University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Public Meeting of the Trust Board of Directors to be held on 26 January 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page*
1. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda.	Chairman	
3. Minutes and Matters Arising from the Previous Meeting To consider the Minutes of a Public Trust Board meeting dated Wednesday 21 December 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	15
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. Care Quality Commission Compliance Update To receive this report to **note**.	Chief Nurse	75
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 23 January 2012, including the Report of the Finance Director b. Quality and Outcomes Committee dated 25 January 2012.	Committee Chairs	79
Strategy and Business Planning		
8. Quarterly Capital Projects Status Report (Bristol Royal Infirmary, Centralisation of Specialist Paediatrics) To receive this report to **note**.	Director of Strategic Development	99

Item	*Sponsor*	*Page*
Monitor Reports		
9. Q3 Compliance Framework Monitoring & Declaration Report To receive and consider this report for **approval**.	Chief Executive	105
Risk		
10. Board Assurance Framework Report (including Strategic, Corporate & Compliance Objectives Status Report) To receive this report to **note**.	Chief Executive	125
11. Corporate Risk Register To receive this report to **note**.	Chief Executive	136
Information and Other		
12. Any Other Business To consider any other relevant matters not on the Agenda.	Chairman	
13. Date of Next Meeting **Public Meeting of the Trust Board of Directors**, Tuesday 28 February 2012 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 21 December 2011 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Board Members Present	
• John Savage – Chairman • Emma Woollett – Vice Chair • Iain Fairbairn – Senior Independent Director • 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	• Robert Woolley – Chief Executive • James Rimmer – Chief Operating Officer • Steve Aumayer – Director of Workforce and Organisational Development • Deborah Lee – Director of Strategic Development • Alison Moon – Chief Nurse • Sean O'Kelly – Medical Director
Present or In Attendance	
• Paul Tanner – Head of Finance • Mike Nevin – Head of Division – Surgery Head and Neck • Jackie Cornish – Head of Division – Womens' and Childrens' Services • 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 • Anne Reader – Assistant Director of Governance and Risk Management	• Rob Pitcher – Joint Clinical Lead for Cellular Pathology for North Bristol NHS Trust & University Hospitals Bristol NHS Foundation Trust • Anne Ford – Governor – North Somerset • Jan Dykes – Staff Governor • Sue Silvey – Public Governor • Ken Booth – Public Governor • Jeanette Jones – Staff Governor • Mo Schiller – Public Governor • Suzanne Green – Tertiary Patient Governor • John Steeds – Patient Governor – Local • Florene Jordan – Staff Governor • Vicki Mathias – Evening Post Health Reporter

Item	*Action*
1. Chairman's Introduction and Apologies The Chairman noted apologies received from Paul Mapson – Director of Finance.	
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 and Matters Arising from Previous Meetings The Board considered the Minutes of the Public Trust Board meeting held on Monday 28 November 2011 and **approved** them as an accurate record. All items on the Board Schedule of Matters Arising were noted as complete	

as reflected in the Schedule.

4. 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 following items of relevance:

- The written report of the Trust Management Executive recorded the publication in December of the 'NHS Health and Innovation Review' and the 'UK Strategy for Life Sciences'. Both reports set out the vision for consolidating the Life Sciences industry in the UK, putting research at the heart of healthcare, to drive innovation and transformation throughout the NHS. The Board was aware that progress was being made with establishing the Bristol Academic Health Science Centre, which placed the Trust in a favourable position in the context of the national direction. The Department of Health would invite application for inclusion in new networks during March 2012 and the Trust Board would be updated of progress in this regard.
- A national outline agreement was in-place between unions and the Government regarding proposed changes to public service pensions. This had reduced the risk of further industrial action in the NHS, as seen on 30 November 2011.
- A 60-day formal consultation with nursing staff had commenced regarding the streamlining of shifts and rosters across the service to rationalise circa eighty different shift patterns down to two. The programme should ensure improved quality of services for patients, and clarity for the staff who deliver the services, whilst generating efficiency savings for the Trust.
- The Care Quality Commission (CQC) made an unannounced visit during the week commencing 12 December 2011, to test the Trust's declaration of compliance with Outcome 5 (Nutrition). The informal feedback received from the Commission indicated that the Trust had made significant strides in the year and would be found compliant, but formal advice was yet to be received in this regard.

The Board discussed related matters. Paul May thanked all who had contributed to achieving compliance with Outcome 5, Nutrition. He was optimistic that continued investment in the initiative would deliver further improvements.

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

Quality, Performance and Compliance

5. 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 overall, the 'health' of the organisation had deteriorated slightly, relative to the previous month, with the number of

'Green' rated indicators increasing by one. This net change included Cash Releasing Efficiency Savings (CRES) achievement and Same-Sex Accommodation Breaches moving to a 'Green' rating.

The Trust was forecast to achieve a 'Green' rating against Monitor's Compliance Framework at the end of Quarter 3, with the full achievement of all cancer standards expected to be confirmed for November and December.

The number of 'Red-rated' indicators had increased by three, which included Hospital Standardised Mortality Ratio (HSMR) and 30-Day Readmissions.

The Board discussed the report. Robert Woolley elaborated on the Hospital Standardised Mortality Ratio indicator, saying that despite the current 'spike' in the indicator, it remained below the national average. That aside, the Executive was assessing whether there were any underlying causes for the anomalous spike.

b. Patient Experience

Alison Moon presented the Patient Experience Report, which differed from the regular format in that this example was a positive example of patient satisfaction.

The account described the patient who suffered from Postural Orthostatic Tachycardia Syndrome (POTS) who had written to the Chief Executive to share her positive experience of treatment at the Bristol Heart Institute. Despite only commencing her treatment in September 2010, she described her own progress as "amazing" and said that she was living independently, which had not been possible before.

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 could work extremely well.
- A team approach to patient care, both within the Trust and provision of expert advice to more general community services, had worked well in this particular situation. This example demonstrated the benefit to patients of having specialist expertise contained within a specialist centre, but being able to link in with local service provision.
- The use of technology, such as emails and blogs, and nurse specialists to provide advice and to support patients, without them having to attend Outpatients was better for patients, as they did not need to travel, and it was more efficient for the Trust as it freed-up appointments for others who needed to be seen in person.

the Board discussed the report.

- Alison Moon highlighted the use of Comments Cards, which were displayed at each Trust Board meeting. They gave a good 'snapshot' of the care provided by the Trust.
- Referring to the Patient Experience, Alison Moon said that a lot could be learnt from it, and that it demonstrated effective team and partnership working with patients.
- Selby Knox thanked Alison for bringing a positive patient experience to the notice of the Public Trust Board.

- Kelvin Blake said that although it was important to hear about a positive patient experience, there was still a requirement for the Trust Board to continue to receive and respond to the cases where failings were identified. Alison Moon assured the Trust Board that the Quality section of the report would continue to highlight the learning from complaints received.

c. Quality

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

- Referring to the Hospital Standardised Mortality Ratio (HSMR), Sean O'Kelly clarified that a ratio of 90 was still well below the national average of 100. This effectively meant that the Trust had prevented 10% of 'expected' (otherwise considered to be unpreventable) deaths within its patient population. Hospital Standardised Mortality Ratio performance was noted to be significantly better than most other Trusts, but Sean emphasised that despite this, the Trust would not be complacent with respect to its Hospital Standardised Mortality Ratio performance. The Quality Intelligence Group planned to explore the increase by establishing whether there were any possible anomalies at sub-Divisional level.
- Alison Moon explained that the Chair of the Quality and Outcomes Committee, had requested a report on Hospital Acquired Pressure Ulcers be brought to the Committee; this was scheduled for January 2012.
- Following a query by Paul May, Sean O'Kelly confirmed that the Trust would soon begin reporting the new measure of mortality, the Summary Hospital Mortality Indicator (SHMI). There was debate as to whether the Indicator was complementary, as it included deaths post-discharge from hospital. There was a possibility that University Hospitals Bristol NHS Foundation Trust may track both measures, but this was unconfirmed.
- Following a question by Kelvin Blake regarding the continued incidences of Hospital Acquired Pressure Ulcers, Alison Moon explained that the active imbedding of practices to prevent pressure sores was on-going. She said that she visited every matron or sister when a Grade 3 or 4 ulcer occurred, and it was systematically reflected throughout the department.
- The Director of Infection Prevention and Control, Christine Perry, added that the Trust was at a 'tipping point' with staff awareness of pressure ulcers had significantly increased, with improved reporting. Alison stressed the importance of working together with North Bristol NHS Trust to use the same metrics and methodologies.
- Selby Knox reported that he had seen draft versions of the "unsettling" new pressure ulcer awareness posters planned for display in patient areas. Christine Perry confirmed that the posters would be printed and distributed to hospital wards in January 2012.
- John Moore questioned the increase seen in 30-Day Emergency Readmissions. James Rimmer responded that they had reduced year-to-date, but the financial value of cases had increased.
- Following a request by Emma Woollett for clarity around the reporting of Serious Incidents reported in recent months. Alison Moon confirmed that

two issues had related to pressure ulcers where and that delays had been found in identifying incidents in department clinical areas, and also in the "turnaround" process at Trust Headquarters. Alison reported that both matters were now resolved and problems should not recur, either at Divisional or Corporate level.

- Iain Fairbairn felt that many patient complaints related to the on-going delays in Pharmacy distributing prescriptions. James Rimmer said that a report had been brought to a recent meeting of the Membership Council, where it was confirmed that Pharmacy were achieving the prescribed standards. System failures added to problems in Pharmacy, but some had recently been reviewed and changed as a consequence.
- Robert Woolley stressed that the Board should not perceive delayed discharge issues as relating solely to Pharmacy. He assured the Board that it "sat right in the heart of our Transformation Programme" and the whole process of hospital discharge was under scrutiny, including Pharmacy services.
- John Moore recommended reporting the work done through the Transformation Programme to the Quality and Outcomes Committee. Robert Woolley said that the Transformation Programme reported to the Trust Management Executive, but that it was appropriate for the Quality and Outcomes Committee to take assurance about the Trust's discharge processes.
- Selby Knox had noted from the Exception Reports that overall, Antibiotic Prescribing Compliance across Divisions had significantly improved. Sean O'Kelly agreed, saying that he still expected further progress in this regard.
- Lisa Gardner informed the Board of her recent personal experience of the discharge process and made a plea for improved communication with patients in this phase of their interaction with the hospital. On the day in question it was noted that the Pharmacy robot had malfunctioned, causing a delay, but she had not been informed of this problem at the time and therefore had no insight into the cause of her delayed discharge. There was a brief discussion of the possibility for medicines to follow the patient after their discharge.
- James Rimmer agreed with Lisa regarding the merits of better communication and the alternative to waiting for prescriptions in some cases.
- Emma Woollett added that issues with inadequate communication linked with recent complaints. She emphasised the importance of keeping people informed and embedding Trust Values further.
- Robert Woolley added that effective communication was part of core nursing practice and was equally important for all staff.

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:

- With the exception of sickness absence, which was higher than expected, the Trust continued to achieve its targets on all indicators, with further improvements seen in the last week. Pilots were commencing in two Divisions regarding sickness absence in outliers, which would involve intervention by the Occupational Health service early on in the sickness episode. Steve was hopeful that investment in this new initiative would deliver improvements.
- Regarding the reassessment of statutory and mandatory training methodology continued across the Trust, there was a target of 80% compliance for all areas, with the exception of Fire Safety training, with a target of 50% for the month. Fire Safety had been set a target of an increase in compliance of 5% each month, to achieve 80% by the end of May 2012.

Discussion commenced:

- Paul May congratulated Steve Aumayer regarding the work underway to engage staff in the Transformation Programme.
- In response to a question regarding Dementia training, Alison Moon confirmed that it would be included in Statutory/Mandatory figures for 2012-2013, as would Information Governance training.

e. Access

The Chief Operating Officer, James Rimmer, introduced the Access element of the Summary Quality and Performance Report, reporting that performance had been maintained from the previous month and that the Trust was on-track to achieve a 'Green' rating against Monitor's compliance framework. It was noted, however, that some standards had not been achieved either in the current Quarter (3) or in the year to-date. These are identified below, along with actions to address:

- 31-Day Diagnosis to Treatment Cancer Standard: performance had improved since October and the Trust would hit the Quarter 3 target.
- Last-minute Cancelled Operations and 28-Day Readmissions: performance remained on-track against the recovery plan agreed with the Primary Care Trust, however, it was marginally below the national standard of 0.8% ('Amber').
- Infant Health Breastfeeding Rate: the local stretch target remained a challenge for the Trust.
- Reperfusion times (call-to-balloon-time of 150 minutes) had dropped again in-month, due to out-of-hours issues. The Trust was reviewing this with key partners – the ambulance trusts and cardiac network partners – to address the issue.

In summary, James Rimmer reported good progress and thanked the work of the divisional teams, but noted the areas that required improvement.

On a related matter, Lisa Gardner congratulated the achievements of both the Accident and Emergency Department and the Children's Hospital, following a recent personal experience.

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

6. Histopathology Action Plan Update

The Board received the report by the Chief Executive to **note**.

Robert Woolley introduced the routine quarterly report on the progress achieved on delivering the actions set out in the Histopathology Action Plan to implement the recommendations of the Inquiry Panel.

Noting the progress recorded in the report, Robert Woolley added that the outcomes of recent external regulatory scrutiny provided sources of additional external assurance as to the efficacy of actions being undertaken in accordance with the plan. These included:

- The Care Quality Commission finding that the Trust was meeting the essential standards of quality and safety,
- Monitor had accepted the evidence submitted by the Board as to the actions being taken to assure itself that the late 2011 breast misdiagnosis was not indicative of wider governance failings within the Trust, and,
- The General Medical Council had closed their investigation into one of the Trust's histopathologists, and would be taking no further action.

Noting that December was the anniversary of the publication of the publication of the Histopathology Inquiry report, Robert confirmed that the Inquiry Panel had been invited back to the Trust review the implementation of the Panel's recommendations. The Board noted the 'completed actions' shown in the second part of the report which were highlighted.

Alison Moon commented that one of the recommendations was to increase and improve patient and public involvement, including relationships with LINks (Healthwatch). She reported that this objective was progressing well in terms of patient involvement, following focus group work which had identified that 'tests' and timeliness of test results was vital. Feedback on this aspect had been included in regular Patient Surveys. In addition, University Hospitals Bristol NHS Foundation Trust was delighted to support Bristol and South Gloucestershire LINks in their role as a pathfinder site for Healthwatch.

Dr Pitcher, who started work across both Trusts as Joint Clinical Lead in May, was then invited to update the Board on his on-going work in three main areas:

1. Integration

Dr Pitcher described his main remit as creating an integrated Cellular Pathology service across Bristol. Since taking up his post in May 2011, it had become evident that the wider Pathology Review was the best vehicle for achieving full integration. However, some aspects could be addressed earlier.

To further integrate the management structure, and following discussion at the Histopathology Core Working Group with Alison Moon and others, Dr Pitcher had developed a proposal to partially integrate the Head Scientist roles, together with formalising records of working together to provide assurance of this.

Both departments had quality management systems in place and work had started on bringing these together into a single system. The specialist teams had been asked to develop common ways of working for cut-up protocols,

coding and other areas, and were working to develop their own audit programmes.

2. Consultant Staffing Levels

The initial analysis of staffing compared against Royal College of Pathology recommendations had been completed. This showed a significant shortfall, but it was recognised that Royal College recommendations were aspirational. Further work on skill-mix and benchmarking had been completed and the next steps were job planning and submission of a business case for an additional Oral and Maxillofacial Pathologist. The latter was driven by the overall shortfall, and this appointment was needed to meet the recommendation from the Inquiry Panel that there should be at least two pathologists working in each specialist area. Dr Pitcher was working closely with the Division of Diagnostics and Therapies in this regard.

3. Assurance of the Quality of the Service

Dr Pitcher reported having extensive discussion with the Medical Directors at both University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust on service matters. He asserted that the quality of the Pathology service relied on providing the right diagnosis in a timely way and avoiding errors. However, he conceded that as diagnosis in histopathology required judgement, it was liable to human error. To understand this in more detail, it was useful to consider how errors occurred and the measures in place to avoid them affecting patient care. Errors could be categorised as follows:

- **No Fault Errors** – Where it was not possible to come to the correct diagnosis. The biopsy might be inadequate, or insufficient information might have been provided by clinicians;
- **System Errors** – Where the working environment was not conducive to safe working. The physical environment might be too noisy or poor teamwork provided inadequate support;
- **Cognitive Errors** – Where the pathologist did not have the right knowledge or had applied it incorrectly. The evidence was that errors of ignorance were uncommon, whilst most cognitive errors resulted from poor application of knowledge.

The service needed to be designed both to avoid error and, if it did occur, to 'trap' error before it affected patient care. Many measures already existed and more were in the development stages.

'No fault errors' were mostly outside the remit of Pathology, but could be reduced to some extent by dialogue with the clinicians and the insistence of being provided with good information.

Avoiding system errors required a good working environment. Work had been done on the physical state of the department, but more would be beneficial. It also required good systems and processes. The governance framework was being strengthened with clear policies, procedures and guidance.

In avoiding errors of ignorance, consultants were required to have completed rigorous training. The Royal College of Pathology regarded awarding the Fellowship Examination of the Royal College of Pathologists (FRCPath) as an indication that a pathologist could work as an independent practitioner.

Consultants were required to demonstrate that they keep abreast of their training with Continuing Professional Development (CPD) activities, and in Cellular Pathology they had External Quality Assessment (EQA) schemes which tested the ability of consultants to perform. This was formalised within appraisal and revalidation. The need to learn from errors was crucial and above all, the consultants had to be reflective practitioners.

Error-trapping systems were in-place. Double reporting was underway in areas of recognised diagnostic difficulty, and a second pathologist confirmed the diagnosis. Multidisciplinary Teams (MDTs) were a more sophisticated method where cases were reviewed and discussed with the clinical teams. Clear guidance had been developed regarding the content of reports and how to record diagnostic uncertainty.

In providing assurance that this was working, there was both internal and external assessment. Internally, audits were performed to measure aspects of performance and there was a joint audit plan in-place. From an external perspective, the Service was accredited with Clinical Pathology Accreditation (CPA), which looked at the Quality Management System and its application. The national screening programmes had Quality Assurance processes which looked at our service and, as already mentioned, other regulators such as the Care Quality Commission (CQC) inspected certain aspects of the service.

Robert Woolley thanked Dr Pitcher for his leadership in uniting the two departments with a common approach. He agreed with Dr Pitcher that the context of Royal College of Pathology guidelines were "aspirational", but not obligatory. He suggested that the Board could take assurance that the risks associated with Histopathology staffing were being actively managed and Dr Pitcher agreed.

The Board discussed Dr Pitcher's briefing.

- Paul May reported on the detailed consideration of the report by Dr Pitcher at the Quality and Outcomes Committee and in terms of governance, the assurance that was evidenced. He added that the Quality and Outcomes Committee had considered a full audit of Multi-Disciplinary Team practice and noted "a lot of good progress", including the work of Dr Pitcher.
- Iain Fairbairn thanked Dr Pitcher for the report and asked whether there had been consideration of a temporary managerial arrangement to support him in "knitting the services together". Robert Woolley confirmed that the Executive was in discussion with Dr Pitcher to address any resource requirements he identified, and this would be kept under active review.
- Following a question by Kelvin Blake, Robert Woolley confirmed that resourcing issues were due for discussion in the planning round in February 2012. Kelvin went on to ask about how the teams worked together in the interim, while the review progressed. Dr Pitcher recognised that the question about team working was very apposite, and replied that the Medical Directors of both Trusts had supported intervention where necessary.
- Emma Woollett praised Dr Pitcher's verbal briefing for its detail. She realised that work was still needed in terms of 'human' issues.
- Robert Woolley agreed with Emma, saying that there was a need to keep reporting to the Board on Service integration.

The Chairman acknowledged the reassurance provided by Dr Pitcher's report.

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

Finance and Governance

7. 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 19 December 2011, including the Report of the Finance Director

The Vice Chair of the Committee, Emma Woollett, presented the report of the Finance Committee meeting in December, in lieu of Lisa Gardner, who was unable to attend the meeting.

1. The Trust had delivered a surplus of £4.088m for the eight months to 30 November. This was £0.643m or 2.9% better than the Annual Plan projection for this stage of the year. The Trust's Financial Risk Rating remained at 3 (actual = 3.45) – the Annual Plan showed 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 with concern the further deterioration in the Divisional financial position, with the cumulative overspending increasing by £0.332m in the month to £4.866m. Across the Trust there was an encouraging trend emerging for the performance on pay budgets, with a small underspend noted for November. Non-pay budgets overspent by £1.136m in November before the reduction for the distribution of surplus R&D moneys (£0.336m). Significant overspendings were reported this month against Specialised Services (£306k); Diagnostic and Therapies (£275k) and Surgery, Head and Neck (£171k). Executive Directors advised on the further work which was being undertaken to identify the causes of these adverse movements and the required level of remedial action. There would also be a push to develop a more pro-active approach to budgetary management.

The Committee noted that the Division of Medicine had recently been moved to the escalation stage and a Board-to-Board meeting was to be held shortly. The Committee was to receive a report on the review of high costs in the Medicine Division at the February meeting.

Income from Activities showed an under performance of £0.032m for November (October activity reported a month in arrears). The cumulative position on Income from Activities showed a shortfall to date of £0.638m (net of the balance of the over performance for March 2011 (£0.81m), received in 2011/12). It was noted that it had been a long time since the Trust had such a challenge in delivering activity in line with service agreements. Further analysis was underway to assess the potential impact on the Trust's plans for 2012/13. Operating income showed an in-month favourable variance of £0.269m bringing the cumulative favourable variance to £0.644m to date.

3. The Committee received an update report on the potential disposal of properties owned by the Trust. The Committee approved the proposal to sell

the Brentry site to the current tenant (with an overage provision) with proceeds expected to be c£1.5m.

4. Jan Bergman attended for the discussion on Cash Releasing Efficiency Savings and Service Transformation. He gave a progress report on CRES plans and achievement to date. The forecast savings for the year currently totalled £21.032m or 79% of the 2011/12 target of £26.636m. Jan went on to report the progress made to develop 'engagement plans' for each workstream. Jan reported that based on the 2012/13 CRES returns made at the end of November, the risk assessed schemes for next year at £15.92m equated to 60% of next year's target of £26.429. A further submission of CRES plans was planned for 22 December.

5. The Committee received a summary report of 'The Operating Framework for the NHS in England 2012/13'. The Framework covered four main areas: Quality, Reform, Resources and Planning and Accountability. For 2012/13 the potential value of Commissioning for Quality and Innovation (CQUINs) receipts would be up to 2.5% of turnover (2011/12 = 1.5%). Whilst the moneys were to be received non-recurrently, it was expected that similar sums would be available each year. At this stage, the Trust aimed to secure at least 1.75% (c£6.25m) in 2012/13.

Discussion commenced:

- The Head of Finance, Paul Tanner, who was present in the absence of the Director of Finance, added that Commissioning for Quality and Innovation (CQUINs) could potentially earn the Trust £8.9 million in 2012-2013.
- Following a question by John Moore, Emma Woollett confirmed that 'volume' drove the reduction in income, and not 'tariff'. This was known to be the national picture.
- Paul Tanner commented on the reduction in income, saying that year-on-year the Trust had consolidated activity over performance into the starting position for the following year. This had seen significant year-on-year increases in recent years. The requirement to make cash releasing efficiency savings each year has had an impact, as had the planned reduction in income for Skills for Health services.
- In response to John Moore, Robert Woolley confirmed a 3%-5% reduction in income across activity, year-on-year.
- Iain Fairbairn said that he would welcome a breakdown of assumptions behind income predictions for forthcoming budget planning. Robert Woolley acknowledged that the Board would be briefed in this regard.

b. Quality and Outcomes Committee dated 20 December 2011

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

- The Committee met with a full quorum of members, and was attended by the requisite attendees, including Dr Rob Pitcher.
- Additional issues arising from the meeting for consideration at future meetings, included: a) IT/clinical impacts, b) A drug cupboard security update, and c) Systems of ensuring that staff could effectively understand

important issues, including junior doctor communications.

- The Committee reviewed the Histopathology Action Plan implementation position in detail The issues discussed by the Committee and Dr Pitcher included:

- **Integration** – The mix of local and combined service opportunities and the use of specialisms that bridged both Bristol Trusts. Joint working included education and informal discussions, and established clear quality standards, leadership and future measures.

- **Staffing levels –** Advice had been sought regarding staffing levels and Dr Pitcher had made recommendations to the Medical Directors of both Trusts. There was potential for development of the specialisms between the Trusts, but in more detailed areas, there might be a need for a wider use of skills.

- **Engagement with the public and carers** – Additional questions were added to Trust surveys, focus group work and active involvement with Healthwatch.

- Other issues discussed by Dr Pitcher included: the wider Pathology review, consultant job planning, quality assessment through qualification, Continuing Professional Development (CPD) records, spot-checks and reflective practices. Performance measures, such as error-trap systems, Multidisciplinary Team review, framework standards, direct measure, external assessments, Qualitative Assessments, and working with the Care Quality Commission, all gave longer-term assurance.

- Discussion points included: Assurance during the transition period, openness, sustainability when the "spotlight" moved away, learning lessons for the Organisations regarding joint work, the depth of change within the two areas, and ensuring IT systems were accessible to both Trusts.

In addition, a Quality audit of the Multidisciplinary Teams was presented to the Committee, which, according to Mr May, "demonstrated the excellent progress being made". The Director of Workforce and Operational Development agreed to work with the Medical Director to check that the personal professional responsibility of Consultants to refer to the Multidisciplinary Team co-ordinator uniformly understood and adopted by Consultants.

- **Update on Recommendations of the Toft Report –** This was deferred from the November meeting of the Committee. Details of the actions underway were examined in a detailed presentation. It was noted that the three most important actions would be completed by January 2012 and Divisional actions would be audited. The IT systems may require further consideration if they impacted upon clinical outcomes.

- **Last Minute Cancellations of Operations & Readmissions within 28-Days of Cancelled Operations Themed Report** – There was a long history of not achieving standards, and this was acknowledged with a clear action plan for change, which the Committee would review in April 2012.

c. Audit Committee dated 12 December 2011

The Chair of the Committee, John Moore, gave a verbal report on the main issues discussed at the Audit Committee meeting for December:

• **External Auditor Progress Report** – Substantive testing was underway and the Audit Plan was approved by the Committee. • **Internal Audit** – Good progress was noted and recommendations were being addressed. The Draft Audit Plan was 'noted' by the Committee. • It was agreed that the appointment of a new auditor could be extended to not later than the Annual General Meeting on 30 September 2012. • A report on the review of Facilities and Estates was expected in early 2012. *There being no further questions or discussions, the Board resolved to note the Committee Chairs' Reports.*	
Strategy and Business Planning	
8. Partnership Programme Board Report The Board received this report by the Director of Strategic Development to **note**. This was a summary report of the key points raised at the Partnership Programme Board meeting held on 19 October 2011 at Frenchay Hospital. • Jackie Cornish referred to the fourth item in the Key Points table, clarifying that "major trauma" should read as "major adult trauma". *There being no further questions or discussions, the Board resolved to **note** the Partnership Programme Board Report.*	
Monitor Reports	
9. Report Results of Q2 Compliance Framework Monitoring Exercise The Board received the report by the Chief Executive to **note**. Robert Woolley introduced the report, saying that he was pleased to inform the Trust Board that Monitor had concurred with the Trust's self-declaration of 'Amber-Green' for the Governance Risk Rating and a Finance Risk Rating of 3 for Quarter 2. • The Trust had been assigned the 'Amber-Green' rating to reflect its failure to meet the Cancer 62-Day Wait for First Treatment target (from Consultant-Led Screening Service Referral) in Quarter 2. • The Trust's Finance Risk Rating of 3 was noted to be on-plan. • The Executive Summary at Appendix 2 provided Monitor's assessment of the risks affecting compliance. John Savage gave his congratulations to all, and Robert Woolley confirmed that the Trust anticipated a 'Green' declaration for the Quarter 3 period, but felt it was important to remain mindful of winter pressures and 4-Hour Waiting times, and the possible impact of these on Quarter 3 compliance. *There being no further questions or discussions, the Board resolved to **note** the Report Results of Q2 Compliance Framework Monitoring Exercise.*	
Information and Other	

10. Any Other Business There was no other formal business of the Trust Board.	
11. Date of Next Meeting **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.	

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 January 2012 at 10:30 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 - JANUARY 2012

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 **agreed** to recommend a green governance self-certification to Monitor for Quarter 3, given satisfactory performance against the compliance framework standards, and the assessment that risks to prospective compliance in Quarter 4 were manageable, notwithstanding existing pressures on accident and emergency waiting times.

The group **noted** a report of lessons learned from the Trust's management of the national day of action by public services staff on 30 November 2011, including the requirement for business continuity plans and associated training to be kept under routine review at the Civil Contingencies Group.

The Trust Management Executive **noted** the advice of the Executive Directors that the Trust was now compliant with all Care Quality Commission outcome standards, as planned, and acknowledged the hard work in Divisions which had led to this position. Informal feedback from the Care Quality Commission, following an unannounced inspection in respect of Outcome 5 (Nutrition), was that the Trust was compliant, with minor concerns about sustainability. The group **noted** the content of the recently published NHS Outcomes Framework for 2012/13.

The group **agreed** a recommendation, arising from the Outpatient Services Review in the Transforming Care programme, that booking of out-patient services across the Trust should be centralised, on a phased basis starting in April 2012.

The Trust Management Executive **agreed** a proposal for managing the Trust's approach to the Commissioning for Quality and Innovation scheme in 2012/13 contracts, noting the importance of this scheme to Divisional financial positions given that related incentives would amount to 2.5% of total service income (equivalent to c. £9m for the Trust).

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

- confirmation that Internal Audit recommendations following a review of Divisional governance arrangements in 2011 had been fully implemented
- positive progress in the development of an academic health science partnership to be known as Bristol Health Partners, with recruitment of a Director-designate expected shortly

- consideration by the Clinical Quality Group of the status of actions relating to the Toft report and short-term work to address the outstanding issue of assurance around internal policy dissemination
- continuing progress with the Clinical Systems Implementation Programme which was now in testing phase for go-live in March.

The group **noted** a report on the status of actions arising from the Gritten Report in 2007, which outlined follow-up actions for taking assurance about the quality management system in perfusion, policy dissemination and reviewing the coverage of human factors training.

3. STRATEGY AND BUSINESS PLANNING

The Trust Management Executive **approved** draft corporate objectives for the 2012/13 Annual Plan for the further consideration of the Trust Board and Membership Council.

The group **noted** the status of identified capital and revenue proposals for prioritisation in the business current planning round.

The group **approved** a proposal to commission an external assessment of the market for private patient services to inform a strategic review of the opportunities and threats facing the Trust. The group **agreed** that appropriate consultation with clinical staff would be required.

4. RISK, FINANCE AND GOVERNANCE

The Trust Management Executive **approved** a recommendation to alter the internal risk assessment matrix in line with wider changes to the reporting of corporate and Divisional risks.

The group **noted** risk exception reports form a number of Divisions.

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
17 January 2012

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 January 2012 at 10:30 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)

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
		25 Jan 2012			

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

January 2012

CONTENTS

PERFORMANCE OVERVIEW

SECTION A – Performance Overview

Summary

Overall, the 'health' of the organisation has improved relative to last month, with the number of GREEN rated indicators increasing by three. The number of RED rated indicators has stayed the same. This net change includes the Hospital Standardised Mortality Ratio (HSMR) and the Outpatient Follow-up Ratio moving from RED to GREEN, and the monthly A&E 4-hour wait and Contract Penalties going from GREEN to RED.

All three of the Patient Experience indicators are now GREEN rated, with the number of Patient Complaints reducing in the month. All four measures of Being Efficient are also now GREEN rated, following an improvement in the Outpatient Flow-up ratio. The HSMR (Hospital Standardised Mortality Ratio) has returned to a GREEN rating, but continues to be closely monitored. Financial performance has remained strong, with all four measures being GREEN rated for a second month running. This is despite a deterioration in the level of Contract Penalties expected to be incurred relative to the planned position. CRES (Cash Releasing Efficiency Savings) Achievement remains AMBER rated for the year to date, but has improved.

The Trust achieved a GREEN rating against Monitor's Compliance Framework at the end of Q3, as forecast, with the full achievement of all standards for the quarter as a whole, including A&E 4-hours and Cancer Standards.

SECTION B – Organisational Health Barometer

Providing a Good Patient Experience

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
A01	Patient Climate Survey (Overall CQUIN Score)	76.2	75.9	N/A	Green: >= 74.4 Red: <72.4	↓	Current month is November 2011.
A02	Number of Patient Complaints	126	85	1002	Green: <120 Red: >=135	↓	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	0	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)	3	2	25	Green: 0 Red: > 1	↓	No RAG rating for YTD. Timeliness of reporitng has improved, so now "Current" is only one month behind, i.e. it is December
B02	Number of Inpatient Falls Per 1,000 Beddays	4.68	5.45	4.73	Green < 5.6 Red: >= 5.6	↑	Current month is November

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
C01	Number of Serious Incidents (SIs)	8	3	57		↓	
C02	Number of C.Diff cases	4	2	44	Below Trajectory	↓	

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
D01	18 Weeks Admitted Pathways	91.2%	90.6%	91.8%	Green: >=90% Red: <85%	↓	
D02	Number of Cancer Standards Failed	1	0	1	Green: 0 Red: >=2	↓	Previous is confirmed Quarter 2 2011/12. Current is Q3 to date (i.e. Oct/Nov combined). YTD is Apr-Sep quarterly performance. Forecast is for achievement of all standards in Q3.
D03	A&E 4 Hour Standard	97.06%	94.50%	97.10%	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)	90.2	73.6		Green: <80 Red: >=90	↓	Previous is July and Current is August 2011
E02	30 Day Emergency Readmissions	402	376	3547	Below 10/11 volumes	↓	Historic data has been refreshed

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
F01	Elective Length of Stay Reduction	3.42	3.57	3.57	Green: <= 3.64 Red: >= 3.83	↑	
F02	Emergency Length of Stay Reduction	4.66	4.51	4.95	Green: <= 5.07 Red: >= 5.34	↓	
F03	Theatre Productivity - Percentage of Sessions Used	95.5%	91.1%	94.4%	Green: >= 90% Red: < 90%	↓	Historic data was refreshed as there were some sessions at BEH which should have been excluded.
F04	Outpatient Follow-Up To New Ratio	2.04	2.01	2.07	Green: <2.03 Red: >=2.03	↓	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
G01	Workforce Costs	-0.2%	-1.5%	0.6%	current month and ytd budget	↓	current month below budget, ytd over budget, a reduction on previous ytd figure
G02	Staff Sickness	4.3%	4.2%	3.9%	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)	£2,328	£2,555	£2,555	Green:>Same Period Last Year Red:<Same Period Last Year		Previous is Apr-Nov cumulative total. Current (and YTD) is Apr-Dec cumulative total. Trend arrow is not applicable, as Current will always be higher than Previous.
H02	Weighted Patients Recruited Into NIHR Trials	1,996	2,041	17,262	Green: > YTD Last Year Red: < YTD Last Year	↑	Previous and Current are rolling 3 month totals Aug-Oct 2011 and Sep-Nov 2011 respectively). YTD is Apr-Nov 2011

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
J01	Monitor Governance Risk Rating	0	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)	£2.89	£2.90	£2.90	> 50% Green < 50% Red	↑	YTD/Current = Forecast year-end rewards. The Trust is taking a prudent view at this stage and has assumed 75% of the forecast.
K02	Contract Penalties Incurred (£millions)	-£0.09	£0.08	£0.53	Green: Below Plan Red: Above Plan	↑	Previous is movement in Oct; Current is movement in Nov; YTD is April to Nov.Data is variance above (+) or below (-) plan, with a higher negative value representing better performance.

