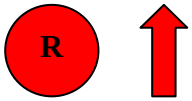
There is a Trust target of 80% compliance for all areas, with the exception of Fire Safety with a target of 50% for the month. Fire Safety has been set a target of an increase in compliance of 5% each month, to achieve 80% by the end of May 2011. All areas, except Manual Handling, have achieved this target, and are therefore rated "GREEN". This report has been included in the *Supporting Information* section as, whilst we are achieving 80%, we are still falling short of the overall Trust-imposed stretch target of 90%.

WORKFORCE

2.3.2 Changes in the period

Performance is monitored against workforce costs, workforce numbers, bank and agency usage, turnover, sickness and appraisal numbers. Indicators on a rolling reporting programme are: Statutory and mandatory training (December 2011) European Working Time Directive (EWTD) (February 2012).

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

Indicator	RAG Rating[1]	Commentary	Notes
Workforce Costs		Workforce costs increased by 0.1%, and budgeted workforce costs increased by 0.2% in November 2011. November's costs were 0.3% below the budgeted workforce costs compared with 0.1% below budget in October.	See supporting information
Workforce Numbers		Workforce numbers reduced by 0.2% compared with October 2011, 1.3% below the budgeted workforce numbers. This compares with October 2011, when workforce numbers were 1.5% below budget.	See supporting information
Turnover		Rolling voluntary turnover increased by 0.2% to 9.1%.	
Sickness		Sickness increased by 0.4 percentage points compared with October 2011 across the Trust, 0.8 percentage points above the monthly target for 2011/12.	See exception report
Bank/Agency		Bank and agency reduced by 8.25 fte compared with October 2011, 7.6% below monthly target for 2011/12.	See Summary
Appraisal		Appraisal rates increased by 1.2 percentage points to 83.0% compared with October 2011.	See supporting information
Statutory and Mandatory Training		Key topic areas of main statutory and mandatory training increased in compliance compared to November 2011.	See supporting information

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

2.3.3 Monthly forecast and overview

Measure	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Nov 11 Planned
Budgeted Posts (FTE)	7198.8	7197.4	7201.0	7196.9	7211.5	7090.1	7140.7	7189.1	7374.1	7379.3	7401.1	7378.4	7351.1	7270.9
Total Employed (FTE)	6805.9	6865.4	6892.1	6951.8	6945.2	6895.7	6932.5	6940.7	6993.0	6898.2	6866.1	6944.8	6919.5	6866.8
Sickness Rate (%)	4.4%	5.2%	4.9%	4.4%	4.3%	3.6%	3.7%	3.9%	3.7%	3.7%	3.9%	3.9%	4.3%	3.5%
Bank (FTE) Admin & Clerical	84.3	78.9	81.5	80.1	89.1	73.6	73.0	77.8	79.2	80.9	78.7	64.4	63.6	65.6
Bank (FTE) Ancillary Staff	25.0	23.9	23.4	20.6	25.5	20.3	20.5	19.1	17.4	12.8	16.1	11.4	11.7	22.2
Bank (FTE) Nursing & Midwifery	245.9	212.9	239.8	214.8	232.4	231.5	233.1	230.8	239.7	193.9	220.7	178.7	178.1	143.8
Agency (FTE) Admin & Clerical	7.3	5.2	6.2	6.8	9.4	7.0	4.3	3.2	2.6	3.4	5.5	3.5	2.9	3.7
Agency (FTE) Ancillary Staff	43.1	41.7	28.5	32.1	35.2	31.1	34.7	34.3	18.1	34.1	37.7	30.6	33.5	40.0
Agency (FTE) Nursing & Midwifery	8.0	8.4	14.0	6.9	10.0	17.5	12.3	7.4	8.4	8.2	11.7	13.5	13.8	5.6
Overtime	74.8	50.8	57.3	66.0	72.1	61.6	63.6	78.0	62.9	40.4	65.3	62.7	81.1	71.6
Appraisal (%) excluding Junior Doctors	75.9%	76.1%	77.6%	81.1%	82.3%	82.6%	80.8%	80.3%	78.8%	80.8%	80.3%	81.8%	83.0%	80.0%
Appraisal (%) Junior Doctors										80.3%	88.3%	93.5%	94.5%	80.0%
Rolling Average Turnover (%)	15.6%	15.4%	15.3%	15.3%	15.4%	15.1%	14.9%	15.0%	14.7%	14.4%	15.1%	15.0%	15.2%	
Rolling Average Voluntary Turnover (%)	9.6%	9.6%	9.5%	9.3%	9.4%	9.2%	9.1%	9.0%	8.6%	8.7%	8.9%	8.9%	9.1%	
Vacancy Rate (%)	5.5%	4.6%	4.3%	3.4%	3.7%	2.7%	2.9%	3.5%	5.2%	6.5%	7.2%	5.9%	5.9%	

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 November 2011**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 3)***, 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 (4)**
- 31-day diagnosis to treatment cancer standard - *first* - 31-day diagnosis to treatment cancer standard – *all subsequent treatments (except surgery)* - 62-day referral to treatment cancer standard – *GP & Screening referred* - 2-week wait urgent GP referral cancer standard - Symptomatic breast patients (cancer not initially suspected) 2-week wait - Referral to Treatment Time for admitted patients (95th percentile) - Referral to Treatment Time for non-admitted patients (95th percentile) - Genito-Urinary Medicine (GUM) 48-hour access - 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	- 31-day diagnosis to treatment cancer standard – *subsequent surgery* - Last-minute cancelled operations - 28-day readmission – *a date for re-admission within 28 days of cancellation* - Infant health – breastfeeding rate
Failing (1)	**Not reported/scored (0)**
- Reperfusion times (call to balloon time of 150 minutes)	

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

3.2 ACCESS DASHBOARD

Access Standards - dashboard

	Target	Thresholds Green	Thresholds Red	2010/11 to date	2011/12 To Date	Month Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Quarterly Performance 2011/12 Q1	Q2	Q3	Q4
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	88%	95.8%	95.1%	95.9%	94.6%	91.9%	96.8%	96.9%	96.0%	95.4%	94.6%	95.4%	96.4%	93.4%	94.2%	Cancer standards report two months in arrears	95.4%	95.1%	94.2%	
	Cancer - Symptomatic Breast (cancer not suspected) in Under 2 Weeks	93%	88%	90.3%	98.0%	90.9%	100.0%	100.0%	100.0%	100.0%	100.0%	98.1%	98.6%	97.7%	97.0%	100.0%	93.6%		99.0%	98.1%	93.6%	
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	93%	98.6%	97.8%	100.0%	96.1%	96.0%	97.8%	98.0%	97.3%	96.8%	96.7%	97.2%	99.1%	99.1%	98.1%		97.1%	98.5%	98.1%	
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	93%	99.7%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	99.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.7%	100.0%	100.0%	
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	89%	96.2%	96.9%	95.7%	91.7%	92.3%	93.0%	98.0%	98.2%	100.0%	96.8%	97.8%	94.0%	98.3%	93.6%		98.2%	96.5%	93.6%	
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	89%	Not applicable	99.5%	Standard not in effect		99.2%	100.0%	99.5%	100.0%	99.4%	100.0%	99.4%	100.0%	98.9%	99.0%		99.8%	99.4%	99.0%	
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	80%	85.1%	86.0%	89.9%	90.0%	79.3%	85.7%	91.2%	88.1%	85.7%	82.7%	85.4%	85.1%	87.7%	88.1%		85.1%	86.2%	88.1%	
	Cancer 62 Day Referral To Treatment (Screenings)	90%	85%	93.7%	92.2%	81.5%	100.0%	94.4%	70.8%	87.5%	96.8%	100.0%	95.3%	85.3%	86.1%	95.2%	88.1%		97.1%	89.3%	88.1%	
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	95.5%	95.5%	96.8%	92.5%	97.9%	100.0%	100.0%	100.0%	100.0%	88.9%	92.6%	100.0%	94.9%	94.4%		96.2%	95.2%	94.4%	
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	80%	93.1%	91.9%	92.6%	93.4%	94.0%	92.7%	91.5%	93.0%	92.4%	92.7%	91.8%	91.3%	91.9%	91.2%	91.2%	92.7%	91.7%	91.2%	
	Referral To Treatment Non Admitted Under 18 Weeks	95%	85%	98.4%	97.9%	98.5%	98.6%	98.4%	98.0%	98.0%	98.1%	98.7%	98.4%	98.0%	97.6%	97.7%	97.8%	97.2%	98.4%	97.7%	97.5%	
	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	22.6	23.0	21.1	21.9	22.9	
	Referral to treatment time non-admitted patients (95th percentile - weeks)	18.3	18.3	Not applicable	14.1	Standard not in effect					13.6	13.7	14.0	15.0	15.1	15.3	15.6	16.3	13.9	15.1	15.9	
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	96.8%	97.4%	95.9%	90.8%	89.5%	90.8%	94.2%	97.0%	98.8%	98.4%	97.7%	98.1%	97.1%	95.4%	97.1%	98.0%	97.6%	96.2%	
	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	14	12	55	13	13	
	A&E Time to treatment decision (median) - in minutes	60	60	Not applicable	17	Standard not in effect					24	20	20	18	15	18	19	17	20	16	18	
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	Not applicable	1.7%	Standard not in effect					2.1%	1.6%	1.1%	1.1%	1.8%	1.9%	2.0%	1.9%	1.6%	1.6%	2.0%	
	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%	1.3%	0.6%	1.1%	1.0%	1.0%	
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	1.10%	0.88%	1.78%	1.69%	2.21%	1.44%	1.69%	0.97%	0.92%	1.01%	1.13%	0.89%	0.31%	0.90%	0.89%	0.97%	0.77%	0.90%	
	28 Day Readmissions	95%	85%	94.8%	94.0%	96.1%	88.2%	80.5%	91.1%	82.9%	94.1%	91.5%	95.8%	93.0%	93.2%	96.1%	100.0%	92.0%	93.9%	94.0%	94.0%	
	GUM Offer Of Appointment Within 48 Hours	98%	95%	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%	100.0%	100.0%	100.0%	
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	Not applicable	85.9%	100.0%	93.8%	84.2%	75.0%	88.0%	94.1%	80.0%	81.8%	78.4%	85.2%	97.1%	85.7%		85.2%	86.9%	85.7%	
	Infant Health - Mothers Initiating Breastfeeding	76.3%	76.3%	76.2%	76.2%	74.3%	77.9%	75.5%	75.1%	77.1%	72.3%	74.7%	78.4%	77.0%	78.1%	73.8%	78.2%	77.1%	75.1%	76.2%	77.7%	

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

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 amednded, following late corrections to the data.

All CANCER STANDARDS are reported nationally two months in arrears. Monthly figures are indicative, until they are finalised at the end of the quarter.

3.3 CHANGES IN THE PERIOD

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

- 62-day referral to treatment cancer standard – Screening referred ↓ (down from 95.2% in September to 88.1% in October) – *although achieved for the quarter to date based upon draft figures for November*
- 31-day Subsequent surgery ↓ (down from 98.3% in September to 93.6 % in October) – *forecast to be achieved for the quarter as a whole, but flagged as a risk*
- 28 day readmission following a last-minute cancellation ↓ (down from 100% in October to 92.0% in November)
- Call to Balloon Time of 150 minutes ↓ (down from 97.1% in September to 85.7% in October)

Please note the above performance figures only show the final reported position and do not include the draft November performance for the cancer standards.

3.4 EXCEPTION REPORTS

Exception reports are provided for the one (1) RED and four (4) AMBER rated performance indicators.

1) 31-day cancer subsequent surgery – *reported as a risk based upon October and November's performance, although forecast to be achieved for the quarter as a whole*
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: 31-day subsequent surgery cancer standard	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients requiring subsequent surgery for a cancer treated within 31 days of the decision to treat, as a percentage all cancer patients treated during the period under that standard. Subsequent surgery can be a follow-up to another form of treatment, or be further surgery following a recurrence of the cancer.

