University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

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 Meeting of the Trust Board of Directors dated Thursday 28 June 2012 for **approval**.	Chairman	01
4. Chief Executive's Briefing To receive this briefing to **note**.	Chief Executive	20
Board: Quality, Performance and Compliance		
5. Quality and Performance Report To receive the Quality and Performance Report for **review**. 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	23
6. Annual Reports To receive the following annual reports **note**: a. Infection Control Annual Report – Chief Nurse b. Health and Safety Annual Report – Acting Director of Workforce & Organisational Development c. Information Governance Annual Report – Medical Director d. Fire Safety Annual Report – Chief Operating Officer e. Security Annual Report – Chief Operating Officer	Executive Leads	92
Board: Finance and Governance		
7. Committee Chairs' Reports To receive reports on the activities of Board Committees by their respective Chairs and consider any recommendations for **review**. a. Finance Committee dated 23 July 2012, including the Report of the Finance Director b. Quality and Outcomes Committee dated 26 July 2012.	Committee Chairs	151

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Board: Strategy and Business Planning			
8. Integration of Health Services in Bristol To receive this briefing to **note.**	Chief Executive		To Follow
9. Report from the Transformation Programme Board To receive this report to **note**.	Chief Executive	171	
10. Pathology Services Review – Advisory Panel Findings and Recommendations To receive this report to **note**.	Director of Strategic Development	177	
11. Quarterly Capital Projects Status Report To receive this report to **note**.	Director of Strategic Development	188	
12. Urology Services Transfer To consider the recommendations of this report for **approval**.	Chief Operating Officer	196	
13. Clinical Systems Strategy – The Way Forward To consider this strategy for **approval**.	Finance Director	213	
14. Big Green Scheme To consider the recommendations of this report for **approval**.	Chief Operating Officer	257	
Board: Risk			
15. Board Assurance Framework Report To receive this report for **review**.	Director of Strategic Development	279	
16. Corporate Risk Register To receive this report for **review**.	Chief Executive	288	
Board: Monitor Reports			
17. Quarter 1 Compliance Framework Monitoring & Declaration Report To consider the recommendations of this report for **approval**.	Chief Executive	298	

Membership Council			
18. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman		
19. 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		
20. Minutes and Matters Arising from the Previous Meeting To consider the Minutes of a meeting of the Membership Council dated Tuesday 29 May 2012 for **approval**.	Chairman	319	
21. Governor Representative's Report To receive this report to **note**.	Governor Representative	324	
Membership Council: Quality, Performance and Compliance			
22. Governors' Quality Working Group Report To receive this report to **note**.	Chair of the Group	325	
Membership Council: Corporate Governance			
23. Governors' Nominations and Appointments Committee Report To receive this report to **note**.	Chairman	328	
24. Resignation of the External Auditor To receive this report to **note**.	Trust Secretary	330	
25. Governors' Membership Working Group Report To receive this report to **note**.	Chair of the Group	332	
26. Membership Council Task and Finish Report To consider the recommendations of this report for **approval**.	Trust Secretary	340	
Membership Council: Strategy and Business Planning			
27. Governors' Strategy Working Group Report To receive this report to **note**.	Chair of the Group	342	
28. Integration of Health Services in Bristol To consider the recommendations of this report for **approval**.	Chief Executive		To Follow
Membership Council: Information and Other			
29. Foundation Trust Members' Questions	Chairman		

To receive questions from Foundation Trust Members present.		
30. Date of Next Meetings **Annual Members Meeting,** Thursday 20 September 2012 from 17:00 – 19:00 in Lecture Theatre 1 of the Education Centre, Upper Maudlin Street, Bristol, BS2 8AE. **Trust Board Meeting,** Thursday 27 September 2012 from 10:30 – 13:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU. **Membership Council Meeting,** Thursday 08 November 2012 from 13:00 – 15:00 in Lecture Theatre 1 of the Education Centre, Upper Maudlin Street, Bristol, BS2 8AE.	Chairman	