Managing Our Finance

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
L01	Monitor Financial Risk Rating	3	4	4	Green: >3 Red: <3	↑	
L02	EBIDTA (Compared To Plan)	103%	105%	103%	Green: 100% Red: <95%	↑	
L03	CRES Achievement	93%	96%	76%	Green: >=90% Red: <75%	↑	
L04	Liquidity (in Days)	33.6	32.5	32.5	Green: 25+ days Red: <=14 days	↓	

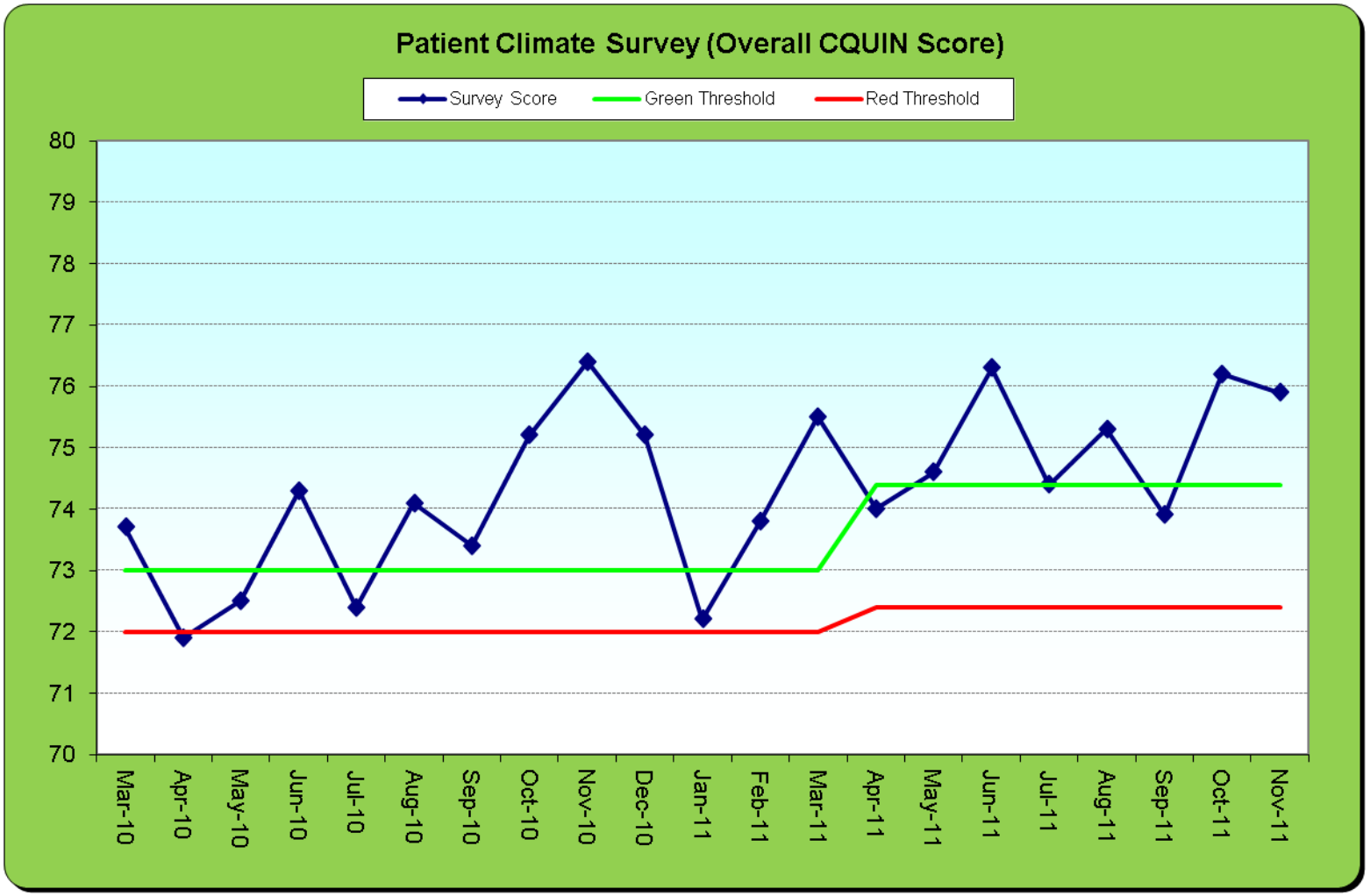
Notes

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



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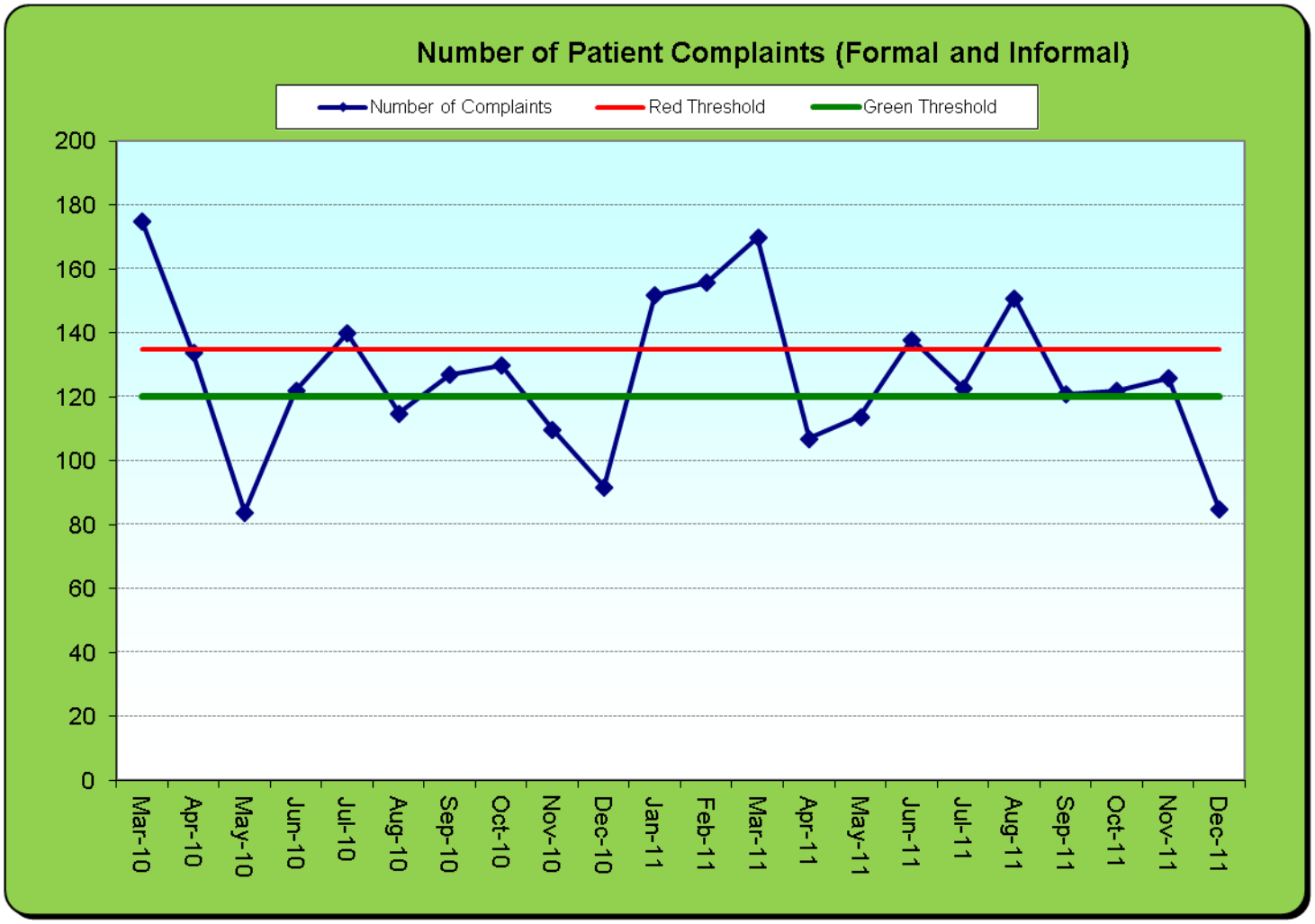
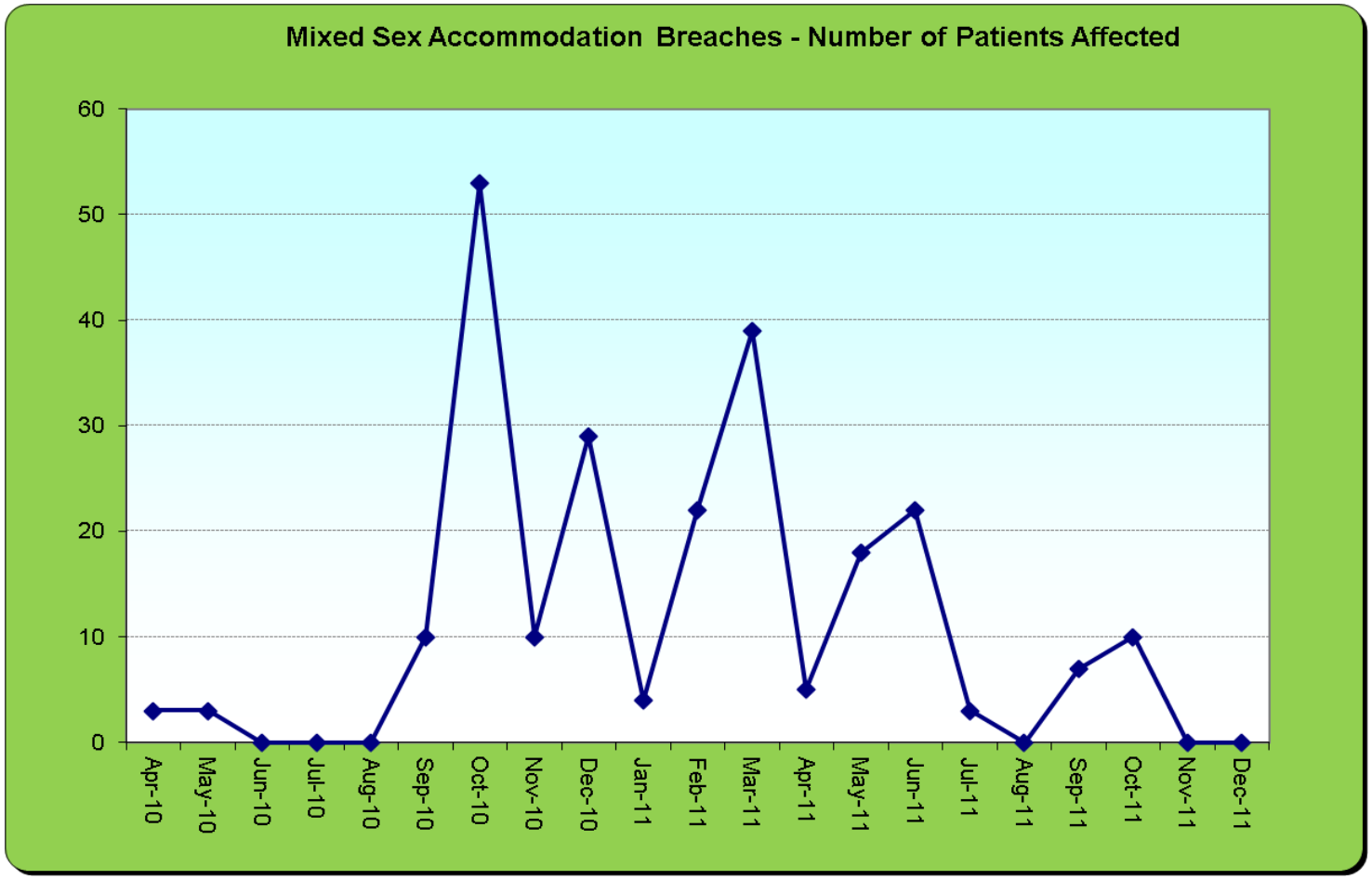
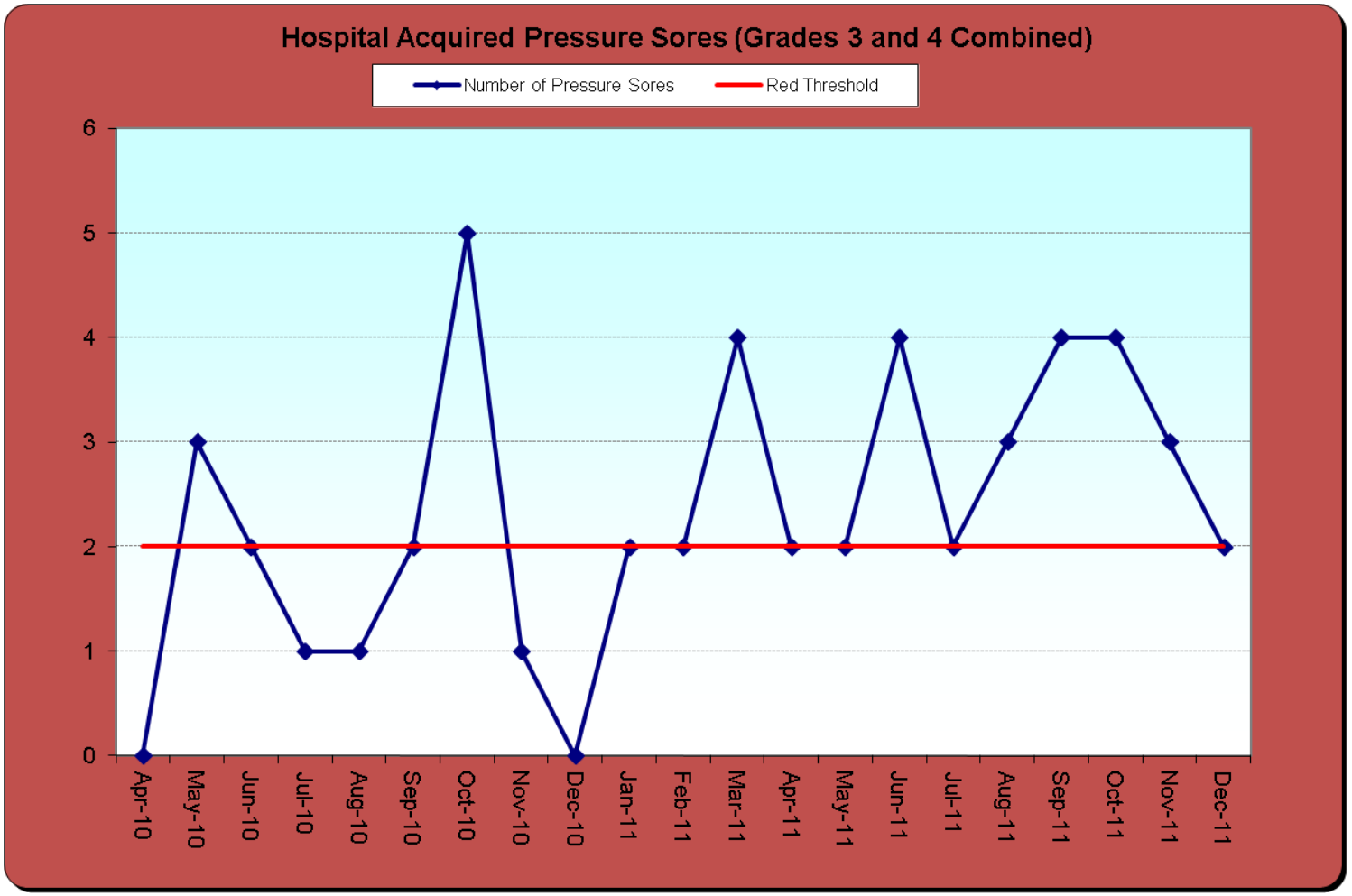



Mixed Sex Accommodation Breaches - Number of Patients Affected
60
50
40
30
20
10
0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11

PERFORMANCE OVERVIEW



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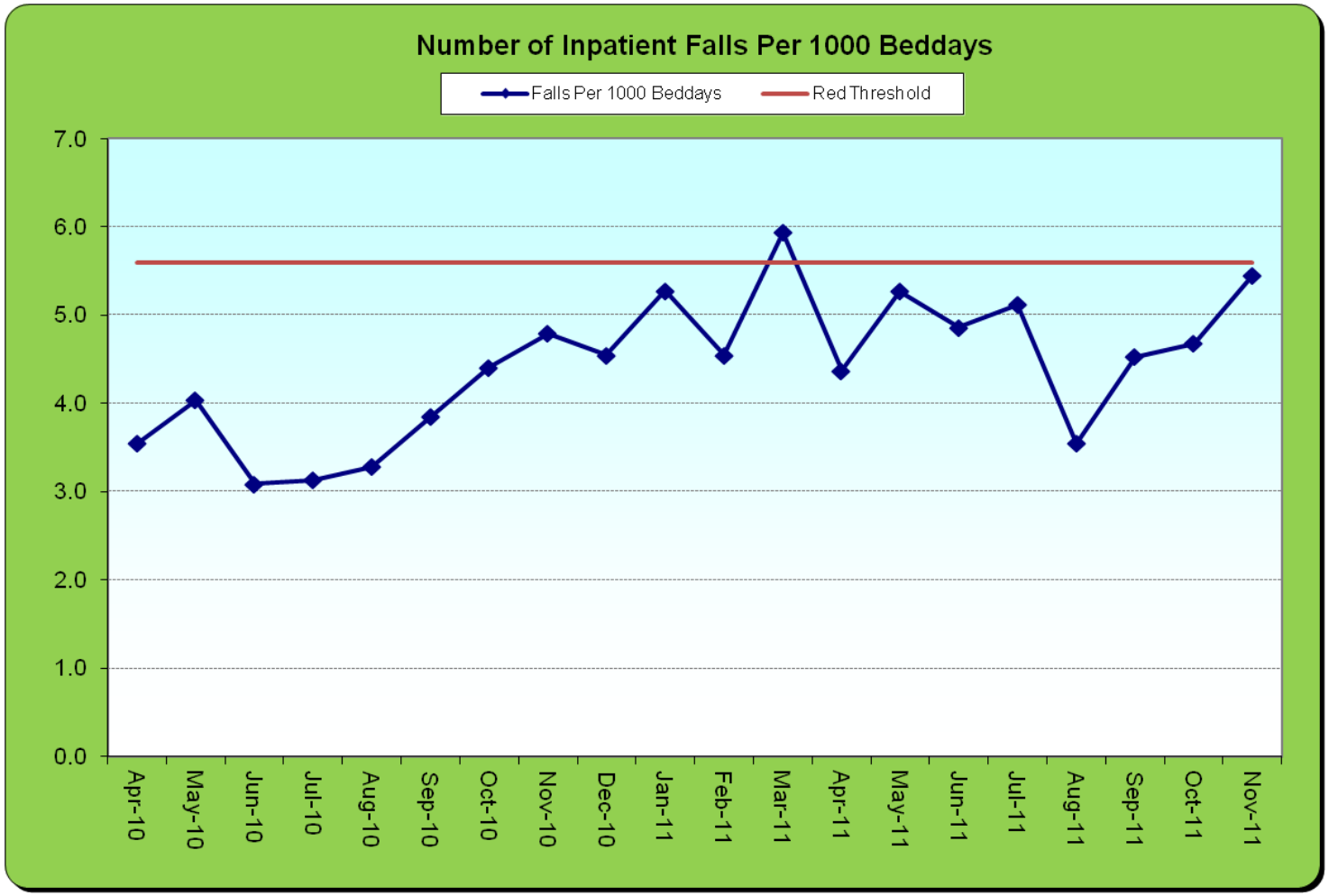
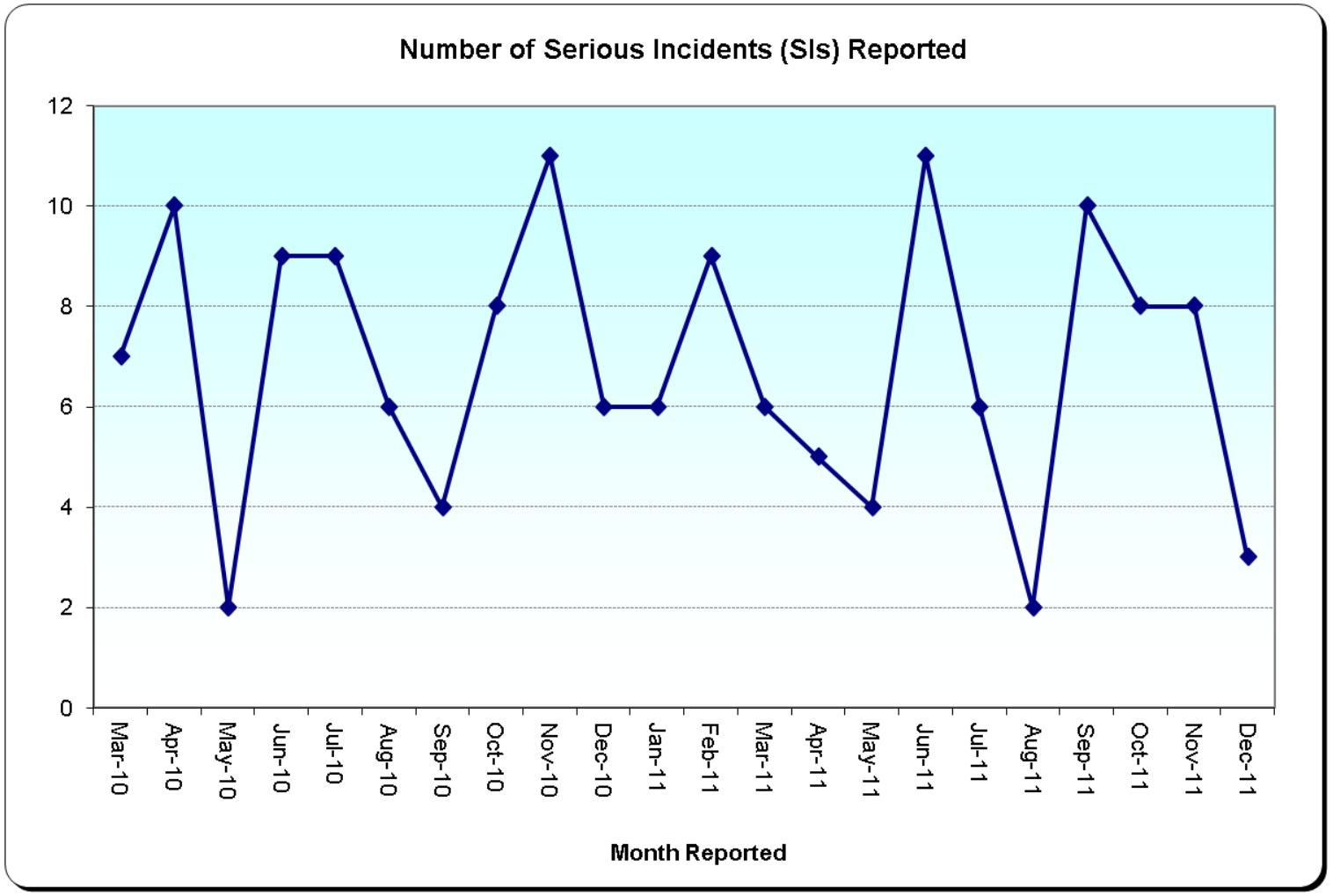
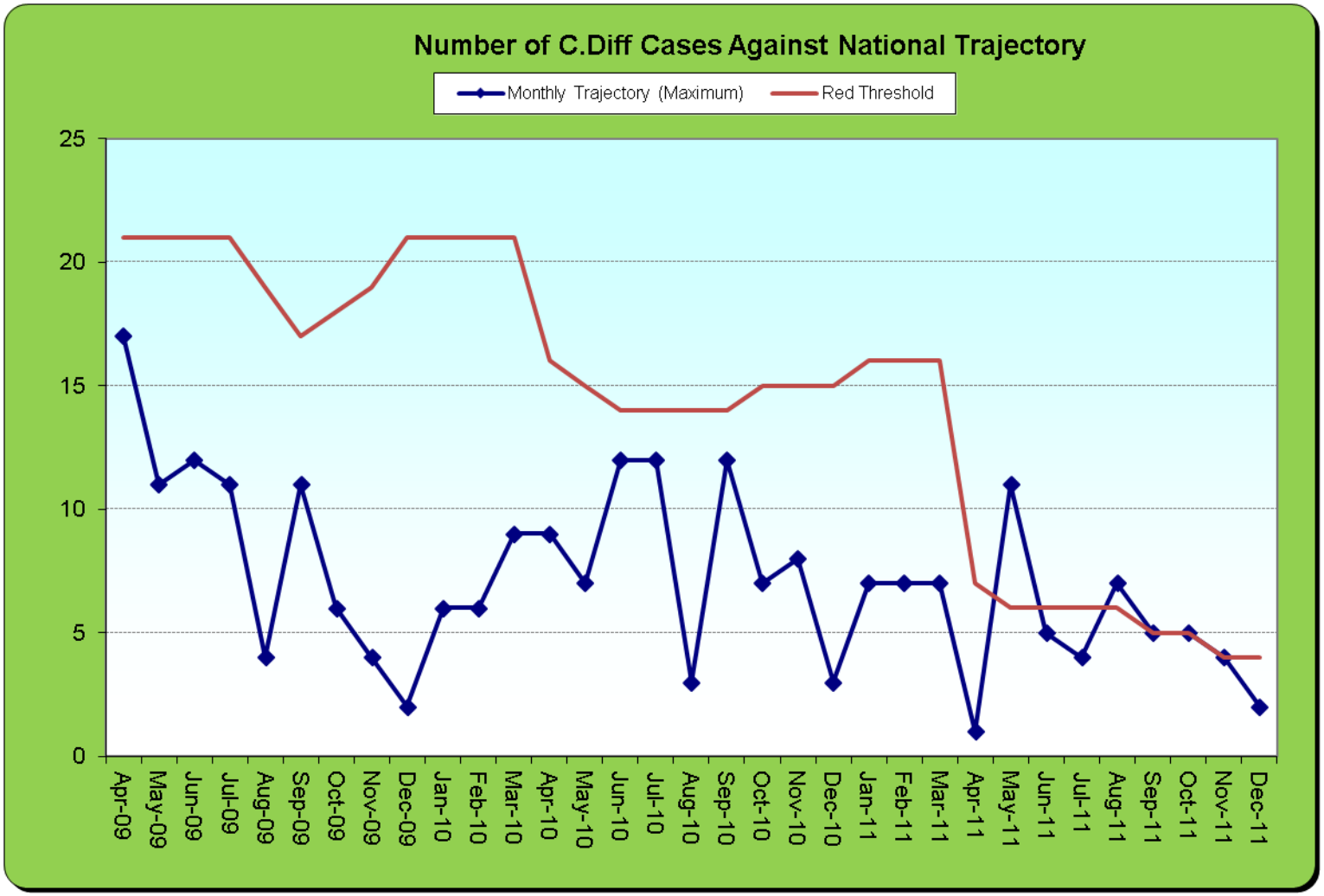



Number of Serious Incidents (SIs) Reported
12
10
8
6
4
2
0
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Month Reported


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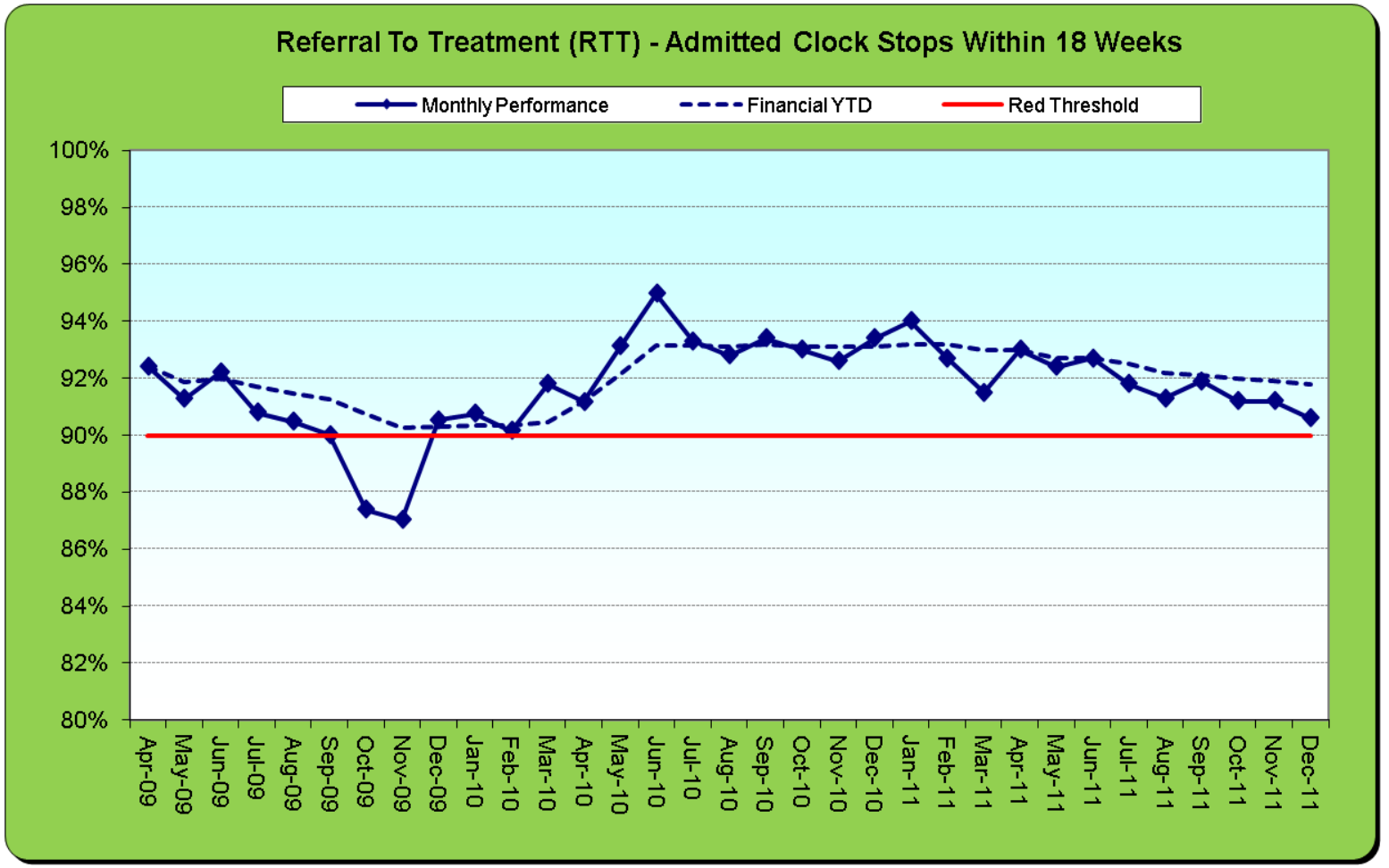
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11

PERFORMANCE OVERVIEW



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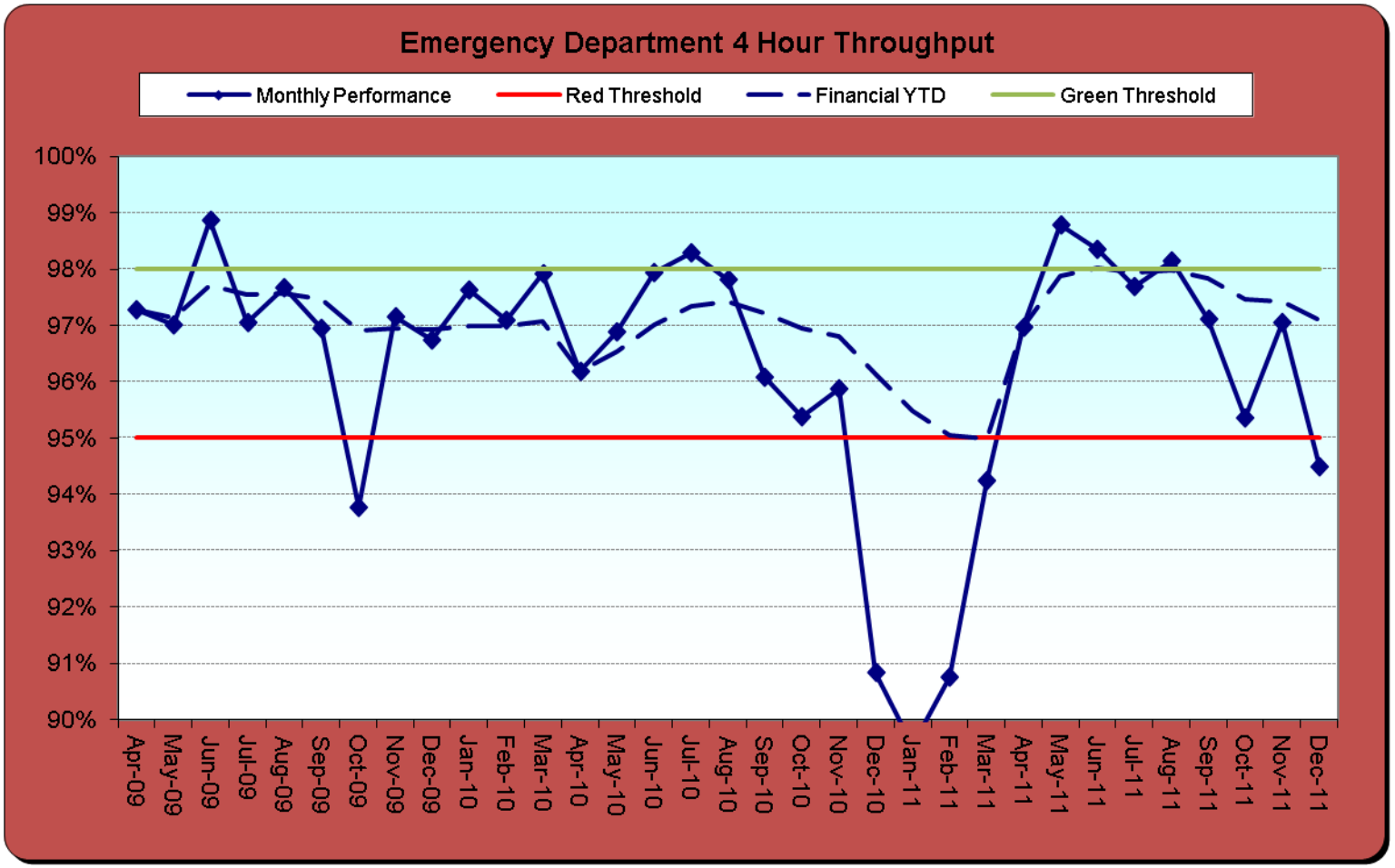

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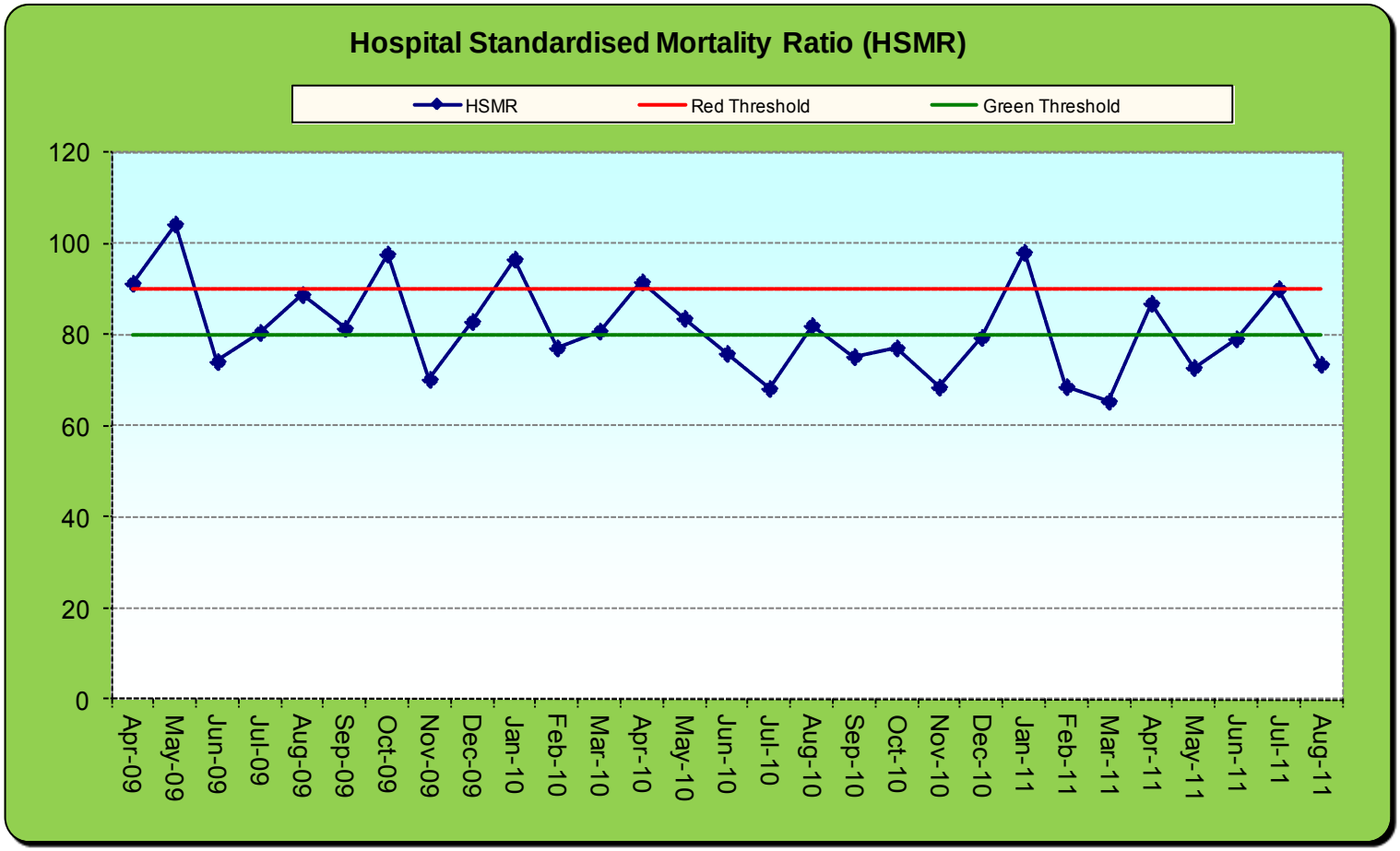

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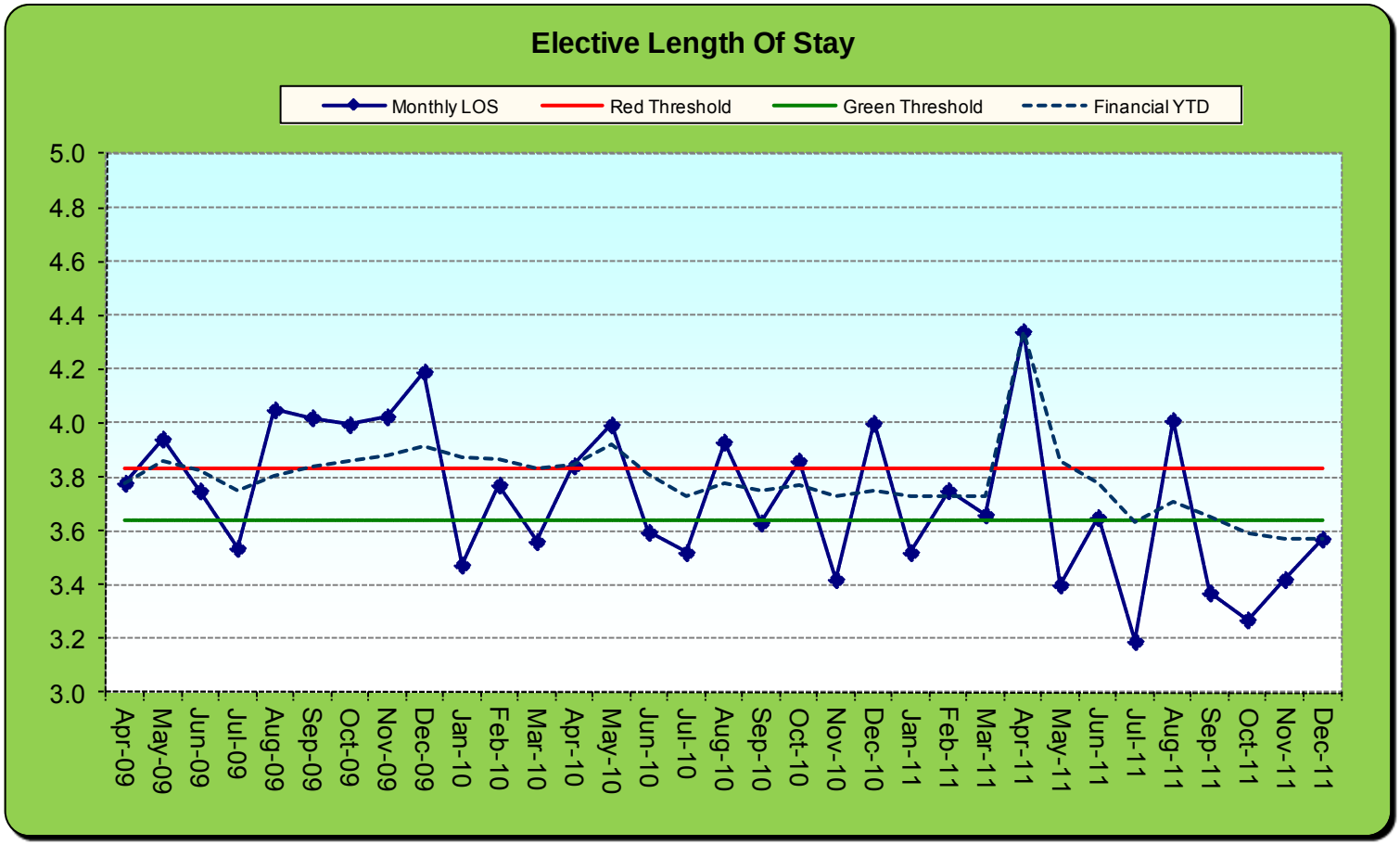