Monitor measurement period: Quarterly, as part of a combined 31-day subsequent treatment cancer standards (weighted 1.0)

Performance during the period, including reasons for exceptions:

In October 93.6% of patients received surgery within 31 days of the decision to treat, against the national standard of 94%. However, the draft performance figures for November (94.2%) show achievement of the national standard. December's figures are currently 100%, with no forecast breaches for the remainder of the quarter.

There were three breaches of the 31-day subsequent surgery standard recorded in October, were as reported last month. There were three further breaches of standard in November. These figures are still subject to final validation and may change. The breach reasons are expected to be confirmed as follows:

- Two complex colorectal cases requiring joint surgery between the colorectal team and the North Bristol Trust (NBT) plastics team; the dates for the operations could not be scheduled within target due to the availability of the plastics team
- One urology case cancelled by the anaesthetist on the day because the patient had not stopped taking their warfarin, as requested. The procedure could not be re-scheduled within target due to the complexity of the case and the availability of the particular surgeons able to perform the procedure

These three breaches incurred during November were for the most part outside of the control of the Trust. In the last case though, the patient's date for admission could have been booked earlier in the month. This would have given the clinical team a greater opportunity to re-book the patient within 31days of the decision to treat. The actions below also include those identified from the October breaches.

Recovery plan, including expected date performance will be restored:

The actions being taken as part of the remedial action plan are detailed below.

- From 1st January 2012 aim to book treatment for all 31-day subsequent surgery patients at least 10 days before their breach date to allow more flexibility for re-booking patients

ACCESS STANDARDS

- In-depth review being conducted of the reasons for patients not being on the Cancer Register and accountability for making sure this happens in the future (Action complete)
- Review of Multi Disciplinary Team (MDT) Co-ordinator cover arrangements being undertaken by the Division of Surgery with a view to improving the robustness of support arrangements when staff are on leave/off sick, and improving the information system fail-safes (Action complete) – *A proposal will be developed to re-organise MDT and Waiting List Co-ordinators into a team based approach to patient and tumour site management. This will require staff consultation. Consultation will commence after the current administrative and clerical review by the Division of Surgery, Head & Neck has been completed. It is therefore expected that the new team based working arrangements will not be fully in place until summer 2012. For this reason interim cover arrangements have been put in place, within budgeted staffing levels, to provide more support for the cover of MDT co-ordinator duties when one of the team is on leave or off sick. Teams are also going to be physically co-located in January 2012.*
- Continue the cross city working to improve the scheduling of surgery for cases requiring intervention by both NBT and our own surgical teams.

Progress against the recovery plan:

November draft performance is 94.2%. December's performance is currently at 100%, with no forecast breaches for the remainder of the month. The Trust is expecting to report performance of the quarter of over 95% against the 94% standard.

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:

There were 49 last-minute cancellations of surgery in **November** (0.89% of operations) which is just above the national standard of 0.8%. The main reasons for cancellations in the month were as follows:

- 24% of cancellations (11 cancellations) were to no ward bed being available
- 16% (8 cancellations) were due to equipment failure
- 14 % (7 cancellations) were due to emergency patients being prioritised on the day
- 10% (5 cancellations) were due to no theatre staff being available

Of the 49 cancellations, 17 were day-cases and 32 were inpatients (34% day cases). On average, seventy percent (70%) of the Trust admissions in a month are day-cases.

On the 14th and 15th of November a total of 7 patients' operations were cancelled at last minute due to beds not being available within the BRI. This equates to 14% of the month's cancellations. This followed exceptional levels of emergency admissions within the BRI (i.e. levels that were in the top 5% every recorded when compared to the nationally used baseline of 2008/09).

Four of the eight cancellations recorded as being due to equipment failure, were within one of the Cardiology Catheter Labs. However, this involved more than one piece of equipment breaking on different days. The number of patients impacted was greater than initially expected due to repairs by external companies not having been completed when expected.

Due to robust advance planning for the National Day of Action on the 30th November, there was only one last-minute cancellation that day.

92% of patients were re-admitted within 28 days of the cancellation of surgery at last-minute in November, which is below the 95% national standard. Four patients were not re-booked within 28 days. This was due to the difficulty in finding an alternate theatre slot with the surgeon needing to undertake the procedure.

ACCESS STANDARDS

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*):

- Advance planning for the National Day of Strike Action on the 30th November (Action complete)
- Review of causes of high levels of cancellations on the 14th and 15th November (Action complete)
- Review of causes of high levels of cancellations due to equipment failure (Action complete)
- The avoidance of last-minute cancellation is 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
- 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 (On track for completion)

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 within the trajectory agreed with the PCT. November's performance (at 0.89%) was better than the 1.2% forecast and significantly better than last years' performance of 1.78%. The Trust is currently on track to achieve the actions and performance trajectory agreed with the PCT for December.

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 for the quarter to date is 77.7%, with both October and November's performance being above the 2010/11 average of 76.5%. 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 is for Call to Balloon times to be within 150 minutes for at least 90% of patients. To support achievement of Call to Balloon times there is also a local target for Door (arrival in hospital) to Balloon times of 50 minutes. The standards apply for direct admissions to the Bristol Heart Institute only.

Monitor measurement period: Not applicable

Performance during the period, including reasons for exception:

During October 85.7% of patients had a Call to Balloon time of less than 150 minutes. September's figures were previously reported at 100%. However, a correction had to be made to one of the figures, which has changed September's figures to 97.1%, still well above the 90% standard. Year to date performance is 85.9% against the 90% standard.

There have been **35 breaches** of the Call to Balloon 150 minute standard for the year to date, of these:

- 28 (78%) happened overnight or at weekends (i.e. out-of-hours)
- 8 happened in-hours, four of which happened during one week in June
- 33 had a Door to Balloon times of over 50 minutes (20 were also over the 90 minute national standard)

There were 6 breaches of standard in October. Of these, 2 were in-hours and 4 were out-of hours.

This analysis continues to suggest that the delays are primarily in-hospital rather than from the call for professional help through to the arrival at the hospital. It also shows that the main delays arise out-of-hours. So actions are mainly focusing on improving the timeliness of the out-of-hours service.

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 (ongoing)
- 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 (ongoing)

ACCESS STANDARDS

Progress against recovery plan:

The Trust is currently achieving 85.9% against the 90% standard year to date, following a significant improvement in performance in August and September this year.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 21 December 2011 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 06 – Histopathology Action Plan Update

Purpose

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

Abstract

The latest version of the action plan is provided to update the Board on progress.

Monitoring of the action plan is as follows:

- An internal histopathology group meets fortnightly to drive the actions forward
- Monthly meetings take place with NHS Bristol and North Bristol NHS Trust.

Progress is reported quarterly to the Trust Management Executive, the Clinical Quality Group, the Quality and Outcomes Committee, the Trust Board, Bristol Health Overview and Scrutiny Committee and the Care Quality Commission.

Recommendations

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

Executive Report Sponsor or Other Author

Sponsor – The Chief Nurse, Alison Moon

Author – Anne Reader, Assistant Director of Governance and Risk Management.

Appendices

- Appendix 1 – Histopathology Action Plan Update

University Hospitals Bristol NHS
NHS Foundation Trust

Recommendations from Histopathology Inquiry – Action Plan

Actions not yet due

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
Section 1 Section Lead: Rob Pitcher	**Overarching recommendation A: A single Histopathology Service should be established for Bristol with the potential to be one of the leading service and academic centres.**					
1.2	Develop Service Structure and Proposition for integrated cellular pathology service Agreed sub-milestones: • Integration of the management tier beneath Clinical Lead • Common reporting template for each speciality • Agreement of specialist and team roles & profiles • Common KPI suite and associated metrics agreed and in place	31 Dec 2011	Rob Pitcher	These issues are being considered as part of the Pathology Services Review being led by NHS Bristol. Clinical Lead for Cellular Pathology is feeding into the review accordingly. Meanwhile, a governance structure has been put in place.		Revised management structure/Job Descriptions. Reporting template. Specialist and team role profiles. KPI suite.

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
1.7	Review consultant staffing levels in accordance with the Royal College of Pathologists' "Guidelines on staffing and workload for histopathology and cytopathology departments" (2nd edition) June 2005, and, if necessary, adjust to ensure they are sufficient for a safe, timely and reliable service. Further milestones:	Review 31 Aug 11.	Rob Pitcher	The review is complete. A paper has been produced to include recommending an in depth Job Planning and skill mix exercise.	√	Review paper.
	• Complete comprehensive Job Planning process for all Consultants working in Cellular Pathology across both UHB and NBT.	30 Nov 2011	Rob Pitcher	Complete. Process in place and job planning underway to be completed by end February 2012.		Agreed process.
	• Complete skill mix exercise to determine what work currently performed by Consultants could be carried out by other staff.	30 Nov 2011	Rob Pitcher	Skill mix exercise underway.		Skill mix exercise outcome.
	• Review outcome of the Job Planning and skill mix exercises and, if necessary, adjust staffing configuration to ensure sufficient support for a safe, timely and reliable service.	29 Feb 2012	Sean O'Kelly/ Chris Burton.			As above.

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
1.9	Identify short term and longer term location plan for department.	31 Oct 11	Rob Pitcher	The Inquiry recommended that the service should for the time being remain on two sites. The longer term plan is subject to the outcome of the Pathology Services Review. See actions for 1.2.	√ Linked to 1.2.	
Section 10 Section Lead: Alison Moon	**Overarching recommendation I: Patients and Histopathology** For information: The Royal College of Pathologists has an active programme to inform the public about histopathology. Next year is designated National Pathology Year.					
10.2	Implement PPI strategy – Year 2 (Expansion of Year 1 approach into Outpatients – pending identification of funding)	31 Mar 12	Alison Moon	Year 2 funding obtained. Two major internal surveys of outpatients to complement the National Outpatients Survey are taking place in 2011/12. Comments Cards are being implemented in Outpatients Departments and plans for surveys using hand held devices are currently under discussion.	√ On track	Minutes and papers of Patient Experience Group and its predecessor. Six monthly PPI strategy update to the Board October 2011.
10.4	Develop proactive and constructive working relations with new 'Local HealthWatch', including its proposed responsibilities for patient advocacy (detail has yet to be	DH expects HW to be "up and	Tony Watkin	Bristol LINk is a national pathfinder for HealthWatch status and is attending the Trust's Patient Experience Group in November 2011 to	On-going	Notes of meeting.

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
	announced by the DH).	running by 2012"		present its plans. UH Bristol representation on Bristol LINks Acute Hospital Group to facilitate operational activity. UH Bristol workshop with Bristol and South Gloucester LINks has taken place to inform 2010/11 Quality Account. Robert Woolley has met with Chair of Bristol LINk to provide assurance of positive working relations. Two new pieces of Patient and Public Involvement work relating to histopathology have commenced: 1. Interviewing patients in named UH Bristol outpatient clinics about their experiences of having tests and receiving results.		Minutes of LINks Acute Hospital Group Third party comments from LINks on UHB Quality Account. Survey outcomes.

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
				2. Supporting NHS Bristol in broadening participation of parents and carers of young people in the "What Patients Want" document which identifies four key themes which matter to patients regarding histopathology services: quality, timeliness, convenience of access and communication. In addition, we have added questions about tests and results to our monthly in-patient survey, outpatient survey and bi-monthly ward based surveys. The outcomes of which provide both assurances about our services and areas for patient led service improvements.		"What Patients Want" document. In electronic evidence files. Inputs from UH Bristol and outputs from the partnership involvement work. As above.
Section 13 Section Lead: Rob Pitcher						

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
13.1	The Royal College of Pathologists should review its guidance on specialist histopathology with the intention of making it more explicit where possible.	For RC Path to determine	RC Path	Rob Pitcher has met informally with the President of the Royal College of Pathologists. There is a current Royal College of Pathologists document in existence and the College Histopathology Specialist Advisory Committee have been asked to comment on whether further work is required.	To be advised by Royal College.	
13.2	There should be at least two specialist histopathologists in each subspecialist area to allow proper review and to provide cover for meetings and periods of leave.	Dependent on the outcome of 1.2	Rob Pitcher	Linked to action 1.2.		

Completed Actions

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
Section 1 Section Lead: Rob Pitcher	**Overarching recommendation A: A single Histopathology Service should be established for Bristol with the potential to be one of the leading service and academic centres.**					
1.1	Appoint Clinical Lead for Cellular Pathology	30 Jun 11	Jane Luker/ Chris Burton	Complete. Clinical Lead in post as of 3 May 11.	√	Job Description and staff in post.
1.3	Short term Consultants should work across both sites when necessary to provide the optimum service to patients.	31 Mar 11	Jane Luker/ Chris Burton	Agreed and implemented where appropriate. Cross site working in place for haemato-malignancy, Head and Neck, Lung and Her 2 Breast pathology. Further work underway to develop greater cross site working in line with planned service reconfiguration.	√	Letter of expectation sent to pathologists by Acting Medical Director. Honorary contracts in place. In pathologists' HR files.

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
1.4	Put in place honorary contracts for cellular pathologists with reciprocal trust.	31 Mar 11	Philippa Finch/ Tracy Smallwood	Honorary contracts issued to pathologists to be signed and returned by 17 Jun 11. UH Bristol and NBT pathologists have all signed their honorary contracts.	√	Honorary contracts in place. In pathologists' HR files. Letter from Acting Medical Director to pathologists March 2011.
1.5	All new cellular pathology appointments to be joint	31 Dec 10	Jane Luker/ Chris Burton	Agreed. March 11: Two new adult pathologists appointed on 50:50 contracts	√	Appointment process documentation i.e. Job Description and advert. Contracts for new staff. In pathologists' HR files.
1.6	Clarify roles and responsibilities of Heads of Division, Lead Doctor and Specialty Lead	31 Dec 10	Robert Woolley	Complete. Communications to relevant staff and revised job descriptions completed. This will be evidenced through Job Planning and appraisal. The UH Bristol Medical Director team will conduct an initial assessment of compliance with the clarified responsibilities.	√	Letters from CEO to Heads of Division. Lead Doctor Job Descriptions.

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
						Written confirmation from divisions.
1.8	Identify areas of urgent staffing need and produce action plan	31 May 11	Rob Pitcher	Complete. Necessary measures in place to manage current workload, including outsourcing.	√	Specialist working overview.
1.10	Develop process to ensure service changes are fully supported by Histopathology	31 Oct 11	Rob Pitcher	The Bristol Cellular Pathology Forum described is part of developing the wider team ethos and will include discussions with clinical teams on issues such as service reconfiguration, standards etc.	√	Minutes of meetings.
Section 2 Section Lead: Mark Callaway	**The MDTs in both Trusts should be reviewed to promote collaboration.**					
2.1	Complete MDT reviews	31 May 11	Mark Callaway/ Chris Burton/Rob Pitcher	UH Bristol MDT review for pathology completed. NBT review has been completed and a report received by their Board in June 2011.	√	MDT review report and meeting minutes.
2.2	Agree a plan for on-going development of joint MDT	31 July 11	Mark Callaway/ Chris Burton/Rob Pitcher	A joint UH Bristol and NBT meeting took place on 16th June to agree a joint approach for MDT development going forward. A joint report was produced by the end of July 2011.	√	Joint Report. Minutes of meetings SDG 25/07/2011.

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
						Minutes of Cancer Board.
2.3	Ensure slides are available at MDTs.	30 Mar 11	Lis Kutt	Complete. The MDT outcome records indicate where a patient referred in from another Trust is deferred to the next meeting if their slides are not yet available from the referring trust.	√	June 2011 spot check slide audit report. MDT audit results. On-going results presented to SDG.
2.4	Agree and implement process to ensure patients are aware that a diagnosis given pre MDT may be refined at the MDT meeting.	30 May 11	Teresa Levy/ Dany Wells	Cross Trust patient information leaflet finalised and being piloted. The pilot is due to be completed by the end of August 2011.	√	Patient Information Leaflet. Evaluation of pilot.
Section 3 Section Lead: Rob Pitcher	**Quality Assurance** For information: The Royal College of Pathologists is working on a set of Key Performance Indicators for pathology.					

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
3.1	Agree audit programme 2011/12 for Histopathology	30 April 11	Lis Kutt	Complete and shared with NBT 5 audits are planned, of which 3 are underway: • An audit of the double reporting protocol (not yet started) • An audit of reporting systems (not yet started). • Review of supplementary reports after multi-disciplinary team meeting (started August) • High grade serous carcinoma of endometrium-network audit (started August) • Correlation of breast tumour grading between core biopsies and resection specimens in a screened population (started July)	√	UH Bristol Clinical Audit Forward Plan 2011/12. Joint Histopathology Audit Programme
3.2	Develop joint audit plan across both Trusts	30 June 11	Rob Pitcher	Complete.	√	Joint Histopathology Audit Plan.
3.3	Ensure current involvement in all appropriate EQAs and CPD to develop specialisation	31 Mar 11	Lis Kutt	UHB EQA involvement identified. All specialist pathologists have an appropriate EQA programme. Relevant UH Bristol pathologists are registered for the regional lung EQA.	√	EQA Matrix.

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
3.4	Develop full joint EQA and CPD programmes	31 Aug 11	Rob Pitcher	The interviews with consultants demonstrated the current position on EQA. This information is held within the consultants' appraisal folders and reviewed annually as part of their appraisal. The Bristol Cellular Pathology Service in its policy statement on the recognition of specialist roles in cellular pathology recognises the need for pathologists to partake in appropriate EQA schemes. This will be monitored on an annual basis	√	Updated EQA Matrix.
Section 4 Section Lead: Lis Kutt	**Upgrade Histopathology Department**					
4.1	Upgrade work to be completed	31 Jul 11	Sven Howkins	Complete.	√	Site visit Works Project Plan.
Section 5 Section Lead: Rob Pitcher	**Double Reporting** For information: There is a current Royal College of Pathologists document in existence about double-reporting. The College Histopathology Specialist Advisory Committee is meeting in June 11 and will be asked to comment on whether further work is required.					
5.1	Agree and implement a revised joint double reporting protocol	31 May 11	Rob Pitcher	Complete. Protocol has been finalised and disseminated.	√	Double Reporting Protocol.

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
Section 6 Section Lead: Rob Pitcher	**Overarching Recommendation E: Raising Concerns about diagnostics** **Any concerns about the standard of pathology reporting should be thoroughly, rapidly and, where appropriate, independently investigated and the results made available to all those involved.** **Concerns should be dealt with at the lowest possible level and not escalated unnecessarily.** **The pathologist(s) involved should be consulted directly.**					
6.1	Agree and implement a revised raising concerns protocol	31 May 11	Rob Pitcher	Complete. Protocol has been finalised and disseminated.	√	Raising Concerns Protocol..
Section 7. Section Lead Sarah Pinch	**Overarching recommendation F: Whistleblowing** **The Department of Health should review advice on whistleblowing to ensure that local policies include clear guidance on raising concerns about the work of a pathologist or any other clinician who works for a different Trust from the Trust employing the person raising the concern.**					
7.1	Strengthen UHB Whistleblowing policy	31 May 11	Sarah Pinch	Complete. Policy agreed and confidential staff helpline in place.	√	Revised policy. Evidence of advertising this to staff
Section 8 Section Lead: Sarah Pinch	**Overarching recommendation G: Media Relationships.** **Relationships with the media should be proactive with an emphasis on openness, honesty and the involvement of senior managers and clinicians** **Relationships with the media should reinforce positive relationships with patients. Service change should be explained including the Chief Executive**					

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
8.1	The Trust Board will approve the revised communications strategy and plan in light of the report's recommendations	30 June 11	Sarah Pinch	The Communications Strategy was approved by the Board on 28 June 2011.	√	Revised Communications Strategy. Evidence in June 2011 Board papers and minutes.
8.2	The Trust's media protocols will be revised in light of the report's recommendations and will include consultation with relevant staff groups. The revised protocol will then be reissued to all staff. The protocol will be included in the revised communications strategy.	31 Mar 11	Sarah Pinch	Complete. Revised media protocols approved 13 April 11.	√	Revised Media Protocols. Evidence in TEG papers and minutes 13 April 2011.
8.3	The Trust's website is currently being redeveloped and will deliver a more responsive, interactive up-to-date tool for Trust communications, direct to patients, staff, FT members and the media.	30 June 11	Sarah Pinch	The new website was launched on 1st July 2011.	√	New website.
Section 9 UHB Section Lead: Lis Kutt	**Overarching recommendation H: Paediatric and Perinatal Pathology** **Paediatric and perinatal pathology should be valued and supported by managers, pathologists and other clinicians.** **The minimum level of staffing should be one paediatric pathologist, one perinatal pathologist and one pathologist trained in both paediatric and perinatal pathology.**					

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
9.1	Recruit and permanently appoint to proposed staffing levels demonstrating full commitment to the service	31 Jul 11	Lis Kutt/ Rob Pitcher	Interviews held Feb 2011. No appointment made. Further interviews were held 23 June 11 and an offer has been made subject to references and employment checks. Anticipated start date end of September. Interim outsourcing provision in place.	√	Staff in post. Recruitment update in November 2011 minutes of Bristol Cellular Pathology Forum
9.2	CEO to write to Southampton and Oxford to seek opportunities for joint working in principle	31 Dec 10	Robert Woolley	Complete. Positive responses received from Southampton CEO and Oxford MD.	√	Letters between Trusts.
9.3	Establish joint working arrangement	31 Jul 11	Sean O'Kelly	UH Bristol Medical Director has met with the Medical Directors from Southampton and Oxford to explore networking opportunities for paediatric pathologists. Agreement in made in principle, an operational specification is being drawn up.	√	Operational Specification.
Section 10 Section Lead: Alison Moon	**Overarching recommendation I: Patients and Histopathology** For information: The Royal College of Pathologists has an active programme to inform the public about histopathology. Next year is designated National Pathology Year.					

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
10.1	Implement PPI strategy – Year 1 (Inpatient feedback systems)	31 Mar 11	Alison Moon	Complete. Inpatient feedback mechanisms in place and providing timely information on the quality of patients' experiences, the results of which are being acted upon within the Trust.	√	Minutes and papers of Patient Experience Group and its predecessor. Six monthly PPI strategy update to the Board October 2011. In Board papers and minutes.
10.3	Devise and delivery four UH Bristol patient focus groups to explore current awareness and future involvement in the on-going development of histopathology at UH Bristol	30 Apr 11	Tony Watkin \ Lis Kutt	Complete. The report from the focus groups has been finalised and has been shared with the Pathology Services Review.	√	Focus Group Outcome report..
10.5	Agree process to promptly inform patients of diagnostic errors	31 Jan 11	Jane Luker	Complete. Staff Support and Being Open Policy 2009 is already in place. Next update will make link to diagnostic errors more explicit.	√	Current policy. on DMS. Policy due for review by end December 2011
10.6	Explore options for providing service users with information about the purpose of role and multi-disciplinary cancer teams and team meetings.	31 Mar 11	Teresa Levy	Cross Trust leaflet finalised and being piloted. The planned date for completion of the pilot is 31 August 2011.	√	Patient Information Leaflet..

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
10.7	Where a patient's care is going to be discussed at a multidisciplinary team meeting, patients should not be given information contained in histopathology reports until the reports have been considered by the multidisciplinary team.		The Trusts have agreed that implementing this recommendation could lead to a delay in patients being given information concerning their diagnosis and could put clinicians in the position of having to withhold important information from patients. The Trusts' ability to run one-stop clinics would also be compromised. Instead the Trusts propose that patients should be given information appropriate to their care, with an explanation of the diagnostic and treatment decision process by the Multidisciplinary Team.		N/A	N/A
Section 11 Section Lead: Rob Pitcher	**Training**					
11.1	Trainees should have supervised involvement in the full range of specimens, including the most complex cases, in accordance with their seniority	Nov 10	Lis Kutt	Complete. Trainees are supervised by individual consultants as befits their experience and seniority. The number of educational supervisors has been increased from 1 to 4 to further improve monitoring of progress with subsequent adjustments to individual learning plans as required.	√	Annual report to Severn Deanery.