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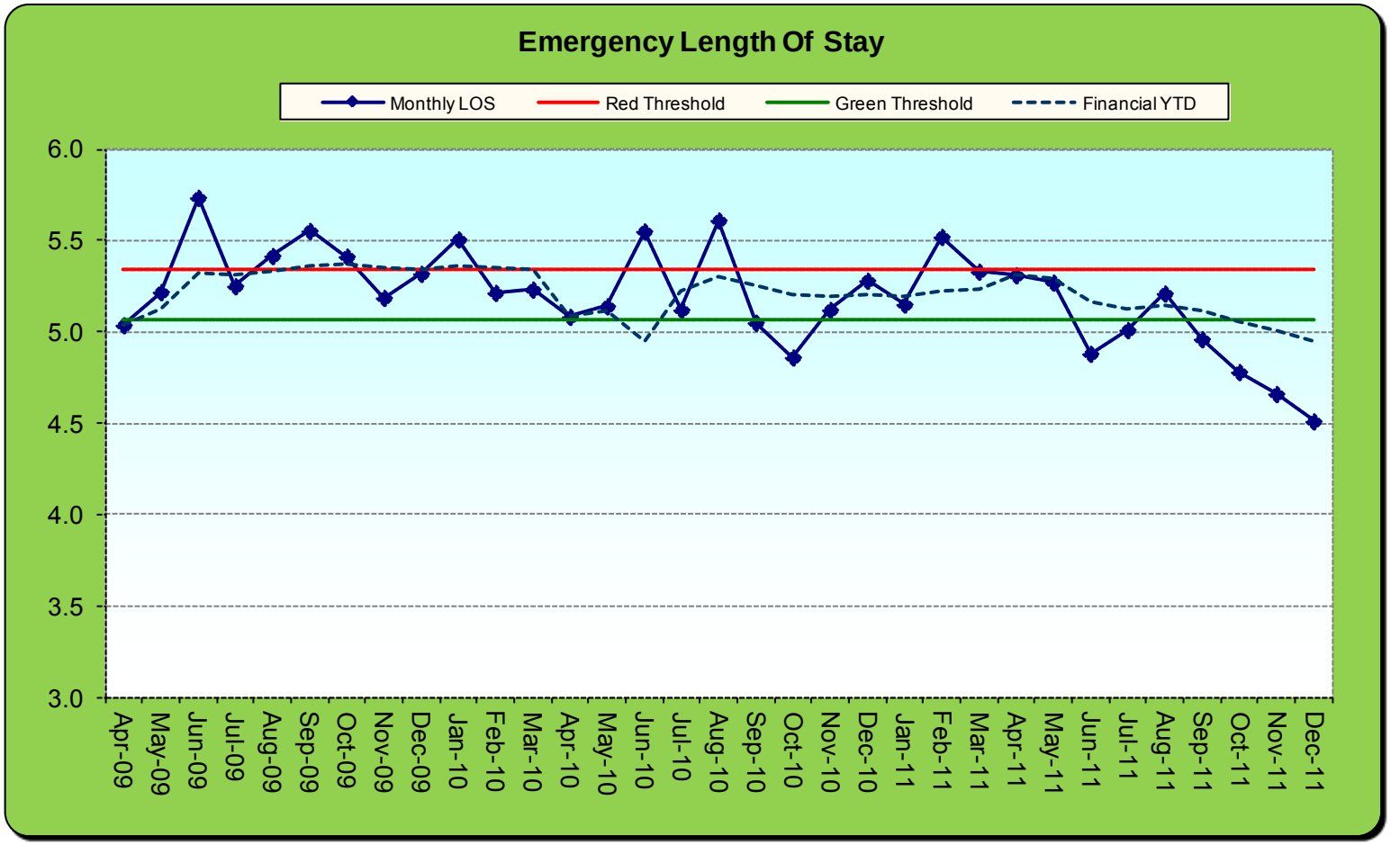
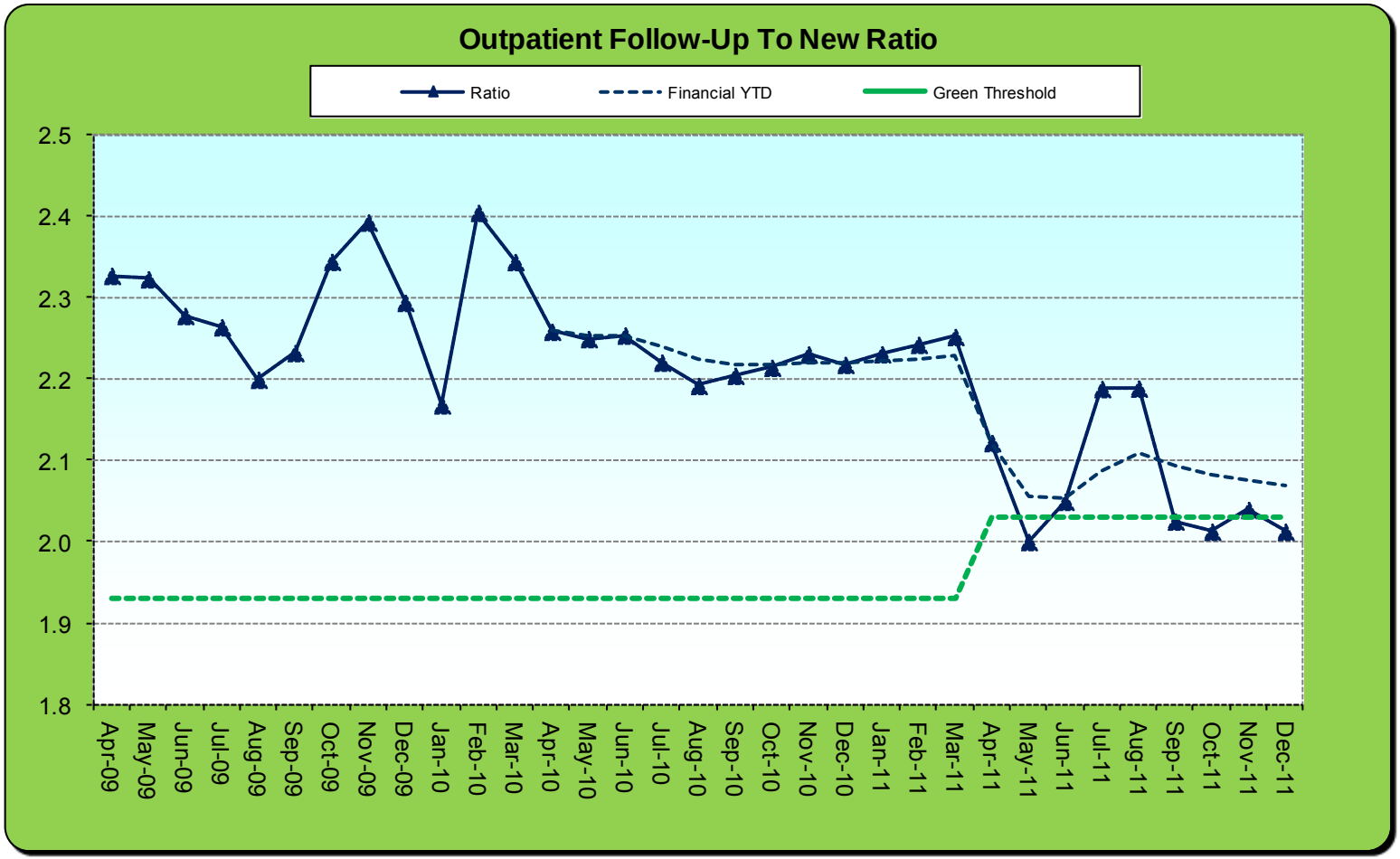


PERFORMANCE OVERVIEW



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	
A&E maximum wait (4 hours)	In the *Access* section of this report	
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.
Contract Penalties Incurred	See additional information	There was a deterioration in the level of contract penalties incurred in the month. The Trust receives 70% of the tariff for emergency admissions above the 2008/09 levels. The increase in contract penalties reflects the increase in the volumes of emergency admissions subject to this marginal tariff.

SECTION C – Monitor's Compliance Framework

At the end of December the Trust is expecting to confirm achievement of all of the targets in Monitor's Compliance Framework during quarter 3. This assessment is subject to finally reporting of draft cancer performance figures.

The Trust therefore has a score of zero against Monitor's Compliance Framework and a GREEN Governance Risk Rating. This is the lowest rating out of four. The current forecast for quarter 4 is GREEN.

Monitor's Compliance Framework - dashboard

	Number	Target	Weighting	Target threshold	Year To Date	Q4 10/11	Q1 11/12	Q2 11/12	*Q3	Q3 Actual	Notes	Q3 Governance rating
Monitor Compliance Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	44	✓	✓	✓	11	✓	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%	✓		Achieved
	3b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	96.6%	✓	✓	✓	95.9%	✓		
	3c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	99.5%	✓	✓	✓	99.1%	✓		
	4a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85.0%	86.3%	✓	✓	✓	87.8%	✓		Achieved
	4b	Cancer 62 Day Referral To Treatment (Screenings)		90.0%	93.0%	✗	✓	✗	94.9%	✓		
	5	Referral to treatment time for admitted patients (95th percentile) - in weeks	1.0	23	Achieved each month	Not applicable	Achieved each month	Achieved each month	Achieved each month	✓		Achieved
	6	Referral to treatment time for non-admitted patients (95th percentile) - in weeks	1.0	18	Achieved each month	Not applicable	Achieved each month	Achieved each month	Achieved each month	✓		Achieved
	7	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	0.5	96%	97.8%	✓	✓	✓	97.6%	✓		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	0.5	93%	95.3%	✓	✓	✓	95.9%	✓		Achieved
	8b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	97.5%	✓	✓	✓	95.5%	✓		
	9	A&E Total time in A&E 4 hours (95th percentile)	1.0	5%	97.1%	✓	✓	✓	95.6%	✓		Achieved
	10	Stroke indicators - to be confirmed	0.5	To be confirmed (TBC)	Not applicable	Not scored				Not scored		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	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/November and draft figures for December.**

QUALITY

1.1 PATIENT EXPERIENCE

Mrs X is a lady who is terminally ill with cancer which has spread to her bones. Her sister wrote to complain about the care Mrs X received whilst attending the Radiology Department. She described how her sister is in constant pain, which is extremely debilitating, leaving the simple acts of walking, standing and lying down an arduous and painful experience.

In her complaint letter, Mrs X's sister explained how Mrs X attended the Bristol Royal Infirmary for a Magnetic Resonance Imaging (MRI) scan and when she asked for assistance to get up from the stretcher she was lying on, the radiographer emphatically told her she could not help her as she had a bad back herself. Mrs X asked if anyone else was available who could help her but was told by the radiographer there was not and that she should get up by herself. Mrs X asked the radiographer if her two sisters, who were in the waiting room, could be called to help her but this request was denied.

Mrs X eventually managed to struggle up by herself but this left her in a great deal of pain, and by the end of the scan, she was in tears, pale and breathless and extremely stressed.

Several days after the scan, Mrs X was still very distressed by what had happened and her condition and the pain she was experiencing had worsened considerably. Her sister explained that Mrs X has been depressed since this incident and feels that people do not want to help her and that she is a nuisance.

Investigation

Mrs X's MRI scan was scheduled for after 5pm when there was only one radiographer in the MRI department, although a colleague was available in a nearby department. The investigation concluded that Mrs X should most certainly have been assisted from the table by radiography staff. Whilst the radiographer had a bad back, this did not prevent her from asking staff from a nearby department to help and an apology was given that this did not happen.

The MRI environment is strictly controlled due to the high magnetic field and there are potential safety risks. Access is therefore restricted to staff who have been through specific safety checks and it is policy not to ask a relative to enter the department to help in such circumstances. This should have been communicated better to Mrs X.

Individual Learning

- The radiographer has been advised by the Radiology Section Head for MRI that she was unhelpful and apparently unsympathetic toward Mrs X and reminded of the need to treat all patients with compassion and the appropriate level of care as she is professionally accountable for her actions and inactions. The explanation for why Mrs X's relatives could not enter the department to assist should have been communicated better.

- The radiographer has been advised that she should have asked for help from colleagues and should have had a more holistic and patient centred approach. She has expressed her regret that this did not happen and has apologised for causing Mrs X distress.

Departmental Learning

- The findings of the investigation have been communicated across the whole department to ensure all staff are aware of the particular points of this case and also of the links to the Trust values.
- Manual handling equipment is available within the Radiology Department but there is no MRI compatible hoist and space is limited. The MRI Department are contacting the Trust's Manual Handling Advisor to request they visit and advise on possible solutions should this situation arise again.

Organisational Learning

- One of the Trust values is "Respecting Everyone", where staff should put patients first and deliver the best care possible and have a 'can do' attitude in everything they do. "Living the Values" training sessions for all staff groups are being launched. Complaint examples are being used as part of these sessions to bring home key messages about acceptable and unacceptable attitudes, as well as care and compassion, and to reinforce expectations of staff to reflect these in their everyday work.

1.2 QUALITY DASHBOARD

		ID	Title	Green Threshold	Year To Date	Monthly Totals												Quarterly Totals			
						Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-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%	93.1%	90.4%	92.0%	91.7%	91.5%	93.3%	92.5%	92.7%	93.1%	93.2%	93.4%	94.1%	93.8%	91.3%	92.4%	93.0%	93.8%
		PS-A3	Hand Hygiene Audit Compliance	95%	97.6%	96.1%	96.0%	97.3%	97.8%	95.0%	98.3%	99.1%	98.8%	97.3%	97.2%	96.2%	98.5%	96.4%	97.0%	98.4%	97.3%
		PS-A4	Antibiotic Compliance	90%	80.6%	77.5%	79.4%	76.5%	81.5%	78.4%	84.1%	80.1%	76.3%	76.7%	81.5%	83.3%	82.9%	77.7%	81.4%	77.4%	82.7%
		PS-A5	Matron's Checklist	95%	94.3%	94.8%	94.8%	93.7%	94.8%	93.1%	93.7%	94.2%	93.8%	94.5%	95.2%	94.9%	95.2%	94.4%	93.8%	94.2%	95.1%
		PS-A6	Cleanliness Monitoring - Overall Score	95%		96%	95%	95%	95%	96%	96%	95%	95%	96%	95%	96%	94%				
		PS-A7	Cleanliness Monitoring - Very High Risk Areas	95%		97%	97%	97%	97%	97%	97%	97%	96%	97%	97%	96%	95%				
		PS-A8	Cleanliness Monitoring - High Risk Areas	95%		97%	96%	96%	96%	96%	96%	96%	97%	97%	96%	97%	96%				
		PS-A9	Number of GRE Bacteraemias	<=2	5	3	1	1	1	0	0	0	3	1	0	0		5	1	4	0
		PS-A10	Infection Control - C.Diff Infections Against National Trajectory	<Traj.	44	7	7	7	1	11	5	4	7	5	5	4	2	21	17	16	11
		PS-A11	MSSA Cases Against Trajectory	<Traj.	31				3	2	4	0	8	4	5	2	3		9	12	10
	Incidents	PS-B1	Number of Serious Incidents (SIs) Reported		57	6	9	6	5	4	11	6	2	10	8	8	3	21	20	18	19
		PS-B2	Serious Incidents Reported Within 48 Hours	80% (Q3)	72%				60%	100%	91%	83%	100%	50%	62%	75%	33%		85%	67%	63%
		PS-B3	Percentage of Serious Incident (SI) Investigations Completed Within Timescale	80% (Q3)	91%						100%	100%	100%	100%	100%	100%	57%		100%	100%	79%
		PS-B4	Total Never Events	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0
		PS-B5	Total Number of Patient Safety Incidents Reported		6653	862	748	860	645	790	740	710	681	688	839	782	778	2470	2175	2079	2399
	Falls	PS-C1	Number of Inpatient Falls Per 1,000 Beddays	<5.6	4.73	5.28	4.55	5.94	4.36	5.25	4.85	5.11	3.56	4.54	4.68	5.45		5.28	4.82	4.42	5.06
		PS-C2	Repeat Inpatient Falls		22.9%	21.2%	26.9%	20.0%	31.9%	15.4%	31.8%	21.7%	20.3%	13.4%	28.6%	17.7%		22.6%	26.3%	18.5%	22.8%
		PS-C3	Number of Inpatient Falls - Patients Aged 65 And Over		689	100	88	132	79	104	88	94	63	78	87	96		320	271	235	183
		PS-C4	Number of Inpatient Falls - Patients With Cognitive Impairment		346	28	41	73	40	53	45	43	26	44	48	47		142	138	113	95
	Pressure Ulcers	PS-D1	Total Pressure Ulcer Incidence per 10,000 Bed Days	6.51	16.78	8.26	11.51	11.54	8.46	16.77	17.75	16.40	15.06	16.67	25.15	17.97	16.91	10.41	14.28	16.05	20.09
		PS-D2	Percentage of Hospital Acquired Pressure Ulcers Not Graded	<5%	0.0%	0.0%	4.2%	14.8%	0.0%	0.0%	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	283	17	21	19	16	34	31	32	27	29	49	33	32	57	81	88	114
		PS-D4	Number of Hospital Acquired Grade 3 Pressure Ulcers	<1	25	2	2	3	2	2	4	2	3	4	4	3	1	7	8	9	8
		PS-D5	Number of Hospital Acquired Grade 4 Pressure Ulcers	<1	1	0	0	1	0	0	0	0	0	0	0	0	1	1	0	0	1
	Venous Thrombo-embolism (VTE)	PS-E1	Adult Inpatients who Received a VTE Risk Assessment	90%	97.0%	82.4%	84.4%	91.6%	94.2%	95.1%	97.0%	97.5%	98.0%	97.6%	97.5%	98.0%	98.4%	86.8%	95.5%	97.7%	98.0%
		PS-E2	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	90%	92.5%							87.5%	93.3%	89.6%	97.5%	89.7%	97.5%			90.4%	94.4%
	Nutrition	PS-F1	Patients who Received Fully Completed Nutritional Screening Within 24 Hours	90%	80.0%			76.1%			66.2%			92.0%			83.0%	76.1%	66.2%	92.0%	83.0%
	Safety	PS-G1	WHO Surgical Checklist Compliance	98%	94.9%	97.7%	98.7%	98.0%	98.6%	92.6%	90.2%	87.3%	96.8%	97.7%	97.0%	97.3%	97.5%	98.1%	93.5%	93.9%	97.3%
		PS-G2	Reduction in Medication Errors	<2.84%	1.40%	3.73%	5.10%	5.93%	2.08%	0.79%	0.85%	0.85%	1.77%	1.05%	2.56%			4.86%	1.17%	1.23%	2.56%
	Leadership	PS-H1	Number of Executive Director Patient Safety Walk-arounds	>=6	68	5	5	5	7	11	9	6	5	10	9	5	6	15	27	21	20
		PS-H4	Percentage of Non-Estates Actions Completed Within 2 Months	80%	88%	100%	80%	67%	100%	100%	77%	95%	75%	91%	100%	86%	83%	75%	89%	88%	86%

Please note *December's performance against the stroke and inpatient falls standards has not been reported this month. This is because discrepancies were found in the figures which need to be validated.*

QUALITY

		ID	Title	Green Threshold	Year To Date	Monthly Totals												Quarterly Totals			
						Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Q4	Q1	Q2	Q3
Clinical Effectiveness	Mortality	CE-A1	Hospital Standardised Mortality Ratio (HSMR)	<=80		98.1	68.8	65.5	87	72.9	79.2	90.2	73.6								
	Length of Stay	CE-C1	Average Length Of Stay - Elective	<=3.64	3.57	3.52	3.75	3.66	4.34	3.40	3.65	3.19	4.01	3.37	3.27	3.42	3.57	3.64	3.78	3.53	3.41
		CE-C2	Average Length Of Stay - Emergency	<=5.07	4.95	5.15	5.52	5.33	5.31	5.27	4.88	5.01	5.21	4.96	4.78	4.66	4.51	5.33	5.16	5.06	4.65
	Learning Disability	CE-D1	Risk Assessment of Patients with Known Learning Disability within 48 Hours	85%	64.8%				50.0%	37.5%	60.0%	33.3%	42.9%	87.5%	85.7%	81.8%	83.3%		51.7%	61.1%	83.3%
	Readmissions	CE-E1	Emergency Readmissions Within 30 Days	<412 mth	3547				442	409	402	396	363	339	418	402	376		1253	1098	1196
	Maternity	CE-G1	Percentage of Spontaneous Deliveries Compared to All Births	64.4%	62.73%	64.67%	62.34%	65.04%	63.83%	65.01%	63.53%	64.88%	61.22%	57.79%	63.84%	61.97%	62.48%	64.05%	64.13%	61.32%	62.77%
	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%	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%	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%	66.19%	78.95%	52.38%	74.07%	70.00%	75.00%	42.86%	50.00%	63.16%	77.78%	75.00%	64.29%	72.22%	68.66%	63.04%	65.31%	70.45%
	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	6				
Patient Experience	Single Sex Accom.	PE-A1	Same Sex Accommodation Breaches - Number of Patients	0	65	4	22	39	5	18	22	3	0	7	10	0	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	75.9			75	75	76
		PE-B2	Monthly Patient Survey - Noise At Night	81					83	83	81	82	83	80	83	82			82	82	83
		PE-B3	Monthly Patient Survey - Help To Eat Meals	76					77	81	80	80	76	76	80	79			79	77	80
		PE-B4	Monthly Patient Survey - Patients Who Would Recommend The Trust	92%					96%	96%	96%	97%	96%	96%	95%	97%			96%	96%	96%
		PE-B5	Monthly Patient Survey - Local Score	83					87	87	89	86	88	86	88	88			88	87	88
	Complaints/Complim ents	PE-C1	Number of Patient Complaints	<=120	1087	152	156	170	107	114	138	123	151	121	122	126	85	478	359	395	333
		PE-C3	Percentage of Complaints Resolved Within Timeframe (Formal Complaints)	98%	91.1%	100.0%	98.7%	98.4%	88.9%	92.2%	89.5%	97.4%	92.7%	92.6%	90.2%	90.9%	84.2%	99.1%	90.4%	93.9%	88.7%
		PE-C4	Number of Complainants Disatisfied with Response	0-5 mth	69	4	6	9	3	4	14	10	8	4	7	12	7	19	21	22	26
		PE-C6	Complainants Disatisfied with Response (Not Responded In Full)		7										6	1	0				7
		PE-C7	Complainants Disatisfied with Response (Additional Information Requested)		19										1	11	7				19

Please note *December's performance against the stroke and inpatient falls standards has not been reported this month. This is because discrepancies were found in the figures which need to be validated.*

1.3 SUMMARY

This month the quality report includes an update for Quarter 3 of those metrics which report quarterly rather than monthly. The report shows many metrics are sustaining good performance e.g. infection control, patient experience, length of stay and mixed sex accommodation as well as improvements in thrombo-prophylaxis, learning disability risk assessments and executive director walk rounds.

Disappointingly, timely serious incident reporting remains challenging. The percentage measurements are not particularly helpful when dealing with small numbers; nevertheless these are the basis of contractual fines which will be triggered again for Quarter 3. The exception report provides further information on actions to improve performance.

Also of note is the slight dip in performance for nutrition screening and the continued significant challenge in reducing pressure ulcer incidence. The exception reports provide further detail.

Data for the stroke care and falls requires further validation so is not available for reporting this month.

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

Achieving set threshold (28)	**Thresholds not met or no change on previous Month (4)**
- 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 high risk areas - Never Events - Percentage of hospital acquired pressure ulcers not graded at all - Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment - Percentage adult in-patients who received thrombo-prophylaxis - Reduction in medication errors - Number of executive director patient safety walk rounds	- Antibiotic prescribing compliance - Matrons checklist (*C. difficile* dashboard) - Cleanliness monitoring very high risk areas - WHO surgical checklist compliance

QUALITY

- 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 - 30 day emergency re-admissions - High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours - 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 - Total number of complaints - Number of complainants dissatisfied with the response - Hospital Standardised Mortality Ratio (HSMR)	
Quality metrics not achieved or requiring attention (11)	**Quality metrics with thresholds not yet finalised (11)**
- Serious Incidents reported with 48 hours - Serious incident investigations completed within required timescales - 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 hospital acquired grade 4 pressure ulcers - Patients who received fully completed nutritional screening within 24 hours - Risk assessment of patients with known learning disability within 48 hours - Percentage of spontaneous deliveries compared to all births - Lobectomy patients median length of stay - Percentage of complaints resolved within formal timescale	**Data not available** - In-patient falls incidence per 1,000 bed days - Stroke care: percentage spending 90% + time on a stroke unit - Stroke care: percentage receiving brain imaging within 1 hour **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 98.4% in December against the monthly target of 90%.
- Spontaneous vaginal births. Performance of 62.48% in December against a target of 64.4%
- Patient Experience overall score relating to the discharge survey. Score for November 75.9 against target of 74.4.
- Patient Experience: reducing noise at night. Score for November 82 against target of 81.
- Patient Experience: assistance at mealtimes. Score for November 79 against a target of 76.
- Reduction in medication errors of 15% on 2010/11 outturn of 3.5%. Performance of 2.56 % in October 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 6 days in December 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:

- Number of executive patient safety walk rounds up ↑ from 5 in November to 6 in December.
- Lung lobectomy median length of stay up ↑ from 3.5 days in November to 6 days in December.
- Serious incident investigations completed within required timescales down ↓ from 100% in November to 57% in December.
- Percentage of adult in-patients who received appropriate thrombo-prophylaxis ↑ from 89.7% in November to 97.5% in December.
- Patients who received fully completed nutritional screening with 24 hours down ↓ from 92% in Q2 to 83% in Q3.
- Number of complaints down ↓ from 126 in November to 85 in December

1.5 EXCEPTION REPORTS

Exception reports are provided for twelve (12) indicators in total, eleven (11) 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. Serious incident investigations completed within required timescales
4. Total pressure ulcer incidence per 10,000 bed days
5. Number of hospital acquired grade 2 pressure ulcers
6. Number of hospital acquired grade 3 pressure ulcers
7. Number of hospital acquired grade 4 pressure ulcers
8. Patients who received fully completed nutritional screening within 24 hours
9. Risk assessment of patients with known learning disability within 48 hours
10. Percentage of spontaneous deliveries compared to all births
11. Lobectomy patients median length of stay
12. Percentage of complaints resolved within formal timescale

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 decreased from 83.4% in November to 82.6% in December. Compliance increased in:

- Medicine (89.4%, up from 84.6% in November)

Compliance fell in:

- Specialised Services (73.2%, down from 73.5% in November)
- Women and Children (83.5%, down from 86.3% in November)
- Surgery, Head & Neck (76.6% down from 83.5% in November)

The quarter 3 antibiotic prescribing compliance results table shows that inclusion of a stop or review date continues to be the major reason why prescribing compliance fails to reach the 90% target, with 182 of 1492 reviews (12% of reviews) omitting a stop or review date.

Division	No. Reviews	% Compliant	No. Compliant	No. Not Compliant	Not to Guideline	No Stop/ Review Date	No Indication
Medicine	594	86.0%	511	83	20	58	17
Specialised Services	187	75.4%	141	46	4	28	17
Surgery, Head & Neck	394	80.7%	318	76	16	55	20
Women's & Children's	317	83.0%	263	54	2	41	27
Trust wide Total	**1492**	**82.6%**	**1233**	**259**	**42**	**182**	**81**

QUALITY

Recovery plan, including expected date performance will be restored:

- The Medical Director has requested that the Heads of Division for Specialised Services and Surgery Head & Neck provide a recovery plan which will be monitored at quarterly divisional reviews
- All previously described actions continue
- We are now using quarterly and year to date figures to target specific wards that have shown a long term inability to achieve good antibiotic prescribing compliance results.
- Week commencing 16/01/2012, the joint microbiology/pharmacy ward rounds are expanding to include more surgical wards and the cardiology and cardiac surgery wards, areas which have shown lower than required prescribing compliance results.
- Clinical sub-Divisions with an enhanced engagement of consultants in antibiotic prescribing compliance are showing an improvement, and we need support to engage all consultants throughout the Trust.

QUALITY

Q2. EXCEPTION REPORT: Serious Incidents reported within 48 hours **Q3. EXCEPTION REPORT: Percentage of Serious Incident investigations completed within timescale**	**RESPONSIBLE DIRECTORS: Medical Director / Chief Nurse**

Description of how the standard is measured:

Serious Incidents Reported within 48 hours: 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. Of these late reported incidents in December, one may subsequently be downgraded if the investigation shows it was not a serious incident which would amend the figure to 50% for December and slightly reduce the magnitude of the fine for Quarter 3.

Percentage of Serious Incident investigations completed within timescale: There is a contractual requirement to complete Serious Incident investigations within the timeframes set out in the "National Framework for reporting and learning from Serious Incidents" of 45 days, 60 days and 6 months depending on the level of serious incident. 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 the number of investigations is small it only takes a few late investigation reports to fail to achieve the target for the quarter.

The level of both Q3 fines is subject to validation with NHS Bristol.

Performance in the period, including reasons for the exception:

Serious Incidents Reported within 48 hours: Of the three serious incidents reported in December, two were reported outside of the 48 working hour deadline = 33%. Quarter 3 performance is 63% and the associated fine is currently calculated to be £17k.

Of the two incidents not reported with 48 hours:

- One incident was a Grade 4 pressure ulcer which was not reported by the ward nor by the tissue viability team who have agreed to act as a back stop. There had already been pressure ulcer incidents previously reported for the same patient, not all hospital acquired, and review of the system shows it is easy to see how reporting the incident could have been overlooked. Subsequently, it has been established that the Grade 4 pressure ulcer was a deterioration of a previously reported Grade 2 ulcer.
- One incident involved a weekend failure of number of clinical IT systems which was managed at the time from a business continuity perspective. But reporting the situation as an incident was overlooked for several days until brought to the attention of the Assistant Director.

Percentage of Serious Incident investigations completed within timescale: Of the seven incident investigations closed in December, three were outside of the 45 day timescale. For Quarter 3 the fine is calculated to be at £1k.

QUALITY

Of the three serious incident investigations not completed within the 45 day timescale:

- One was a complex clinical incident requiring input from multiple clinicians within the Division of Medicine which delayed the completion of the investigation and resulted in the deadline being missed by two days.
- One was in the Division of Specialised Services whose Patient Safety Advisor post is currently vacant. This post is key in ensuring the timeliness and quality of serious incident investigations.
- One was in the Division of Women's & Children's and the report came in on the afternoon of the day it was due with NHS Bristol, but was not picked up and sent to NHS Bristol until the following day.

Recovery plan, including expected date performance will be restored:

- This has been discussed at the Patient Safety Group, and Divisional Patient Safety Managers have reminded 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.
- Divisional Managers are routinely made aware of fines triggered for each Division by delays in serious incident reporting and investigation. This will be reiterated again. 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 revisited the covering arrangements for the processing of serious incidents in Trust Headquarters in the absence of key personnel and 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. Review of the processing of incidents once reported show this is largely working; the most recent delays are due to the initial reporting of the incident.
- The vacant Patient Safety Advisor post in the Division of Specialised Services is being progressed.
- Going forward, junior doctors' induction will emphasise the expectation and importance of contributing to patient safety investigations in a timely manner.
- 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 to achieve the required reporting times, and thereby avoid fines for Quarter 4.

QUALITY

Q4- Q7 EXCEPTION REPORTS:	**RESPONSIBLE DIRECTOR: Chief Nurse**
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 hospital acquired grade 4 pressure ulcers**	

Description of how the standard is measured:

Pressure Ulcers identified at nursing/medical assessment are categorised 1-4 (Category 1 being 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:

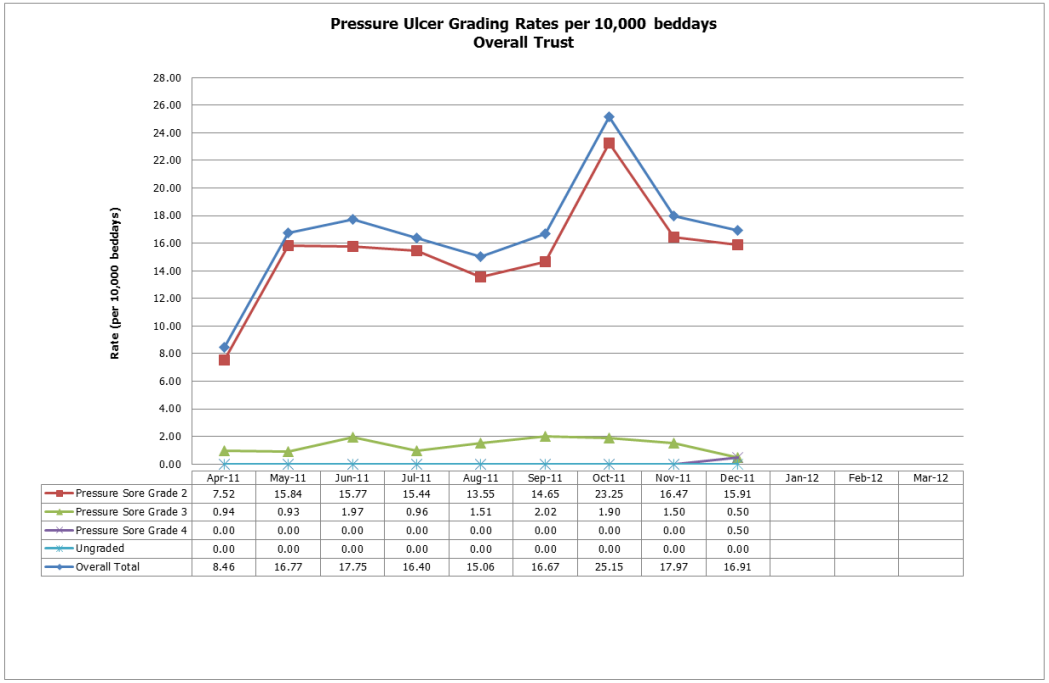
The rate of hospital acquired pressure ulcers grade 2 and above was 15.91 per 10,000 bed days in December 2011. Divisional rates are shown in the table below.

Division	December 2011	November 2011	October 2011
Medicine	15.59	23.32	30.94
Specialised Services	12.47	28.14	11.50
Surgery Head and Neck	28.01	20.02	37.45
Women and Children's	6.82	6.15	2.92

There was one Category 3 pressure ulcer and one Category 4 pressure ulcer reported in December 2011. In both cases a root cause analysis will be undertaken and results of this will be formally reported through the patient safety group. Learning from these incidents is also shared across the Trust through the weekly tissue viability operational meeting.

The graph below shows pressure ulcer incidence per 10,000 bed days by pressure ulcer type. As previously reported to the Board, until recently the apparent increase in pressure ulcer incidence was due to rectifying historic under-reporting.

QUALITY



	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Pressure Sore Grade 2	7.52	15.84	15.77	15.44	13.55	14.65	23.25	16.47	15.91			
Pressure Sore Grade 3	0.94	0.93	1.97	0.96	1.51	2.02	1.90	1.50	0.50			
Pressure Sore Grade 4	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.50			
Ungraded	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
Overall Total	8.46	16.77	17.75	16.40	15.06	16.67	25.15	17.97	16.91			

Recovery plan, including expected date performance will be restored:

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 100% of patients, 99% of patients were on the correct pressure relieving surface and 98% of patients had intentional rounding carried out; this remains an area for continued focus.

Following a national consensus meeting of Tissue Viability Nurses, the process for reporting pressure ulcers has been reviewed and in line with national guidance and other Trusts, skin damage that are 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 lesions rather than pressure ulcers.

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 in the first half of quarter 4.

QUALITY

Q8. EXCEPTION REPORT: Patients who received fully completed nutritional screening within 24 hours	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

Audits are completed on each ward in adult areas once every fortnight.

Performance in the period, including reasons for the exception:

At the end of Quarter 2 performance was 92%, and we were able to demonstrate evidence to support compliance with Care Quality Commission Outcome 5 (Nutrition). Audit data is gathered fortnightly for nutritional screening and Quarter 3 performance is 83%

Focus is required on this indicator as we note when pressure is taken off performance drops, suggesting it is not yet fully embedded in practice. The first fortnight of Quarter 4 was published 17th January 2012 and shows an improvement to 85%.

Recovery plan, including expected date performance will be restored:

A comprehensive sustainability plan for Outcome 5 has been produced and will be monitored by the Clinical Quality Group and Trust Management Executive. The Board is asked to note that the Care Quality Commission conducted a follow up visit for Outcome 5 on 13th December 2011.

We have recruited an additional Dietetic Assistant who:

- Has begun assisting with data collection on adult wards
- Commenced auditing wards at the Bristol Royal Hospital for Children previously not covered
- Will be assisting with education delivery to support completion of nutritional screening at ward level.

QUALITY

Q9. EXCEPTION REPORT: Risk assessment of patients with known Learning Disability within 48 hours	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

Patients with a known learning disability will receive an assessment within 48 hours of admission to an inpatient bed. The CQUIN target is 85% to be achieved by Quarter 4 2011/12.

Performance in the period, including reasons for the exception:

Performance in December 2011 and for Quarter 3 as a whole was 83.3%. Whilst it is disappointing that we have not achieved 85% in Quarter 3, it is important to note that, 83.3% is a significant improvement since Quarter 1, when performance was 51.1% and in Quarter 2 61.1%. A new Learning Difficulties (LD) nurse was appointed in August 2011, taking the team to 1.00 Whole Time Equivalent (WTE), prior to this appointment there was a gap for a period of time when there was only 0.20 WTE in post. Since this time a strong and sustained focus on improving performance in this area has been made.

Recovery plan, including expected date performance will be restored:

- The Learning Difficulties (LD) Nurses are currently implementing the role of the Learning Difficulty Champion and have currently recruited 16 nurses across the Trust. The champions will be supported to ensure that staff in their area are able to complete the risk assessments, so that this does not rely purely on the LD nurses alone. This is already having an impact on performance, seen in Quarter 3
- The LD nurses are also reviewing the current risk assessment form to ensure it captures all key information in a succinct way and is intuitive to use.
- We are incorporating key aspects, such as the importance of completing the risk assessment, into the level 1 Safeguarding training session, with the aim of raising awareness.
- The development of a training matrix and programme will be a key priority for the LD nurses and LD Steering group.
- With the significant improvement made during this last quarter, it is anticipated that we will achieve 85% for Quarter 4.

QUALITY

Q10. 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:

62.48% in December. Q3 overall 62.77%. A significant increase in spontaneous vaginal deliveries would therefore be required in Q4 in order to achieve the CQUIN. There is currently 50% confidence of meeting this target.

Recovery plan, including expected date performance will be restored:

- The service has set-up a normal birth working party to ensure the service is proactive 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) based on delivery suite each shift; the team triage women and encourage women to remain at home longer in early labour to avoid unnecessary intervention. They are also supporting home births, going out as the second midwife to the community midwife and covering the clinics in the community when the community midwife has been up at night.
- Telemetry is in use on delivery suite which allows women who require continuous foetal heart monitoring to have this but remain mobile and thus encourage a more normal birth.
- The service is reviewing all maternity pathways 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 midwifery led unit. This would allow fewer non-labouring women to be on delivery suite and reduce the risk of intervention for low risk women by having them on a unit away from the main unit. This will promote normality and improve normal birth rates.

QUALITY

Q11. EXCEPTION REPORT: Lobectomy patients' median length of stay in hospital	**RESPONSIBLE DIRECTOR: Medical Director**

Description of how the target is measured:

The median length of stay for patients undergoing lobectomy surgery, against a target of 5 days.

Performance during the period, including reasons for exceptions:

The 5 day median length of stay target was achieved during July, August, September and November, with October and now December being exceptions. The reason for the recent increase in median length of stay to 6.0 days is the clinical complexity of cases treated in the month. The volume of cases was low for December, just 10 patients, and the Video Assisted Thorascopic Surgery (VATS) lobectomy rate was lower due to one Thoracic Surgeon taking annual leave which affects overall performance. During the latter part of December the impact of Christmas and New Year bed pressures within the Bristol Royal Infirmary (BRI) led to significantly more outliers which shifts the ward focus from Enhanced Recovery.

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*:

- Review the December lobectomy cases to identify the reasons behind length of stay having increased (Action complete)
- Work closely with Productive Theatre programme and Surgery Head & Neck Divisional Management Team to restore protected beds within Thoracic Surgery – this will be discussed in the newly formed Enhanced Recovery Steering Group as part of the Transforming Care project
- Continue to work with Enhanced Recovery Project nurses, funded by CQUIN pump priming, to embed Enhanced Recovery pathway
- Submit amended bid for pump primping funds to ensure maximum gain from the funding available for achievement of this standard

Progress against the recovery plan:

The target 5 days is on track to be achieved in January 2012.

QUALITY

Q12. EXCEPTION REPORT: Number and percentage of complaints resolved within timescale agreed with complainant	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

December 2011 performance was 84.2%, which equates to six breaches of timescale for this month. Five of these breaches relate to the Division of Surgery, Head & Neck and one relates to the Division of Trust Services.

Two of the Division of Surgery, Head & Neck's breaches were due to the delay in arranging a meeting to discuss the outcome of the complaint investigation with the complainant by the date agreed. Two other breaches relate to the delay in obtaining statements from staff and one relates to the delay in another NHS organisation providing statements on a complaint which was being jointly managed. The Trust Services delay was due to a misunderstanding about the lead for the investigation.

Recovery plan, including expected date performance will be restored:

- Following the outcome of the externally commissioned review of complaints a comprehensive work plan has been agreed with Divisions, which is designed to improve efficiency of systems for managing complaints and improve performance in timeliness of responses. This work includes improving the frequency of proactive and local resolutions e.g. through meetings with complainants to provide opportunity for further issues to be raised, which should allow more in-depth investigation of the more complex complaints. The work plan is due to be fully implemented by the end of March 2012.
- Each individual breach has been discussed with the relevant Divisional Complaints Co-ordinator.
- Performance issues relating to the Division of Surgery Head & Neck are to be discussed by the Chief Nurse with the Head of Nursing.
- A task list has been produced to facilitate monthly monitoring of actions to sustain compliance with Care Quality Commission Outcome 17 (Complaints) at the Patient Experience Group, chaired by the Chief Nurse. In addition, complaints performance is monitored at quarterly Divisional Reviews.
- An action plan has been agreed with Divisional Complaints Leads and Co-ordinators, which includes actions to improve performance in relation to this standard and Assistant Director of Governance & Risk Management has met with Divisional Complaints Leads and Co-

ordinators to establish how to best work together to implement the actions for optimum results.

WORKFORCE

2.1 SUMMARY

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

 **Achieving (4)**	 **Underachieving (1)**
- Workforce costs – *compared with budget* - Workforce numbers – *compared with budget* - Sickness absence - *compared with target* - Appraisal compliance - *compared with target*	- Bank and agency usage - *compared with target*
 **Failing (0)**	 **Not reported/scored (1)**
	- Turnover *(no target)*

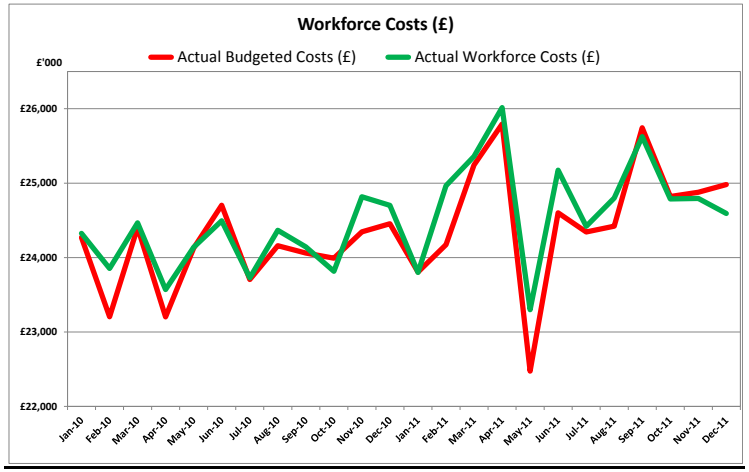
2.2 EXCEPTION REPORTS

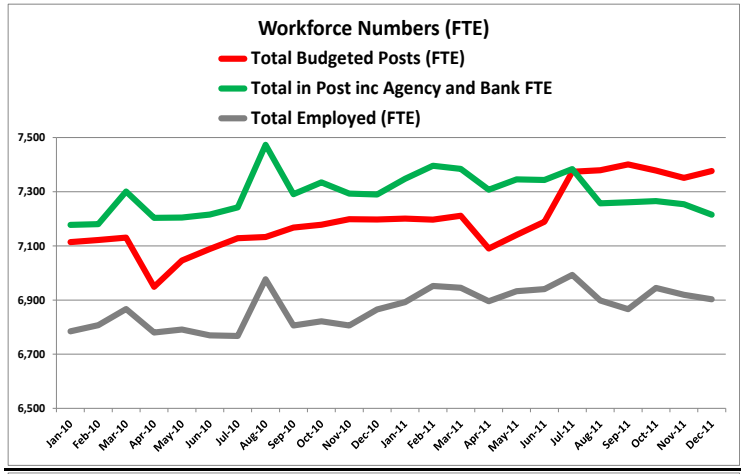
No reported exceptions in December 2011:

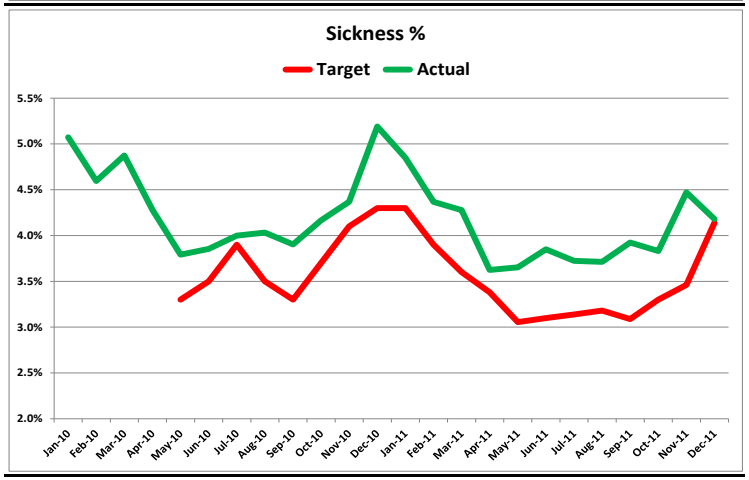
2.2 SUPPORTING INFORMATION

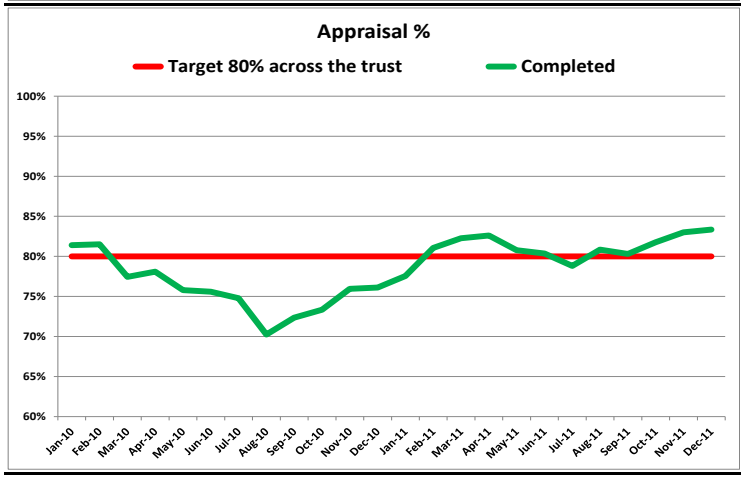
This report provides an outline of the Trust's position against key workforce standards for the month of December 2011 and year to date performance for 2011/12.

2.3.1 Summary







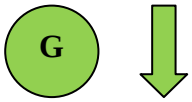
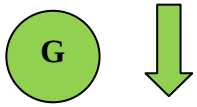
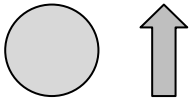
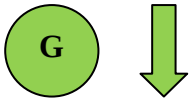
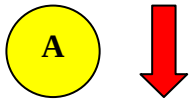


WORKFORCE

2.3.2 Changes in the period

Performance is monitored against workforce costs, workforce numbers, bank and agency usage, turnover, sickness and appraisal numbers. Indicators on a rolling reporting programme are: European Working Time Directive (EWTD) (February 2012) Statutory and mandatory training (April 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 reduced by 0.8%, budgeted workforce costs increased by 0.4% in December 2011. December's costs were 1.5% below the budgeted workforce costs compared with 0.3% below budget in November.	See supporting information
Workforce Numbers		Workforce numbers reduced by 0.5% compared with November 2011, 2.2% below the budgeted workforce numbers. This compares with November 2011, when workforce numbers were 1.3% below budget.	See supporting information
Turnover		Rolling voluntary turnover increased by 0.1% to 9.2%.	
Sickness		Sickness reduced by 0.3 percentage points compared with November 2011 across the Trust, 0.1 percentage points above the monthly target for 2011/12.	See supporting information
Bank/Agency		Bank and agency reduced by 22.2 fte and the target reduced by 37.5 fte, compared with November 2011. Bank and agency 4.2% above monthly target for 2011/12.	See Summary
Appraisal		Appraisal rates increased by 0.3 percentage points to 83.3% compared with 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	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Dec 11 Planned
Budgeted Posts (FTE)	7197.4	7201.0	7196.9	7211.5	7090.1	7140.7	7189.1	7374.1	7379.3	7401.1	7378.4	7351.1	7376.8	7264.0
Total Employed (FTE)	6865.4	6892.1	6951.8	6945.2	6895.7	6932.5	6940.7	6993.0	6898.2	6866.1	6944.8	6919.5	6903.1	6857.8
Sickness Rate (%)	5.2%	4.9%	4.4%	4.3%	3.6%	3.7%	3.9%	3.7%	3.7%	3.9%	3.9%	4.5%	4.2%	4.1%
Bank (FTE) Admin & Clerical	78.9	81.5	80.1	89.1	73.6	73.0	77.8	79.2	80.9	78.7	64.4	63.6	52.3	58.5
Bank (FTE) Ancillary Staff	23.9	23.4	20.6	25.5	20.3	20.5	19.1	17.4	12.8	16.1	11.4	11.7	12.7	21.7
Bank (FTE) Nursing & Midwifery	212.9	239.8	214.8	232.4	231.5	233.1	230.8	239.7	193.9	220.7	178.7	178.1	175.3	138.1
Agency (FTE) Admin & Clerical	5.2	6.2	6.8	9.4	7.0	4.3	3.2	2.6	3.4	5.5	3.5	2.9	2.1	3.5
Agency (FTE) Ancillary Staff	41.7	28.5	32.1	35.2	31.1	34.7	34.3	18.1	34.1	37.7	30.6	33.5	31.0	30.5
Agency (FTE) Nursing & Midwifery	8.4	14.0	6.9	10.0	17.5	12.3	7.4	8.4	8.2	11.7	13.5	13.8	12.0	7.2
Overtime	50.8	57.3	66.0	72.1	61.6	63.6	78.0	62.9	40.4	65.3	62.7	81.1	64.9	69.2
Appraisal (%) excluding Junior Doctors	76.1%	77.6%	81.1%	82.3%	82.6%	80.8%	80.3%	78.8%	80.8%	80.3%	81.8%	83.0%	83.3%	80.0%
Appraisal (%) Junior Doctors									80.3%	88.3%	93.5%	94.5%	97.4%	80.0%
Rolling Average Turnover (%)	15.4%	15.3%	15.3%	15.4%	15.1%	14.9%	15.0%	14.7%	14.4%	15.1%	15.0%	15.2%	15.4%	
Rolling Average Voluntary Turnover (%)	9.6%	9.5%	9.3%	9.4%	9.2%	9.1%	9.0%	8.6%	8.6%	8.9%	8.9%	9.1%	9.2%	
Vacancy Rate (%)	4.6%	4.3%	3.4%	3.7%	2.7%	2.9%	3.5%	5.2%	6.5%	7.2%	5.9%	5.9%	6.4%	

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 December 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 (1)**
- 31-day diagnosis to treatment cancer standard - *first* - 31-day diagnosis to treatment cancer standard – *all subsequent treatments* - 62-day referral to treatment cancer standard – *GP & 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	- Infant health – breastfeeding rate
Failing (3)	**Not reported/scored (0)**
- Reperfusion times (call to balloon time of 150 minutes) - Last-minute cancelled operations - 28-day readmission – *a date for re-admission within 28 days of cancellation*	

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

3.2 ACCESS DASHBOARD

Access Standards - dashboard

		Thresholds		2010/11	2011/12	Month												Quarterly Performance 2011/12			
	Target	Green	Red	to date	To Date	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Q1	Q2	Q3	Q4
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	88%	95.8%	95.3%	91.9%	96.8%	96.9%	96.0%	95.4%	94.6%	95.4%	96.4%	93.4%	94.2%	96.7%	Cancer standards report two months in arrears	95.4%	95.1%	95.5%	
	Cancer - Symptomatic Breast (cancer not suspected) in Under 2 Weeks	93%	88%	90.3%	97.5%	100.0%	100.0%	100.0%	100.0%	98.1%	98.6%	97.7%	97.0%	100.0%	93.6%	95.3%		99.0%	98.1%	94.6%	
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	93%	98.8%	97.8%	96.0%	97.8%	98.0%	97.3%	96.8%	96.7%	97.2%	99.1%	99.1%	98.1%	97.5%		97.1%	98.5%	97.8%	
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	93%	99.7%	99.9%	100.0%	100.0%	100.0%	99.1%	100.0%	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%	96.6%	92.3%	93.0%	98.0%	98.2%	100.0%	96.8%	97.8%	94.0%	98.3%	93.6%	94.5%		98.2%	96.5%	94.1%	
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	89%	Not applicable	99.5%	99.2%	100.0%	99.5%	100.0%	99.4%	100.0%	99.4%	100.0%	98.9%	99.0%	99.5%		99.8%	99.4%	99.2%	
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	80%	85.7%	86.3%	79.3%	85.7%	91.2%	88.1%	85.7%	82.7%	85.4%	85.1%	87.7%	88.1%	88.2%		85.1%	86.2%	88.1%	
	Cancer 62 Day Referral To Treatment (Screenings)	90%	85%	91.9%	93.0%	94.4%	70.8%	87.5%	96.8%	100.0%	95.3%	85.3%	86.1%	95.2%	88.1%	100.0%		97.1%	89.3%	92.8%	
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	95.6%	95.4%	97.9%	100.0%	100.0%	100.0%	100.0%	88.9%	92.6%	100.0%	94.9%	94.4%	94.7%		96.2%	95.2%	94.6%	
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	80%	93.1%	91.8%	94.0%	92.7%	91.5%	93.0%	92.4%	92.7%	91.8%	91.3%	91.9%	91.2%	91.2%	90.6%	92.7%	91.7%	91.0%	
	Referral To Treatment Non Admitted Under 18 Weeks	95%	85%	98.4%	97.9%	98.4%	98.0%	98.0%	98.1%	98.7%	98.4%	98.0%	97.6%	97.7%	97.8%	97.2%	98.0%	98.4%	97.7%	97.6%	
	Referral to treatment time admitted patients (95th percentile - weeks)	23	23	Not applicable	22.0	Standard not in effect			21.3	21.6	20.6	21.7	21.9	21.9	22.6	23.0	22.7	21.1	21.9	22.9	
	Referral to treatment time non-admitted patients (95th percentile - weeks)	18.3	18.3	Not applicable	14.9	Standard not in effect			13.6	13.7	14.0	15.0	15.1	15.3	15.6	16.3	14.3	13.9	15.1	15.4	
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	96.1%	97.1%	89.5%	90.8%	94.2%	97.0%	98.8%	98.4%	97.7%	98.1%	97.1%	95.4%	97.1%	94.5%	98.0%	97.6%	95.6%	
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	Not applicable	13	Standard not in effect			85	53	15	15	12	13	14	12	13	55	13	14	
	A&E Time to treatment decision (median) - in minutes	60	60	Not applicable	18	Standard not in effect			24	20	20	18	15	18	19	17	21	20	16	19	
	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%	1.8%	1.6%	1.6%	1.9%	
	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%	0.9%	1.1%	1.0%	0.9%	
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	1.16%	0.87%	2.21%	1.44%	1.69%	0.97%	0.92%	1.01%	1.13%	0.89%	0.31%	0.90%	0.89%	0.85%	0.97%	0.77%	0.88%	
	28 Day Readmissions	95%	85%	93.6%	93.9%	80.5%	91.1%	82.9%	94.1%	91.5%	95.8%	93.0%	93.2%	96.1%	100.0%	92.0%	93.9%	93.9%	94.0%	94.0%	
	GUM Offer Of Appointment Within 48 Hours	98%	95%	100.0%	100.0%	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%	100.0%	
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	Not applicable	84.6%	84.2%	75.0%	88.0%	94.1%	80.0%	81.8%	78.4%	85.2%	97.1%	85.7%	77.3%		85.2%	86.9%	81.4%	
	Infant Health - Mothers Initiating Breastfeeding	76.3%	76.3%	76.4%	76.2%	75.5%	75.1%	77.1%	72.3%	74.7%	78.4%	77.0%	78.1%	73.8%	78.2%	77.1%	76.5%	75.1%	76.2%	77.3%	

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 amedned, 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:

- 31-day Subsequent surgery ↑ (up from 93.6 % in October to 94.5% in November)
- 62-day referral to treatment cancer standard – Screening referred ↑ (up from 88.1% in October to 100% in November)
- A&E Maximum wait (4 hours) ↓ (down from 97.1% in November to 94.5% in December)
- Call to Balloon Time of 150 minutes ↓ (down from 85.7% in October to 77.3% in November)

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

3.4 EXCEPTION REPORTS

Exception reports are provided for the three (3) RED and one (1) AMBER rated performance indicators. An exception report is also provided for the A&E maximum wait (4 hours), which whilst achieve for the quarter as a whole was not achieved for the month of December.

1) Last-minute cancelled operations + 28-day readmission
2) Infant health – breastfeeding rate
3) Reperfusion times (call to balloon time of 150 minutes)
4) A&E Maximum wait (4 hours)

ACCESS STANDARDS

A1. 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 42 last-minute cancellations of surgery in **December** (0.85% of operations) which is just above the national standard of 0.8%. The main reasons for cancellations in the month were as follows:

- 29% of cancellations (13 cancellations) were due to equipment failure
- 22% (10 cancellations) were to no ward bed being available
- 15 % (7 cancellations) were due to emergency patients being prioritised on the day
- 13% (6 cancellations) were due to another complicated patient being in theatre, which took longer than expected

Of the 42 cancellations, 19 were day-cases and 23 were inpatients (45% day cases). On average, seventy percent (70%) of the Trust admissions in a month are day-cases.

Forty-eight percent (20 of the 42) of the cancellations were within Cardiac Services. Nine of these cancellations were due to equipment failure.

93.9% of patients were re-admitted within 28 days of the cancellation of surgery at last-minute in December, which is below the 95% national standard. Three patients were not re-booked within 28 days. One case was cancelled at a private facility due to equipment failure, and could not be re-scheduled within target due to consultant and equipment availability. The remaining two could not be re-scheduled within 28 days due to difficulty in finding an alternate theatre slot and the availability of the specific surgeon needing to undertake the procedure.

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*):

- Christmas / New Year plan will be developed and implemented for elective services, to reduce the risk of cancellations as a result of peaks in emergency demand or staff availability (Action completed)
- Review of causes of high levels of cancellations due to equipment failure (Action complete). Most of the equipment related cancellations were

due to equipment failure within the catheter laboratories and covered a three-day period. The equipment took longer to repair than expected, but is now operational again.

- The avoidance of last-minute cancellation remains 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
- Implementation of the Optimising Use of Beds work-steam will continue – with the aim of balancing bed capacity and demand for beds
- Planning for the closure of beds ahead of the transfer of services to South Bristol Community Hospital (SBCH) (end March)
- Operational plan for bed/admission management during the transition to the new Patient Administration (PAS) planned for mid March

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. December's performance (at 0.85%) was better than the 1.13% forecast and significantly better than last year's performance of 1.69%. The Trust is currently within the target trajectory agreed with the PCT for January.

ACCESS STANDARDS

A2. 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:

The 76.3% standard was achieved in quarter 3. Variation in monthly performance will continue to be monitored.

ACCESS STANDARDS

A3. 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 November 77.3% of patients had a Call to Balloon time of less than 150 minutes, with the standard not being met in 10 cases. Year to date performance is 84.6% against the 90% standard.

There have been **45 breaches** of the Call to Balloon 150 minute standard for the year to date, of these:

- 34 (76%) happened overnight or at weekends (i.e. out-of-hours)
- 41 had a Door to Balloon times of over 50 minutes (26 were also over the 90 minute national standard)

The specific reasons for the failure to carry-out the procedure within the 150 minutes were as follows:

- 19 (42%) resulted from delays due to another patient already being in the lab and having the procedure
- 7 (16%) were due to the ambulance ECG (Electrocardiograph) not being diagnostic, and this having to be repeated
- 7 (16%) having a long ambulance conveyance
- 6 (13%) due to the patient having a cardiac arrest and the procedure not being able to be carried-out for clinical reasons
- 4 (9%) clinically complex case
- 2 (4%) other reasons

This detailed analysis suggest that the primary reason for a delay in the procedure being carried-out is that another patient is already being treated in the Catheter Laboratory (42% of breaches). Clinical exceptions (cardiac arrest and/or clinical complexity) account for a further 22% of breaches.

Recovery plan, including expected date performance will be restored

The following actions are being taken to improve Call to Balloon times (*please note: actions completed in previous months have been removed from*

ACCESS STANDARDS

the following list):

- Establish a GWAS alert system to Bristol Heart Institute's Catheter Lab, so that the labs can be prepared ahead of every patient's arrival (Action complete)
- 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 (Action complete) Carry-out in-depth analysis of the causes to failures to achieve the 150 minute standard has been undertaken (Action complete)
- Clinical team will meet with Great Western Ambulance Service (GWAS) to discuss ambulance ECG issues and conveyance times, with a view to understanding what further contribution the Bristol Heart Institute (BHI) can make to Call to Balloon performance (timescale to be confirmed)
- Further analysis will be undertaken to review the timings for patients who are delayed due to another patient being in the lab. This will help to identify whether there are significant benefits associated with having a second on-call team, and what alternative options exist for reducing delays for this category of patients (timescale to be confirmed).

Progress against recovery plan:

The Trust is currently achieving 84.6% against the 90% standard year to date.

ACCESS STANDARDS

A4. EXCEPTION REPORT: A&E maximum wait 4 hours	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients admitted, discharged or transferred within 4 hours of arrival in the Trust's Bristol Royal Infirmary (BRI), Bristol Children's Hospital and Bristol Eye Hospitals, as a percentage of all patients seen. The local Walk in Centre attendances are no longer included in the performance figures.

Monitor measurement period: Quarterly

Performance during the period, including reasons for exceptions:

Performance dipped in December to 94.5%, although the 95% national standard was achieved for the quarter as a whole. Performance within the Bristol Children's Hospital and Bristol Eye Hospital remained well above 95% standard in the month, at 98.2% and 100% respectively. However, within the BRI only 90.9% of patients had a maximum wait of less than 4 hours, which is 4.1% below the level of performance achieved in November.

Within the BRI the volume of attendances to the Emergency Department (ED) that resulted in an admission to hospital rose by 289 (18%) compared with November. The level of emergency admissions was also above the same period last year. A lack of beds was a major cause of breaches of the 4 hour standard. There were also 159 (5%) fewer minor illness/injury related attendances than in the previous month. The reason for this is not understood. Minor illness/injury patients (category 1), by definition, do not require an admission to hospital, so there is no wait for a bed. They are quicker to treat and discharge, and for this reason, a drop in this category of attendances reduces the overall performance against the 4 hour standard.

Recovery plan, including expected date performance will be restored:

The following actions continue to be taken to ensure continued achievement of the 4-hour standard in quarter 4 (*please note: actions completed in previous months have been removed from the following list*):

- A navigator role will be established within the Medical Assessment Unit (MAU), staffed on a rotational basis by the senior nursing teams in Medicine (end January). This will help to ensure assessment beds are available at key times in the day.
- The current BRI escalation process will be reviewed and named escalation leads will be established, when a certain level of escalation is reached. The escalation lead will have specific, measurable outcomes to achieve (end January)
- Four Medical Assessment Unit (MAU) and four Surgical and Trauma Assessment Unit (STAU) beds will aim to be made available by 10:00 each weekday (three at the weekends) to improve the flow of patients out of the ED early in the day and prevent a build-up of patients needing

admissions (end January).

- A fortnightly Professional Standards group will be established and chaired by the Head of Division for Medicine, to review examples of good and poor compliance with the previously agreed standards for specialist opinion in the BRI Emergency Department.
- The above actions were reviewed and endorsed by both the Service Delivery Group and Trust Management Executive (TME) Group in January (Action complete), and will be reviewed again by TME in February, to ensure whole-Trust buy-in to the plans

Progress against the recovery plan:

The national 95% standard was achieved in quarter 3, despite the dip in performance in December. Historically, quarter 4 has been a challenging period in which to achieve the national 4-hour standard. However, over the last year key changes have been made to process by which bed availability and patient flow is managed. This is on top of the significant enlargement of the Medical Assessment Unit (MAU). Through this, performance has improved relative to the same period last year, with December's performance being 3.7% up on December 2010. If a similar level of improvement is seen in quarter 4 this year, it is forecast that the Trust will achieve 95.3% for the quarter as a whole. Although January's performance to date is below the 95% standard, we are on track to deliver the planned trajectory for achievement of the 95% standard in the quarter.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 January 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 06 – Care Quality Commission Compliance Update

Purpose

The purpose of this report is to update the Trust Board on key matters relating to the Trust's registration with the Care Quality Commission (CQC) and compliance with all CQC 'essential standards'. A more detailed report covering each of the points below will be reviewed by the Quality and Outcomes Committee of the Board on 25 January 2012.

Abstract

The Executive Directors met on 15 December 2011 to conduct a detailed review of compliance with the CQC Judgement Framework Outcomes. On 22 December 2011, the Trust subsequently made a self-declaration of compliance with all 16 key quality and safety standards, pending formal approval by the Board in January. The Executive further reviewed the twelve CQC Non-Judgement Framework Outcomes on 04 January 2012, concluding that the Trust continues to be compliant.

The Trust received a CQC Responsive Review for Outcome 5 (Meeting nutritional needs) on 13 December 2011. A draft report has been received from the CQC and a final report is anticipated on 25 January 2012. The inspection team noted many examples of good nutritional care. The provisional finding of the CQC is 'Minor Concerns', which means that the Trust is compliant with the relevant regulation of the Health and Social Care Act, but there are areas where the CQC has suggested further improvements could be made.

Preparation also continues ahead of an anticipated Scheduled Inspection by the CQC in 2012.

Recommendations

The Board is recommended to Note the report and to formally approve the declaration of compliance made to the CQC on 22 December 2011.

Executive Report Sponsor or Other Author

- Sponsor – The Chief Nurse, Alison Moon
- Author – The Assistant Director for Audit and Assurance, Chris Swonnell

Appendices

List your appendices, including your Report in the following format:

- Appendix A – Care Quality Commission update (registration and compliance)

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
15 December 2011 and 04 January 2012	11 January 2012	25 January 2012			Clinical Quality Group – 05 January 2012 Regulatory Compliance Group – 17 January 2012

Subject: **Care Quality Commission update (registration and compliance)**
Report to: **Trust Board**
Author: **Chris Swonnell, Assistant Director for Audit and Assurance**
Date: **17 January 2012**

1. Introduction

The purpose of this report is to update the Trust Board on key matters relating to the Trust's registration with the Care Quality Commission (CQC) and compliance with all CQC 'essential standards'. A more detailed report covering each of the points below will be reviewed by the Quality and Outcomes Committee of the Board on 25 January 2012.

2. Executive Director review of Judgement Framework Outcomes

The Executive Directors conducted their annual review of compliance with standards (called 'Outcomes') set out in the CQC Judgement Framework on 15 December 2011. This was a comprehensive review: each Outcome was considered in turn, based on summary evidence provided by the Operational Leads for each Outcome. The conclusion of the Executive was the Trust is now compliant with all 16 Judgement Framework Outcomes. Compliance with Outcomes 11 (Equipment) and 21 (Records) was agreed, based on the following key evidence:

Outcome 11:
- All Divisions hold comprehensive equipment maintenance records and these have been audited to confirm they are fit for purpose.
- The Trust has met a self-imposed target that at least 80% of all medical and dental staff have completed a formal Training Needs Assessment for the use of high risk equipment.
- In December, the Trust met a further self-imposed target that at least 80% of monthly ward/departmental medical equipment training matrices for nursing and AHP staff should be completed and returned to our medical equipment department. The target of 80% has been achieved in all five Divisions. Analysis of these matrices has identified a small number of staff with additional training requirements (gaps in staff competencies) which are being addressed.

Outcome 21:
- A concerted focus on the quality of medical, nursing and allied health professional records during the second half of 2011 has included reviews of documentation, audits and re-audits to confirm improved practice. The quality of nursing records is now monitored using a ward-based *Quality in Care* tool: wards are assigned a 'Bronze', 'Silver', 'Gold', or 'underachieving' level according to the results of systematic audits. Significant progress has been made during 2011. The quality of medical records in all major specialties has been sampled in a series of rapid-cycle audits and re-audits. The Medical Director set a target that at least 75% of records should meet at least 75% of the good practice criteria agreed at the outset of the exercise. This target has been achieved. Elsewhere, core physiotherapy and occupational therapy documentation has been revised and subjected to spot-check audits.

3. Declaration of compliance

Subsequent to the Executive Directors' meeting on 15 December 2011, the Trust wrote to the CQC on 22 December, declaring compliance with all Judgement Framework Outcomes, subject to formal approval from the Board in January.

4. Sustaining performance

During 2011/12, the Trust has at various times declared non-compliance with Outcomes 5 (Nutrition), 7 (Safeguarding), 11 (Equipment), 14 (Supporting Staff) and 21 (Records). Significant work has been undertaken to provide the necessary assurances to give the Executive and Board the confidence to declare compliance. The challenge is now to sustain (and improve) our position. Operational Leads for Outcomes 7, 11, 14 and 21 have produced sustainability plans which have been reviewed by the Trust Management Executive and the Quality and Outcomes Committee. A sustainability plan for Outcome 5 will be agreed as part of developing the Trust's action plan in response to the recent Responsive Review (see below).

5. Responsive Review for Outcome 5 (Nutrition)

The Trust received an unannounced Responsive Review inspection of Outcome 5 on 13 December 2011. This was the third such inspection of compliance with Outcome 5 since registration. The Trust received a draft report from the CQC on 22 December 2011 and replied with comments on factual accuracy on 05 January 2012. A final report is anticipated on 25 January, after which the Trust will have 14 days in which to provide an action plan addressing any issues reported by the inspection team. The draft report is very positive, highlighting numerous examples of good practice in nutritional care: there is also clear evidence of improvement since the CQC's previous inspection. The CQC's provisional finding is 'Minor Concerns': this means that the Trust is compliant with the relevant regulation of the Health and Social Care Act, but there are some specific improvements which could be made. Based on the draft CQC report, the key points for improvement are completion of nutritional care plans (implicitly, reconsidering their design) and patients' awareness of the availability of menu choices which are culturally and religiously appropriate.

6. Preparing for Scheduled Inspection

The Trust anticipates receiving a Scheduled Inspection in 2012. This inspection will be unannounced and could potentially include review of any CQC Outcomes – inspectors reserve the right to pursue lines of enquiry as they see fit. The CQC is the process of changing its regulatory framework: Scheduled Inspections will now take place annually (previously every two years) and will involve an increased emphasis on observed practice. Inspectors will be seeking evidence of non-compliance (as opposed to evidence of compliance) and providers will be judged either compliant or non-compliant (the scale of Minor/ Moderate/Major Concerns is to be dropped). Inspectors will visit wards and theatres; they will observe practice and ask staff questions; they will talk to patients and will want to see patient records. Preparation for a Scheduled Inspection has included a trust-wide information leaflet explaining the day-to-day relevance of the CQC standards for each member of staff. Operational Leads for the Judgement Framework Outcomes are ensuring that corporate evidence of compliance is up-to-date and Divisions are expanding their own local evidence base.

7. Non-Judgement Framework Outcomes

In addition to the 16 Judgement Framework Outcomes, there are a further 12 so-called Non-Judgement Framework Outcomes. The majority of these Outcomes describe requirements of registration, as opposed to required standards of patient care. The Executive Directors reviewed these Outcomes on 04 January 2012 and concluded that the Trust continues to be compliant.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Public Meeting of the Trust Board of Directors to be held on 26th January 2012 at 10:30am 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 £5.150m for the nine months to 31st December 2011. The operating surplus (EBITDA) at £25.698m is £1.154m (or 4.7%) greater than Plan for the period. The Trust's Financial Risk Rating is 4 (actual = 3.65) an improvement on the FRR of 3 reported for earlier months in the year.

The financial performance for the month of December is encouraging as there is a net underspending on Divisional budgets and the headline message for CRES is that savings equate to 96% of Plan. The forecast outturn has been re-assessed at month 9 (quarter 3) to a surplus of £7m, an improvement on the Annual Plan forecast of £6m. This is within the range of a pessimistic forecast of a surplus of £5m and an optimistic forecast surplus of £9m for the year.

Recommendations

To note the financial position at 31st December 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
	18/01/12		23/01/12		

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £5.150m for the nine months to 31st December 2011. This is better than the Annual Plan projection for this period. The operating surplus (EBITDA[1]) at £25.698m is £1.154m (or 4.7%) greater than Plan for the period. The Financial Risk Rating has improved to 4 (actual 3.65), further information on this is given in section 5 below.

The original financial plan for the year is a £6m income and expenditure surplus. The forecast has been re-assessed at month 9 (quarter 3) to a surplus of £7m. This is within the range of a pessimistic forecast of a surplus of £5m and an optimistic forecast surplus of £9m for the year.

The achievement of cash releasing efficiency savings headline message is that December has seen a small increase in the rate of delivery of CRES savings with £2.413m achieved. This is encouraging as it equates to 96% of the Plan for the month. The December report reflects an adverse variance of £5.332m year to date on the CRES programme. Actual savings of £14.645m represents slippage of £4.095m when compared with phased planned savings for the first nine months of £18.740m. The adjustment to bring CRES plans on to a 1/12ths basis adds a further £1.237m to the reported non achieved CRES in the December report.

The latest CRES forecast is that savings of £21.071m, a further improvement on last month's forecast, will be achieved this year of which the non recurring element is £4.753m (November = £4.478m). This represents an under achievement of £5.565m 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 £20.698m. 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. The underspending against divisional budgets totalled £0.407m in December. 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 30th November	Variance this month	Variance to 31st December	Memorandum CRES Variance
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(1,234)	390	(844)	(2,604)
Non Pay	(3,638)	(476)	(4,114)	(2,842)
Operating Income	644	80	724	87
Income from Activities	(638)	413	(225)	27
Totals	**(4,866)**	**407**	**(4,459)**	**(5,332)**

[1] Earnings Before Interest Depreciation Taxation and Amortisation

It can be seen that the non achievement of savings within the CRES programme is still a feature on the expenditure lines shown in the table above to the extent that had the savings been achieved then a surplus would be reported on the pay headings and the overspend on non pay budgets would be greatly reduced.

Pay budgets have underspent in December by £0.390m reducing the cumulative overspending to £0.844m. Taken with the favourable results for September to November this is an encouraging trend. Underspendings are reported by 4 of the 5 clinical divisions and there is a noted improvement on the run rate for the fifth division. 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 and providing a solid platform for 2012/13.

Non pay budgets show a further overspending in December of £0.480m to a cumulative adverse variance of £4.118m. Slippage on CRES schemes of £2.842m is embedded within this position. Significant overspendings are reported this month against Medicine (£147k), Diagnostic and Therapies (£115k) and Surgery, Head and Neck (£103k).

Operating Income budgets show a cumulative favourable variance of £0.724m with an improvement of £0.080m recorded in December.

Income from Activities shows an over performance of £0.413m for December (November activity reported a month in arrears). The cumulative position on Income from Activities shows a shortfall to date of £0.225m (net of the balance of the over performance for March 2011 (£0.81m), received in 2011/12).

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

	£'000
Clinical Systems Implementation Programme	110
European Working Time Directive	109
Energy inflation	89

3. Income

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

Clinical Income by Worktype - £m	**Plan**	**Actual**	**Variance**
Accident & Emergency	7.18	7.44	0.27
Emergency Inpatients	48.31	48.85	0.55
Day Cases	22.72	23.48	0.77
Elective Inpatients	32.20	31.03	(1.17)
Non-Elective Inpatients	19.76	20.28	0.52
Excess Bed days	5.90	5.09	(0.81)
Outpatients	43.78	43.45	(0.33)
Bone Marrow Transplants	6.11	5.56	(0.55)
Critical Care Bed days	22.70	23.11	0.41
PbR Exclusions / NICE	24.85	22.87	(1.98)
Contract Penalties / Rewards	(4.58)	(5.11)	(0.53)
Other	31.22	34.07	2.86
Sub-Totals	**260.13**	**260.13**	**-**
2010/11 Estimate v Actual	-	0.81	0.81
Totals	**260.13**	**260.94**	**0.81**

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

(Penalties) / Rewards	Month 8 Year to Date £m	Current Month £m	Month 9 Year to Date £m
CQUINS	1.42	0.18	1.60
Emergency Readmissions *(Variance against Plan)*	(0.27)	0.03	(0.24)
Emergency Marginal Tariff *(Variance against Plan)*	(0.02)	(0.12)	(0.14)
Others	(0.16)	0.02	(0.14)
Totals	**0.97**	**0.11**	**1.08**

The contract penalties associated with emergency admissions following an elective or emergency spell total £2.66m for the first 8 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.

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

SLA Variances - £m	**BNSSG[2]**	**South West Specialist Commissioning**	**Other Commissioners**	**Totals**
Over / (under) performance as at Month 8	7.21	(2.12)	(5.09)	-
QIPP	(7.06)	-	7.06	-
A&E / Emergencies	0.30	0.12	(0.64)	(0.22)
Residual Over / (Under) performance	**0.45**	**(2.00)**	**1.33**	**(0.22)**

This demonstrates that, for example, of the £7.21m over-performance to date for BNSSG £6.76m is due to QIPP and A&E / Emergency activity. In total there is, therefore, a net residual over performance of £0.45m.

4. Expenditure

In total, Divisions are shown as overspent by £4.459m for the nine month period to 31st December. The position for each Division, together with comparable results with CRES accounted for on the Divisional Phased Plan basis, is summarised below:

Division	**CRES on 1/12ths profiling**		**CRES on Phased Plan**	
	Variance to 31st December Favourable / (Adverse)	Memorandum CRES Variance to 31st December	**Variance to 31st December Favourable / (Adverse)**	**Memorandum CRES Variance to 31st December**
	£'000	£'000	£'000	£'000
Diagnostic and Therapies	(37)	(101)	43	(21)
Medicine	(987)	(1,040)	(669)	(722)
Specialised Services	(1,301)	(788)	(1,135)	(622)
Surgery, Head and Neck	(859)	(2,117)	(416)	(1,674)
Women's and Children's	(1,465)	(1,044)	(1,287)	(866)
Facilities and Estates	(17)	(110)	25	(68)
Trust Services	99	48	109	58
Other Services	108	(180)	108	(180)
Totals	**(4,463)**	**(5,332)**	**(3,222)**	**(4,095)**

[2] 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 9. For each Division the shortfall, using results to date, is in excess of £0.4m.