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
11.2	Training plans to be adjusted to provide access to all levels of case	30 Nov 10	Lis Kutt	Complete. Training plans for the trainees have been revised by Dr Mohammed Sohail. A written training plan has been in use since the January 2011 which advises on the type of case mix trainees should expect to see to ensure that they have opportunities to work with a broad range of specimens of varying complexity.	√	Training Plan
Section 12 Section Lead: Steve Aumayer	**Overarching recommendation L: The histopathologists should be given whatever support they need to face the aftermath of this Inquiry including skilled facilitation.**					

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence

12.1	Develop detailed organisational development plan to support the move towards an integrated cellular pathology service	31 Aug 11	Steve Aumayer/ Rob Pitcher	**Integrated Cellular Pathology Service:**
				• Joint Trust Monthly formal business meetings in place (Meeting 3 in September)
				• Joint Trust workshop programme enabling discussion on key issues – resulted to date in:
				  ○ The recognition of specialist roles in cellular pathology
				  ○ Definitions of Lead Roles in Cellular Pathology
				  ○ Policy on the content of the reports from the Bristol Cellular Pathology Service
				• Educational activities including case discussion, audit presentations, research, feedback from external educational activities being planned
				• A series of workshops is planned to examine at specialist team level what cellular pathology service is required on which site to support the clinical service – commencement date TBA
				Working with NHS Improvement
				• Launch event 5th September for a core team who will be working on LEAN review of processes across sites.
				• Programme supported by site visits, the purpose of which to see how others provide integrated services to more than one acute Trust and to look at the work to improve efficiency (LEAN) that some have done.
					√	Training resources, attendance records and notes of meetings.

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
12.2	Provide Counselling and Occupational Health support to affected staff	31 Dec 10	Steve Aumayer	Complete. Some staff have accessed this	√	Letter from Acting Medical Director to pathologists March 2011
12.3	Provide facilitation and mediation	As required	Lis Kutt	Facilitation and mediation are available to staff should this be required. Externally facilitated event took place in Jan 11 with NBT and meetings of the Bristol Cellular Pathology Forum continue.	√	Letter from Head of Division to pathologists Jan 2011. Agenda, minutes and papers of Bristol Cellular Pathology Forum.
12.4	Support to assist in development of single service	On-going.	Lis Kutt/ Rob Pitcher	As for completed action 12.1 and ongoing.	On-going	
Section 14 Section Lead: Rob Pitcher	**Pathology reports**					

Ref No	Actions	Timescale	Responsible person	Progress	Complete	Evidence
14.1	Review style of reporting and implement any changes if deemed appropriate	To be agreed	Rob Pitcher	The Bristol Cellular Pathology Forum has topics already identified to be built into its work programme. These topics for discussion, debate and development into policy and procedure include pathology reporting. A draft policy is in development.	√	Reporting policy.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Public Meeting of the Trust Board of Directors to be held on 21 December 2011 at 14:00h in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Committee Reports - Item 7a– 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 £4.088m for the eight months to 30th November 2011. This is marginally better than the Annual Plan projection for the first eight months of the year. The Trust's Financial Risk Rating is 3 (actual = 3.45). The principal areas of concern are the slippage on the CRES programme and for November the significant levels of overspending recorded against non pay budgets in the Specialised Services, Diagnostic and Therapies and Surgery, Head and Neck Divisions.
Recommendations
To note the financial position at 30th November 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
			19/12/11		

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £4.088m for the eight months to 30th November 2011. This is marginally better than the Annual Plan projection for this period. The operating surplus (EBITDA[1]) is £22.558m. This is £0.643m (or 2.9%) greater than Plan for the period. The Financial Risk Rating is 3 (actual 3.45), further information on this is given in section 5 below.

The achievement of cash releasing efficiency savings continues to be of concern. The headline message is that November has seen a small increase in the rate of delivery of CRES savings with £2.297m achieved. This equates to 93% of the Plan for the month. The November report reflects an adverse variance of £5.525m year to date on the CRES programme. Actual savings of £12.232m represents slippage of £4.0m when compared with phased planned savings for the first eight months of £16.232m. The adjustment to bring CRES plans on to a 1/12ths basis adds a further £1.525m to the reported non achieved CRES in the November report.

The latest CRES forecast is that savings of £21.032m, a further improvement on last month's forecast, will be achieved this year of which the non recurring element is £4.478m (October = £3.877m). This represents an under achievement of £5.604m 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 £20.733m. The Finance Committee will receive a more detailed report on CRES as a separate item on this month's agenda.

The table below shows that the in-month movement on the Trust's income and expenditure position. A distribution of surplus research funds totalling £0.535m has been made this month. The distribution is based on divisional 2011/12 Flexibility and Sustainability Funding income with £0.336m (8/12ths) being brought into account this month. The overspending against divisional budgets, excluding the R&D income increase, totalled £0.668m in November. Detailed information and commentary for each Division is to be considered by the Finance Committee (report included under agenda item 5.3 below). A summary table setting out the variances on the four main income and expenditure categories together with a note on the impact of CRES slippage to date, on a 1/12ths basis is provided below.

	Variance to 31st October	Distribution of Research Funds	Variance this month	Variance to 30th November	Memorandum CRES Variance
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(1,465)	-	231	(1,234)	(2,515)
Non Pay	(2,838)	336	(1,136)	(3,638)	(3,094)
Operating Income	375	-	269	644	75
Income from Activities	(606)	-	(32)	(638)	9
Totals	**(4,534)**	**336**	**(668)**	**(4,866)**	**(5,525)**

[1] Earnings Before Interest Depreciation Taxation and Amortisation

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.

Pay budgets have underspent in November by £231k reducing the cumulative overspending to £1.234m. Taken with the favourable results for September and October this is an encouraging trend although there are significant (£70 – 133k) adverse variances recorded against three divisions i.e. Medicine, Surgery, Head and Neck and Women's and Children's. It is anticipated that with further CRES schemes coming on stream that cost controls on pay budgets will continue. This is an essential element of the Trust delivering its projected outturn for the year.

Non pay budgets show a further overspending in November to a cumulative adverse variance of £3.638m. Slippage on CRES schemes of £3.094m is embedded within this position. Significant overspendings are reported this month against Specialised Services (£306k), Diagnostic and Therapies (£257k and Surgery, Head and Neck 9£171k). Further work is underway to identify the causes.

Operating Income budgets show a cumulative favourable variance of £0.644m with an improvement of £0.269m recorded in November.

Income from Activities shows a small under performance of £0.032m for November (October activity reported a month in arrears). The cumulative position on Income from Activities shows a shortfall to date of £0.638m (net of the balance of the over performance for March 2011 (£0.81m), received in 2011/12). This month's report includes the impact of a number revisions to the basis of income receivable including Readmissions (£0.190m) and Specialised Services – CICU (£0.252m) both favourable and CPAP[2] devices (£0.226m adverse).

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

	£'000
MARS (Mutually Agreed Resignation Scheme)	468
Clinical Systems Implementation Programme	109
European Working Time Directive	132

3. Income

For the year to date, contract income is £0.49m greater than plan. This position includes £0.81m related to 2010/11 activity; therefore 2011/12 contract income is less than plan by £0.32m. Further information on principal commissioner Service Level Agreement variances is given below.

Clinical Income by Worktype - £m	**Plan**	**Actual**	**Variance**
Accident & Emergency	6.29	6.52	0.23
Emergency Inpatients	42.37	42.59	0.23
Day Cases	19.74	20.56	0.81
Elective Inpatients	27.98	26.97	(1.01)
Non-Elective Inpatients	17.33	17.83	0.50
Excess Bed days	5.17	4.37	(0.80)
Outpatients	38.06	37.47	(0.59)
Bone Marrow Transplants	5.46	5.25	(0.20)
Critical Care Bed days	19.90	20.16	0.26
PbR Exclusions / NICE	21.66	19.92	(1.75)
Contract Penalties / Rewards	(4.01)	(4.46)	(0.45)
Other	27.33	29.77	2.44
Sub-Totals	**227.28**	**226.96**	**(0.32)**
2010/11 Estimate v Actual	-	0.81	0.81
Totals	**227.28**	**227.77**	**0.49**

[2] Continuous Positive Airway Pressure

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

(Penalties) / Rewards	Month 7 Year to Date £m	Current Month £m	Month 8 Year to Date £m
CQUINS	1.29	0.13	1.42
Emergency Readmissions	(0.39)	0.12	(0.27)
Emergency Marginal Tariff	(0.04)	0.02	(0.02)
Others	(0.10)	(0.06)	(0.16)
Totals	**0.76**	**0.21**	**0.97**

The contract penalties associated with emergency admissions following an elective or emergency spell total £2.38m for the first 7 months of 2011/12. There are also a number of significant SLA risks from potential fines and limiters including cancelled operations, 18 week referral to treatment, INNF (interventions not normally funded) cases subject to prior approval etc. These are currently being reviewed.

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

SLA Variances - £m	**BNSSG**[3]	**South West Specialist Commissioning**	**Other Commissioners**	**Totals**
Over / (under) performance as at Month 7	5.71	(1.74)	(4.29)	(0.32)
QIPP	(6.18)	-	6.18	-
A&E / Emergencies	0.36	0.20	(0.59)	(0.03)
Residual Over / (Under) performance	**(0.11)**	**(1.54)**	**1.30**	**(0.35)**

This demonstrates that, for example, of the £5.71m over-performance to date for BNSSG £5.82m is due to QIPP and A&E / Emergency activity. In total there is, therefore, a net residual under performance of £0.11m.

4. Expenditure

In total, Divisions are shown as overspent by £4.866m for the eight month period to 30th November. 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 November Favourable / (Adverse)	Memorandum CRES Variance to 30th November	**Variance to 30th November Favourable / (Adverse)**	**Memorandum CRES Variance to 30th November**
	£'000	£'000	£'000	£'000
Diagnostic and Therapies	(210)	(250)	(102)	(142)
Medicine	(1,215)	(1,164)	(790)	(739)
Specialised Services	(1,380)	(775)	(1,159)	(554)
Surgery, Head and Neck	(820)	(2,062)	(336)	(1,578)
Women's and Children's	(1,508)	(984)	(1,291)	(767)
Facilities and Estates	(25)	(117)	30	(62)
Trust Services	84	(1)	99	14
Other Services	208	(172)	208	(172)
Totals	**(4,866)**	**(5,525)**	**(3,341)**	**(4,000)**

[3] Bristol, North Somerset and South Gloucestershire Commissioner

This shows that two Divisions in particular – Women's and Children's and Specialised Services are not mitigating the under delivery of CRES i.e. other financial factors are contributing to the adverse position to Month 8. For each Division the shortfall, using results to date, is in excess of £0.5m.

The **Diagnostic and Therapies Division** reports a cumulative over spending of £210k – an overspending of £121k in the month. Pay budgets have underspent this month by £61k reducing the cumulative overspending to £56k. The principal reason for the adverse movement this month relates to Pharmacy services. The correction of the overstated credits attributed to the Parenteral Services Unit in October has resulted in an adverse variance this month of £169k. In addition, the introduction of the new Pharmacy system in November has seen a higher than usual wastage figure (£50k) identified in the course of a stocktake. These adverse variances have been partially offset by the recovery of a credit (£76k) to recover the excess costs incurred as a result of a supplier being unable to supply drugs at the contracted price in the June – August period. The Division also reports continued higher than planned spending in Laboratory Medicine. This includes high costs for a service provided by a local trust which is currently subject to challenge.

The **Division of Medicine** reports an adverse variance of £1,215k for the eight months to 30th November. This moves the Division's RAG status from Amber/Red to Red. To date pay budgets are overspent by £508k, an increase of £70k in the month. The overspending relates to the recruitment of a new consultant in the Emergency Department, backdated locum and weekend working claims and an increase in Junior Doctor numbers. Non pay budgets show a cumulative overspending of £819k (October £694k adverse). This is a continuation of the previously reported trend relating to slippage on CRES and overspendings on clinical supplies. Operating income budgets continue to perform well with the in month underspending of £51k increasing the cumulative favourable position to £249k. Income from Activities shows an adverse movement this month of £280k. This results in a cumulative adverse variance of £137k to date. The significant change this month is the correction to the CPAP income at £226k adverse. The non achievement of CRES at £1.164m continues to be a significant factor in the Division's reported position.