The **Diagnostic and Therapies Division** reports a cumulative over spending of £37k – an underspending of £173k in the month. Pay budgets have underspent this month by £209k bringing the cumulative position to £153k favourable. The improvement reflects the holding of vacancies in Radiology and Laboratory Medicine, the recovery of a salary overpayment and maintenance of controls on bank and agency usage together with waiting list and overtime payments. The principal reason for the adverse movement of £115k on non pay headings this month is the non recurrent budget transfer to Specialised Services of a share (£94k to date) of income received for the Cardiac MRI service. Income from Activities shows a favourable movement this month of £255k reflecting SLA over-performance by the Division and a share of other services provided by the Trust together with CQUINs income. Operating Income has under achieved in the month reflecting for example the volatility of MEMO income and a provision for a doubtful debt on a provider-to-provider service.

The **Division of Medicine** reports an adverse variance of £987k for the nine months to 31st December – an improvement of £228k in the month. To date pay budgets are overspent by £373k, an improvement of £135k in December. The underspending relates to a reduction in nursing bank and substantive staff expenditure as tighter controls on expenditure are implemented following ward closures, a review of nursing establishments and an assessment of minimum staffing levels. Non pay budgets show a cumulative overspending of £966k (November £819k adverse). This is a continuation of the previously reported trend relating to slippage on CRES and overspendings on clinical supplies including blood products recharge. Operating income budgets continue to perform well with the in month underspending of £41k increasing the cumulative favourable position to £290k. Income from Activities shows a favourable movement this month of £199k. This results in a cumulative favourable variance of £62k to date. The non achievement of CRES at £1.040m 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 £1,301k, a net underspending of £79k in December. The Division has benefitted this month from a transfer from the Diagnostic and Therapies Division of £94k in respect of income for the Cardiac MRI service. The net performance without this adjustment is an in month overspending of £15k. Nonetheless this is a welcome improvement when considered against the monthly financial performance in earlier months. The Division has flagged up that cardiac surgery in December (to be reported in the January position) was less than plan and it is likely that the financial impact of this will feature adversely in next month's report.

Pay budgets are reported as having a cumulative overspending of £846k, an overspending of £37k in the month. This follows the continuing use of higher than budgeted staff through agency, waiting list initiatives and additional sessions paid - albeit at a lower level than previous months. Non pay budgets have underspent by £12k in the month resulting in a cumulative overspending of £330k. The results for December include a share of the income gain associated with cardiac MRI services offset by higher than planned expenditure on clinical supplies and slippage on CRES and other structural funding issues. CRES slippage of £324k is clearly a significant factor in non pay budgets being overspent to date. The over performance on Operating Income budgets has continued with a favourable variance in the month of £78k thereby increasing the cumulative favourable variance to £215k. Income from Activities shows a favourable variance of £26k in the month and a cumulative adverse position of £340k.

The Surgery, Head and Neck Division reports a cumulative adverse variance on its income and expenditure position of £859k, an overspending of £39k in December. Pay budgets have a cumulative underspending of £158k an improvement in the month of £138k. Non pay budgets are

overspent by £991k to date an increase of £103k in the month. The principal cause of the non pay overspending is slippage on CRES at £1,246k. Income from Activities shows an adverse variance of £72k this month to bring the cumulative position to £262k adverse. Operating Income budgets have an adverse variance of £2k in December reducing the cumulative over achievement to £236k.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £1,465k – a net underspending of £43k in December. Pay budgets are overspent by £743k – an adverse movement of £17k in the month. The pay underspending this month was achieved by reduced nursing staff bank spend. Capacity was lower over Christmas and there was also less annual leave taken as part of the Winter Plan. There have been some increases in staffing to address capacity issues for Midwifery services and further funded appointments in NICU as part of the 4 cot expansion. Non pay budgets show a cumulative overspending of £473k – an underspending of £22k in December. Income budgets are broadly unchanged in the month with a net favourable variance recorded of £4k. Slippage to date on the CRES programme of £1.049m is a significant factor in the Division's reported financial position.

The Facilities and Estates Division reports a cumulative overspending to date of £21k, an improvement of £4k in the month.

Trust Services report an in-month underspending of £15k thereby increasing the cumulative underspending to date to £99k.

5. Financial Risk Rating

The Trust's overall financial risk rating, based on results to 31st December is 4. The actual financial risk rating is 3.65 (November = 3.45) which rounds up to 4. The actual value for each of the 5 metrics is given in the table below together with the bandings for each metric.

	31st December 2011		
Metric	Metric Result	Metric Score	Weighted Average Score
EBITDA			
Margin	6.9%	3	0.75
Plan achieved	105.0%	5	0.50
Return on Capital Employed	5.0%	4	0.80
I&E surplus margin	1.4%	3	0.60
Liquidity ratio (days)	32.5 days	4	1.00
			3.65

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

Overall Financial Risk Rating	**4**

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

6. Forecast Out-turn

The original financial plan for the year is a £6m income and expenditure surplus. The forecast has been re-assessed at Month 9 (Quarter 3) as follows:

Surplus / (Deficit) For Year	Pessimistic £'000	Projection £'000	Optimistic £'000
Clinical Divisions			
– Diagnostics & Therapies	(200)	(50)	-
– Medicine	(1,500)	(1,300)	(1,100)
– Specialised Services	(1,900)	(1,700)	(1,400)
– Surgery, Head & Neck	(1,300)	(1,150)	(900)
– Women's & Children's	(2,300)	(2,000)	(1,500)
Sub Total	**(7,200)**	**(6,200)**	**(4,900)**
Corporate Divisions			
– Facilities & Estates	(150)	(50)	-
– Miscellaneous Support Services	(200)	-	100
– Research & Development	-	50	100
– Other Corporate Divisions	-	200	300
Sub Total	**(350)**	**200**	**500**
Reserves/Other Provisions			
– Skills for Health	-	-	-
– Contingency	400	500	600
– Inflation Reserve	1,500	1,600	1,700
– Transfers to Capital	300	400	500
– Corporate CRES	(1,260)	(1,260)	(1,260)
– Other Recurring Reserves	4,860	5,010	5,110
– Support to Divisions	(3,250)	(3,250)	(3,250)
– Non-recurring reserves/provisions	4,000	4,000	4,000
Sub Total	**6,550**	**7,000**	**7,400**
Financing Items			
– Fixed Asset Impairments	-	-	-
– Depreciation	-	-	-
– Interest payable	-	-	-
– PDC Dividend	-	-	-
Sub Total	**-**	**-**	**-**
Planned surplus for year	**6,000**	**6,000**	**6,000**
Forecast Surplus/(Deficit) for year	**5,000**	**7,000**	**9,000**

The forecast given above is based on nine months expenditure data and eight months activity.

The improvement in forecast outturn from £6m to £7m is due to the following key factors:

- A likely improvement in the financial position of Clinical Divisions and in particular the realistic opportunity to earn CQUINs income this year (currently only £1.6m is being included – the potential income receivable is £3.5m). Divisions are in receipt of £3.25m non-recurring support which is included in the positions shown. So it needs to be made clear that the realistic positions are based on projections only and require mitigating actions to achieve the plans agreed with the Chief Executive.

- Firming up of requirements from SLA risks, fines etc.

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

- Transfer to Capital – this is relates to those items purchased from revenue budgets which are properly charged to capital expenditure.

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

- Other Recurring Reserves – these including the following:

  – MADEL/SIFT Reserve (pending rebasing) £0.8m
  – Strategic Reserve (from 10/11 activity changes) £3.7m
  – Slippage on other Reserves £0.5m

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

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

  – Surgery, Head & Neck £2.0m
  – Specialised Services £0.75m
  – Women's & Children's £0.5m

7. Capital Programme

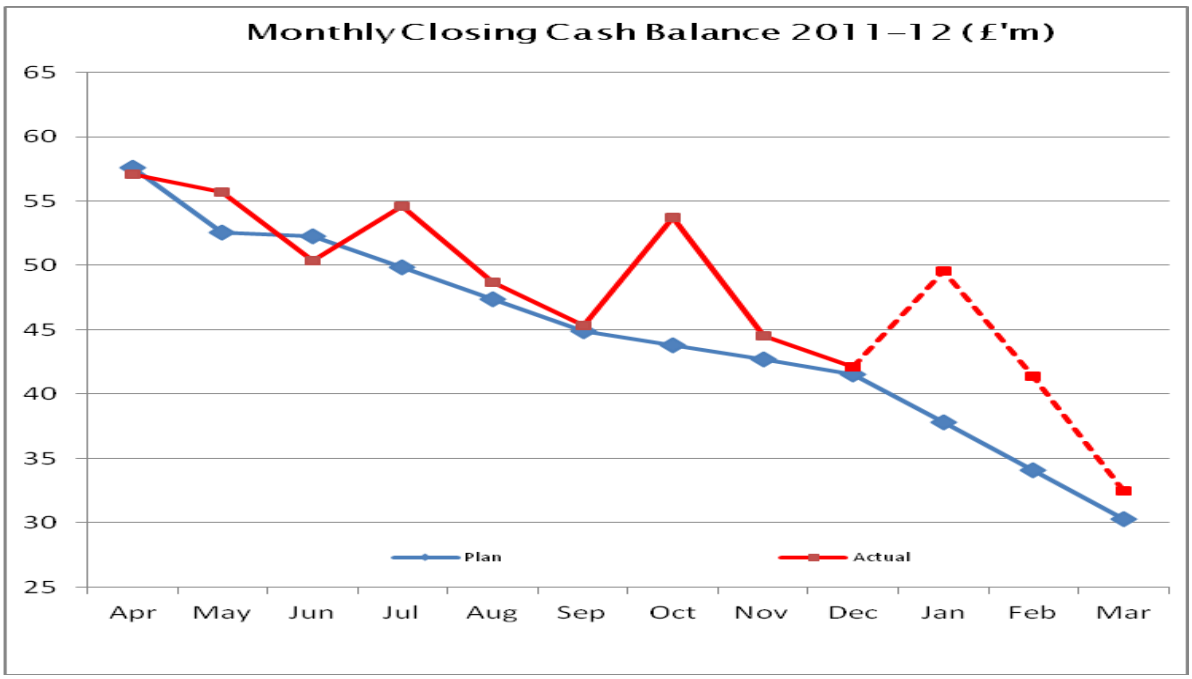
A summary of income and expenditure for the nine months to 31st December is given in the table below. Expenditure for the nine months of £27.147m is £0.141m less than the current Plan.

Plan for Year		9 Months Ended 31st December 2011		
		Plan	Actual	Variance Favourable / (Adverse)
£'000		£'000	£'000	£'000
	Sources of Funding			
1,426	Donations	-	-	-
16,833	Retained Depreciation	12,730	12,717	(13)
1,808	Sale of Property	1,808	1,987	179
600	Grant - University of Bristol	600	600	-
31,402	Cash balances	12,150	11,843	(307)
52,069	**Total Funding**	**27,288**	**27,147**	**(141)**
	Expenditure			
(27,181)	Strategic Schemes	(14,745)	(15,945)	(1,200)
(5,613)	Medical Equipment	(620)	(400)	220
(5,497)	Information Technology	(3,912)	(3,839)	73
(2,205)	Roll Over Schemes	(1,074)	(1,046)	28
(3,836)	Refurbishments	(2,389)	(2,113)	276
(10,958)	Operational / Other	(4,548)	(3,804)	744
3,221	Anticipated Slippage	-	-	-
(52,069)	**Total Expenditure**	**(27,288)**	**(27,147)**	**141**

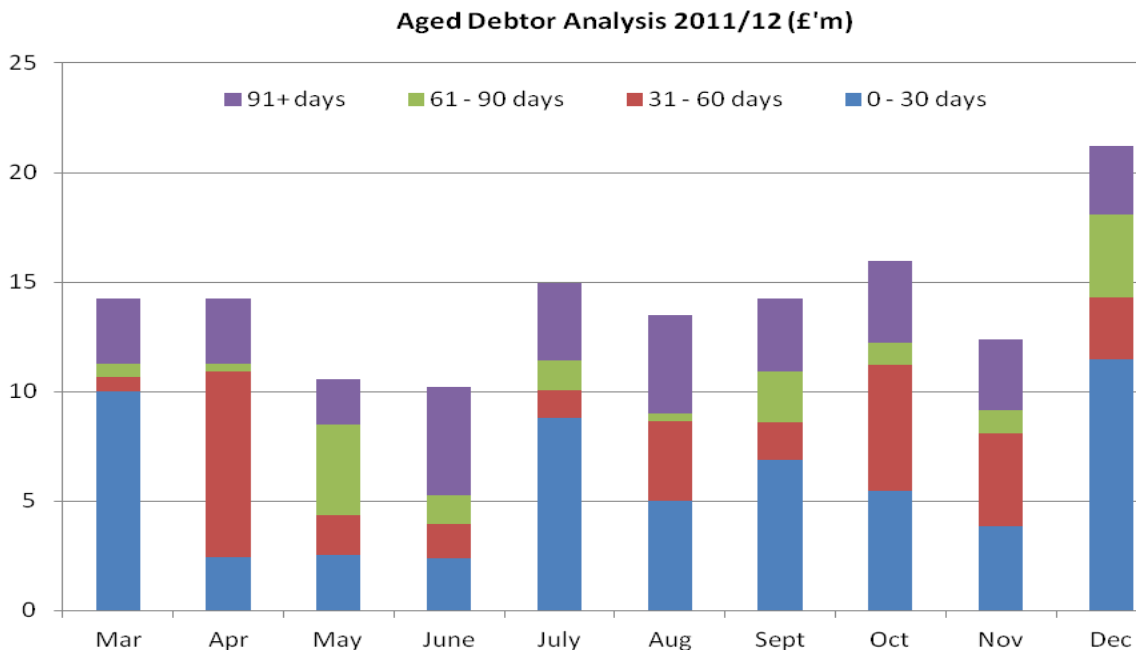
Expenditure for the year is projected to be £44.585m.This reflects anticipated slippage on medical equipment, operational capital and contingency funds which are not expected to be required in 2011/12.

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

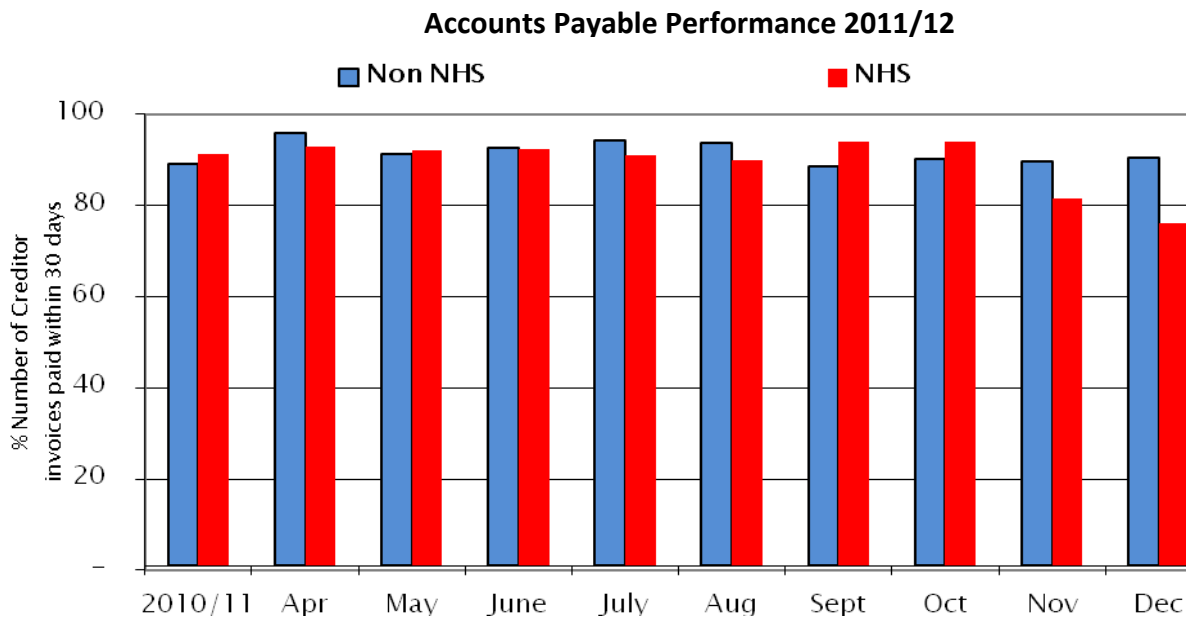
Cash - The Trust held a cash balance of £42.1m as at 31st December. The graph, shown below, sets out the current forecast for month end cash balances to March 2012.



Debtors - The total value of invoiced debtors has increased by £8.84m during December to a closing balance of £21.221m. The principal changes relate to an invoice raised on the North West SHA for Skills for Health services (£1.735m) and NHS Bristol re Clinical Excellence Awards funding. The total amount owing is equivalent to 17.3 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In December the Trust achieved 76% 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 December 2011- Summary Income & Expenditure Statement

Approved Budget / Plan 2011/12	Heading		Position as at 31st Dec Plan	Actual	Variance Fav / (Adv)	Actual to 30th Nov	Forecast Outturn
£'000			£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)						
394,954	From Activities		296,155	295,740	(415)	262,966	396,256
106,240	Other Operating Income		78,338	78,870	532	70,909	105,078
501,194	Sub totals income		**374,493**	**374,610**	**117**	**333,875**	**501,334**
	Expenditure						
(309,317)	Staffing		(232,143)	(232,969)	(826)	(207,813)	(310,015)
(148,981)	Supplies and services		(111,763)	(115,943)	(4,180)	(103,515)	(156,928)
(458,298)	Sub totals expenditure		**(343,906)**	**(348,912)**	**(5,006)**	**(311,328)**	**(466,943)**
(9,264)	**Reserves**	Reserves	(6,043)	-	6,043	11	-
(9,264)		Sub Total Reserves	**(6,043)**	-	**6,043**	**11**	**-**
33,632	**EBITDA**		**24,544**	**25,698**	**1,154**	**22,558**	**34,391**
6.71	**EBITDA Margin - %**			**6.86**		**6.76**	**6.86**
(206)	Fixed asset impairments		(207)	(207)	-	(205)	(207)
	Profit/ loss on sale of asset			190	190		190
(18,204)	Depreciation & Amortisation		(13,681)	(13,680)	1	(12,173)	(18,204)
357	Interest Receivable		275	290	15	255	350
(411)	Interest payable on loans & leases		(308)	(308)	-	(274)	(411)
(9,162)	PDC Dividend		(6,871)	(6,833)	38	(6,073)	(9,109)
6,006	**NET SURPLUS / (DEFICIT)**		**3,752**	**5,150**	**1,398**	**4,088**	**7,000**
1.20	**Net margin - %**			**1.37**		**1.22**	**1.4**

Appendix 2

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

Approved Budget / Plan 2011/12	Division	Total Net Expenditure / Income to Date	Position as at 31st Dec [Favourable / (Adverse)] Pay	Non Pay	Operating Income	Income from Activities	Total Variance to date	Memorandum CRES Variance to Date	Cumulative Variance to 30th Nov	Forecast Outturn Variance
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements									
389,700	Service Agreements	291,468	–	–	–	–	–	–	–	–
(1,800)	Overheads	(1,990)	–	–	–	(190)	(190)	–	(168)	–
40,463	NHSE Income	30,343	–	–	–	–	–	–	–	–
428,363	**Sub Total Service Agreements**	**319,821**	**–**	**–**	**–**	**(190)**	**(190)**	**–**	**(168)**	**–**
	Clinical Divisions									
(42,156)	Diagnostic & Therapies	(31,264)	153	(459)	(344)	613	(37)	(102)	(210)	–
(56,817)	Medicine	(43,689)	(373)	(966)	290	62	(987)	(1,040)	(1,215)	(996)
(65,375)	Specialised Services	(49,340)	(846)	(330)	215	(340)	(1,301)	(788)	(1,380)	(1,963)
(87,186)	Surgery Head & Neck	(66,065)	158	(991)	236	(262)	(859)	(2,117)	(820)	(1,223)
(85,662)	Women's & Children's	(65,552)	(743)	(473)	6	(255)	(1,465)	(1,044)	(1,508)	(900)
(337,196)	**Sub Totals (1)**	**(255,910)**	**(1,651)**	**(3,219)**	**403**	**(182)**	**(4,649)**	**(5,091)**	**(5,133)**	**(5,082)**
	Corporate Services									
(2,066)	Trust Wide Acrruals	(2,066)	–	–	–	–	–	–	136	
(52)	Community	(19)	–	21	–	–	21	(2)	18	27
(6,802)	Trust HQ	(5,210)	73	(146)	89	–	16	–	13	–
(5,251)	Human Resources	(3,784)	189	(172)	6	–	23	9	21	40
(5,685)	Information Technology	(4,225)	185	(140)	(38)	–	7	–	5	–
(5,090)	Finance	(3,728)	178	(51)	(74)	–	53	40	45	50
(26,350)	Facilities & Estates	(19,302)	154	(217)	81	(39)	(21)	(110)	(25)	–
(7,752)	Misc Support Services	(6,505)	12	(240)	231	(4)	(1)	(178)	(26)	–
9,428	Research and Development	5,819	16	6	14	–	36		35	81
(26,336)	Capital Charges	(19,751)	–	40	12	–	52	–	42	–
(75,956)	**Sub Totals (2)**	**(58,771)**	**807**	**(899)**	**321**	**(43)**	**186**	**(241)**	**264**	**198**
(413,152)	**Sub Totals (1) and (2)**	**(314,681)**	**(844)**	**(4,118)**	**724**	**(225)**	**(4,463)**	**(5,332)**	**(4,869)**	**(4,884)**
–	**Skills for Health**	10	18	(6)	(2)	–	10	–	5	–
(413,152)	**Totals I & E**	**(314,671)**	**(826)**	**(4,124)**	**722**	**(225)**	**(4,453)**	**(5,332)**	**(4,864)**	**(4,884)**
	Reserves									
(9,205)	General	–	–	6,043	–	–	6,043	–	5,714	5,884
(9,205)	**Sub Total Reserves**	**–**	**–**	**6,043**	**–**	**–**	**6,043**	**–**	**5,714**	**5,884**
6,006	**TRUST TOTALS**	**5,150**	**(826)**	**1,919**	**722**	**(415)**	**1,400**	**(5,332)**	**682**	**1,000**

Analysis of pay spend 2010/11 and 2011/12

Division		2009/10 Total	2010/11 Total	2011/12 April	May	June	Q1	July	August	Sept	Q2	Oct	Nov	Dec	Q3	YTD Total	Mthly Average	2009/10 Mthly Average	2010/11 Mthly Average
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Women's and Children's	Pay budget	62,853	65,891	5,560	5,526	5,552	16,638	5,535	5,617	5,564	16,716	5,639	5,690	5,573	16,901	50,255	5,584	5,238	5,491
	Bank	1,946	2,076	119	165	212	496	169	165	189	524	184	203	134	521	1,541	171	162	173
	Agency	370	654	39	88	55	182	40	59	29	128	62	35	65	162	471	52	31	55
	Waiting List initiative	502	304	26	25	22	73	16	24	2	42	10	1	5	16	131	15	42	25
	Overtime	90	91	4	5	5	14	5	3	3	11	2	2	3	7	33	4	8	8
	Other pay	61,039	62,798	5,401	5,447	5,371	16,219	5,372	5,577	5,325	16,274	5,401	5,582	5,350	16,333	48,826	5,425	5,087	5,233
	Total Pay expenditure	63,947	65,923	5,589	5,730	5,665	16,984	5,602	5,828	5,548	16,979	5,660	5,823	5,556	17,039	51,002	5,667	5,329	5,494
	Variance Fav / (Adverse)	(1,094)	(32)	(29)	(204)	(113)	(346)	(67)	(211)	16	(263)	(21)	(134)	17	(138)	(747)	(83)	(91)	(3)
Medicine (incl Central Services for 2011/12)	Pay budget	40,756	41,745	3,548	3,791	3,695	11,034	3,644	3,599	3,657	10,900	3,692	3,631	3,616	10,938	32,873	3,653	3,396	3,479
	Bank	3,763	3,434	236	270	339	845	227	276	255	758	243	271	175	689	2,292	255	314	286
	Agency	521	559	30	62	65	157	59	21	61	141	34	25	54	113	411	46	43	47
	Waiting List initiative	361	315	9	10	11	30	3	0	1	4	21	(12)	17	26	60	7	30	26
	Overtime	48	69	5	7	13	25	5	5	5	15	4	5	7	16	55	6	4	6
	Other pay	37,314	38,883	3,413	3,405	3,500	10,318	3,378	3,367	3,349	10,094	3,373	3,438	3,231	10,041	30,454	3,384	3,110	3,240
	Total Pay expenditure	42,007	43,260	3,693	3,754	3,928	11,375	3,672	3,669	3,670	11,012	3,676	3,726	3,483	10,884	33,271	3,697	3,501	3,605
	Variance Fav / (Adverse)	(1,251)	(1,515)	(145)	37	(233)	(341)	(28)	(70)	(13)	(111)	16	(95)	132	54	(398)	(44)	(104)	(126)
Surgery Head and Neck	Pay budget	62,265	66,148	5,541	5,245	5,630	16,416	5,607	5,605	5,735	16,947	5,652	5,686	5,706	17,045	50,408	5,601	5,189	5,512
	Bank	2,592	2,100	119	127	204	450	183	152	191	525	166	190	141	497	1,472	164	216	175
	Agency	1,730	1,206	41	69	11	121	(2)	53	44	95	67	68	40	175	391	43	144	101
	Waiting List initiative	2,158	1,209	98	127	79	304	16	27	7	50	59	96	65	220	574	64	180	101
	Overtime	276	152	7	7	8	22	15	8	12	35	12	14	13	40	96	11	23	13
	Other pay	58,271	61,071	5,143	5,327	5,314	15,784	5,337	5,352	5,406	16,096	5,383	5,229	5,309	15,921	47,801	5,311	4,856	5,089
	Total Pay expenditure	65,027	65,738	5,408	5,657	5,616	16,681	5,549	5,592	5,660	16,801	5,688	5,597	5,568	16,853	50,335	5,593	5,419	5,478
	Variance Fav / (Adverse)	(2,762)	410	133	(412)	14	(265)	58	13	75	146	(35)	90	138	192	73	8	(230)	34
Specialised Services	Pay budget	32,323	33,790	2,669	3,066	2,900	8,635	2,829	2,865	2,919	8,613	2,858	2,933	2,850	8,641	25,888	2,876	2,694	2,816
	Bank	1,025	1,049	61	74	95	230	87	93	85	265	81	102	58	241	736	82	85	87
	Agency	363	654	(69)	230	82	243	116	104	73	293	75	93	77	245	782	87	30	55
	Waiting List initiative	587	537	51	42	45	138	34	29	23	86	38	72	17	127	351	39	49	45
	Overtime	119	20	2	0	1	3	1	1	2	4	1	5	1	6	14	2	10	2
	Other pay	30,949	32,290	2,684	2,813	2,786	8,283	2,857	2,765	2,741	8,362	2,749	2,737	2,732	8,219	24,864	2,763	2,579	2,691
	Total Pay expenditure	33,043	34,550	2,729	3,159	3,009	8,897	3,095	2,992	2,924	9,011	2,944	3,009	2,886	8,839	26,747	2,972	2,754	2,879
	Variance Fav / (Adverse)	(720)	(760)	(60)	(93)	(109)	(262)	(266)	(127)	(6)	(398)	(85)	(76)	(37)	(198)	(858)	(95)	(60)	(63)

Analysis of pay spend 2010/11 and 2011/12

Division		2009/10 Total	2010/11 Total	2011/12 April	May	June	Q1	July	August	Sept	Q2	Oct	Nov	Dec	Q3	YTD Total	Mthly Average	2009/10 Mthly Average	2010/11 Mthly Average
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Diagnostic & Therapies	Pay budget	35,327	36,929	3,045	2,998	3,078	9,121	3,089	3,126	3,066	9,280	3,120	3,041	3,210	9,371	27,772	3,086	2,944	3,077
	Bank	537	544	46	50	48	144	35	43	29	108	35	52	42	129	380	42	45	45
	Agency	692	389	24	32	17	73	13	29	4	46	9	18	36	63	183	20	58	32
	Waiting List initiative	131	156	14	15	8	37	15	6	6	27	17	6	5	28	92	10	11	13
	Overtime	169	264	22	20	26	68	17	19	13	49	21	19	28	67	184	20	14	22
	Other pay	33,437	35,515	2,937	2,961	3,017	8,915	3,025	3,015	2,989	9,029	3,068	3,007	2,891	8,965	26,909	2,990	2,786	2,960
	Total Pay expenditure	34,966	36,868	3,043	3,078	3,116	9,237	3,105	3,112	3,041	9,258	3,150	3,102	3,001	9,253	27,748	3,083	2,914	3,072
	Variance Fav / (Adverse)	361	61	2	(80)	(38)	(116)	(16)	13	24	22	(30)	(61)	209	119	24	3	30	5
Facilities & Estates	Pay budget	17,714	18,706	1,398	1,532	1,727	4,657	1,567	1,647	1,593	4,807	1,515	1,611	1,528	4,655	14,119	1,569	1,476	1,559
	Bank	572	483	29	29	35	93	26	22	27	75	25	19	28	72	240	27	48	40
	Agency	1,295	1,300	128	105	118	351	148	99	133	380	100	87	126	312	1,044	116	108	108
	Waiting List initiative	19	7	1	1	0	2	0	0	0	0	0	0	0	0	2	0	2	1
	Overtime	1,178	1,160	79	95	112	286	97	53	100	250	98	123	87	308	843	94	98	97
	Other pay	14,944	15,591	1,164	1,300	1,448	3,912	1,281	1,435	1,305	4,021	1,306	1,300	1,300	3,906	11,840	1,316	1,245	1,299
	Total Pay expenditure	18,008	18,541	1,401	1,530	1,713	4,644	1,552	1,609	1,565	4,726	1,529	1,529	1,541	4,598	13,968	1,552	1,501	1,545
	Variance Fav / (Adverse)	(294)	165	(3)	2	14	13	15	37	28	80	(14)	83	(12)	57	150	17	(25)	14
Trust Services	Pay budget	26,181	26,763	4,034	316	2,019	6,369	2,073	1,962	3,212	7,248	2,344	2,286	2,497	7,127	20,743	2,305	2,182	2,230
	Bank	619	609	38	24	53	115	47	68	42	157	(9)	(6)	4	(11)	261	29	52	51
	Agency	196	209	13	(4)	0	9	21	5	27	53	29	38	16	83	144	16	16	17
	Waiting List initiative	3	7	1	1	(3)	(1)	0	0	0	0	0	0	0	0	(1)	(0)	0	1
	Overtime	88	108	7	5	4	16	3	4	10	17	5	8	9	23	56	6	7	9
	Other pay	25,114	26,087	4,093	365	2,074	6,532	1,774	1,920	3,137	6,832	2,117	1,971	2,528	6,617	19,981	2,220	2,093	2,174
	Total Pay expenditure	26,020	27,020	4,152	391	2,128	6,671	1,845	1,997	3,216	7,059	2,143	2,011	2,557	6,711	20,441	2,271	2,168	2,252
	Variance Fav / (Adverse)	161	(257)	(118)	(75)	(109)	(302)	228	(35)	(4)	189	201	274	(60)	416	303	34	13	(21)
Trust Total (excl Skills for Health)	Pay budget	277,419	289,972	25,795	22,474	24,601	72,870	24,344	24,421	25,745	74,510	24,820	24,877	24,981	74,678	222,058	24,673	23,118	24,164
	Bank	11,054	10,295	648	739	986	2,373	774	820	819	2,413	725	830	582	2,137	6,923	769	921	858
	Agency	5,167	4,971	206	582	348	1,136	395	370	371	1,136	377	363	414	1,154	3,425	381	431	414
	Waiting List initiative	3,761	2,535	200	221	162	583	84	86	39	209	145	163	109	417	1,209	134	313	211
	Overtime	1,968	1,864	126	139	169	434	143	93	144	380	143	176	147	466	1,281	142	164	155
	Other pay	274,844	286,411	24,835	21,618	23,510	69,963	23,024	23,432	24,252	70,708	23,398	23,264	23,341	70,003	210,673	23,408	22,904	23,868
	Total Pay expenditure	283,018	291,900	26,015	23,299	25,175	74,489	24,420	24,800	25,625	74,845	24,788	24,795	24,593	74,177	223,511	24,835	23,585	24,325
	Variance Fav / (Adverse)	(5,599)	(1,928)	(220)	(825)	(574)	(1,619)	(76)	(379)	120	(335)	32	82	388	502	(1,453)	(161)	(467)	(161)

Key Issue	RAG	Executive Summary	Table
Service Level Agreement Income and Activity	G	For the year to date contract income is £0.81m 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 £0.14m adverse (last month £0.02m adverse) and SLA Contract Penalties / Rewards at a net reward of £1.22m (November net reward £0.99m). A&E Attendances at 76,817 are 2,185 **higher** than planned. The average number of daily attendances is 315. Emergency activity at 24,976 is 103% or 335 spells **lower** than planned. Non Elective activity at 10,418 is 2.4% or 190 spells **higher** than planned. Elective activity at 9,545 is 6.1% or 620 spells **lower** than planned. Day case activity at 32,706 is 4.2% or 1,323 spells **higher** than planned. Outpatient Procedure activity at 17,652 is 3.3% or 571 attendances **higher** than planned. New Outpatients activity at 89,810 is 1.1% or 960 attendances **lower** than planned. Follow up Outpatient activity at 209,130 is 2.2% or 4,699 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 nine months to 31st December is £5.15m. The EBITDA surplus of £25.698m equates to 104.7% of the Annual Plan target for the period. Total income to date £374.61m is £0.117m greater than Plan. This includes £0.810m of residual over performance relating to 2010/11. Expenditure at £348.912m is greater than Plan by £5.006m, 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 £244k.	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 nine months to 31st December total £14.645m compared with a target for the period of £18.740m, a shortfall of £4.095m (November cumulative shortfall £4.0m). The forecast savings for the year is £21.071m.	I&E 4a – 4b
Statement of Financial Position & Treasury Management	G	The cash balance on 31st December was £42.148m. The forecast cash balance for 31st March 2012 at £32.443m is marginally higher than the Annual Plan forecast of £30.312m. The balance on Invoiced Debtors has increased by £8.84m in the month to £21.221m. This is mainly due to money owed by NHS Bristol in relation to Clinical Excellence Award funding, and by North West SHA in relation to Skills for Health. The invoiced debtor balance equates to 17.3 debtor days. Creditors and accrual account balances total £66.558m although £13.906m relates to deferred income. Invoiced Creditors - payment performance for the nine months to 31st December Non NHS invoices and NHS invoices within 30 days was 92% and 88% respectively.	BS 1 BS 2 BS 3 BS 4
Capital	G	Expenditure for the nine months to 31st December totals £27.147m - this is £0.141m less than profiled for the period. Expenditure for the year is projected to be £44.585m. The principal areas of slippage to date are recorded against Operational capital schemes (£0.744m) and Refurbishments (£0.276m). Expenditure on Strategic schemes is £1.2m ahead of plan.	
Financial Risk Rating	G	The Trust's overall financial risk rating using the results for the nine months to 31st December 2011 has been calculated to be 4 (actual score 3.65). 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 £2.124m or 0.72% 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 December 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 @ 0.72% 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	-	

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report December 2011 - Risk Matrix

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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	-	
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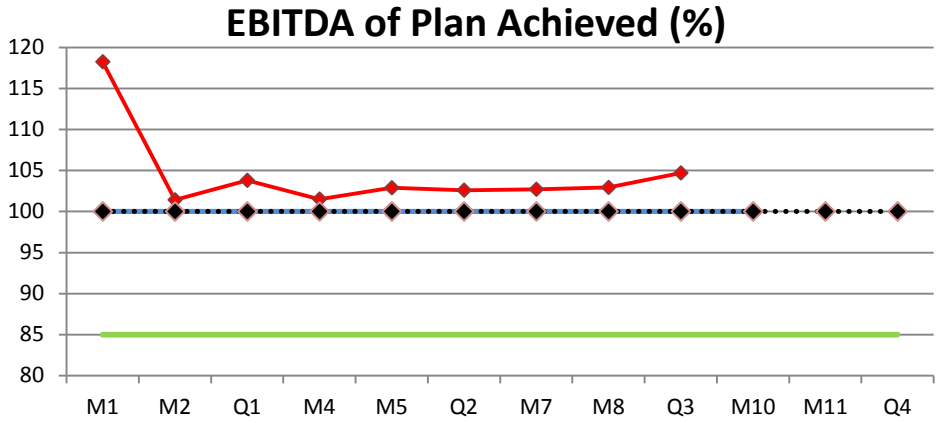
1418	Breach of Private Patient Income Cap	Low	-	Monitoring and reporting to Finance Committee.	PM	Low	-	Private patient income @ 0.72% of patient related income remains well within the Trust's Cap of 1.1%.
1858	Non receipt of pledges of charitable moneys to partly finance capital expenditure	Low	-	Monitoring of capital expenditure. Maintain dialogue with respective trustees.	PM	Low	-	

Financial Risk Ratings – December 2011 Performance

1. Financial Risk Rating

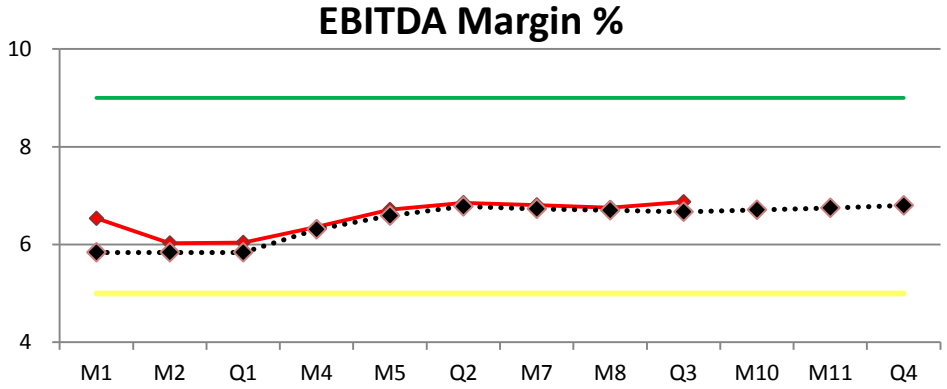
The following graphs will show performance against the 5 Financial Risk Rating metrics. The 2011/12 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 5 (blue line)**; **FRR 4 (green line)** and **FRR 3 (yellow line)**.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

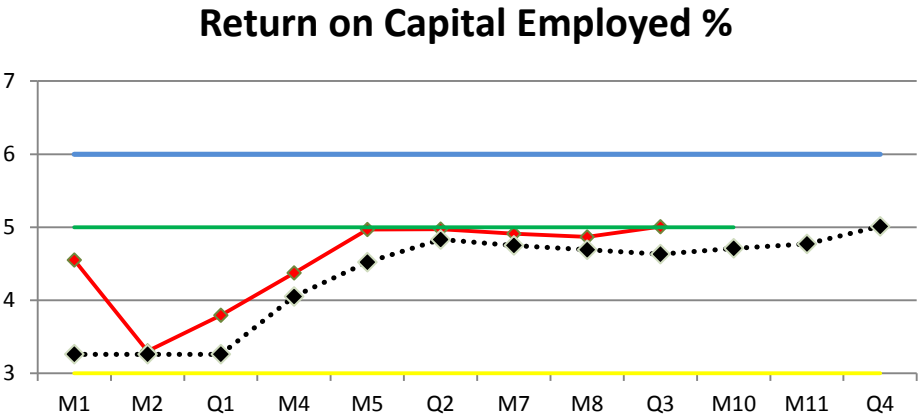


An EBITDA of £25.698m was achieved. This is 4.7% better than the proportion of the Annual Plan for the period value of £24.544m.

EBITDA Achievement of 104.7% of Plan earns a metric score of 5.

The EBITDA Margin of 6.86% for December achieves a metric score of 3. This is slightly better than the Annual Plan forecast of 6.67% to date.



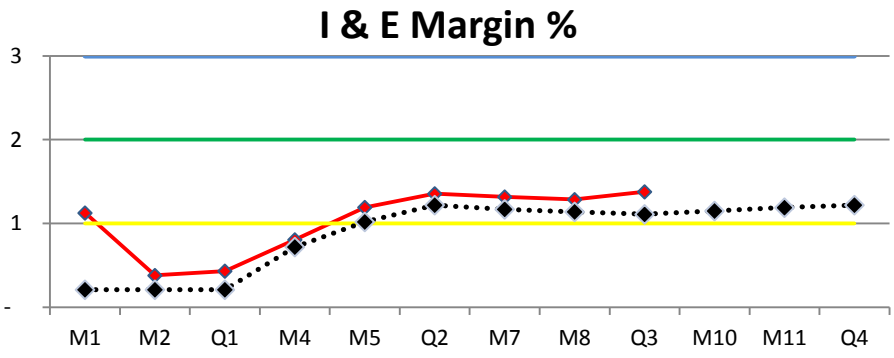


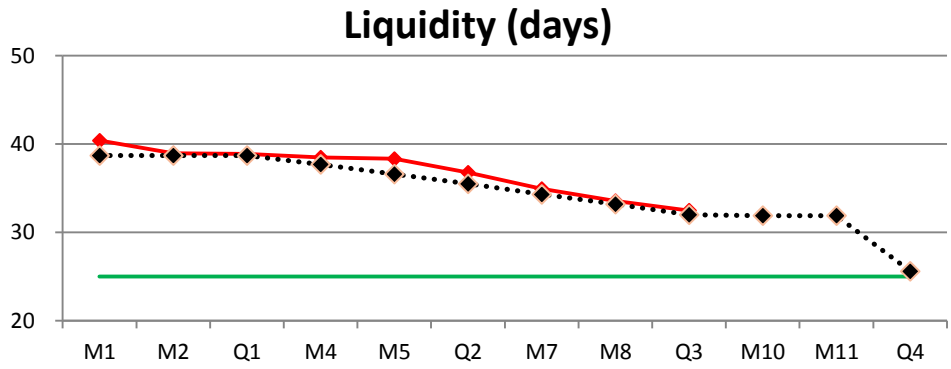
The Return on Capital Employed for the nine months to December is 5.00%. The result earns a metric score of 3.

Annual Plan = 4.63% to date.

2011/12 Annual Plan Income & Expenditure surplus margin is 1.11% for the nine months to 31st December.

The Income and Expenditure surplus margin for the period is 1.38%, a metric score of 3.





2011/12 Annual Plan liquidity ratio is 32.0 days at 31st December.

The actual liquidity ratio for December is 32.5 days and remains above the band 4 minimum of 25 days.

The Trust's Financial Risk Rating is calculated by using a weighted average score to determine the overall rating. The weighted average score is 3.65. The Trust has therefore achieved a Financial Risk Rating of 4 for the nine months to 31st December 2011.

2. Prudential Borrowing Limit

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

Prudential Borrowing Limit Performance	Monitor Ratio Tier 1	31st December 2011
Minimum Dividend Cover	>1x	3.8x
Minimum Interest Cover	>3x	84x
Minimum Debt Service Cover	>2x	60x
Maximum Debt Service to Revenue	<2.5%	0.1%

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

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 January 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 08 – Quarterly Capital Projects Status Report (Bristol Royal Infirmary, Centralisation of Specialist Paediatrics)

Purpose

To update the Board on the current status of the Trust's major capital development schemes.

Abstract

The purpose of this report is to update the Board on progress, issues and risks arising from the Trust's four major capital developments which are governed through the Strategic Development Department and associated programme infrastructure.

Progress in the period includes Board approval for the BRI Welcome Centre Business Case, commencement of significant works to the BRI Emergency Department and wide communication to stakeholders heralding the completion of Phase 1 of the redevelopment programme.

There are no residually high risks identified, at this stage, in any of the four projects.

Recommendations

The Board is asked to **note** this report.

Executive Report Sponsor or Other Author

- Sponsor – Deborah Lee, Director of Strategic Development
- Author – Andy Headdon, Strategic Programme Director

Appendices

- Appendix A – Quarterly Status Report

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
					Capital Programme Steering Group - 11 January 2012

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT

1. Introduction

This status report provides a summary update for Quarter 3 of the Trusts Strategic Capital Schemes, all of which are managed through their respective Project Boards which in turn report to the Trust's Management Executive.

2. Project Updates

CENTRALISATION OF SPECIALIST PAEDIATRICS			
1	**Decisions required**	None.	
2	**Progress**	Target price agreed and contracts signed. Audiology development and service re-location successfully completed and extensions to structural frame complete.	
3	**Budget**	A capital allocation of £36.9m is in the capital programme including charitable funding support of £5.83m through The Grand Appeal. Scheme currently on budget though formal pledge regarding charitable support still outstanding from The Grand Appeal. Actions to address this are in hand but the absence of this agreed detail has now ben escalated	
4	**Programme**	Project on programme.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Workforce plan cannot be implemented leading to failure to deliver models of care. Theatre staff key risk group.	UH Bristol Human Resources reviewing strategies for training and recruitment of current and future staff to ensure workforce is available, with required skills. Theatre recruitment plan in development.
		Transfer of Adult BMT not achieved.	Full Business Case now being developed for March Board with significant progress made since Outline Business Case was received by Finance Committee.
		Charitable funding target not achieved.	Contingency plan developed which prioritises major equipment provision and phases non-critical investment as funds are secured.
		Service model for interventional angiography and paediatric laser	Task group established with a deadline to reach agreement on

		remain unresolved with resulting risk of unknown potential cost pressure.	models by end of January with report to CSP Board in February. Quantification of capital and revenue risk can then be undertaken.
		Additional revenue costs materialise as future designation standards and operational service models become clearer	All future costs will need to be accommodated within agreed FBC revenue envelope and investments re-prioritised to reflect any additional "must do" items.
		Income assumptions do not come to fruition in response to changed commissioner intentions and designation impacts; key risk areas scoliosis care and paediatric neurosurgery activity.	Robust designation bid being developed for neurosurgery and most recently paediatric epilepsy surgery (in partnership with NBT), strengthened links with S Wales and Peninsula provider for scoliosis provision.
BRISTOL ROYAL INFIRMARY PROJECT INCLUDING AIR AMBULANCE ACCESS			
1	**Decisions required**	None. The scheme now incorporates the Helipad and the Site Wide Generators.	
2	**Progress**	Target price agreed and contracts signed. Demolition, cycle store, orthotics and temporary main entrance complete. Main ground works for ward block progressing. ED refurbishment and lift installation commenced. Site Wide Generators scheduled for completion June 2012.	
3	**Budget**	A capital allocation of £86.3m is in the capital programme including charitable funding support of £3m through Above and Beyond. Allocation of £86.3m includes funding for the Helipad and Site Wide Generators, which is now part of the target price agreement.	
4	**Programme**	Project on programme.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Delay to construction works and delayed cost certainty.	Constant monitoring and control of scope and cost plan.
		Logistics solution to allow disposal of Old Building not achievable.	Detailed enabling works and decant programme developed. Final approval of decant

		Retention of Old Building for non-clinical functions required.	locations to be agreed at Strategic Estate Steering Group.
		Charitable funding target not achieved.	Contingency plan developed which prioritises single bed provision and phases non-critical investment as funds are secured.
		Construction and refurbishment stage proves problematic causing additional delays and cost.	Robust monitoring of programme.
		Delay to construction; increased cost and potential health and safety hazards.	Robust monitoring of programme.

WELCOME CENTRE			
1	**Decisions required**	None. To note: the Comprehensive Business Case (CBC) was approved by the Trust Board 21 Dec 2011 and will be progressed through a Trust funded model.	
2	**Progress**	Market test completed and retail sector remain positively engaged. Pre application submitted and full planning application due to be submitted 20 Jan 2012 to Bristol City Council. Public consultation with residents, local businesses, staff and physical impairment groups completed with general support for the scheme as currently proposed.	
3	**Budget**	£4.95m through loan from FTFF, yet to be secured.	
4	**Programme**	On programme.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Retail rentals not high enough to enable a successful scheme to be delivered.	Aim to attract high profile anchor tenants. Market test underway to provide additional certainty for CBC.
		Loan not secured.	Robust loan bid being developed along lines of successful bid for BRI / CSP funding. Conversations with private lenders also continuing to ensure second option should FTFF not lend.
BRISTOL HAEMATOLOGY & ONCOLOGY CENTRE			
1	**Decisions required**	None.	
2	**Progress**	Proceeding to Full Business Case to be submitted in March 2012 and still on schedule. Capital funding gap at Outline Business Case stage has now been resolved, work to resolve revenue gap and capital cost gap progressing well. Planning application to be submitted Jan 2012 to Bristol City Council. Public consultation process has been implemented; drop in sessions for residents have taken place. Operational issues, such as maintaining public car parking have been considered; plans to retain disabled spaces close to BHOC entrance.	

3	**Budget**	Capital cost identified at £15.5m (incl. £2m for Linac replacement) supported by £6.5m of charitable funding pledged by Above and Beyond, TCT and the Friends of BHOC.	
4	**Programme**	On programme.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Unable to transfer Adult BMT beds out of BRHC.	Current operational work around is extended for a further period which would still enable the critical elements of CSP to be delivered to ensure Frenchay closure is not compromised.
		Business continuity during construction.	Ensure robust site logistic co-ordination through principle supply chain to provide continuity.
		Operational impact on radiotherapy service during Linac construction phase.	Robust construction logistic planning in place. Close working between operational and strategic development teams.
		Unable to resolve revenue and/or capital gap with resulting risk to scheme success	Review of models of care and accommodation requirements to reduce gap.

3. Conclusion

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

Date: 10/01/2012

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

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 January 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 09 – Q3 Compliance Framework Monitoring & Declaration Report

Purpose

To consider the quarterly governance, quality, and finance self-certification to Monitor for Quarter 3 of 2011-2012.

Abstract

Background

The Trust is required to make its Quarter 3 declaration of compliance with the 2011-2012 Monitor Compliance Framework on or by 31 January 2012.

Governance Risk Rating Declaration

The Compliance Framework scoring remains as:

Score less than 1 = GREEN

Score 1 or 1.5 = AMBER-GREEN

Score 2 to 3.5 = AMBER-RED

Score 4 or more = RED

The context for the declaration is a Monitor Annual Plan Governance Declaration prediction of AMBER-RED with risks recorded for Clostridium Difficile reduction (reflecting the 32% year-on-year reduction required, and for Accident and Emergency (reflecting risks related to the achievement of the 4-hour waiting time standard during the winter months). This rating was revised from AMBER-GREEN following the changes made to the weighting of the Accident and Emergency 4-hour standard.

The dip in Accident and Emergency 4-hour performance in December calls into question the risks to achievement of the 95% standard in Q4, in the context of a failure to achieve in Q4 2010/11. However, performance in December 2011 was 3.7% higher than in December 2010. If this level of improvement is applied to the Q4 2010/11 figures, the forecast for Q4 is 95.3% (i.e. achievement).

Further plans to support delivery of the 4-hour standard in Q4 have been developed. The robustness of these plans was considered by the Service Delivery Group on 16 January. Noting the specific risks detailed in Appendix A, the Service Delivery Group approved the 4-hour plans and made a commitment to on-going achievement of the 4-hour standard in Q4.

Finance Risk Rating Declaration – Forthcoming Twelve Months

The Director of Finance has provided assurances to the Finance Committee that the Trust expects to maintain a financial risk rating of at least 3 over the next 12 months.

This position is supported by the provision of a written report to the Finance Committee on 23 January, which is summarised for the Trust Board of Directors at Appendix B “Quarter 3 Financial Performance Commentary for Monitor Return”.

Quality Declaration

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

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

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

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

The Quality and Outcomes Committee extends the Board's monitoring and scrutiny function, and has a standing remit to assess 'quality governance' on the Board's behalf.

Recommendations

The Trust Board of Directors is recommended by the Trust Management Executive to:

1. Approve the declaration of a GREEN governance risk rating for Quarter 3, 2011-12.
2. Approve the declaration that the Board anticipates that the Trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.
3. Approve the declaration for Quality as set out above.

Executive Report Sponsor or Other Author

- Sponsor – Chief Executive, Robert Woolley
- Authors –
  - Deborah Lee, Director of Strategic Development
  - Xanthe Whittaker, Head of Performance Assurance & Business Intelligence and Deputy Director of Strategic Development
  - Paul Tanner, Head of Finance
  - Charlie Helps, Trust Secretary

Appendices

- Appendix A – Monitor Declaration Quarter 3 - Targets Indicator Risk Assessment
- Appendix B – Quarter 3 Financial Performance Commentary

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	11 January 2012	25 January 2012	23 January 2012	n/a	Service Delivery Group 16 January 2012

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

Measure	Threshold	Performance in Q3	Risks	Risk	Mitigation of risks	Residual risk
Clostridium difficile	64 cases per annum 19 cases for Q1 17 cases for Q2 13 cases for Q3	**44 cases Year to date (YTD) against a YTD target of 49.** 11 cases against a target of 13 for Q3. This represents a 38% reduction on Q3 2010/11, when 18 cases were reported.	32% reduction on 2010/11 out-turn required	High	Improvement plan developed and implemented. A prolonged outbreak of norovirus, with more testing, may be sufficient for us to breach our annual target. So mitigation actions also includes a refresh of the norovirus outbreak, which has been completed. Testing regimen changed to a 2-stage, which reduces the likelihood of false positives.	Medium
MRSA	6 cases per annum Q1 – 1 case Q2 – 2 cases Q3 – 1 case Q4 – 2 cases	1 case in Q3 2011/12 1 case in Q3 2010/11	Although the required standard of performance has previously been achieved, the annual objective of six cases gives no margin for error.	Medium	Zero tolerance to MRSA bacteraemia cases adopted. Continued focus on good clinical practice.	Low
Cancer: 31-day wait for subsequent treatment	Surgery – 94% Drug therapy – 98% Radiotherapy – 94%	Achieved all standards in Q1, Q2 and Q3 2011/12. Achieved all standards in all quarters of 2010/11.	Performance is not impacted by other providers and therefore should be able to be managed internally. The main cause of breaches has been around a shortage of adult ITU beds which has been improved during 2011/12. However, there is also a known shortfall of skin cancer operating capacity in Q4, due to the main surgeon having sustained a shoulder injury.	Medium	Adult Intensive Therapy Unit (ITU) expansion. Prospective planning of subsequent treatments. Tight management of cancer pathways to continue, along with regular monitoring of the skin cancer surgery workload. Some skin cancer surgery cases are being undertaken by the Maxillo Facial surgery team where appropriate.	Low
Cancer: 62-day wait for first treatment	GP referred – 85%	GP referred standard achieved in Q1, Q2 and Q3	Significant proportion of breaches wholly attributable to late receipt	High	Refreshed action plan focusing on eliminating avoidable delays	Medium

Measure	Threshold	Performance in Q3	Risks	Risk	Mitigation of risks	Residual risk
		2011/12. Achieved in all quarters of 2010/11.	from another provider; this risk is more difficult to mitigate. Internal risks are focussed predominantly in diagnostic and surgical elements of pathway. However, the standard was achieved throughout 2010/11.		in internal pathways. This includes theatre capacity and delays between diagnostic tests and MDT. Action plan tracked via Service Delivery Group (SDG). Network-wide policy for re-allocation of breaches due to late referral by other providers has been developed and remains under discussion within the network.	
	Screening referred - 90%	Screening referred standard achieved in Q1 but not Q2 2011/12. Achieved in all quarters of 2010/11 except Q4.	The number of breast screening breaches increased significantly in Q2 due to changes to the clinical pathway and a shortfall of capacity. The screening standard would have been achieved without the increase in breast breaches. In Q3, 2 of the 2.5 breaches were for patients on the breast pathway, but the breaches were unrelated to pathway changes or service capacity (admin errors at the point of referral from Avon Breast Screening). The nationally prescribed bowel screening pathway is difficult to complete within 62 days. Any delays can result in a breach and these delays can also be outside of the control of the Trust (e.g.		The breast screening pathway has been reviewed and steps taken to ensure it can be completed within 62 days. Bowel screening pathway continues to be reviewed, and local changes adopted. Patient choice to delay diagnostics, staging and certain types of treatments remains an unmitigated risk, which is why the residual risk is medium with other risks mitigated.	

Measure	Threshold	Performance in Q3	Risks	Risk	Mitigation of risks	Residual risk
			patient choice; late tertiary referrals)			
18-week Referral to Treatment Time (95th percentile) – admitted patients	23 weeks	Achieved in all months except April 2010 and March 2011 (when previously cancelled patients were booked-in, in high volumes). Achieved in Q1, Q2 and Q3. But same specialties continue to under achieve (Cardiology, Paediatric ENT, Urology, Colorectal, Max Facs and Upper GI)	Backlog of over 23 week waiters remains high. Tight management of booking of breached patient remains critical. Clinical concerns remain about "managing" volumes of breached patients to achieve target.	Medium	Risk to non achievement can be managed by robust monitoring and escalation to optimise the number of long waiters booked each month, within the constraints of the contract. Cross Divisional approach to "breach quota" to support whole Trust achievement.	Low
18-week Referral to Treatment Time (95th percentile) – non-admitted patients	18.3 weeks	Achieved every month in 2009/10 and 2010/11. Achieved every month to date in 2011/12.	No significant risks to ongoing achievement	Low	Routine management of 18-week non-admitted pathways to continue.	Low
Cancer: 31-day wait for first treatment	96%	Achieved in all quarters	Lower risk than some of the other cancer standards as not impacted by tertiary referrals.	Low	Routine management of cancer pathways/performance to continue.	Low
Cancer: 2-week wait for urgent suspected and symptomatic breast referrals	93%	Urgent suspected – achieved in all quarters. Symptomatic breast – achieved Q2 to Q4 (100% in Q4). Achieved well above 93% target in Q1, Q2 and Q3 2011/12.	Short-term capacity problems for breast 2-week wait represent the greatest risk.	Low	Robust escalation process in place to ensure any capacity problems are addressed before they impact on performance.	Low

Measure	Threshold	Performance in Q3	Risks	Risk	Mitigation of risks	Residual risk
A&E Total visit time (95th percentile)[1]	4 hours	Achieved 95.4% in October, 97.1% in November and 94.5% in December 2011.	Key risk remains unpredicted growth in emergency admissions or significant deterioration in level of patient discharges. There will also be a planned reduction in beds associated with the transfer of some services to South Bristol Community Hospital. This follows the implementation of the new Patient Administration System (PAS) in March, which may temporarily pose risks to the smooth management of patient flow. 95% standard (excluding WiC) not achieved in any month from December 2010 to March 2011 inclusive. However, performance was 3.7% higher in December 2011, than in December 2010. If this level of improvement is applied to the Q4 2010/11 figures, the forecast for Q4 2011/12 is 95.3%. Also, the number of BRI patients waiting less than 4 hours was lower in the last two weeks in December than in the same period in the previous two years. This suggests that there is further room for improvement within the existing process/resources.	Medium	Patient Flow action plan, including work to reduce delayed discharges and long lengths of stay. Larger adult Medical Assessment Unit (MAU) from 1st August. However, the Trust has failed the 98% and 95% standards in at least one quarter each year since the standards came into effect. Growth in emergency demand is also outside of the Trust's control, and could impact upon target achievement, as could a prolonged outbreak of norovirus.	Medium

Measure	Threshold	Performance in Q3	Risks	Risk	Mitigation of risks	Residual risk
Stroke care	To be confirmed	To be confirmed	Depends upon which standards are selected.	To be confirmed	To be confirmed	To be confirmed once Monitor finalises the indicators
Access to healthcare for patients with a learning disability	Achievement of standards	Standards were met and continue to be met	None	Low	Monitoring of standards to continue.	Low

Appendix A – Targets and Indicators draft Q3 2011/12 submission to Monitor

Declaration of performance against healthcare targets and indicators for BRISTOL as at Q3 2011/12

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

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

Quarter 3

Target or Indicator (per 2011-12 Compliance Framework)	Threshold/ agreed target YTD	Achieved / Not Met	explanation	Actual
Clostridium Difficile -meeting the C.Diff objective	49	Achieved	11 cases against a target of 13 for Q3	44
MRSA - meeting the MRSA objective	4	Achieved	1 case against a target of 1 for Q3	2
Cancer 31 day wait for second or subsequent treatment - surgery	>94%	Achieved	Figures subject to final confirmation	95.9%
Cancer 31 day wait for second or subsequent treatment - drug treatments	>98%	Achieved	Figures subject to final confirmation	100.0%
Cancer 31 day wait for second or subsequent treatment - radiotherapy	>94%	Achieved	Figures subject to final confirmation	99.1%
Cancer 62 Day Waits for first treatment (from urgent GP referral)	>85%	Achieved	Figures subject to final confirmation	87.8%
Cancer 62 Day Waits for first treatment (from Consultant led screening service referral)	>90%	Achieved	Figures subject to final confirmation	94.9%
Referral to treatment time, 95th percentile, admitted patients	<23Wks	Achieved	Standard met each month	-
Referral to treatment time, 95th percentile, non-admitted patients	<18.3Wks	Achieved	Standard met each month	-
Cancer 31 day wait from diagnosis to first treatment	>96%	Achieved	Figures subject to final confirmation	97.6%
Cancer 2 week (all cancers)	>93%	Achieved	Figures subject to final confirmation	95.9%
Cancer 2 week (breast symptoms)	>93%	Achieved	Figures subject to final confirmation	95.5%
A&E Clinical Quality- Total Time in A&E (was 95th percentile now 95%)	<4Hrs	Achieved		95.6%
Compliance with requirements regarding access to healthcare for people with a learning	N/A	Achieved		0.0%

Risk of, or actual, failure to deliver mandatory services	Yes/No	No	
CQC compliance action outstanding	Yes/No	No	
CQC enforcement notice currently in effect	Yes/No	No	
Moderate CQC concerns regarding the safety of healthcare provision	Yes/No	No	
Major CQC concerns regarding the safety of healthcare provision	Yes/No	No	
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place	Yes/No	No	
		0	
		0.0	
			No over-ride
		GREEN	

University Hospitals Bristol NHS
NHS Foundation Trust

For consideration and approval by

Finance Committee	23rd January 2012 – Agenda Item 7
Trust Board	26th January 2012 – Agenda Item 9

To be Received by

Membership Council	1st February 2012 – Agenda Item 9

QUARTER 3 FINANCIAL PERFORMANCE COMMENTARY FOR MONITOR RETURNS

Director of Finance
January 2012

1. EXECUTIVE SUMMARY

This commentary covers the results for the nine months to 31st December 2011.

The Trust reports an EBITDA[1] surplus for the period of £25.698m. This is £1.154m higher than the Annual Plan for the period of £24.544m. EBITDA is at 104.7% of Plan. The summary income and expenditure statement shows a surplus for the 9 months to 31st December of £5.150m (EBITDA and financing costs). The financial risk rating of 4 is better than the Annual Plan forecast of 3.

	Weighting	31st December 2011	5	4	3	2	1
EBITDA							
Margin %	25	6.86%	11	9	**5**	1	<1
Achievement of Plan	10	104.7%	**100**	85	70	50	<50
Return on Capital Employed	20	5.0%	6	**5**	3	-2	<-2
I&E surplus margin	20	1.38%	3	2	**1**	-2	<-2
Liquid ratio (days)	25	32.5 days	60	**25**	15	10	<-10
Overall rating				**4 (actual weighted score = 3.65)**			

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

Prudential Borrowing Limit Performance	**Monitor Ratio Tier 1**	**31st December 2011**
Minimum Dividend Cover	>1x	3.8x
Minimum Interest Cover	>3x	84x
Minimum Debt Service Cover	>2x	60x
Maximum Debt Service to Revenue	<2.5%	0.1%

The original financial plan for the year is a £6m income and expenditure surplus. The forecast has been re-assessed at month 9 (quarter 3) to a surplus of £7m. This is within the range of a pessimistic forecast of a surplus of £5m and an optimistic forecast surplus of £9m for the year.

[1] Earnings Before Interest Taxation Depreciation and Amortisation

2. CLINICAL INCOME

Clinical income is £1.954m higher than the Monitor Annual Plan, standing at £295.740m for the year to date. Clinical income includes income from NHS commissioners, territorial bodies, and non-NHS clinical income.

The variance for the nine months is explained in table 1 below:

Table 1 – Clinical Income – Quarter 3 - Variance from Plan

	£m
Monitor Plan	293.786
Other Changes To The Plan	2.369
Current Plan	296.155
Over Performance (See Table 2 Below)	(0.415)
Year To Date Income	295.740

Activity and Income by Worktype

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

i. Elective Inpatients

Overall Elective Inpatients are £1.427m behind plan. The under-performance is across a number of specialties particularly Paediatric Medical Oncology, Paediatric Cardiac Surgery, and Paediatric Surgery.

ii. Non-Elective / Emergency Inpatients

Non-Elective Inpatients are £1.115m ahead of plan for the year. The key areas of over-performance are Obstetrics, Clinical Haematology, Paediatric Cardiology and Medical Oncology. This position excludes the impact of contract penalties which are included in Other NHS activity below.

iii. Day Cases

Day Cases are £0.895m ahead of plan for the year. The key areas of over-performance are Clinical Oncology, Paediatric Surgery and Urology.

iv. Outpatients

Outpatient activity is under-performing by £0.348m; the key areas of under-performance are Ophthalmology, Medical Oncology and Paediatric Respiratory Medicine.

v. Accident and Emergency

A&E is over-performing by £0.430m.

vi. Other NHS

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

vii. Private Patient Revenue

Private Patient Revenue is over-performing by £0.074m.

viii. Other Clinical Revenue

Other Clinical Revenue is over-performing by 0.130m.

Table 2 – Clinical Income by Worktype

Worktype	Plan £m	Actual £m	Variance £m
Elective Inpatient	36.212	34.785	(1.427)
Non-Elective Inpatient	76.715	77.830	1.115
Day Case	25.422	26.317	0.895
Outpatient	51.641	51.293	(0.348)
Accident & Emergency	8.088	8.518	0.430
Other NHS	95.515	94.230	(1.285)
Private Patient Revenue	1.886	1.960	0.074
Other Non Mandatory Clinical Revenue	0.676	0.806	0.130
Grand Total	296.155	295.740	(0.415)

Over Performance by Commissioner

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

Table 3 Over Performance by Commissioner

Commissioner	Variance £'m	Variance %
NHS Bristol	3.809	3
NHS North Somerset	1.874	6
NHS South Gloucestershire	1.525	7
NHS Wiltshire	0.466	9
South West Specialised Commissioning	(2.119)	(3.5)
NHS Somerset	0.005	-
NHS Gloucestershire	1.239	18.9
Prior Year Income	0.898	-
Variable Estimates	(7.694)	-
Other (including Exceptional Funding)	(0.418)	-
Total	(0.415)	0%

3. OTHER OPERATING INCOME

Overall other income is £4.635m higher than planned for the year to date. The main reasons are:

- Higher than planned levels of Education and Training income of £0.285m due to changes in the contracts for SIFT and MADEL.
- Higher than planned levels of Research and Development income due to changes in the CLRN contract £0.817m.
- Additional CRES schemes not in the original plan £1.501m.
- Lower than planned other income £0.138m.
- Lower than planned Patient Transport Services Income £0.046m
- Higher than planned Skills for Health income £2.216m.

4. EXPENDITURE

Overall operating costs of £348.912m for the year to date are £5.435m higher than plan. Trust pay costs are £2.956m greater than plan and non pay costs are £2.479m higher than plan.

4.1 Pay Costs

Pay costs for the year to date were £2.956m, higher than plan. The main reasons for this are an underachievement against the planned CIP savings target, higher than planned spend within Skills for Health and redundancy costs not in the original plan offset by underspending on various staff groups including scientific and technical staff and other clinical staff.

4.2 Drugs

Drug costs of £31.2m are £0.383m higher than plan for the nine months to 31st December.

4.3 Clinical supplies and services

Clinical supplies and services costs for the quarter were £1.904m lower than plan this includes lower than planned spend in Cardiac Services due to lower than planned activity levels. CRES achievement was higher than planned by £0.797m and spend on Blood and Blood products was £0.460m lower than planned.

4.4 Other Costs

Other costs to date are £3.855m higher than plan. This is due mainly to lower than expected CRES delivery £1.195m and other smaller overspends including external staffing and consultancy costs £0.501m, CNST contributions £0.662m and training costs £0.194m.

4.5 Non Operating Expenses

The principal variances within this section are the higher than planned depreciation charges on purchased assets in quarter 1 (£153k). The updated medium term capital programme also provides for a higher level of capital expenditure than originally included in the Annual Plan with expenditure on strategic schemes being brought forward from 2012/13.

The December report provides for the net cost of asset impairments and the partial reversal of historical impairment losses (£202k).

5. CAPITAL

Actual expenditure for the 9 months to 31st December totals £27.147m. This represents expenditure at 98% when compared with the Annual Plan projection of £27.746m for the period.

There have been a number of approved changes to the Trust's Capital Programme since the submission of the Annual Plan in May. These are reflected in the summary table below. It can be seen that expenditure for the nine month period is marginally less than Plan. For 2011/12 projected expenditure is £44.6m this is marginally greater than the Annual Plan forecast of £44m.

Plan for Year		9 months to 31st December 2011		
		Plan for Period	Actual for Period	Variance
£'000		£'000	£'000	£'000
	Sources of Funding			
1,426	Donations	-	-	-
16,833	Retained Depreciation	12,730	12,717	(13)
1,808	Asset Disposals	1,808	1,987	179
600	Univ. of Bristol Grant	600	600	-
31,402	Cash balances	12,150	11,843	(307)
52,069	**Total Funding**	**27,288**	**27,147**	**(141)**
	Expenditure			
(27,181)	Strategic Schemes	(14,745)	(15,945)	(1,200)
(5,613)	Medical Equipment	(620)	(400)	220
(5,497)	Information Technology	(3,912)	(3,839)	73
(2,205)	Roll Over Schemes	(1,074)	(1,046)	28
(3,836)	Refurbishments	(2,389)	(2,113)	276
(10,958)	Operational / Other	(4,548)	(3,804)	744
3,221	Anticipated Slippage	-	-	-
(52,069)	**Total Expenditure**	**(27,288)**	**(27,147)**	**141**

6. STATEMENT OF FINANCIAL POSITION (Balance Sheet)

The significant balance movements and variances are explained below.

6.1 Non Current Assets

The balance of £304.396m at the end of December is £3.824m lower than the planned £308.220m. This mainly reflects the reclassification of the Bristol General Hospital and the Brentry site as Non-current assets held for sale.

6.2 Inventories (formerly referred to as Stock)

At the end of December the value of inventories held totalled £7.945m. The increase above the plan forecast of £7.179m relates to clinical supplies and a temporary increase in drugs on the introduction of the new Pharmacy system in November.

6.3 Trade and Other Receivables (Including Other Financial Assets)

The balance at the end of December is £25.340m, which is £6.865m above plan of £18.475m. This is mainly due to an increase in NHS Trade Receivables (£7.062m).

6.4 Prepayment

The prepayment balance at the end of December is £2.603m. This is mainly due to payments for maintenance contracts for servicing of equipment. This is higher than the plan of £1.612m.

6.5 Non Current Assets held for Sale

This item relates to the expected sale proceeds relating to the disposal of the Bristol General Hospital site and the Brentry site. The Trust plans to complete disposal of these assets within the next 12 months.

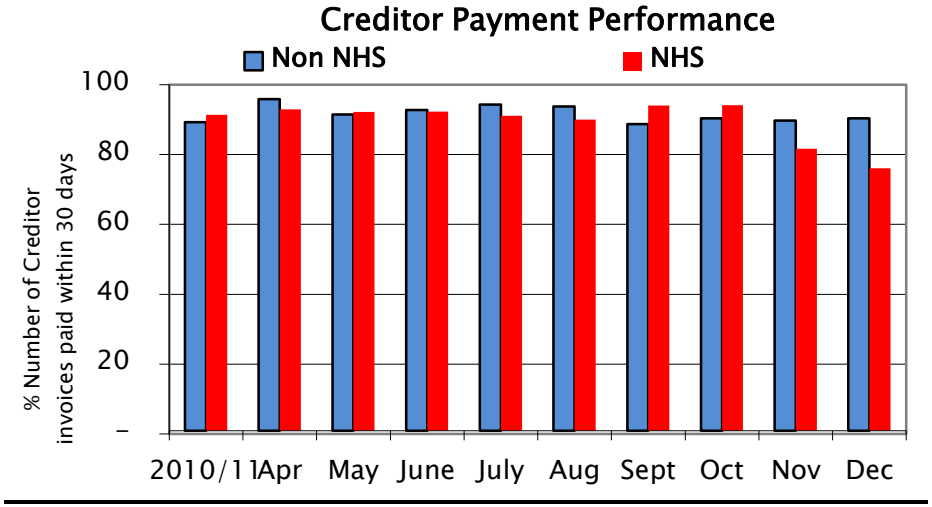
6.6 Deferred Income

Deferred income of £13.765m is £3.911m higher than the plan of £9.854m. The current figure includes balances relating to Skills for Health (£5.8m), Research fund balances (£2.4m) and changes in accounting for donated assets (£1.1m).

6.7 Trade Creditors / Other Creditors / Capital Creditors

Trade Creditors and Other Creditors which total £16.982m are £6.671m lower than the planned position of £23.653m. This is due to the Trust paying those invoices it has received promptly in accordance with its policy.

The Trust aims to pay at least 90% of undisputed invoices within 30 days. In the nine months to December the Trust achieved 88% and 92% compliance against the Better Payment Practice Code for NHS and Non NHS creditors.



6.8 Other Financial Liabilities

The balance of £23.389m is £10.697m higher than the planned value of £12.692m most of which relates to expenditure accruals. This is mainly due to accruals for invoices not yet received. This is offset by a lower level of trade and other creditors (£6.671m) in section 6.7 above. It is difficult to plan for the dates that expenditure invoices are received from suppliers so these could be classified as either Trade creditors or Accruals depending on whether or not an invoice has been received by the month end date.

6. 9 Summary Statement of Financial Position

A summary statement is given below showing the balances as at 31st December together with comparative information taken from the Trust's Annual Plan.

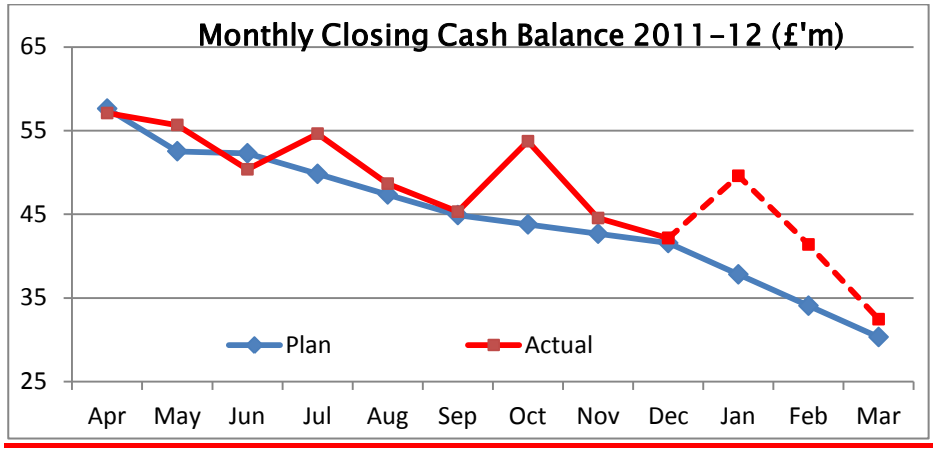
Summary Statement of Financial Position (Balance Sheet)

	Position as at 31st December 2011		
	Plan	Actual	Variance Fav/ (Adv)
	£'000	£'000	£'000
Non Current Assets			
Intangible	2,708	4,993	2,285
Property, Plant and Equipment	305,512	299,403	(6,109)
	308,220	**304,396**	**(3,824)**
Current Assets			
Inventories	7,179	7,945	766
Current Tax Receivables	553	205	(348)
Trade and Other Receivables	17,956	24,749	6,793
Other Financial Assets	519	591	72
Prepayments	1,612	2,603	991
Cash & Cash Equivalents	41,549	42,231	682
Non Current Assets held for sale	889	6,776	5,887
Assets Current Totals	**70,257**	**85,100**	**14,843**
ASSETS TOTALS	**378,477**	**389,496**	**11,019**
Current Liabilities			
Deferred Income	(11,014)	(13,906)	(2,892)
Provisions	(493)	(338)	155
Current Tax Payables	(6,903)	(6,520)	383
Trade and Other Payables	(23,653)	(16,982)	6,671
Other Financial Liabilities	(12,692)	(23,389)	(10,697)
Other Liabilities	(5,390)	(5,423)	(33)
Liabilities Current Totals	**(60,145)**	**(66,558)**	**(6,413)**
NET CURRENT ASSETS/(LIABILITIES)	**10,112**	**18,542**	**8,430**

	Position as at 31st December 2011		
	Plan	Actual	Variance Fav/ (Adv)
	£'000	£'000	£'000
Liabilities Non Current			
Deferred Income	(12,995)	(12,486)	509
Provisions	(259)	(257)	2
Finance Leases	(6,020)	(6,019)	1
Liabilities Non Current Totals	**(19,274)**	**(18,762)**	**512**
TOTAL ASSETS EMPLOYED	**299,058**	**304,176**	**5,118**
Taxpayers' and Others' Equity			
Public Dividend Capital	191,011	191,011	-
Retained Earnings	37,550	42,194	(4,644)
Revaluation Reserve	70,412	70,886	474
Other Reserves	85	85	-
TAXPAYERS' EQUITY TOTALS	**299,058**	**304,176**	**(5,118)**

7. Cash and Cash Flow

The Trust held cash balances at the end of December of £42.231m. This is £0.682m more than the plan to date of £41.549m. The graph shown below provides a comparison of actual compared with planned month-end cash balances for 2011/12.



The Trust has a working capital facility of £37.5m. This has been agreed with Barclays Bank for an initial period of 2 years from 1st September 2010.

8. Potential Financial Risk Indicators

Monitor has identified 10 potential financial risk indicators. The Trust's position against each of these is summarised below.

8.1 Unplanned decrease in quarterly EBITDA margin in two consecutive quarters.

UH Bristol = Not applicable. The EBITDA achieved for the nine months to 31st December at £25.698m is 4.7% better than Plan. The EBITDA margin of 6.86% compares favourably with the Plan for the period of 6.67%.

8.2 Quarterly self-certification by the Trust that the Financial Risk Rating may be less than 3 in the next 12 months.

UH Bristol = Not applicable. The Board anticipates that the Trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.

8.3 Financial Risk Rating 2 (or less) for any one quarter.

UH Bristol = Not applicable.

8.4 Working capital facility used in the reporting period.

UH Bristol = Not applicable.