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £1,380k, a net overspending of £113k in November. This is a disappointing performance as the in month adverse variance is £467k before taking account of the distribution of surplus Research moneys for which the division will benefit by £182k with £121k having been brought into account in this month's report. In addition the in month variance reflects a retrospective income adjustment in respect of CICU services – an improvement of £252k in this month's reported position. Therefore, the residual adverse variance in the month is £486k.

Pay budgets are reported as having a cumulative overspending of £809k, an overspending of £76k in the month. This follows the continuing use of higher than budgeted staff through agency, waiting list initiatives and additional sessions paid. Non pay budgets have overspent by £185k (net of R&D income) in the month resulting in a cumulative overspending of £342k. The results for November include non recurring costs of £75k for time-expired valves and 'lost' recharges for activity carried out earlier in the year. Clinical supplies in cardiology have overspent by £103k in the month – checks are being made to see if there has been a corresponding increase in clinical activity. Blood costs, other than clotting factors, are £56k overspent in the month as a result of treating a number of high cost patients. There are on-going investigations into the source of the non pay gross overspend of £463k. CRES slippage of £495k is clearly a significant factor in non pay budgets being overspent to date. Income from Activities shows a favourable variance of £113k in the month and a cumulative adverse position of £366k.

The Surgery, Head and Neck Division reports an adverse variance on its income and expenditure position of £820k. This represents an underspending of £103k in November with the inclusion of the Divisions share of the distribution of research moneys, with a beneficial effect of £120k in this report, being a significant factor. Pay budgets have a cumulative underspending of £20k an improvement in the month of £90k. Non pay budgets are overspent by £888k to date an increase of £51k in the month. The principal cause of the non pay overspending is slippage on CRES at £1,144k. Income from Activities shows an adverse variance of £10k this month to bring the cumulative position to £190k adverse. Income from Operations budgets have a favourable variance of £74k in November to bring the cumulative over achievement to £238k.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £1,508k – a net overspending of £27k in November. Pay budgets are overspent by £760k – an adverse movement of £133k in the month. Contributing factors to the pay overspending include consultant savings plans not being delivered, agency costs re junior doctors to cover vacancies and high nursing unsocial hours for a 5-week month. Non pay budgets show a cumulative overspending of £495k. The principal reasons for the net increase of £67k in the month is in respect of BMT donor charges for 11 transplants of £175k (offset by higher income), partially offset by the division's share of the Research moneys distribution (£68k). Income budgets show an adverse variance of £253k to date, an improvement of £0.173m in the month. Slippage to date on the CRES programme of £0.984m is a significant factor in the Division's reported financial position.

The Facilities and Estates Division reports a cumulative overspending to date of £25k, an improvement of £2k in the month.

Trust Services report an in-month underspending of £26k thereby increasing the cumulative underspending to date to £84k.

5. Financial Risk Rating

The Trust's overall financial risk rating, based on results to 31st October is 3. This is in line with 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.

	30th November 2011		
Metric	Metric Result	Metric Score	Weighted Average Score
EBITDA			
Margin	6.8%	3	0.75
Plan achieved	102.9%	5	0.50
Return on Capital Employed	4.9%	3	0.60
I&E surplus margin	1.3%	3	0.60
Liquidity ratio (days)	33.6 days	4	1.00
			3.45

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

Overall Financial Risk Rating	**3**

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

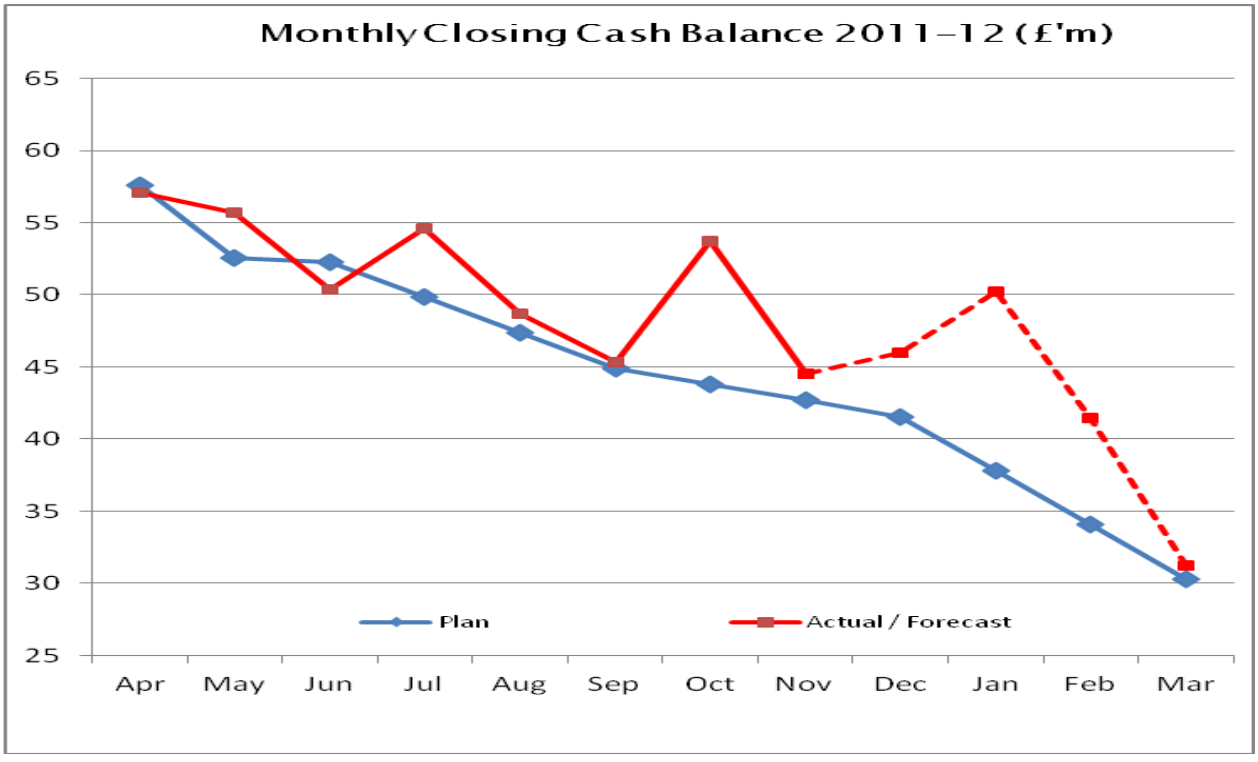
6. Capital Programme

A summary of income and expenditure for the eight months to 30th November is given in the table below. Expenditure for the eight months to 30th November of £23.714m is £0.340m less than Plan.

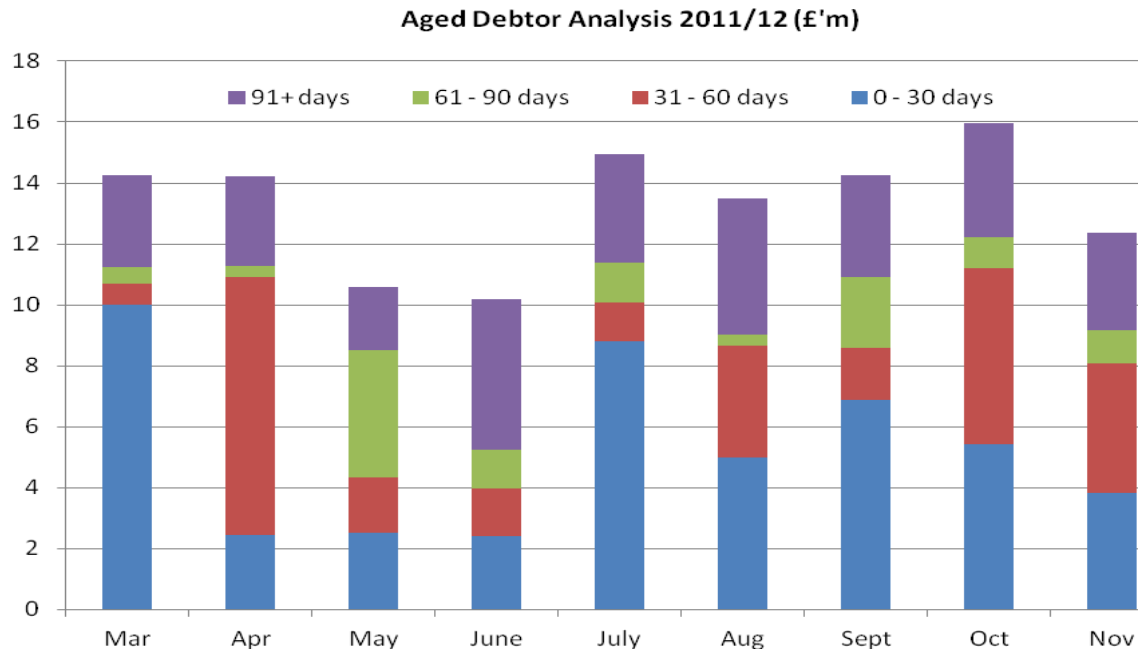
Plan for Year		8 Months Ended 30th November 2011		
		Plan	Actual	Variance Favourable / (Adverse)
£'000		£'000	£'000	£'000
	Sources of Funding			
1,426	Donations	-	-	-
16,833	Retained Depreciation	11,315	11,308	(7)
1,808	Sale of Property	879	879	-
600	Grant - University of Bristol	600	600	-
31,388	Cash balances	11,260	10,927	(333)
52,055	**Total Funding**	**24,054**	**23,714**	**(340)**
	Expenditure			
(27,179)	Strategic Schemes	(12,760)	(13,968)	(1,208)
(5,613)	Medical Equipment	(599)	(359)	240
(5,497)	Information Technology	(3,499)	(3,099)	400
(2,226)	Roll Over Schemes	(943)	(805)	138
(3,810)	Refurbishments	(2,108)	(2,026)	82
(10,950)	Operational / Other	(4,145)	(3,457)	688
3,220	Anticipated Slippage	-	-	-
(52,055)	**Total Expenditure**	**(24,054)**	**(23,714)**	**340**

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

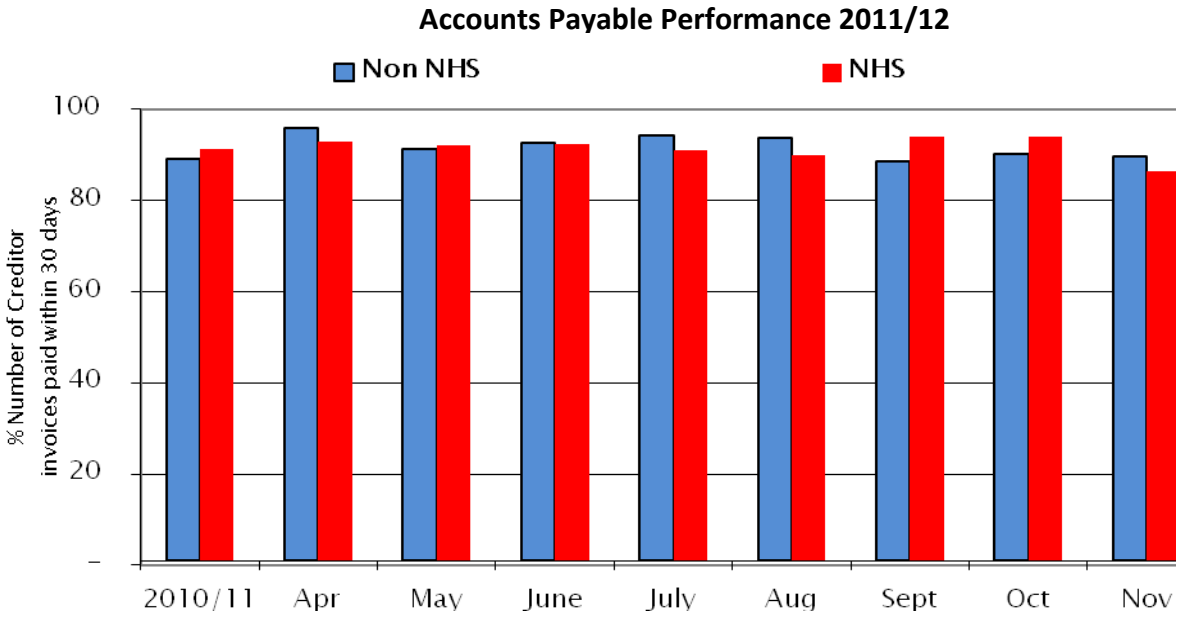
Cash - The Trust held a cash balance of £44.5m as at 30th November. The cash position is £1.1m lower than the forecast made last month. The graph, shown below, sets out the current forecast for month end cash balances to March 2012.