8.5 Debtors over 90 days past due account for more than 5% of total debtor balances.

UH Bristol = 13% (£3.14m) of the Trust's total debtor balances exceed 90 days. Within this total is an amount of £1.861m which relates to the NHS Injury Recovery Unit. The nature of these cases inevitably means that there are delays, sometimes several years, before accounts are settled. The Trust continues to ensure that invoices are raised at the earliest opportunity and that requests for follow up information are dealt with promptly.

The Trust held a number of meetings in 2011 with local provider trusts in order to reduce the amount owing to UH Bristol. There has been some progress in recent months and further improvements are anticipated in 2012. Our efforts to streamline processes and secure earlier settlement will continue at Chief Accountant level with further escalation taken up if required.

A significant proportion of aged debtors relate to moneys owed by commissioners. Meetings have been held with Finance Directors from South Wales and key principles agreed on information requirements to enable settlement of outstanding amounts. These items are currently being actively followed up by the senior Commissioning Accountant. For a number of commissioners in England there have been significant delays brought about because these organisations have engaged NHS Shared Business Services to process payments on their behalf. The transition to the new arrangements has resulted in delays as supporting information has had to be re-provided. This is subject to escalation with commissioners to secure an improvement.

Information on aged debtors is presented to and considered by the Trust's Finance Committee on behalf of the Trust Board each month. A provision has been made for all potential bad or doubtful debts as at 31st December. Further progress is anticipated in the coming months to minimise debtor balances over 90 days.

The Trust is aware that this metric has been triggered for the seventh consecutive quarter (it is understood that around 50% of all NHS Foundation Trusts are in a similar position). Whilst every effort is being made to reduce debtor balances it is unlikely that debtors over 90 days will be less than 5% of total debtors at any time during 2012.

8.6 Creditors greater than 90 days past due account for more than 5% of total creditor balances.

UH Bristol =Not applicable.

8.7 Two or more changes in Finance Director in a twelve month period.

UH Bristol = Not applicable.

8.8 Interim Finance Director in place over more than one quarter end.

UH Bristol = Not applicable.

8.9 Quarter end cash balance less than 10 days of annualised operating expenses.

UH Bristol = Not applicable.

8.10 Capital expenditure outside the range 75 – 125% of Plan for the year to date.

UH Bristol = Not applicable. The Trust's capital expenditure for the nine months to 31st December at £27.1m is equivalent to 98% of the Annual Plan forecast for the period. The Trust's current plans indicate that expenditure will be marginally greater than that projected in the Annual Plan at £44.6m (Annual Plan = £44m).

9. Other Information

9.1 External Audit Services

The Trust has received the Audit Commission's notice of termination of their engagement to act as the Trust's external auditor at the date of the Trust's 2012 annual general meeting. The Audit Commission has advised that if a new external auditor is appointed with a start date prior to 27 September (date of the AGM) they will resign their appointment at that point provided that they have given their opinion on the 2011/12 Accounts.

The earliest that the Audit Commission are therefore likely to resign their appointment is 1 June 2012. The Trust has commenced the process of securing a new external auditor with a start date in the period 1st June to 27th September 2012.

9.2 Foundation Trust Consolidation forms and Agreement of Balances

In late December, the Trust completed the FTC (Foundation Trust Consolidation) forms required by Monitor to reflect the prior period adjustments for 2010/11 relating to changes in accounting for donated assets and impairments.

The Trust undertook the agreement of balances exercise and submitted the required information to Monitor by the 12th January.

The Trust is now working towards submitting the full set of completed forms for 2011/12 as at month 9 by 19th January 2012.

9.3 Private Patient Income Cap

Private patient income for the period is £2.124m or 0.72% of total patient related income. This is well below the Trust's Private Patient Cap of 1.1%.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 January 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 10 – Board Assurance Framework Report (including Strategic, Corporate and Compliance Objectives Status Report)

Purpose

To provide the Board with the quarterly update on progress against the Trust's objectives at the end of Quarter 3 and to provide assurance of the control of any associated risks to delivery.

Abstract

Context

This reporting format brings together the former Board Assurance Framework and the report on Corporate Objectives into a single monitoring and assurance framework.

The purpose of the Framework is to track progress against the Trust's stated medium term objectives and specifically tracks progress against the 2011/12 milestones which were derived as part of the 2011/12 Annual Planning programme. Importantly, the framework also describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks so as to ensure delivery is not compromised.

Any inherent risk rating that is high or extreme (RED rated) is also captured within the Trust's Corporate Risk Register to ensure appropriate executive oversight through the Risk Management Group.

Quarter 3 Position

There are 3 objectives where the inherent risk to delivery is considered High (RED) contrasted to 5 in the previous quarter, all of these are de-escalated to AMBER through the application of effective controls; this is the first quarter where no objectives have a residual RED rating.

Overall there are 40 objectives with a residual rating of GREEN and 16 AMBER rated objectives, this is an improvement on Q2 when there were 38 GREEN rated objectives.

Recommendations

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

Executive Report Sponsor or Other Author

- Executive Sponsor – Chief Executive, Robert Woolley
- Authors – Director of Strategic Development, Deborah Lee.

Appendices

- Appendix A – Board Assurance Framework

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
04 January 2012					

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2011-2012	Progress Towards Achievement %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk Rating	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
1	T&L	1.1	We will develop and implement a teaching and learning Strategy that is fully integrated with all other strategies in order to support the Trust's mission.	Improved Teaching and Learning provision within the Trust. Improved recognition externally of UH Bristol as a Teaching Hospital	Strategy developed and signed off	75% to 100%	Strategy signed off at Board	Nil / strategy completed	Amber	Strategy completed	n/a	Green		Dir W&OD	Teaching and Learning Group
					New Teaching and Learning Structure identified and delivered	75% to 100%	Head of Teaching and Learning appointed (starts 31 Oct). Consultation on structure change commences 7 November.	Consultation identifies new issues.		Full consultation plan in place and due to complete April 2012.	Teaching and Learning Group	Green			
					Teaching and Learning systems in place to enable delivery of volume e-learning and Continuing Professional Development	50% to 75%	Systems in place - technical issues identified and solutions under testing	Systems issues not resolved and require significant capital spend		Systems specification being confirmed for future PCs. Performance issues being investigated.		Amber			Teaching and Learning Group; IM&T Committee
1	R&I	1.2	We will focus on and foster our priority areas of high quality translational and applied health services research and innovation where we are, or have the potential to be world leading		Goals, priorities and investment agreed for each identified priority group Developmental groups identified	50% to 75%	Research Priorities agreed and illustrated in the BRIG-H diagram of research strengths. Strategies in place for each area. Investments yet to be agreed. Developmental groups of Nutrition and Obesity identified	Nil	Green	Nil	n/a	Green		Dir Med	Research Group
1	R&I	1.3	We will develop a culture in which research and innovation are embedded in routine clinical services leading to improvements in clinical care		Transparency within Divisions of research funding achieved; Divisional governance structures for research in place. Agreed goals and research plan for each division in place	50% to 75%	Transparency exists with regard to Delivery funding in the Divisions. Divisional governance structures in place for Divisions. All Divisions have targets for recruitment and income.	Nil	Green	Nil	n/a	Green		Dir Med	Research Group
1	R&I	1.4	We will demonstrate our undertaking to improve patient health through our excellence in world-class translational and applied health services research and our culture of innovation by increasing participation in NIHR trials		Increase in the number of patients entering NIHR trials by 15% over previous year.	0% to 25%	We are off target for increasing the number of patients recruited. There is a detailed action plan in place to address the known barriers to recruitment. We Have now appointed to key research support positions. Discussions with WCLRN have been positive with regard to the actions taken.	we have an unbalanced portfolio of research, concentrating on complex, low participant number projects led by our clinical academics. We need to run more band 1/2 studies to encourage nascent NHS researchers	Amber	Progress against recruitment action plan monitored weekly and reported to TME monthly	Trust Research Group	Amber		Dir Med	Research Group
1	CSS	1.5	We will consolidate and expand our specialist services portfolio through designation of target services and repatriation of work from outside the South West	An increase in income from specialised services and a greater proportion of Trust income coming from the specialist portfolio.	Achieve designation for cardiac paediatric surgery and Teenage and Young Adults Scope the opportunity, by speciality, work type and finance for work that could be repatriated Agree priorities for repatriation activities and develop plans to effect the change.	75% to 100%	UH Bristol designated for TYA. Consultation for Paediatric Cardiac Safe & Sustainable concluded with UH Bristol in all 4 options under consideration. Scoping of opportunities and priorities for repatriation of specialist work completed in Adult BMT with commissioner support. SW Repatriation Project now underway.	Risk of change to national designation process or recommended options for paediatric cardiac surgery. Repatriation of specialist activity contingent in large part to success of Specialised Commissioning Group Repatriation Project.	Green	Engagement with emerging and confirmed processes for designation and other commissioner processes. Risks are monitored and actions developed at Division and Trust-level groups.	Clinical Strategy Group; Commissioning & Planning Group	Green		Dir SD	Clinical Strategy Group
1	CSS	1.6	We will work with our partners to ensure the optimal configuration for acute services across the City	Single strategy for acute services developed and agreed between NBT and UHB and endorsed by commissioners. Reduction in the number of specialities duplicated across the City, fewer opportunities for competition between acute Trusts.	Develop and agree, with NBT and commissioners, a plan for acute services configuration Agree priorities for service change, if requirement identified as part of Acute Services Configuration work. Achieve Monitor Review and Board sign off for CSP and BRI Full Business Cases . Conclude Pathology Services Review and agree configuration of pathology services for BNSSG	25% to 50%	Monitor Review and Board sign-off now gained for CSP and BRI Full Business Cases. Collaborative work in train with NBT, under auspice of Partnership Programme, to develop scenarios for further service change in support of the optimal City wide configuration of acute services. UH Bristol has declared "support in principle" for the development of NBT as the Lead Provider for Bristol, North Somerset and South Gloucestershire Pathology services. Work on "BHSP 2" now underway through PCT led Capacity Review. Progress on cross City strategy slower than anticipated due to deliberations associated with Trust integration.	These are complex and sensitive projects with multiple stakeholders - often outside of this organisation - with attendant risks to project delivery and agreement of solutions. Potential financial impact of scenarios on Long Term Financial Model for this Trust.	Amber	Participation of senior Trust representatives in Bristol health community programmes such as Healthy Futures, to influence work plans, objectives and outcomes in our favour.	Clinical Strategy Group; Commissioning & Planning Group	Amber		Dir SD	Clinical Strategy Group
1	CSS	1.7	We will undertake a feasibility study of the opportunities and models for increasing Private Patient Services and Income	Options for private patient services scoped and model for UH Bristol agreed and progressed	Undertake market analysis of business opportunity Undertake option appraisal (if market opportunity is confirmed) for expanding private patient provision.	0% to 25%	Brief for Private Patient Market Opportunity Assessment developed in draft with view to identifying a partner to take work forward in Q4. TME to sign off proposal January meeting.	Management capacity to progress scoping work	Green	Risks will be monitored and actions developed Trust Executive Management Group and Clinical Strategy Group.	Trust Management Executive Group; Clinical Strategy Group	Green		Dir SD	Clinical Strategy Group
1	CSS	1.8	Grow the non-clinical income base through exploiting greater commercial opportunities for income generation	Increase in the number of third party providers to whom UH Bristol provides its services. Increase in non-clinical income	Undertake a feasibility study for expanding the footprint of the BRI Redevelopment to incorporate a greater level of income generating patient and staff facilities Identify further opportunities for commercial developments / partnerships	75% to 100%	Market test has confirmed potential for Retail Based Welcome Centre. Comprehensive Business Case in development for presentation to November Board appraising both third party developer and Trust led scheme.	Unable to financially stack up retail centre in terms of acceptable Return on Investment against capital required.	Green	Robust market test of opportunity. Maximising retail space to promote strong ROI. Exploring Trust led scheme which can support lower ROI.	BRI Redevelopment Board; Trust Management Executive Group	Green		Dir SD	BRI Redevelopment Board

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2011-2012	Progress Towards Achievement %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk Rating	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
1	CES	1.9	Fully embed the Trust's values in everything we do and say and establish them as the behaviours that drive the way we do things around here.	Improvements in staff survey questions which pertain to morale and positive work place. Reduction in number of staff experiencing bullying and harassment. Achieve place in top 20% of Trusts for UH Bristol being a "good place to work". Reduction in staff sickness and turnover	Every member of staff has a values based objective set in their appraisal and cascaded down through divisions/teams. Loud & Clear research provides base line data to inform Communications strategy for 2011-14. Key Performance Indicators monitored by TEG and board. Staff, inpatient and outpatient surveys triangulated to provide cross reference information relating to behaviours.	50% to 75%	Strategy approved by TME and Board in June 2011. Living the Values programme launched October 2011. Performance framework in development.	Staff resistance to adopting values. Leadership focus inadequate. Insufficient capacity to deliver the Living the Values Programme to time.	Green	Executive Leadership. Trust-wide programme of staff engagement.	Reports to Transformation Programme Board/TME oversight.	Green	n/a	CE	Trust Management Executive
2	CSS	2.1	We will further refine our strategic intentions and operational role in community service provision	Clear position statement on the provision of community services by UH Bristol. Direction of travel agreed for community services currently provided by UH Bristol.	Conclude strategic analysis and option appraisal in relation to any future vertical integration and community provision. Agree target areas for community service expansion or retrenchment.	75% to 100%	Board strategy seminar in September 2011 confirmed Board position on local versus tertiary provision and our role in community service provision. SBCH Lead Provider role awarded and commences April 2012.	Unforeseen developments may test or go against previously stated intentions regarding community services provision. Economic case for future developments unclear.	Green	Active identification of opportunities, responses and governance of decision-making for community services developments. Dialogue with Bristol Community Health commenced to explore merits of a more formal partnership agreement.	Clinical Strategy Group	Green		Dir SD	Clinical Strategy Group
2	CSS	2.2	We will confirm our intentions with regard to major strategic opportunities that are likely to arise in the medium term including our role on the provision of services to the Weston community, our role in the running of SBCH and the organisational model through which we will work with North Bristol Trust.	Decision and if applicable timeline for merger with NBT agreed. UH Bristol position in relation to SBCH and Weston formulated and agreed by Board.	Develop Strategic Outline Case for Change for models of working with NBT and agree preferred way forward. Clarify opportunities regarding Weston and undertake strategic analysis and option appraisal in relation to any future role for UH Bristol Clarify opportunities regarding SBCH and undertake strategic analysis and option appraisal in relation to future role for UH Bristol	50% to 75%	Partnerships Programme over seeing on-going work in relation to UHB / NBT service integration. Successful strategy seminar undertaken in September with clear strategic position on DGH / community integration established. UH Bristol confirmed as Lead provider for SBCH. Weston Futures work progressing more slowly than anticipated but UH Bristol interest in supporting Weston services firmly flagged.	Potential for options to face clinical, public or business case challenges.	Amber	Engagement with NBT, commissioners and stakeholders - e.g. NBT and UH Bristol Partnership Board and NHS Bristol Healthy Futures Programme Board. Internally, through Trust groups and Board discussions.	Clinical Strategy Group	Amber		Dir SD	Clinical Strategy Group
2	T&L	2.3	Partnership Working - We will further develop our academic partnerships and relationships with the wider health community both locally and nationally to broaden our teaching hospital reputation beyond the south west region	UH Bristol will be recognised as a top Teaching Trust and will be a provider of choice for the wider health community	Relationships fully scoped and stakeholder maps / development plans created Business plan developed and approved for the provision of services	0% to 25%	Work on track - stakeholders identified	None	Green	Not applicable	Not applicable	Green		Dir W&OD	Teaching and Learning Group
						25% to 50%	High level plan developed - full financial analysis underway. This includes a review of where budgets will be held going forward to ensure best value spend.	None		Not applicable	Not applicable	Green			
2	R&I	2.4	Partnership Working – we will work with our Bristol Research and Innovation Group for Health and regional partners to align our research and clinical strengths leading to the establishment of a Bristol Academic Health Sciences Centre.	Academic Health Sciences Centre operating across health partners with demonstrable increase in research activity as a result.	Programme director and chair of Academic Health Sciences Centre programme Board appointed; Agreed model of Academic Health Science Centre in place	75% to 100%	Leadership group agreed on AHSC model. Operating principles agreed and key documents in preparation.	Changing policy landscape for academic health science centres in UK and developments following NHS Innovation Review which may affect timescale for delivery.	Green	Executive Leadership. Partnership Working.	Partner feedback.	Green	n/a	CE	Bristol Research and Innovation Group for Health
3	T&L	3.1	Learning and Development Centre of Excellence - We will create a recognised Academy that delivers high quality learning and development which is aligned with trust strategies and culture.	The trust will have a Training Academy that delivers quality assured solutions to its staff and the wider community	Teaching and Learning brought together into one cohesive unit under a single leadership. Academy framework document developed.	50% to 75%	Head of Teaching and Learning appointed. Structures and relationships identified and fully mapped. Stage 1 consultation commences 07/11/11.	Discussions with Divisions on structure takes longer than planned.	Amber	Tight project management of process.	Teaching and Learning Group	Green		Dir W&OD	Teaching and Learning Group
						0% to 25%	Planned for later in year								
3	T&L	3.2	Skilled and flexible workforce - We will ensure that learning and career pathways are developed based on Trust priorities, are flexible and responsive to changes in service and are supported by effective development solutions	All training is based on Trust requirements, linked to required competencies and provides career development for individuals.	KSFs established for all roles.	75% to 100%	Knowledge and Skills Framework in place for all roles with multiple staff in them	Managers of non "bulk" roles do not agree KSFs	Green	Communications plan to engage leaders	Teaching and Learning Group	Green		Dir W&OD	Teaching and Learning Group
					Learning solutions in place for KSF development	50% to 75%	Significant solutions in place - others under development	Nil		Not applicable	Not applicable				
					A common set of management and leadership competencies is in place	75% to 100%	LQF agreed for management staff - Links to supervisory roles under development. Incorporated into leadership development programme.	Nil		Not applicable	Not applicable				

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2011-2012	Progress Towards Achievement %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk Rating	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
					Learning linked to corporate requirements	50% to 75%	being reviewed alongside performance management. New performance management process approved linking	Training plans not aligned to actual business needs		Training needs analysis process being reviewed	Not applicable				
3	CSS	3.3	To be recognised by our patients and their families for the consistently high quality of the care they receive whilst in our care	By 2013/14, we will achieve a Top 5 ranking amongst peer trusts for at least 50% of patient experience measures (as measured as the 2013 National Inpatient Survey).	We will extend our patient experience strategy to include Outpatients and carers, learn from feedback and improve scores in measures of satisfaction.	50% to 75%	First comprehensive local survey of outpatients completed and results shared with Divisions. 'Kiosk'-style comments boxes sourced for comment cards. Action plans to be delivered through Transformation programme. Inpatient ratings show that local patient experience CQUINs (for patient-reported noise at night, and support at mealtimes) have high likelihood of being achieved.	Low risk associated with Outpatient aspects. Also low risk associated with achievement of local Commissioning for Quality and Innovation, based on current progress. Achievement of national patient experience CQUIN is unpredictable: based on results of 2011 National Inpatient Survey (approximately 450 patients seen in July 2011 - results available April 2012).	Green	This objective is being achieved. Patient experience strategy is being rolled out into Outpatients; inpatient patient experience CQUIN targets are being achieved.	Not applicable	Green	N/A	Chief Nurse	Patient Experience Group, reporting to the Clinical Quality Group
3	CSS	3.4	We will strive to eliminate all incidents of unintended harm to patients and be recognised nationally for the safety of the services we offer.	The spread of all key changes relating to the NHS South West Quality and Patient Safety Improvement Programme will have been achieved in all work streams with at least 50% penetration into other applicable patient populations and areas. We will achieve zero 'Never' events. We will learn from the findings of the Inquiry into Histopathology services.	We will achieve sustained improvement (three months without sliding backwards) in process and outcome measures for pilot populations in all five work streams of the NHS South West Quality and Patient Safety Improvement Programme*. We will also achieve spread - including testing, training, communication, etc. - of all key changes beyond the pilot populations of the same Programme. We will achieve zero 'Never' events We will focus specifically on seeking improvements in hospital acquired thrombosis (VTE), medication errors, inpatient falls and pressure ulcer prevention and management. Success criteria will be defined via the CQUIN framework We will fully implement the agreed action plan following the Inquiry into Histopathology services.	50% to 75%	There have been no further Never Events since Q1. Venous Thromboembolism risk assessments are at 98% for November 2011. Reduction in medication error figures for September 2011 are within target at 1.05%. Falls incidence for October 2011 is below the benchmarked average of 5.16 per 1,000 bed days and CQUIN measures are in place for Q3. Pressure ulcer incidence is significantly above the target at 21.21 per 10,000 bed days for October 2011. Numbers of Grade 2 and Grade 3 pressure ulcer continue to breach the CQUIN target. The Histopathology Action Plan is on target to be implemented by the agreed dates.	Never Event objective cannot be reversed. Risk to achieving a reduction in pressure ulcers remain until action plan is fully implemented and embedded in practice. Current risk to South West Quality and Patient Safety Improvement Programme we will not achieve the objective as described by March 2012, but we will have opportunity to recover progress by 2014.	Red	Refocusing of NHS South West Quality and Patient Safety Improvement Programme underway. Launch of Being the Best rapid improvement programme September 2011. Robust pressure ulcer and falls action plans in place.	Quality dashboards scrutinised by Quality and Outcomes Committee. Monitoring of Risks by Clinical Quality Group. NHSLA level 2 assessment pass for VTE and falls standards June 2011. External Pressure Ulcer prevalence audits.	Amber	Pressure Ulcers 1755 Falls 1705	Chief Nurse	Patient Safety Group reporting in to the Clinical Quality Group
3	CSS	3.5	To be recognised for the excellent clinical outcomes we achieve for our patients across all areas of service.	We will achieve clinical outcomes that are consistently in the upper quartile of comparable Trusts' performance, including a relevant measure of hospital mortality.	We will maintain our Dr Foster "Lower than expected mortality" status for Hospital Standardised Mortality Ratios and Mortality in high-risk conditions. The Trust will implement a new Quality Intelligence Group to ensure early detection of and response to statistical outliers, supported by strengthened M&M review in Divisions In line with the NHS Outcomes Framework, the Trust will seek to achieve year-on-year improvements in one year survival rates for colorectal, breast and lung cancer. Actions will include: review of respiratory Multi Disciplinary Team by Division of Medicine to improve outcomes for lung cancer patients; on-going focus on patient access times; implementation of the policy is Improving Outcomes: a Strategy for Cancer (DH, January 2011) • We will achieve improved Dr Foster ratings (measured by comparison with peer trusts) in at least 5 out of 7 stroke-related indicators. The Division of Medicine will create a dedicated stroke unit on the BRI site to improve We will implement the action plan resulting from a local gap analysis of the NICE Quality Standard for Dementia, and agreed standards of dementia care developed by the South West Expert Reference Group. We will seek to increase the proportion of spontaneous vaginal births. Will we do this by actively promoting home births and vaginal delivery after C Section; ensuring 1-1 care in labour; introducing staff study for normal births	50% to 75%	HSMR on track (i.e. sub-100) - monitored by Board. Trust appeared in list of best performing Trusts for HSMR in Dr Foster Hospital Guide 2011 Progress during last quarter re. extracting one year cancer outcomes data, but further work required to determine robustness of data and peer comparison - on-going discussions with SW Observatory Stroke: dedicated stroke unit established. Trust listed in top 5 trusts in 2011 Dr Foster Hospital Guide for low stroke mortality. Other published indicators have changed in 2011 so direct comparison with 2010 not possible in all areas; also peer data as yet unavailable from Dr Foster Dementia action plan being implemented and monitored via steering group No recent improvement in % of	We continue to have an HSMR at 'lower than expected' levels and have successfully initiated the Trust's Quality Intelligence Group to examine quality performance information available from external and internal sources. There is an inherent risk of not achieving any objectives which are based upon our achievements relative to other trusts. Further work is required to extract and analyse one year cancer survival outcome data.	Amber	Active discussions with SW Observatory re. availability and robustness of cancer survival data	All outcomes/ effectiveness objectives are monitored by Clinical Quality Group - reported to TME and Board.	Amber	n/a	Dir Med	Quality Intelligence Group reporting to the Clinical Quality Group
3	R&I	3.6	We will achieve compliance as far as is reasonably practicable with all Health & Safety regulations		Annual external audit undertaken against the HSG 65 Model of Successful Health & Safety management. Whole audit compliance scores provided for 5 clinical Divisions and 3 specific areas in Trust Services - Estates & Facilities - IM&T and rest of Trust Services	50% to 75%	Plans in place for all areas to achieve required standards. Audit outcomes presented to Executives. Health & Safety to be part of Trust and Divisional Operating plan objectives in 2012/13. Exceptions captured on Willis overview report to be put into both Divisional and Trustwide action plan.	Divisional plans not fully implemented	Green	Progress under on-going review	Trust Health and Safety & Fire Safety Committee	Green		Dir W&OD	Risk Management Group

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2011-2012	Progress Towards Achievement %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk Rating	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
4	CSS / CES	4.1	We will play a greater role in shaping the health system in Bristol and the Southwest through our early and constructive engagement with future influencers. We will improve our reputation with our commissioners by understanding their needs better and rapidly responding to the issues they raise.	Established and productive relationships with PCT Clusters, GP Consortia and National Commissioning Board with evidence of UH Bristol leading, not reacting to, change. GPs will report improved levels of satisfaction with UH Bristol's response to their commissioning intentions and ad hoc issues (evidenced through formal market surveying)	Develop and agree a GP engagement strategy and action plan. Agree and establish revised ways of working between Trust Executive, Heads of Division, Consultant body and emerging GP commissioners Re-structure roles and responsibilities of Commissioning and Planning Team to support new commissioning models Co-lead with NBT the development of an Acute Services Configuration Plan for the City.	75% to 100%	The GP Engagement Strategy and Action Plan is agreed and in the process of being implemented. The Commissioning and Planning team is, as of 1st August, at its full complement and workflow/team responsibilities are currently being allocated in order to support the new commissioning models. NHS Bristol has now completed its elections to its Clinical Commissioning Groups (CCG) and liaison meetings have been established between CCG Leads and Heads of Division. CCG Leads have been invited to join UH Bristol Clinical Strategy Group on tri-annual basis for primary care focussed strategy debate. GP Newsletter reviewed and to be re-launched following revisions.	Potential for emerging commissioning structures to change. Difficulty in accessing key primary care decision makers in new structures. Measuring the impact of productive relationships.	Green	Close liaison with commissioner colleagues and agreement of joint priorities for action. Establishment of regular meetings with key primary care influencers.	Commissioning & Planning Group; Clinical Strategy Group	Green		Dir SD	Clinical Strategy Group
4	CSS	4.2	We will strengthen our approach to marketing our services to both GPs and consultant referrers with a view to maintaining or growing market share in our target areas	No service losing market share except where as a response to a Trust business decision.	Develop and agree a GP Marketing and Communications plan Identify early priorities for implementation and embed key changes during 2011 / 12.	75% to 100%	Plan agreed and approved at TME. Liaison between Director of Strategic Development and GP Commissioning Leads underway. Meetings with Clinical Leaders have been implemented and meetings with	GP priorities. System change.	Green	Progress reporting to TME.	None at present	Green	n/a	Dir SD	Trust Management Executive
4	CES	4.3	Agree the nature and form of our future relationships with our major fundraising partners. Agree our priorities for charitable funding and develop cases for support in partnership with charitable leads	Fundraising target for major appeals achieved. Positive working relationships in place with all major charitable partners.	Establish Memorandum of Agreement with each of our major charitable partners Agree model for fundraising for major capital developments in 2014/15 Undertake market analysis to confirm fundraising potential. Agree fundraising targets and priorities with each of our key partners	75% to 100%	External report on opportunities for development of charitable relationships and funding sources received. Charities: Above and Beyond have provide a funding strategy for BRI , target £3m The Grand Appeal support for £5.83m confirmed in principle, detail of individual cases of support still being progressed. Above and Beyond confirmed £2m for BHOC TCT indicate £2.5m £2m support now secured from Friends of BHOC	Risk that fundraising targets are missed and therefore need review of schemes or alternative funding.	Green	Continued close working and representation at Charitable Boards.	Regular updates to TME and involvement of Trust Lead Executive with each of Trustee Boards	Green		Dir SD	Trust Management Executive
4	T&L	4.4	Leaders of the future - We will create leadership and talent pools who are equipped with the skills, knowledge and behaviours required to lead the Trust both now and in the future.	We will have leaders who are fully effective and are able to embrace and deliver change is a safe and sustainable way	A common set of management and leadership competencies is in place	75% to 100%	LQF agreed for leaders - supervisory competencies under development	Minimal Risk	Green	Not applicable	Not applicable	Green		Dir W&OD	Teaching and Learning Group
					Talent pool identified for future leaders at all levels	75% to 100%	Talent pool identified and used to nominate for new transformational leadership programme.	Minimal Risk		Not applicable	Not applicable				
					Formal leadership and talent development programmes launched to meet development needs of talent pool and leaders	75% to 100%	Leadership Forums commenced July. Full development programme launched. 10 sessions booked through December 2011 with 150 attendees.	Leadership development does not meet future business needs		Sign off of content by appropriate leaders. Contents reviewed for each cohort to ensure remains relevant.	Teaching and Learning Group				
4	CES	4.5	We will continue to work with our media partners locally, regionally and nationally to ensure UH Bristol positions itself as a trustworthy and notable commentator on health issues and is recognised as a successful organisation, through case studies of our staff and patients in relation to Research & Innovation, Teaching & Learning and patient care.	Positive to negative media about UH Bristol increases. All proactive media about UH Bristol is balanced; the Trust is consistently featured aligned to its core values and brand through media coverage. The Trust is known for its commentators	Positive to negative media about UH Bristol increases. All proactive media about UH Bristol is balanced; the Trust is consistently featured aligned to its core values and brand through media coverage.	50% to 75%	Coverage for quarter 1: Positive 381; Negative: 61; Neutral: 162. The Trust has strong proactive relationships with the regional media and relationships are being built with the trade media. The communications department actively promotes positive stories about the Trust, responds to media queries to ensure coverage is balanced and manages communications for projects that have the potential for media coverage.	Risk that operational issues result in negative media coverage. Continuing adverse publicity following Histopathology Inquiry.	Green	The Communications department maintains close relationships with all Divisions to ensure that it receives early notification of communications issues and can work in partnership with Divisions. The department's working relationships with the media help to ensure that coverage is balanced. Performance reporting of positive and negative coverage.	SHA analysis. Feedback from media organisations.	Green	1467	CE	Trust Management Executive

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4	CES	4.6	The Trust embraces all appropriate methods of communication, with staff, patients, members and the wider public to involve them in the strategic developments of the Trust.	Staff survey shows improvements in staff perception of communication with respect to capital developments All KPIs being achieved to required standards. Minimal patient complaints about negative impact of construction works	Establishment of Communications steering group for the capital redevelopment projects. Agree objectives and KPIs for that group, monitored by the Trust Capital Steering Group. Implement a coordinated approach across all communications associated with major strategic initiatives. Embed new intranet from June 2011 with greater interactivity.	50% to 75%	Communications Steering Group established. Feedback regular to develop KPIs. Coordination involving internet launched and operational	Failure to effectively engage staff and patients on our redevelopments	Green	Active management of communications agenda through Steering Group and regular review of learning if we get it wrong	Trust Management Executive	Green		CE	Capital Programme Board
5	ES	5.1	An Estates Strategy exists which is agreed by the Board, covering the period up to 2020. Approved Site Development Control Plan exits	Develop a 10 year Estates Strategy and secure Board approval Develop a three year rolling capital planning programme to support Estates Strategy. Develop a Site Development Control Plan	Develop options for the disposal or re-development of the BRI Old Building Agree the detail of Redevelopment Phase 4 – reconfiguration of the King Edward Building to house services displaced from the old Building Review year 1 of the 3-year rolling capital programme to reflect progress made and changing operational requirements	25% to 50%	The layouts for the use of the KEB will be progressed after the business cases for the Welcome Centre and the Bristol Haematology and Oncology Centre expansion have been through the Trust Board in August. A Tracker tool has been developed to track different elements - wards, theatres, outpatients, non-clinical etc. year by year from today through to completion in 2015. This will be worked up and used to intelligently inform the capital programme in the interim years. A plan for development of the strategy has been developed. SESG is reviewing the next steps.	There is a risk that the forthcoming Estates and Facilities Review will take the focus away from the Estates Strategy delivery.	Green	Range of Redevelopment Project related groups, boards etc. to progress aspects of development. Continual review by groups identified in next column. Use of external; consultants for Estates and Facilities Review.	Capital Programme Steering Group, Strategic Estates Steering Group	Green		COO	Trust Management Executive
5	ES	5.2	Ensure on-going compliance with all annual fire and safety audits.	Avon Fire & Rescue Service issue no Improvement Notices. Health & Safety Executive issue no improvement notices. Care Quality Commission Outcome 10 (Safety and Suitability of Premises) remains compliant. Willis Risk Management Audit shows no major unmitigated risks.	Annual external surveys undertaken for fire, legionella, asbestos, windows, water quality, disabled access, security. Whole environment scores provided routinely to Divisions for discussion within quarterly reviews Three year rolling programme of improvements agreed by TEG and funded within capital programme and first year of implementation Annual Willis Risk Assessment undertaken, reviewed against preceding action plan and updated.	50% to 75%	Review of Health Technical Memorandum compliance being reviewed by Divisional Board. Fire Risk assessments reviewed at SDG in December to measure completeness across the Trust. Programme of external reviews for key services being finalised. DDA compliance programme for 2011/12 year investment being progressed - prioritised on Disability Discrimination Act public toilets. Willis Health and Safety review being presented to Exec team August 2011 and to divisions subsequently. New benchmark being established by this.	Lack of delivery can lead to real (safety) or potential (reputational) risks.	Green	Audit of Risk Assessments. Increased incidence of fire training to annual from 2-yearly. Training for risk assessors and fire wardens.	Health and Safety Committee Infection Control Committee Decontamination Group Facilities & Estates Divisional Board Service Delivery Group	Green		COO	Service Delivery Group
5	ES	5.3	To strengthen our approach to business continuity with the aim of ensuring patient safety and minimising operational disruption during times of incident.	UH Bristol viewed as a beacon Trust in the Avon Health Emergency Response Group area. Outcome of test exercises identifies no major shortcomings in Trust arrangements	Conclude a review of back up generation requirements and implementation of short term plan. Review of current arrangements and responsibilities for business continuity re-assessing the balance of corporate and divisional responsibility Review of suitability of existing Business Continuity Plans	75% to 100%	Standard operating procedures are in place for areas identified as not covered by back up generation. Future generator requirements have been identified and business cases presented and accepted. Current business continuity planning arrangements have been reviewed and a business continuity management strategy devised and put in place. All identified trust individual business continuity plans have been reviewed and updated as necessary.	In the event of a power failure there are some areas of Trust premises that are not covered by back up generation or UPS. The risk remains that trust business continuity plans will not be reviewed and updated on a regular, timely basis	Amber	Standard operating procedures are in place for affected clinical areas. Business Continuity management should now sit on all divisional management boards and this feeds into the Business continuity Planning Group. Trust Business Continuity plans being entered onto the Trust Safeguard system which will allow for timely reminder of review management	Recent Trust internal audit 2011, Standard operating procedures, Emergency planning Trust Board report	Amber		COO	Civil Contingencies Committee

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5	ES	5.4	Improvement trust wide satisfaction with the services provided by the Estates Function Development of KPIs and systems of feedback from Divisions to ensure improvements in responsiveness	User surveys indicate an 80% level of compliance with Service Level Agreement Key Performance Indicators User surveys show 80% return being good or excellent	Set standards for estates and facilities services, including response times. Develop a set of KPIs to monitor achievement of standards and report at divisional level Agree key performance requirements with Divisions annually and introduce an annual Division to Division review of estates performance Introduce customer feedback mechanisms to enable estates to pick up concerns over responsiveness or quality routinely	50% to 75%	Project evolving through placement of contract for new estates helpdesk IT system. Work with Transformation Team to carry out exercise with the estates team for modernisation / greater effectiveness / customer focus has started. KPIs and dashboard being developed for discussion with the Service Delivery Group and Trust Management Executive.	Risk that new IT system will not deliver intended benefits.	Amber	Progress to be monitored through Divisional Board.	Health and Safety Committee Infection Control Committee Decontamination Group Facilities & Estates Divisional Board Service Delivery Group	Green		COO	Service Delivery Group
5	ES	5.5	Ensure estates practice contributes fully to infection control objectives	Internal and external Assurances / Audits indicate no major shortcomings in key safety related areas. All improvements to process identified through assurances and audits are fully implemented. Compliance with HTMs 1 -7 Assured regularly (at least once every 2 years) Increased percentage of single rooms available year on year.	Review Asset Base and Project Portfolio Management requirement of that base. Implement review of PPM delivery / completion against pre-agreed KPIs. Produce annual report for Infection Control Committee on Legionella Compliance Implement year 2 of 3-year ward upgrade improvements	50% to 75%	Asset base reviewed as part of helpdesk project and internal audit action plan. External annual and quarterly testing contract put in place with Audere. New External Authorised Person contract in place. Annual report for Infection Control Committee achieved 19 July 2011. HTM compliance review included on Divisional Board work plan for review. Cost pressure for external review etc. of specialist ventilation still to be resolved. Single room review incorporated into Redevelopment "Tracker" tool (see 5.1 above). Update given to SDG.	There is considerable mitigation in place to manage the risks to Legionella and to Hospital acquired infections through the Cleaning regimes.	Green	Planned preventative maintenance. External Audits. Authorised Persons and testing.	Annual & Quarterly reports to Infection Control Committee. Monthly exception reports to Decontamination Committee.	Green		COO	Service Delivery Group
5	ES	5.6	Reduce further our carbon footprint	Carbon footprint is reduced by 5% per annum over next 3 years	Achieve annual reduction in energy consumption of 5% per annum over next three years. Implement annual milestones of three year energy strategy and Big Green Scheme Big Green Scheme to be reviewed by Board of Directors and for appropriate new three year plan developed.	50% to 75%	Progress on 5/6 of the energy saving projects proceeding to plan. All of these due to be complete by January 2012. Summer boiler project reprogrammed due to its interdependency with the site-wide HV generator project. Big Green Scheme progressing awareness and green champions to be involved in identifying additional areas for thermostatic radiator valve heat control installation.	Local uncontrolled energy usage (lights & computers etc.) not switched off when not required.	Green	Active monitoring by Energy Manager. The Big Green Scheme. Energy saving invest-to-save programme.	Periodic reports to SDG, TME and Finance Cttee.	Green		COO	Service Delivery Group
6	T&L	6.1	Implement revised performance management processes to better align individual performance with trust goals	Performance management will fully support the achievement of Trust goals	Performance management timetable changed to align corporate and individual objective setting	75% to 100%	New performance management process signed off by SDG and goes live October 2011.	Risk relates to new process having impact rather than its delivery	Green	Detailed communications and training for appraisers and appraisees.	Trust Management Executive Group	Green	To be reviewed during process launch	Dir W&OD	Teaching and Learning Group
					Managers trained in delivering quality performance management process	50% to 75%	Training underway for all managers in the new system.								
6	LTFP	6.2	Deliver an annual Cost Reduction Programme (CRP) in line with the requirements of the Long Term Financial Plan	The Trust achieves a balanced plan for the next three years	Deliver a programme management approach to Transformation/CRP delivery including review of corporate and divisional roles, responsibilities and leadership Establish Executive Cost Reduction Plan Leadership group to retain oversight of whole trust CRP Review role and focus of transformation team to ensure they are targeted at supporting both divisional and corporate CRPs Sign off and hold to account for delivery a range of Cost Improvement Plans that deliver a balanced plan in year.	50% to 75%	Transformation Director in post July 2011. Outline of accountability agreed. Programme Steering Group refocused. CIP plans all signed off. Transformation half days established. Mid-year review established. Trust on track to deliver 75-80% of CRES target.	Divisions not delivering to plan. Corporate work streams behind plan	Amber	Four Divisions placed in escalation with Board to Board meetings and recovery plans. All corporate work streams have clearer accountability structures for delivery.	Work stream levels held to account at Programme Steering Group and Divisional teams via monthly performance meetings.	Amber		COO	Programme Steering Group

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6	CSS	6.3	Delivery of significant improvement in outpatients by 2014.	The Outpatients function is transformed and is upper quartile nationally on a range of indicators including new to follow-up appointments, Do Not Attends and Cancelled appointments. Clinical Administration is streamlined by using technology, the new Patient Administration System is used to best effect and saved Consultant PAs have been redistributed/eliminated.	Implement Phase 2 of Outpatient Booking Project to include centralisation of bookings, reduction in cancellations, standardisation of outpatient processes, review of helpline. Introduce Digital Dictation and Voice Recognition across the Trust resulting in Clinical Administration savings. Identify consultant PAs that can be reduced by better Outpatient clinic utilisation.	50% to 75%	Commenced Year 1 of the Productive Outpatients Programme includes programme set up and governance, monitoring and delivery. Progressing projects to improve Clinic Scheduling, Booking Process, Clinic Process, the Patient Pathway and to agree and implement an improved booking model for the Trust. Projects will ensure we use our existing capacity to full effect therefore eliminate/minimise the use of Waiting list initiatives through better use of our existing clinic capacity and will identify consultant PAs, and workforce if appropriate, that can be reduced by better outpatient clinic utilisation and processes. TME has agreed to centralise the booking team with plans in place for 2012 and 2013/14.	Risk that programme deliverables will not be achieved as delivery relies on improvement being coordinated, monitored and delivered within the Divisions. Resources will be required in each division to progress the project.	Amber	All Divisions have been alerted to the programme plan, governance and key deliverables with an awareness of resource requirements so they can enable resources to be released when required. Close monitoring of progress against plan for each area and escalation of issues to the Productive Outpatients Steering Group as required.	Productive Outpatients Risk and Issues log established and reviewed by Divisional/Hospital Site Productive Outpatient working groups fortnightly as well as the Productive Outpatients Steering Group every 6 weeks for escalated risks and issues	Green		COO	Transformation Programme Board
6	CSS	6.4	Delivery of significant improvement in theatre productivity by 2014.	Theatre processes have been fully re-engineered and have released significant savings.	Implement Year 2 of the Productive Theatre Programme. Eliminate the use of Waiting list initiatives through better Theatre scheduling and utilisation. Eliminate last minute cancellations for theatre reasons, A short notice protocol for DNA patients (Eye Hospital) and staggered admissions on the day is introduced.	75% to 100%	A number of the key actions from the year plan of the POT are being implemented successfully. There are on-going improvements in the lists starting on time work and the BEH has now fully implemented the short notice protocol, which is functioning well. WLI savings are above trajectory, with month 3 seeing £40k spent on WLI, with £70k standing as the maximum spend per quarter to make the required savings. Work is also progressing on the non-pay savings elements with anaesthetic drugs providing a focus. Escalation process for LMCs established; target achieved in September 2011.	Increasing demand on emergency and elective workloads and requirement to achieve key access targets, mean that there is an on-going demand for WLI in some areas.	Amber	High level authorisation of the use of WLI and management of the cancer and 18 week waiting lists to ensure WLI are only used in extreme situations	Active monitoring of waiting lists and performance targets through 4 PTL meetings a week and increasing demand managed through regular contract monitoring and commissioning and planning meetings. Monthly production of WLI figures and monitoring through Divisional Board.	Green		COO	Transformation Programme Board
6	CSS	6.5	Delivery of improvement to upper quartile for Average Length of Stay (ALOS) and associated bed productivity by 2014.	The Trust's Average Length of Stay (ALOS) is Upper quartile for the majority of HRGs.	Improve discharge processes for routine, more complex and highly complex patients. Reduce the number of non-elective medical patients with a Length of Stay of more than 14 days to 40. These initiatives will enable the permanent closure of beds – in Medicine the current projection is two wards. Move towards upper quartile ALOS for the majority of HRGs. Implement revised urgent care pathways and reduce medical admissions, close flex beds except in times of peak pressure.	75% to 100%	The key priority for 2011/12 is to enable closure of beds through reductions in long length of stay & improvement in discharge processes. The creation of a new operations centre in the BRI and a revamp of bed management processes have delivered in this regard. The daily reviews of 'red list' patients awaiting discharge has resulted in a dramatic reduction in the average number of (particularly medical non-elective) patients staying >14 days (from a peak average >90 in February 2011 to <50 in Q1 2011/12) and a reduction in average length of stay which has enabled the closure of 40 medical beds. Flexi-beds working well over winter period.	Unforeseen increases in emergency demand or changes in case mix which could negatively impact on performance	Amber	Daily focus on indicators of patient flow through revised ops centre in BRI. More strategically there is proactive planning internally (flex capacity) & with community partners, to minimise impact of peaks in demand (e.g. winter pressures / 'flu)	Active monitoring of 'predictor' KPIs using patient flow dashboard at service delivery group fortnightly. Oversight of performance (on amber - trajectory in Q2) at monthly bed optimisation steering group, & review of divisional performance on LOS at monthly operational & finance reviews with exec directors. These should all allow early warning of deviation from plans and	Green		COO	Transformation Programme Steering Group

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7	LTFP	7.1	Develop and implement an engagement programme that ensures staff are fully involved in the work and development of the trust, are able to contribute to its further development and go the extra mile to ensure its success..		Programme defined and developed	75% to 100%	Programme fully defined and implementation plan in place. Leadership development, performance management, recognition, comms, values roll out and commence Oct/Nov.	Implementation seen as a series of unconnected events leading to loss of impact and key messages	Green	Programme includes full communications plan and overall branding to draw into single programme	Transformation Board and the Trust Management Executive Group	Green		Dir W&OD	Trust Management Executive
7	R&I	7.2	We will train, mentor and support research-active staff to deliver high quality translational and applied health services research of direct patient benefit in our priority areas of research		100% research staff aligned with a Divisional research unit. Research staff training and learning needs identified and managed in line with Trust-wide learning and development strategy	25% to 50%	SH&N, Medicine and SS's all have staff in Divisional Research Units: Work underway with W&C. Survey of training needs undertaken. To be implemented in line with T&L strategy	No update	Green	Not stated	Not stated	Green		Dir Med	Research Group
8	IT	8.1	Implement modern clinical information systems in the Trust	Modern clinical information systems are in use in the Trust	Information Management &Technology Strategy moving to Implementation Phase	75% to 100%	Implementation Phase 1 March 2012	Operational engagement. System failure	Amber	Active project management	CSIP Board and IM&T Committee	Amber		DoF	Information Management and Technology Board
					Implementation Teams established.	75% to 100%									
					Complete Procurement	75% to 100%									
					Core systems Implementation commences	50% to 75%									
8	IT	8.2	Review and deliver fit for purpose clinical admin support processes	Fit for purpose clinical admin process in place	Agree Terms of Reference of review and establish review team and processes	75% to 100%	Report October 2011	Changes proposed and timescale for implication	Amber	Project Group	Project Group	Amber		DoF	Clinical Systems Implementation Programme Board
8	IT	8.3	Improve our ability to manage our business through the production of robust and timely business intelligence to both head quarters and divisional staff	20% reduction in analyst time spent on routine report preparation. Improved Divisional satisfaction with information format and flow	Agree and implement model for Business Intelligence Function Procure and install business intelligence software Train all divisional analysts Develop consultant level quality and productivity dashboards	75% to 100%	Business Intelligence software (QlikView) has been procured. Divisional analysts have been trained. Work is underway to establish the data flows from the various Trust data sources (e.g. Patient Administration System; Electronic Staff Record; Ulysses etc.), to enable dashboards to be set-up. The first Access and Finance (Service Line Reporting) dashboards were demonstrated to the Service Delivery Group in early September with agreements on priorities and next steps reached.	No significant risks noted at present	Green	Not applicable	Not applicable	Green	Not applicable	Dir SD	Trust Management Executive
8	LTFP	8.4	Develop better understanding of service profitability using Service Line Reporting	Better resource allocation in the Trust	SLR development and benchmarking with other Trusts	75% to 100%	AUKUH benchmarking data collated. Report to TME and Finance Committee		Green	Continued development of SLR with Clinicians and managers	Finance Committee	Green	962	DoF	Finance Committee
9	T&L	9.1	Deliver a full Trust review of structures using the "spans and layers" approach	Structures will have appropriate spans of control and the number of layers between senior leaders and patients will be minimised	Spans and Layers process agreed and pilot division completed	75% to 100%	Pilot completed and reports being finalised - savings identified	Complete	Amber	Not applicable	Not applicable	Green		Dir W&OD	Trust Management Executive
					Full plan developed with targets	50% to 75%	Pilot outcomes presented to TME. Approach being offered as consulting intervention. Currently being used in Physio, finance, THQ and Estates. Requests will be prioritised based on ROI.	Divisions do not commit to the process		Full communications plan developed to engage with all stakeholders	Programme Steering Group	Amber			
					"light" process delivered across the Trust	0% to 25%	Programmed for later in year. Awaiting feedback from pilot in the Women's and Children's Division.	Divisions do not commit to the process				Amber			
10	LTFP	10.1	Deliver minimum normalised surplus	As per objective	Achieve full delivery of annual CRES programme and positive contract settlement with BNSSG and SCG commissioners	25% to 50%	Year 1 of 4 per LTFM	CRES delivery	Red	In year financial management	Finance Committee	Amber	962	DoF	Finance Committee
10	LTFP	10.2	Deliver minimum cash balance	As per objective	Maintain liquidity ratio of at least 15 days and cash balance of no less than £15m.	75% to 100%	Currently year end £30m	I&E surplus delivery and capital programme	Green	Treasury management policy	Finance Committee	Green	962	DoF	Finance Committee
10	LTFP	10.3	This is a duplicate of Objective 6.2												
11	LTFP	11.1	Maintain Monitor Financial Risk Rating of 3 or above	As per objective	Achieve Earnings Before Tax, Depreciation Amortisation, Return on Assets, Net Surplus Margin and Liquidity ratio in line with plan	75% to 100%	Delivered by 10.1 and 10.2 above	As per 10.1 and 10.2	Green	In year financial controls	Finance Committee	Green	962	DoF	Finance Committee
11	T&L	11.2	Achieve Compliance with EU Working Time Directors for Medical Staff	All staff will be working appropriate hours, ensuring a safe workplace for patients and staff	Ensure all derogated rotas are compliant before expiry of derogation in August 2011	75% to 100%	All rotas now technically compliant. In monitoring period to confirm compliant in practice.	Work continuing to ensure all rota's are compliant.	Amber	Maintain communication with job holders concerning hours worked.	Monitoring of Junior Doctors hours.	Amber	1406	Dir W&OD	Trust Management Executive

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11	CSS	11.3	Maintain 'compliance without conditions' with the Care Quality Commission		Compliance with Outcomes 5 and 14 and 21 is due to be achieved by the end of 2010/11. In 2011/12, we will therefore focus on maintaining compliance with these, and all other, CQC Outcomes. We will continue to foster an open and collaborative relationship with the CQC, including prompt responses to any requests for Planned Reviews and to any issues highlighted during, or as a result of, inspection. (Note: the Trust has further declared non-compliance with Outcomes 7 and 11 in-year)	75% to 100%	Outcome 5 - compliance declared to CQC in October 2011 Outcome 7 - compliance declared to CQC in November 2011 Outcome 11 - compliance declared to CQC December 2011 Outcome 14 - compliance declared to CQC November 2011 Outcome 21 - compliance declared to CQC December 2011	We are currently self-declared as compliant with all CQC Outcomes. The Trust will receive a Scheduled Inspection before 31st March 2012, the outcome of which cannot be predicted.	Amber	Current focus on sustainability of compliance with Outcomes which have previously been non-compliant. Operational leads' focus on updating corporate compliance evidence. On-going development of Divisional compliance evidence.	Monitoring of all CQC Outcomes via designated lead groups, CQC Group, Clinical Quality Group, TME, Board. Positive CQC draft compliance report following unannounced responsive review for Outcome 5 (Nutrition). Positive CQC report following responsive review of histopathology services - Outcomes 4, 6, 13, 14, 16, 21	Amber	n/a	Chief Nurse	Risk Management Group
11	CSS	11.4	Maintaining a Green Governance Risk Rating Clostridium Difficile infections (CDI)		Ensure continued adherence to Norovirus prevention best practice in 2011 / 12 only. The number of side rooms increased as part of the 2011/12 ward refurbishment schemes Increase proportion of single rooms in new BRI development Bed store with hydrogen peroxide cleaning facility available	75% to 100%	Overachievement against quarter 3 target with 11 cases recorded against a ceiling of 13 cases. Year to date (Quarters 1-3) position 44 cases against a ceiling of 49	Limited number of single rooms with reductions due to ward movements Continuing risk of Norovirus outbreaks that would impact on specimen sending and number of colonised cases identified Failure of staff to consistently follow best practice Closure of specialist CDI isolation unit due to insufficient number of in-patients with infections	Green	Use of cubicle tracker and infection control nurse input to isolation decisions Proactive risk assessment of all patients admitted to detect possible Norovirus Monitoring of practice through the infection control dashboard audits Daily clinical review of in-patients with CDI by infection control team and agreement in place to immediately re-open CDI unit if cases increase in number	Monthly monitoring of isolation target through infection control dashboard Weekly operational meetings that review all C diff cases and identify any failures in practice Monitoring of risk assessment completion through Nursing Quality in Care tool	Green		Chief Nurse	Infection Control Committee and then to Clinical Quality Group
11	CSS	11.4.1	Ensure compliance with the revised Accident and Emergency Department access targets.	Compliance is achieved with all Emergency Access Targets in a sustainable way.	Deliver a full programme of work that addresses Patient Flow issues from the 'front door' to discharge in a sustainable way. Key elements o this work stream include: - Delivery of an effective Ambulatory Care Unit that prevents unnecessary admissions - Delivery of an expanded Medical Assessment Unit (MAU) to aid patient assessment and flow - Delivery of a Control Centre and real time reporting so that decisions to expedite flow and discharge can be taken without delay. - Delivery of a new Discharge Lounge to free up beds early in the day.	75% to 100%	Patient Flow included in bed optimisation programme. New MAU opened on 1st August 2011. Operations Centre opened on 4th July 2011. National standard achieved for all national standards.	Admission avoidance does not deliver. Delayed discharges / 'red' patients increase.	Amber	Activity monitoring for meeting with PCT. Length of Stay escalation process.	Regular meetings with PCT. Review at 1/12 Ops and finance meetings.	Green		COO	Emergency Access Steering Group
11	CSS	11.4.2	Ensure compliance with the Cancer Access Targets and ensure improvement against the first National Cancer Patient Experience Survey.	Compliance is achieved with all Cancer Access Targets in a sustainable way and quantifiable improvements are seen in the National Cancer Patient Experience Survey.	Set appropriate priorities for the Cancer Board ensuring that comprehensive plans are in place to meet the cancer standards taking appropriate account of patient choice, stages of diagnosis and treatment and winter and other service pressures. In addition create an action plan to address issues requiring improvement identified in the first National Patient Cancer Survey.	25% to 50%	Q1 62 day cancer target on the line. Tighter monitoring process established. Cancer patient experience plan developed and delivered in all areas.	Delivery of 62 day cancer targets. Failure to improve Cancer Survey results.	Red	Weekly 62 day cancer target meeting. Plan developed and delivered for patient experience, cancer nurse is leading.	Weekly 62 day target meeting. Overview of survey issues at Cancer Board	Amber		COO	Cancer Board onto Trust Management Executive

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 26 January 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11 – Corporate Risk Register

Purpose

To brief the Board on changes in risk management agreed by the Executive team and to present the corporate risk register.

Abstract

The Executive team have had significant discussion on improving risk management arrangements, the rationale and outcome of which is set out in Appendix A.

The key point note is that the corporate risk register now contains only risks with an inherent risk rating score of 15 which have been escalated from a divisional risk register. There is a proviso that any risks identified by exception in the Risk Management Group which require the Board's attention can also be escalated to the corporate risk register. Those risks scoring less than 15 previously residing in the corporate risk register remain owned by an executive director and now sit in the Trust Services Division risk register, unless they are division specific when they sit in the relevant divisional risk register.

These revised risk management arrangements will be set out in a revised Risk Management Strategy (to be approved by the Board) and associated policies and procedures.

The current corporate risk register is provided at Appendix B.

Recommendations

The Board is recommended to **note** the revised risk management arrangements and risks contained within the current corporate risk register.

Executive Report Sponsor or Other Author

- Sponsor – The Chief Executive, Robert Woolley
- Authors – Anne Reader, Assistant Director of Governance and Risk management
  – Deborah Lee, Director of Strategic Development

Appendices

- Appendix A – Risk management Review
- Appendix B – Corporate Risk Register

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
16/12/2011	05/01/2012				Initial discussions at: Risk Management Group August and November 2011.

RISK MANAGEMENT REVIEW

1. Introduction

In 2011/12 the Executive introduced a new style Board Assurance Framework (BAF). The BAF was developed to provide a single reporting structure to the Board, and its sub-structure, on progress towards the achievement of the annual corporate objectives, alongside a description of any identified risks to their achievement and importantly a description of the controls put in place to manage those risks effectively. In this context the Board Assurance Framework is the means through which the Internal Statement of Control is supported.

Alongside this revised approach to Board Assurance, a review of the way in which risks are governed and reported to the Board has also occurred with the aim of ensuring consistency of reporting and that the Board remains sighted on all of the appropriate risks.

The purpose of this paper is to describe the revisions that have been agreed by the Risk Management Group and the Trust Management Executive and the impacts of these agreed revisions to the Corporate Risk Register presented to the Board this month. The Trust Risk Management Strategy continues to guide the approach to risk which remains based upon a model of escalation that ensures risks are managed at the most appropriate level to ensure their mitigation and that the Board remains sighted on all high risks through their inclusion on the Corporate Risk Register (CRR).

2. Current Position

Currently, within the Risk Management Strategy there is no description of what criteria / circumstances trigger escalation of risks sitting in a Divisional Risk Register (which includes Trust Services) or the Board Assurance Framework to the Corporate Risk Register. Equally, there is no guidance to support decisions regarding their subsequent removal (de-escalation). Currently these decisions to include or remove are based on judgment by individual *Risk Owners* and subsequent agreement by the Risk Management Committee.

It is apparent on reviewing the risk register that there has been a lack of consistency in determining the risks that sit on the Corporate Risk Register and a view that guidance would be of use in addressing this as a means of promoting consistency and ensuring the Board is appropriately sighted on key risks.

3. New arrangements

The following is a framework to guide consistent reporting and escalation of risk to the Board via the Corporate Risk Register and to ensure clear read across between risk reporting via the Register and the Board Assurance Framework. It continues to recognise the value of subject review but only following a more consistent trigger to risk escalation.

The following has now been adopted as the approach for escalation of risks to the Corporate Risk Register.

- Any risk on a divisional register or within the Board Assurance Framework that has an inherent risk rating of 15 or more will be included in the Corporate Risk Register unless, by exception, the Risk Management Group approves the addition or removal of a risk that would not otherwise meet this criterion.

  Or

- Any risks with a score below 15 **where mitigation or control of the risk requires the Board itself to take action**

  This approach will ensure that the Board is sighted on all risks where the likelihood of occurrence is rated as 3 or more (possible, likely or certain) and the impact is 3 or more (moderate, major or catastrophic) resulting in a risk of:

  - harm being caused to patients or staff
  - regulatory or contractual non-compliance
  - the failure to deliver one of the Trust's stated corporate objectives
  - the Trust suffering significant reputational damage
  - a significant deterioration in the Trust's financial position

In practice this will mean that the existing inherent risk matrix will change from the current NPSA matrix:

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Where grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 7	Moderate risk
8 - 14	High risk
15 - 25	Extreme risk

To a new matrix with increasing granularity at the higher risk levels:

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 8	Low risk
9 - 14	Moderate risk
15 - 19	High risk
20 - 25	Extreme risk

This new risk matrix will become the Trust's risk assessment matrix and will be incorporated in a revised Risk Assessment Policy for all non-clinical risk assessments e.g. incident risk rating.

The benefits of this approach are:

- consistency of inclusion of risks on the register and elimination of the duplication between Board monitoring frameworks

- that the Board focus will be upon high risks defined by their impact and the real likelihood of them materialising i.e. we will retain more of the "theoretical" risks, where likelihood is low, at Divisional Register level (with robust Risk Management Group oversight) and enable a stronger Board focus upon those risks that require on-going and active management

- a reduction in the number of risks included in the Corporate Register with the associated benefit of greater Board attention on the issues that have the potential to damage the organisation, our patients or our staff.

4. Impact

a) Many organisations devise their own risk matrices depending on the nature of their business and their risk tolerance levels. Such matrices can vary from 2 x 2 to 6 x 6 (and anything in between) and include simple definitions of likelihood and consequence to complex mathematical and financial models. Where organisations have devised their own risk matrix they have done so by first understanding their own risk tolerance levels in the context of their objectives and activities to achieve these. A Board seminar will be convened to crystallise the Trust's approach for the revised Risk Management Strategy.

b) The adoption of the proposed template, based on the descriptor (high, low etc.), has the impact of increasing the organisation's tolerance of risk i.e. there are more low risk categories and fewer moderate risk categories. Also the number of risks which sit above the high risk descriptor will reduce (i.e. from those with a score of 8 and above to those with a score of 15 and above) but there will be no impact on the number of risks that actually receive a score of 15 or above.

c) The new matrix agreed by the executive directors is a move away from the NPSA matrix recently agreed across the Trust. The rationale for the change in position will be communicated throughout the organisation via this paper to TME and subsequently to the Board with a follow up session for key staff involved in risk management.

d) The impact of this revised approach to risk register management has been to reduce the number of risk on Corporate Register from 30 to 7 (as of 18/01/2012).

e) The existing residual risk matrix will remain unchanged.

f) The recent decision, endorsed by the Patient Safety Group, that an incident with a score of 15 (with provision for individual exceptions for incidents with lower scores) executive triggers review for Serious Incident status remains unchanged.

g) There is no impact on the NPSA benchmarking report as this uses actual harm caused by the incident as the basis for comparison with other Trusts in our peer group.

Corporate Risk Register

Extracted 19/01/2012 17:30

Number	Description	Source Of Risk	Risk Group	Risk Type	Date	Last Review Date	Next Review Date	Board Member	Likelihood	Severity	Risk Rate Score	Risk Rating	Controls In Place	Details	Effective	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
402	Maternity staffing is below the recommendation of the Safer ChildBirth report (Royal College of Obstetricians/Royal College of Midwives), which could increase the risk of harm to mothers and their babies, lead to the unit being closed to admissions at times and making birth choices for women more difficult to accomodate. This risk is compounded by an increase in overall birth rate in Bristol and fluctuations in activity and complexity of patient which results in increased workload within maternity both within this unit and across the region.	Incidents Or Near Misses	Governance	3.4 Harm Reduction And Safety	21/07/2010	04/01/2012	03/02/2012	Alison Moon	4 Likely	4 Major	16	High	Workforce Management	The staffing of Central Delivery Suite with 8 midwives per shift is prioritised and any short fall is addressed via bank & redeployment of midwives from wards to ensure that mothers receive the appropriate level of care.	Medium	High	Letter sent to the Local Supervising Authority and the Strategic Health Authority highlighting the impact of high workload within the service	Completed.	30/11/2005	07/03/2011	Divisional Board Women's And Children's
													Workforce Management	The Granby Team midwives (community base) can be called to Central Delivery Suite, and in extreme urgency both the supervisor of midwives and the on-call community midwives can be called to address low staffing levels, ensuring that mothers recieve the appropriate level of care			Repeat Birthrate Plus staffffing assessment tool and bid for funding to meet its recommendations	Completed.	30/11/2005	07/03/2011	
													Workforce Management	Ward clerk cover to support the activity of the Unit is in place for24 hours of each day			Review skill mix and roles - e.g. provision of level 4 maternity worker.	Completed.	30/01/2006	07/12/2011	
													Workforce Management	Appropriately skilled and trained General Nurses employed to support midwives in providing nursing care to mothers on post natal ward			Maternity service review in progress	Completed.	30/01/2006	07/12/2011	
													Planning	Bed management - performed daily to ensure effective use of resources. Escalation plan developed, working with neighbouring Trusts to manage the number of deliveries across the city. Bookings from Mothers outside of Bath North Somerset and South Gloucestershire area managed within a capped limit			Working with Primary Care Trust to reduce admissions of non-labouring women to Central Delivery Suite.	Completed.	01/12/2011	07/12/2011	
													Planning	Guidelines in place for lack of midwives and lack of beds and a procedure for closure of the unit to ensure that mothers and babies can be cared for safely			Expression of interest for additional funding submitted after review of maternity services.	Completed	31/03/2012	Not yet due	
													Planning	Monitoring of deliveries and liaison with Bath and Southmead to re-direct women in labour on an ongoing basis			Working with North Bristol and Weston Trusts to ultilise capacity across the city efficiently	Monthly planning meetings in place	31/03/2012	Not yet due	
													Workforce Management	Employment of appropriately skilled and trained General Nurses to support the midwives. A General Nurse with recovery room experience is available in Central Delivery Suite. Appropriately trained and skilled staff to provide scrub nurse cover to surgical procedures is available on Central Delivery Suite.			Submitting Expression of interest to capital planning to develop an area alongside the delivery suite where assessment of women can occur alongside delivery suite	Plans being developed. Expression of Interest submitted December 2011, outcome expected by end March 2012.	31/03/2012	Not yet due	
													Funding	Funding required for the service is reviewed on a regular basis to align with delivery numbers Additional funding was provided in 2010/11 and 2011/12. Further 5.6 whole time equivalent staff funded in October 2011. Further expression of interest for further funding submitted.			Risk 402 reviewed and a risk assessment regarding maternity capacity and staffing was accepted by the womens Clinical Governance Committee . The Divisional management team requested in October 2011 that this risk be separated into two risks - physical capacity and staffing. Demand for maternity services is increasing year on year and this will have an impact on the amount of equipment needed, equipment usage (which will include wear and tear on equipment). Bids will be put forward to allow:- 1. A resusuciataire for each labour suite. 2. Replacement of heart rate and contraction monitoring equipment which have exceeded their service agreement period. 3. Increase number of delivery suite beds to meet extended capacity (as identified in risk assessment) and will be suitable for women with a high Body Mass Index	Plan to ensure individual risk assessmenst are presented to the Divisional management team in early 2012.	29/02/2012	Not yet due	
													Training	Expediction of mother and baby discharge home through Midwives being trained to undertake clinical examination of newborn babies Introduction of maternity support workers in the community to support mothers and babies following earlier discharges							
													Service Redesign	Improved care pathway through improved management of elective caesarean section cases							

Corporate Risk Register

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Number	Description	Source Of Risk	Risk Group	Risk Type	Date	Last Review Date	Next Review Date	Board Member	Likelihood	Severity	Risk Rate Score	Risk Rating	Controls In Place	Details	Effective	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
741	Cash Releasing Efficiency Savings Plans underachieve and impact on trust annual and planned outturn.	Annual Planning Process	Financial	11.3 Maintain Financial Risk Rating Of 3 Or Above	01/11/2011	19/01/2012	18/04/2012	James Rimmer	4 Likely	4 Major	16	High	Performance Management	Monthly Divisional CRES reviews, Monthly Divisional Performance reviews , Quarterly reviews, Monthly review by CRES Programme Steering Group, monthly updated at a glance reports	High	High	CRES plans to be monitored at divisional perfomance reviews and recovery actions will be put in place if required. CRES plans monitored at Programme Steering Group chaired by Transformation Director.	Divisions currently going through the TME sign off process for 2012/13 operational plans. Corporate CRES workstream plans being developed to merge any gaps	31/03/2012	Not yet due	Service Delivery Group
													Performance Management	Benefits tracking systems - all schemes are tracked based on actual savings to specific budget line and this is monthly reviewed and end of year forecast risk assessed							
													Performance Management	Divisional control of vacancies and procurement monitored at monthly performance meetings. Those Divisions who have challenges meeting the target are given additional external and internal support to assist in managing the recovery.							
													Performance Management	Regular Reporting to the Finance Committee and Trust Board							

Corporate Risk Register

Extracted 19/01/2012 17:30

Number	Description	Source Of Risk	Risk Group	Risk Type	Date	Last Review Date	Next Review Date	Board Member	Likelihood	Severity	Risk Rate Score	Risk Rating	Controls In Place	Details	Effective	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
1640	Pharmacy service unable, at weekends and out of hours, to meet all patient and Trust requirements for medicine supply and clinical support.	Service Wide Risk Reviews	Governance	3.3 High Quality Care	30/04/2010	06/01/2012	05/04/2012	Sean O'Kelly	4 Likely	4 Major	16	High	Workforce Management	Pharmacy project group set up to look at what steps can be taken to improve - see actions for full details of outcome of group.	Medium	High	Raised within division, and a senior review team set up (divisional manager, divisional finance lead, divisional HR lead, pharmacy management team, pharmacy health and safety lead and pharmacy union representative) to review issues and identify solutions. High level outcome - final report presented to Board Transformation Group with plan of funding additional posts to enable dispensary based pharmacy staff contracts to change to 7 days (working 9 day fortnight) to support late evening and weekend service provision. Source of funding investment is the outsourcing of out-patient pharmacy service.	09/01/2012 update - outsourcing of out-patient pharmacy service delayed until April 2013	01/04/2013	Not yet due	Divisional Board Diagnostics And Therapies
													Workforce Management	availability of Director of pharmacy to cover weekend work when no volunteers or unforseen circumstance means pharmacist not able to work			Improve pharmacy recruitment prcoess to enable 'recruiting the best', plus infrastructure to ensure staff are retained	Development of pharmacy recruitment microsite Appointment of training and education lead pharmacists (job share) ensures appropriate support and training provided to junior staff thus leading to better retention of junior pharmacists.	01/06/2010	30/06/2010	
													Workforce Management	Availability of emergency duty pharmacist to cover weekend when no volunteers or unforseen circumstance means no pharmacist available			Lean project to review pharmacy processes for dispensing To-take-away (discharge) medicines, with view to getting majority completed within 2 hours of receipt of valid prescription (at BRI)	marked as complete with the implementation of the pharmacy facilitated discharge (carred out at BRI and BHI wards)	01/01/2011	15/01/2011	
													Planning	Use of Clinical Site Manager to help with workload organisation, ie discharge medicines only accepted in pharmacy after 4pm (Mon - Fri) with CSM approval. This has had positive impact on late finishing times			Increase number of Pharmacy ATOs (basic dispensing functions eg labelling and selection of stock) and accredited checking technicians (able to sign of medicines against a clinically checked (by pharmacist) velid prescription)	Jan 2012 update - issues with PCP process as becoming more difficult to replace staff even at lower grades (ie band 2-5) which impacts such that using higher grade staff (eg 8a or 8b) to carry out as overtime activities that should be done by ATOs/ ACTs (band 2-5) Ongoing	01/05/2012	Not yet due	
													Planning	Provision of urgent TTAs only on Sat and Sunday afternoons			Use the professional standards for discharge to help with the planning and presentation of workload to the BRI dispensary for discharge medicines (impact on late evening work)	Pharmacy guidance produced, need trust support with implementation of this	01/06/2012	Not yet due	
													Workforce Management	Increased number of staff working and optimisation of skill mix (use of pharmacy ATOS and accredited checking technicians) during weekday lates and weekends. This means taht the finish times usually are more manageable but does mean that frequency of working has increased.			Engagement with pharmacy around the implications of service provision for the planned 2014 Terrell St development. Pharmacy submitted a staffing template for consideration by the Integarted Admissions Unit planning team, to facilitate a 7 day medicines optimisation service to the Integrated Admissions Unit.	Staffing template submitted, need outcome decision and trsut support for implementation	01/07/2012	Not yet due	
													Workforce Management	Appointed contracted permanent weekend-based hours staff - this means that continuity at weekends, experience if rest of team not dispensary based plus better finish times for overtime based staff.			Liase with HR on staff consultation regarding ensuring able to make voluntary overtime on saturday and sunday extend from 12.30 to 4pm		01/06/2012	Not yet due	
													Planning	outsource of multidose compliance aids - reduce workload especially late afternoon enabling minised late evening work			manage workload better in week by outsorucing multi compliance aids (MCA/dosettes) as these are very time consuming to dispense	Jan 2012 - process better, action closed Jan 2011 - in place but difficulty in ensuring discharge summaries are written, reviewed and pharmacy screened with the necessary 24 hours notice to enable outsourcine	01/01/2012	09/01/2012	
																	reivew overtime payments to identify if able to put business case for permanent substantive posts	HR review complete and 1 substantive post advertised and recruited to	01/01/2012	09/01/2012	

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Number	Description	Source Of Risk	Risk Group	Risk Type	Date	Last Review Date	Next Review Date	Board Member	Likelihood	Severity	Risk Rate Score	Risk Rating	Controls In Place	Details	Effective	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
1704	There is a risk that patients on ambulance trolleys may come to harm when queuing in the corridor outside the Emergency Department (ED) due to department at full capacity.	Incidents Or Near Misses	Governance	11.4.1 Compliance With Emergency Access Targets	10/01/2012	09/01/2012	08/04/2012	James Rimmer	4 Likely	4 Major	16	High	Workforce Management	Allocation of emergency department (ED) nurse to corridor patients to triage and priortise admission to ED as space becomes available. We do have an assistant nurse who completes vital signs and a pain score within 15 minutes of all ambulance arrivals however the patient may have a low score but still deteriorate whilst in the corridor.	Low	High	Improvements in ambulance handover required. Greater partnership working between GWAS & UH Bristol as well as other acute trusts to manage emergency demand in the city. Automatic 999 re-routing will help mitigate some spikes in demand by moving patients on hospital catchment borders to the least busy ED. Ambulance queues are one of the factors that triggers a higher CMS score. 'Downstream' flow improvements required to avoid ED bottlenecks	Routine review meetings with GWAS as part of ambulance handover improvement project is improving processes to support patient safety. Regular senior manager & executive director meetings regarding emergency pathways & ' divert protocol' should improve emergency processes. Agreement about pre-emptive transfer to wards is underway to ensure that pressure is shared across hospital site. Risk routinely reviewed at daily operations meetings, weekly emergency access breach review meeting & through divisional safety meetings. Plan to review & address risk further as part of planning for unscheduled care & winter 2012/13	30/06/2012	Not yet due	Divisional Board Medicine
													Local Policy In Force	Formal escalation policy for ED when pressure rises. Try to restrict number of patients queuing to 3 by triggering internal escalation plans. Automatic 999 rerouting, using Great Western Ambulance Service and capacity management system (CMS) is intended to mitigate this risk over time. Go live was 6th December 2011 and effectiveness of this remains uncertain.							
1831	Since its inception in August 2009, risk that the department of Inherited Metabolic Disorders (IMDs) cannot meet the minimum standard of care for their patients (as identified by the British Inherited Metabolic Disorders Group (BIMDG) in 2007) due to staffing capacity constraints. In addition, benchmarking information from other regions clearly indicates that the South West is significantly under-resourced.	Individual Or Group Concern	Governance	3.4 Harm Reduction And Safety	04/07/2011	07/12/2011	06/03/2012	James Rimmer	4 Likely	4 Major	16	High	Partnership Working	National commissioning have turned down an initial proposal from the British Inherited Metabolic Diseases to commission all metabolic provision nationally, therefore there are no changes to the commissioning arrangements expected. D Lee has been contacted recently regarding adult outreach service from Guy's and St Thomas' in London, but we are waiting for further clarity from the on-going discussions about the paediatric network before pursuing this.	Low	High	Letter sent from D Lee to A Jarvis in September 2011 noting the risks relating to the current provision of this service. Expression of Interest submitted to Trust executives, asked for full proposal to be developed. Submission deadline 16th December 2011 James Palmer, Medical Director of South West Specialist Commissioning Group meeting with Lead Consultant & Divisional Manager 20th December 2011	Waiting outcome of discussions	31/03/2012	Not yet due	Divisional Board Women's And Children's
													Workforce Management	Appointed to CNS post, in post from 5th December 2011			Funding secured to recruit to CNS post.	Successful appointment made, in post from 5th December 2011	10/12/2011	10/12/2011	
													Workforce Management	Number of clinics has been reduced to enable the clinical staff to manage the planned workload, who are working very efficiently. Patients are referred out of region when necessary.							
1839	Due to a backlog in the Clinical Genetics Service, medical information may not be provided in a timely manner to enable patients & other healthcare professionals to make informed decisions.	Individual Or Group Concern	Governance	3.4 Harm Reduction And Safety	14/12/2011	18/01/2012	17/02/2012	Sean O'Kelly	4 Likely	4 Major	16	High	Workforce Management	Temporary re-alignment of Consultant job plan, no clinical work being undertaken. Focus of work is on responses to previous clinic letters, to referrals and to requests for clinical opinion.	High	High	Daily meetings with Lead Administrator. Weekly meetings with Lead Doctor and Assistant Divisional Manager Supervision from Lead Clinican Provision of external coaching sessions Regular attendance at Occupational Health	Ongoing. Leading to consideration of different ways of working but individual will require further support to make adjustments.	Ongoing	Ongoing	Divisional Board Women's And Children's
													Partnership Working	Proposal that Consultants from Cambridge will contribute to service provision in Bristol and Gloucester to maintain activity to assist with waiting list management.			Increase in administrative staff, 30 hours/week Plus 4 hours of Lead Administrator who meets with Consultant daily and plans workload and reports progress.	Working well, effective arrangement. Will need to be reviewed as recovery plan comes to an end.	Ongoing	Ongoing	
																	Increase of Planned Activity sessions of Consultant colleague to cover. Increase of Clinical Counsellor hours Negogiating service level agreement for clinical support from the team in Cambridge.	Progressing well. Target date for Cambridge support is December 2011 dependant on completion of honorary contracts	31/01/2012	Not yet due	
1859	Risk of not achieving planned financial income from participation in NIHR trials and negative impact on the Trust's reputation as a centre of excellence for research. The Trust is currently off target as it has an unbalanced portfolio of research concentrating on complex low participant number projects.	Individual Or Group Concern	Financial	1.4 Increasing Participation In Research Trials	08/12/2011	08/12/2011	07/03/2012	Sean O'Kelly	5 Almost Certain	3 Moderate	15	High	Partnership Working	Discussions with the Local Research Network have taken place with a view to increasing participation rates.	Medium	High	Action plan in place to increase partcipation in research trials being monitored by the Trust Management Executive.	January 2012 update Recruitment to National Institute for Health Research portfolio trials continues to be off target. It is expected that these figures will improve over the next six months as new resources committed by Research and Innovation result in additional patient recruitment.	31/03/2012	Not yet due	Trust Management Executive
													Workforce Management	Appointments made to key research positions.							