Debtors - The total value of invoiced debtors has decreased by £3.578m during November to a closing balance of £12.381m. The principal changes relate to the settlement by the North West SHA of an invoice for Skills for Health services (£2.7m) and NHS Gloucestershire payment re UH Bristol services (0.745m). The total amount owing is equivalent to 10.4 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In November the Trust achieved 87% and 90% compliance against the Better Payment Practice Code for NHS and Non NHS creditors.



Attachments

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

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

Approved Budget / Plan 2011/12	Heading		Position as at 30th Nov Plan	Actual	Variance Fav / (Adv)	Actual to 31st Oct	Forecast Outturn
£'000			£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)						
395,309	From Activities		263,772	262,966	(806)	229,165	396,905
105,876	Other Operating Income		70,263	70,909	646	61,751	104,497
501,185	Sub totals income		**334,035**	**333,875**	**(160)**	**290,916**	**501,402**
	Expenditure						
(308,133)	Staffing		(206,557)	(207,813)	(1,256)	(181,840)	(310,692)
(149,434)	Supplies and services		(99,860)	(103,515)	(3,655)	(89,266)	(157,134)
(457,567)	Sub totals expenditure		**(306,417)**	**(311,328)**	**(4,911)**	**(271,106)**	**(467,826)**
(9,985)	**Reserves**	Reserves	(5,703)	11	5,714	–	–
(9,985)		Sub Total Reserves	**(5,703)**	**11**	**5,714**	**–**	**–**
33,632	**EBITDA**		**21,915**	**22,558**	**643**	**19,810**	**33,576**
6.71	**EBITDA Margin – %**			**6.76**		**6.81**	**6.70**
(206)	Fixed asset impairments		(207)	(205)	2	(207)	(202)
(18,204)	Depreciation & Amortisation		(12,165)	(12,173)	(8)	(10,643)	(18,204)
357	Interest Receivable		245	255	10	221	350
(411)	Interest payable on loans & leases		(274)	(274)	–	(240)	(411)
(9,162)	PDC Dividend		(6,108)	(6,073)	35	(5,314)	(9,109)
6,006	**NET SURPLUS / (DEFICIT)**		**3,406**	**4,088**	**682**	**3,627**	**6,000**
1.20	**Net margin – %**			**1.22**		**1.25**	**1.2**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report November 2011 - Divisional Income & Expenditure Statement

Approved Budget / Plan 2011/12	Division	Total Net Expenditure / Income to Date	Position as at 30th Nov [Favourable / (Adverse)] Pay	Non Pay	Operating Income	Income from Activities	Total Variance to date	Memorandum CRES Variance to Date	Cumulative Variance to 31st Oct	Forecast Outturn Variance
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements									
389,987	Service Agreements	259,494	–	–	–	–	–	–	–	–
(1,600)	Overheads	(1,768)	–	–	–	(168)	(168)	–	(216)	–
40,466	NHSE Income	26,971	–	–	–	–	–	–	–	–
428,853	**Sub Total Service Agreements**	**284,697**	**–**	**–**	**–**	**(168)**	**(168)**	**–**	**(216)**	**–**
	Clinical Divisions									
(42,487)	Diagnostic & Therapies	(28,026)	(56)	(344)	(168)	358	(210)	(250)	(89)	(32)
(56,795)	Medicine	(39,194)	(508)	(819)	249	(137)	(1,215)	(1,164)	(791)	(663)
(65,355)	Specialised Services	(43,855)	(809)	(342)	137	(366)	(1,380)	(775)	(1,267)	(850)
(87,163)	Surgery Head & Neck	(58,720)	20	(888)	238	(190)	(820)	(2,062)	(923)	(1,181)
(85,495)	Women's & Children's	(58,373)	(760)	(495)	(10)	(243)	(1,508)	(984)	(1,481)	(900)
(337,295)	**Sub Totals (1)**	**(228,168)**	**(2,113)**	**(2,888)**	**446**	**(578)**	**(5,133)**	**(5,235)**	**(4,551)**	**(3,626)**
	Corporate Services									
(2,291)	Trust Wide Acrruals	(2,156)	–	136	–	–	136	–	–	
(52)	Community	(17)	–	18	–	–	18	(2)	16	27
(6,751)	Trust HQ	(4,638)	68	(131)	76	–	13	(2)	(8)	–
(5,250)	Human Resources	(3,375)	177	(158)	2	–	21	8	20	40
(5,577)	Information Technology	(3,711)	163	(123)	(35)	–	5	–	5	–
(5,090)	Finance	(3,317)	165	(62)	(58)	–	45	(8)	41	50
(26,261)	Facilities & Estates	(17,178)	166	(220)	65	(36)	(25)	(118)	(27)	–
(7,040)	Misc Support Services	(5,684)	137	(264)	125	(24)	(26)	(173)	(95)	(250)
9,022	Research and Development	5,202	1	26	8	–	35	3	33	329
(26,336)	Capital Charges	(17,583)	–	27	15	–	42	–	32	–
(75,626)	**Sub Totals (2)**	**(52,457)**	**877**	**(751)**	**198**	**(60)**	**264**	**(292)**	**17**	**196**
(412,921)	**Sub Totals (1) and (2)**	**(280,625)**	**(1,236)**	**(3,639)**	**644**	**(638)**	**(4,869)**	**(5,527)**	**(4,534)**	**(3,430)**
–	**Skills for Health**	5	(20)	23	2	–	5	–	3	–
(412,921)	**Totals I & E**	**(280,620)**	**(1,256)**	**(3,616)**	**646**	**(638)**	**(4,864)**	**(5,527)**	**(4,531)**	**(3,430)**
	Reserves									
(9,926)	General	11	–	5,714	–	–	5,714	–	5,305	3,430
(9,926)	**Sub Total Reserves**	**11**	**–**	**5,714**	**–**	**–**	**5,714**	**–**	**5,305**	**3,430**
6,006	**TRUST TOTALS**	**4,088**	**(1,256)**	**2,098**	**646**	**(806)**	**682**	**(5,527)**	**558**	**–**

Analysis of pay spend 2010/11 and 2011/12

Division		2010/11 Total	2011/12 April	May	June	Q1	July	August	Sept.	Q2	October	Nov.	YTD Total	Mthly Average	2010/11 Mthly Average
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Women's and Children's	Pay budget	65,891	5,560	5,526	5,552	16,638	5,535	5,617	5,564	16,716	5,639	5,690	44,682	5,585	5,491
	Bank	2,076	119	165	212	496	169	165	189	524	184	203	1,407	176	173
	Agency	654	39	88	55	182	40	59	29	128	62	35	407	51	55
	Waiting List initiative	304	26	25	22	73	16	24	2	42	10	1	126	16	25
	Overtime	91	4	5	5	14	5	3	3	11	2	2	30	4	8
	Other pay	62,798	5,401	5,447	5,371	16,219	5,372	5,577	5,325	16,274	5,401	5,582	43,476	5,435	5,233
	Total Pay expenditure	65,923	5,589	5,730	5,665	16,984	5,602	5,828	5,548	16,979	5,660	5,823	45,446	5,681	5,494
	Variance Fav / (Adverse)	(32)	(29)	(204)	(113)	(346)	(67)	(211)	16	(263)	(21)	(134)	(764)	(95)	(3)
Medicine (incl Central Services for 2011/12)	Pay budget	41,745	3,548	3,791	3,695	11,034	3,644	3,599	3,657	10,900	3,692	3,631	29,257	3,657	3,479
	Bank	3,434	236	270	339	845	227	276	255	758	243	271	2,117	265	286
	Agency	559	30	62	65	157	59	21	61	141	34	25	356	45	47
	Waiting List initiative	315	9	10	11	30	3	0	1	4	21	(12)	43	5	26
	Overtime	69	5	7	13	25	5	5	5	15	4	5	48	6	6
	Other pay	38,883	3,413	3,405	3,500	10,318	3,378	3,367	3,349	10,094	3,373	3,438	27,223	3,403	3,240
	Total Pay expenditure	43,260	3,693	3,754	3,928	11,375	3,672	3,669	3,670	11,012	3,676	3,726	29,788	3,723	3,605
	Variance Fav / (Adverse)	(1,515)	(145)	37	(233)	(341)	(28)	(70)	(13)	(111)	16	(95)	(531)	(66)	(126)
Surgery Head and Neck	Pay budget	66,148	5,541	5,245	5,630	16,416	5,607	5,605	5,735	16,947	5,652	5,686	44,701	5,588	5,512
	Bank	2,100	119	127	204	450	183	152	191	525	166	190	1,331	166	175
	Agency	1,206	41	69	11	121	(2)	53	44	95	67	68	351	44	101
	Waiting List initiative	1,209	98	127	79	304	16	27	7	50	59	96	509	64	101
	Overtime	152	7	7	8	22	15	8	12	35	12	14	83	10	13
	Other pay	61,071	5,143	5,327	5,314	15,784	5,337	5,352	5,406	16,096	5,383	5,229	42,492	5,311	5,089
	Total Pay expenditure	65,738	5,408	5,657	5,616	16,681	5,549	5,592	5,660	16,801	5,688	5,597	44,766	5,596	5,478
	Variance Fav / (Adverse)	410	133	(412)	14	(265)	58	13	75	146	(35)	90	(65)	(8)	34
Specialised Services	Pay budget	33,790	2,669	3,066	2,900	8,635	2,829	2,865	2,919	8,613	2,858	2,933	23,039	2,880	2,816
	Bank	1,049	61	74	95	230	87	93	85	265	81	102	678	85	87
	Agency	654	(69)	230	82	243	116	104	73	293	75	93	704	88	55
	Waiting List initiative	537	51	42	45	138	34	29	23	86	38	72	334	42	45
	Overtime	20	2	0	1	3	1	1	2	4	1	5	12	2	2
	Other pay	32,290	2,684	2,813	2,786	8,283	2,857	2,765	2,741	8,362	2,749	2,737	22,132	2,767	2,691
	Total Pay expenditure	34,550	2,729	3,159	3,009	8,897	3,095	2,992	2,924	9,011	2,944	3,009	23,860	2,983	2,879
	Variance Fav / (Adverse)	(760)	(60)	(93)	(109)	(262)	(266)	(127)	(6)	(398)	(85)	(76)	(822)	(103)	(63)

Analysis of pay spend 2010/11 and 2011/12

Item 7a- Appendix 3

Division		2010/11	2011/12											2010/11
		Total	April	May	June	Q1	July	August	Sept.	Q2	October	Nov.	YTD Total	Mthly Average	Mthly Average
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Diagnostic & Therapies	Pay budget	36,929	3,045	2,998	3,078	9,121	3,089	3,126	3,066	9,280	3,120	3,041	24,562	3,070	3,077
	Bank	544	46	50	48	144	35	43	29	108	35	52	339	42	45
	Agency	389	24	32	17	73	13	29	4	46	9	18	147	18	32
	Waiting List initiative	156	14	15	8	37	15	6	6	27	17	6	87	11	13
	Overtime	264	22	20	26	68	17	19	13	49	21	19	156	20	22
	Other pay	35,515	2,937	2,961	3,017	8,915	3,025	3,015	2,989	9,029	3,068	3,007	24,018	3,002	2,960
	Total Pay expenditure	36,868	3,043	3,078	3,116	9,237	3,105	3,112	3,041	9,258	3,150	3,102	24,747	3,093	3,072
	Variance Fav / (Adverse)	61	2	(80)	(38)	(116)	(16)	13	24	22	(30)	(61)	(185)	(23)	5
Facilities & Estates	Pay budget	18,706	1,398	1,532	1,727	4,657	1,567	1,647	1,593	4,807	1,515	1,611	12,590	1,574	1,559
	Bank	483	29	29	35	93	26	22	27	75	25	19	212	26	40
	Agency	1,300	128	105	118	351	148	99	133	380	100	87	918	115	108
	Waiting List initiative	7	1	1	0	2	0	0	0	0	0	0	2	0	1
	Overtime	1,160	79	95	112	286	97	53	100	250	98	123	757	95	97
	Other pay	15,591	1,164	1,300	1,448	3,912	1,281	1,435	1,305	4,021	1,306	1,300	10,539	1,317	1,299
	Total Pay expenditure	18,541	1,401	1,530	1,713	4,644	1,552	1,609	1,565	4,726	1,529	1,529	12,428	1,553	1,545
	Variance Fav / (Adverse)	165	(3)	2	14	13	15	37	28	80	(14)	83	162	20	14
Trust Services	Pay budget	26,763	4,034	316	2,019	6,369	2,073	1,962	3,212	7,248	2,344	2,286	18,246	2,281	2,230
	Bank	609	38	24	53	115	47	68	42	157	(9)	(6)	257	32	51
	Agency	209	13	(4)	0	9	21	5	27	53	29	38	129	16	17
	Waiting List initiative	7	1	1	(3)	(1)	0	0	0	0	0	0	(1)	(0)	1
	Overtime	108	7	5	4	16	3	4	10	17	5	8	46	6	9
	Other pay	26,087	4,093	365	2,074	6,532	1,774	1,920	3,137	6,832	2,117	1,971	17,452	2,182	2,174
	Total Pay expenditure	27,020	4,152	391	2,128	6,671	1,845	1,997	3,216	7,059	2,143	2,011	17,883	2,235	2,252
	Variance Fav / (Adverse)	(257)	(118)	(75)	(109)	(302)	228	(35)	(4)	189	201	274	363	45	(21)
Trust Total (excl Skills for Health)	Pay budget	289,972	25,795	22,474	24,601	72,870	24,344	24,421	25,745	74,510	24,820	24,877	197,077	24,635	24,164
	Bank	10,295	648	739	986	2,373	774	820	819	2,413	725	830	6,341	793	858
	Agency	4,971	206	582	348	1,136	395	370	371	1,136	377	363	3,011	376	414
	Waiting List initiative	2,535	200	221	162	583	84	86	39	209	145	163	1,100	137	211
	Overtime	1,864	126	139	169	434	143	93	144	380	143	176	1,133	142	155
	Other pay	286,411	24,835	21,618	23,510	69,963	23,024	23,432	24,252	70,708	23,398	23,264	187,333	23,417	23,868
	Total Pay expenditure	291,900	26,015	23,299	25,175	74,489	24,420	24,800	25,625	74,845	24,788	24,795	198,918	24,865	24,325
	Variance Fav / (Adverse)	(1,928)	(220)	(825)	(574)	(1,619)	(76)	(379)	120	(335)	32	82	(1,841)	(230)	(161)

NOTE: Other Pay includes all employer's oncosts.

Key Issue	RAG	Executive Summary	Table
Service Level Agreement Income and Activity	G	For the year to date contract income is £0.49m 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 £0.02m adverse (last month £0.04m adverse) and SLA Contract Penalties / Rewards at a net reward of £0.99m (October net reward £0.80m). A&E Attendances at 67,370 are 1,914 **higher** than planned. The average number of daily attendances is 315. Emergency activity at 21,758 is 2.0% or 441 spells **lower** than planned. Non Elective activity at 9,186 is 2.4% or 216 spells **higher** than planned. Elective activity at 8,306 is 6.0% or 528 spells **lower** than planned. Day case activity at 28,640 is 5.0% or 1,370 spells **higher** than planned. Outpatient Procedure activity at 15,468 is 4.2% or 623 attendances **higher** than planned. New Outpatients activity at 77,576 is 1.7% or 1,307 attendances **lower** than planned. Follow up Outpatient activity at 181,805 is 2.2% or 4,022 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 eight months to 30th November is £4.088m. The EBITDA surplus of £22.558m equates to 102.9% of the Annual Plan target for the period. Total income to date £333.875m is £0.160m less than Plan. This includes £0.810m of residual over performance relating to 2010/11. Expenditure at £311.328m is greater than Plan by £4.911m, 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 £39k.	I&E 1 I&E 2 I&E 3a I&E 3b

Key Issue	RAG	Executive Summary	Table
Cash Releasing Efficiency Savings	R	The 2011/12 CRES programme totals £26.636m. Actual savings achieved for the eight months to 30th November total £12.232m compared with a target for the period of £16.232m, a shortfall of £4m (October cumulative shortfall £3.834m). The forecast savings for the year is £21.032m.	I&E 4a – 4b
Statement of Financial Position & Treasury Management	G	The cash balance on 30th November was £44.536m. The forecast cash balance for 31st March 2012 is £31.265m compares favourably with the Annual Plan forecast of £30.312m. The balance on Invoiced Debtors has decreased by £3.578m in the month to £12.381m. The invoiced debtor balance equates to 10.4 debtor days. Creditors and accrual account balances total £65.714m although £11.210m relates to deferred income. Invoiced Creditors - payment performance for the eight months to 30th November Non NHS invoices and NHS invoices within 30 days was 92% and 90% respectively.	BS 1 BS 2 BS 3 BS 4
Capital	G	Expenditure for the eight months to 30th November totals £23.714m - this is £0.340m less than profiled for the period. The principal areas of slippage to date are recorded against Operational capital schemes (£0.688m), Information Technology (£0.4m) and Medical Equipment (£0.24m). Expenditure on Strategic schemes is £1.208m ahead of plan.	
Financial Risk Rating	G	The Trust's overall financial risk rating using the results for the eight months to 30th November 2011 has been calculated to be 3 (actual score 3.45). The Trust's ratings under the Prudential Borrowing Code are satisfactory with all ratios well within the Monitor thresholds.	
Private Patient Cap	G	Private patient income for the period is £1.936m or 0.74% of total patient related income. This is well below the Trust's Private Patient Cap of 1.1%.	

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

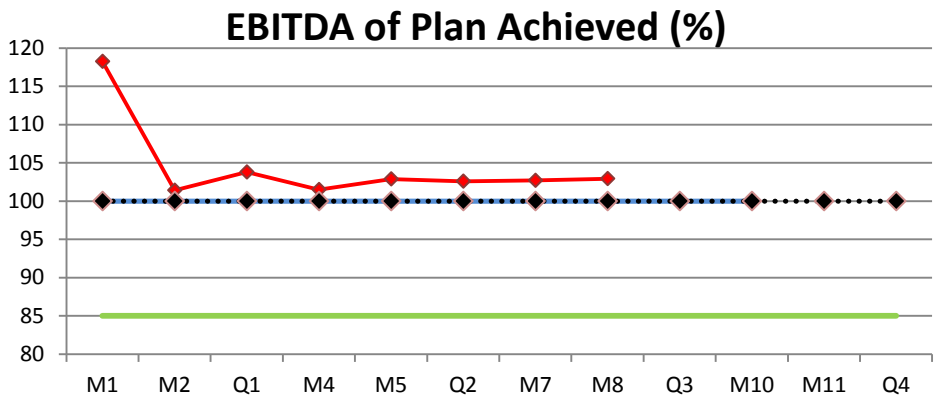
Finance Report November 2011 - Risk Matrix

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 @ 0.74% of patient related income remains well within the Trust's Cap of 1.1%.
1858	Non receipt of pledges of charitable moneys to partly finance capital expenditure	Low	-	Monitoring of capital expenditure. Maintain dialogue with respective trustees.	PM	Low	-	

Financial Risk Ratings – November 2011 Performance

1. Financial Risk Rating

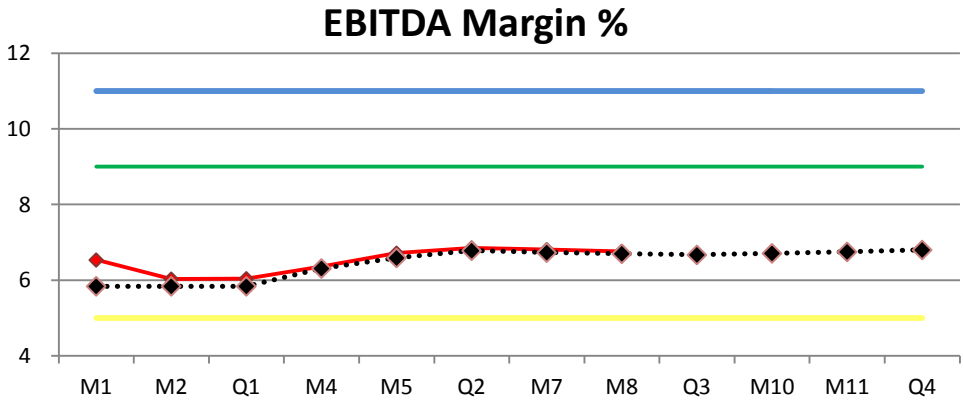
The following graphs will show performance against the 5 Financial Risk Rating metrics. The 2011/12 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 5 (blue line)**; **FRR 4 (green line)** and **FRR 3 (yellow line)**.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

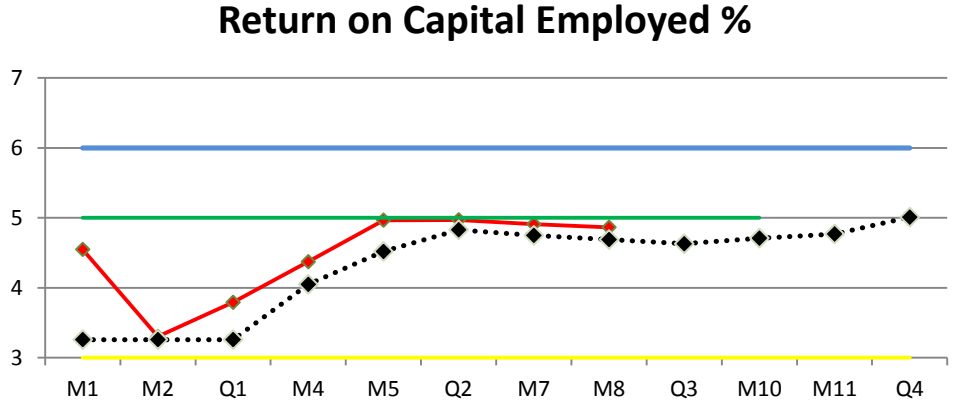


An EBITDA of £22.558m was achieved. This is 2.9% better than the proportion of the Annual Plan for the period value of £21.915m.

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

The EBITDA Margin of 6.76% for November achieves a metric score of 3. This is slightly better than the Annual Plan forecast of 6.70% to date.



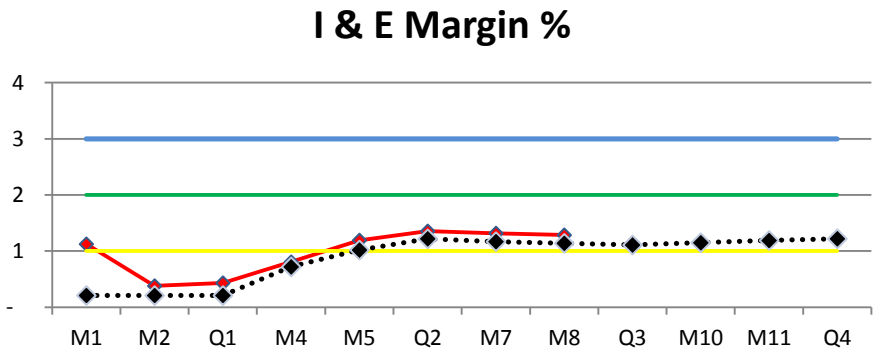


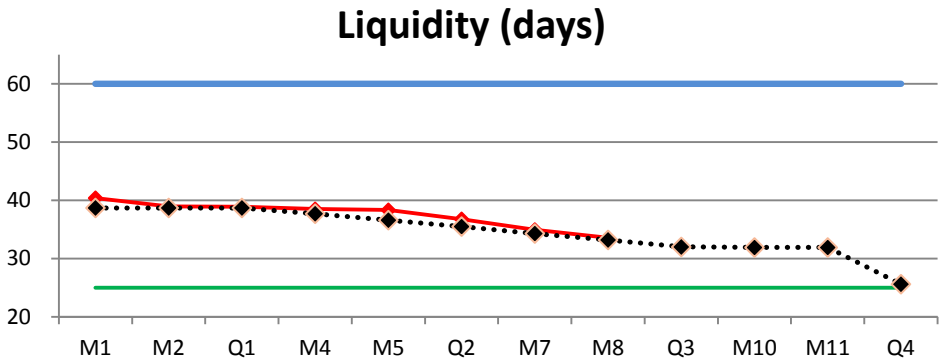
The Return on Capital Employed for the eight months to November is 4.87%. The result earns a metric score of 3.

Annual Plan = 4.69%

2011/12 Annual Plan Income & Expenditure surplus margin is 1.14% for the eight months to 30th November.

The Income and Expenditure surplus margin for the period is 1.29%, a metric score of 3.





2011/12 Annual Plan liquidity ratio is 33.2 days at 30th November.

The actual liquidity ratio for November is 33.6 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 3.45. The Trust has therefore achieved a Financial Risk Rating of 3 for the eight months to 30th November 2011.

2. Prudential Borrowing Limit

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

Prudential Borrowing Limit Performance	Monitor Ratio Tier 1	30th November 2011
Minimum Dividend Cover	>1x	3.8x
Minimum Interest Cover	>3x	83x
Minimum Debt Service Cover	>2x	59x
Maximum Debt Service to Revenue	<2.5%	0.1%

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

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 21 December 2011 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 08 – Partnership Programme Board Report

Purpose

To provide the Board with an update on matters considered at the October 2011 meeting of the University Hospitals Bristol (UH Bristol) and North Bristol Trust (NBT) Partnership Programme Board.

Abstract

The Partnership Programme Board meets on a bi-monthly basis and considers matters of relevance to the partnership agenda between UH Bristol and NBT with the aim of promoting highly effective joint working between the partner trusts for the benefit of patients and staff within the two organisations.

The minutes of the October Board are included at Appendix A.

Recommendations

The Board is recommended to **note** the minutes of the recent Partnership Programme Board.

Executive Report Sponsor or Other Author

- Sponsor – Robert Woolley, Chief Executive
- Author – The Director of Strategic Development, Deborah Lee

Appendices

- Appendix A – Partnership Programme Board Minutes October 2011

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
					Partnership Programme Board 12 December 2011

North Bristol NHS Trust
University Hospitals Bristol NHS Foundation Trust

The Partnership Programme Board

Held on Wednesday 19 October 2011 at 12-2pm
Chief Executive's Office, THQ, Frenchay Hospital

Key Points Summary

Terms of Reference for the Partnership Board had been revised and subsequently approved by both Boards in their public meetings.

Healthcare System Capacity Review
Bristol, North Somerset and South Gloucestershire (BNSSG) PCT Cluster have commissioned a piece of work to look at the likely future demand and supply scenarios across the health system, including both community and hospital based care. This will inform future planning decisions about service and building capacity. The Review will be reported to the Healthy Futures Programme Board.

Histopathology Workforce Planning
Work is in train to consider the future workforce requirements for the developing integrated histopathology service. A proposal to address the most immediate needs is being developed for consideration by the two Trusts in December 2011.

Major Trauma
NBT has been confirmed as one of the two future Major Trauma Centres for the South West with formal designation proposed for 1st April 2012. UH Bristol will operate within the Trauma Network as a Unit and as such will be designated by NBT as part of this national process.

Academic Health Science Centre
Update provided and strong, continuing support from the Partnership Board was noted.

Service Transfers
The Trusts have agreed to do further work on the potential for a transfer of both surgical and medical work from UH Bristol to NBT as part of the wider configuration of acute services across the City. If supported by both organisations, staff and public engagement and consultation would be required. Any agreed transfer would not take place until opening of the new hospital at Southmead in May 2014.

Standing Reports
Updates were received from all leads on the five on-going service transfers. Key issues and milestones noted were
Pathology – The Advisory Panel had met and endorsed the work to date and had recommended that the model be subjected to further work and feasibility testing. The Panel will reconvene in March 2012 to review progress.
Centralisation of Paediatrics – Continued good progress with no major risks noted.
Breast Centralisation – The process to secure this transfer had now recommenced following a period of stand down.
Urology Centralisation – Continued progress though risks to current May 2012 timeline noted and being actively managed.
Head and Neck Centralisation – Change in leadership arrangements at UH Bristol reported. Progress continues but a range of issues relating to workforce and capacity required active management and risks to May 2012 timeline were also noted.

Acute Services Strategy Development Matrix work had been concluded and presented to both Boards. A meeting was now planned between the Trusts, commissioners and Sir Ian Carruthers, NHS South of England to consider next steps.
Human Resources (HR) Services Update Continued good progress to align the HR functions of the two Trusts with the aim of improving service quality, maximising HR staff opportunity and reducing costs; early focus was on the integration of bank staffing, recruitment and teaching & learning provision.
NBT Highlight Update Ruth Brunt, CEO updated the Board on the status of their FT application noting that their Integrated Business Plan (IBP) was proceeding well and staff and public engagement was going extremely well. RB updated the Board on the status of key appointments including their new Chief Executive and Director of Operations.
UH Bristol Highlight Update Robert Woolley, CEO updated the Board on the recent award of Lead Provider for South Bristol Community Hospital to UH Bristol which the Trust was very pleased about and also the developing plans for the Trust's new Clinical Information System which would go live in March 2012.
AOB Harry Hayer suggested that a focus for a future Board meeting should be the Transformation Programmes that both organisations are working on with the aim of promoting intelligence / best practice sharing and identifying areas for joint work.

Attendees
NBT
Ruth Brunt, Chris Burton, Harry Hayer
Robert Mould (Chair)
UHB
Robert Woolley, Iain Fairbairn, Deborah Lee, Emma Woollett

Apologies
UHB
Alison Moon
NBT
Stephen Hughes

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 21 December 2011 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 09 – Results of Q2 Compliance Framework Monitoring Exercise

Purpose

To brief the Board on the results of Monitor's Q2 2011/12 monitoring of NHS foundation trusts.

Abstract

Monitor has confirmed that based on their analysis, the Trust's current ratings are:

- Financial risk rating - 3
- Governance risk rating - AMBER-GREEN

The Trust has been assigned an Amber-Green governance risk rating, which reflects that it has failed to meet the cancer 62 day wait for first treatment target (from consultant led screening service referral) in Quarter 2.

Compliance with targets, national priorities and CQC registration conditions is a requirement of the Trust's Terms of Authorisation. The Compliance Framework sets out the significance that Monitor attaches to a failure to comply. Monitor expects trusts to have plans in place such that your Board will be in a position to submit unqualified self-certifications in future monitoring cycles. Should the Trust fail to meet the cancer 62 day wait target for three consecutive quarters, its governance risk rating may be overridden to Red by Monitor in line with the procedures set out in the Compliance Framework and considered for escalation for potential significant breach of its terms of Authorisation.

The executive summary at Appendix A provides Monitor's assessment of the risks affecting compliance.

In addition to the above, the Trust has met the criteria of having a significant difference between the self-assessment of risk declared in your 2011/12 annual plan submission and subsequent governance performance in relation to the cancer 62 day wait target as the Trust breached this target in Q2 11/12 and failed to identify this risk in the Annual Plan.

Under normal process, Monitor would require the Trust to commission an independent self-certification review. However, given the background to the cancer 62 day target failure, Monitor does not require the Trust to commission a self-certification review at this stage.

Recommendations

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

Executive Report Sponsor or Other Author

- Sponsor – Chief Executive, Robert Woolley
- Author – Trust Secretary, Charlie Helps

Appendices

- Appendix A – Executive Summary of the Trust's Q2 results

University Hospitals Bristol NHS FT
Q2 2011-12 reporting executive summary

Monitor
Independent Regulator of NHS Foundation Trusts

Risk ratings

Financial Risk Rating:					
11/12 Plan:	YTD	FY		**YTD Actual:**	**Q2**
	3	3			**3**

Governance Risk Rating:			
11/12 Plan:	AMBER-RED	**YTD Actual:**	AMBER-GREEN
Risks declared:	• C. Difficile • A&E 4 hour 95% target	**Breaches:**	• 62 day cancer consultant screening referral target.

2011/12 Authorisation limits

Long term borrowing	£102.5m	**Working Capital Facility**	£37.5m	**Private Patient Income**	1.1 %

Financial summary

£m	Quarter			Year to date		
	Plan	Actual	Variance	Plan	Actual	Variance
Operating revenue	**124.5**	**127.6**	**3.2**	**245.7**	**249.4**	**3.6**
Pay	-76.7	-78.9	-2.2	-153.3	-156.1	**-2.8**
PFI Op. expense	0.0	0.0	0.0	0.0	0.0	**0.0**
All other Op. costs	-38.2	-39.0	-0.7	-75.7	-76.2	**-0.4**
EBITDA	**9.6**	**9.7**	**0.2**	**16.7**	**17.1**	**0.4**
Surplus	**2.7**	**2.8**	**0.1**	**3.0**	**3.2**	**0.2**
EBITDA %	7.7 %	7.6 %	-0.1 %	6.8 %	6.8 %	**0.1 %**
CapEx	-11.2	-8.2	2.9	-18.0	-14.7	**3.4**
Net cash flow	-7.4	-5.2	2.2	-8.1	-7.7	**0.4**
Cash & Equiv	**44.9**	**45.3**	**0.4**	**44.9**	**45.3**	**0.4**
FRR Liquidity days	35.5	37.0	1.5	35.5	37.0	**1.5**
CIP% OpEx less PFI	3.4 %	3.7 %	0.3 %	3.3 %	3.3 %	**0.1 %**
Net current assets	15.7	24.2	8.5	15.7	24.2	**8.5**
Borrowing	**-6.2**	**-6.2**	**0.0**	**-6.2**	**-6.2**	**0.0**

- FRR 3 delivered at Q2 which is in line with plan. Trust is forecasting a full year pre-exceptional surplus of £6.2m, broadly in line with plan.

Key risks	Action taken / committed	Gaps and residual concerns
• **Patient safety and quality.** Trust failed to meet the Cancer 62 Day consultant screening target at Q2 (87.6% vs. 90%).	• The Trust has relatively low volumes applicable to this target of c.50 per quarter and has achieved this target in 4 out of the past 6 quarters. Target failure at Q2 relates directly to a decision to change clinical practice to improve clinical care. This work has now been completed. Sustainable compliance expected from Q3 11/12.	• Three consecutive quarter failures may lead to a red governance risk rating and the Trust being considered for escalation by Monitor.
• **Corporate and clinical governance**. Review into Histopathology services at the Trust identified various governance concerns.	• The Trust has reported that it continues to implement its action plan to address recommendations and related governance matters. Trust had sought wider assurance through two reviews of patient safety & risk management and divisional governance which did not find any significant issues or concerns with the Trust's arrangements.	• Trust should continue to report to Monitor *by exception* where it experiences difficulty or material delays in implementing recommendations following the Histopathology Inquiry, which was published in December 2010.
• **Financial risks.** 1 Financial Risk Indicator triggered: • >5% debtors >90 days.	• Appropriate provisions has been made for potential bad debts. • Trust has made some progress resolving longstanding debtor issues and further work is being done to enhance cash collection.	• FRI has been triggered for six consecutive quarters. Should this be triggered again at Q3, Trust should provide greater explanation on the management of this risk within its Q3 return.
• **Major investment.** Delivery of 'significant' capital scheme (Bristol Royal Infirmary and centralising specialist paediatrics).	• This investment has been risk assessed by Monitor as it met the 'significant' threshold. Risk ratings of amber-green/FRR 3 provided.	• No material concerns at this stage. Trust should update Monitor is the business case fundamentals adversely change.
Next steps	• **Continue quarterly monitoring. Trust to update by exception if material issues arise in addressing Histopathology Inquiry recommendations.**	