University Hospitals Bristol NHS
NHS Foundation Trust

Minutes of a Public Meeting of the Trust Board of Directors held on 28 June 2012 at 10:30 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 • John Moore – Non-executive Director • Lisa Gardner – Non-executive Director • Paul May – Non-executive Director • Kelvin Blake – Non-executive Director • Guy Orpen – Non-executive Director	• Robert Woolley – Chief Executive • Alison Moon – Chief Nurse • Deborah Lee – Director of Strategic Development • James Rimmer – Chief Operating Officer • Paul Mapson – Director of Finance • Sean O'Kelly – Medical Director
Present or In Attendance	
• Claire Buchanan – Acting Director of Workforce & Organisational Development • Charlie Helps – Trust Secretary • Victoria Church – Management Assistant to Trust Secretary • Fiona Reid – Head of External Relations • Anne Ford – Public Governor • Philip Mackie – Patient Governor • Ken Booth – Public Governor • Mo Schiller – Public Governor	• John Steeds – Patient Governor – Local • Garry Williams – Patient Governor • Clive Hamilton – Public Governor • Sue Silvey – Public Governor • Pauline Beddoes – Public Governor • Florene Jordan – Staff Governor • Louise Newell – Staff Governor • Jan Dykes – Staff Governor • Dr Robert Spencer – Interim Director of Infection & Prevention Control – Health Protection Agency

Item	*Action*
1. Chairman's Introduction and Apologies John Savage formally welcomed the new Non-executive Director, Professor Anthony 'Guy' Orpen, to his first meeting of the Trust Board of Directors. An appropriate farewell had been given to the previous Non-executive Director, Selby Knox, who had now left the trust following his term as Non-executive Director.	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Board Meeting Agenda. No declarations of interest were made.	
3. Minutes and Matters Arising from Previous Meetings The Board considered the Minutes of the Public meeting of the Trust Board of Directors dated Thursday 31 May 2012 and **approved** them as an accurate record, subject to the following amendments: **Page 3, second bullet point of Item 04, Chief Executive's Report,** to re-	Secretariat

word as follows: *"…Professor Peter Mathieson, current Dean of Dentistry at the University of Bristol, had been appointed as ~~Project~~ Director."*

Page 4, third bullet point of Item 04, Chief Executive's Report, Emma Woollett requested clarity regarding what was considered a "management integration." Robert Woolley recalled that his comment was in response to Garry Williams, a patient governor for Bristol, about whether major service change would commence as a direct component of the possible integration of the organisations, with particular regard to emergency and accident & emergency services. Robert effectively said that the impact would be of governance and management, and there were no plans for major service change on the back of an integration proposal at this stage. He had then explained that there were certain fixed points that were invested inside the project. It was agreed to make this a matter for discussion at a future Board meeting.

In response to a request by Garry Williams, Robert Woolley explained that the trust received a planned, unannounced visit from the Care Quality Commission on 21 June, in which they spent the whole day looking at services. They commented specifically on the welcome received from staff. A draft report was expected in due course.

Guy Orpen requested an update on the Academic Health Science Network, as discussed on page 3 of the minutes. Robert Woolley confirmed that guidance was issued on 21 June, and he had agreed with a number of chief executives in the west of England area to jointly submit an expression of interest to apply into the first wave of Academic Health Science Networks. A small core group of people were working on completion of this by 20 July. The Trust Board would be updated on progress.

The Trust Board was given updates on the outstanding items on the schedule of matters arising:

46 – Alison Moon informed the Trust Board that she had received assurances from the Estates team that the process for implementing alcohol gel at the Trust would be complete by the end of July 2012.

Paul May asked Alison for clarity regarding the provision of alcohol gels, as he had noticed that notices had been left in some places where gel had been removed, which might look like the trust was not doing its job properly. Alison Moon reassured Paul that the Trust would end up with three scenarios, firstly that there would be notices, plus gel, or general notices to raise peoples' awareness when entering a building, or no requirement for either.

47 – At the request of John Moore, Claire Buchanan updated the Board on equality and diversity training targets. A trainer has been in-post for nearly two years' and training had happened, but more work needed to be done in this regard. There was noted to be a problem with releasing staff for training, and Claire said that there were plans to build equality and diversity into more courses.

Alison Moon drew attention to a comment from the May Trust Board meeting which had been overlooked as a 'matter arising'. It referred to John Moore's comment in the Patient Experience Report regarding soundproofing of rooms at the Trust. Alison assured the Board that a piece of work had commenced in the Women's and Children's division, where the complaint

originated, and there were plans to check sound-proofing across the trust.

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:

- During the roll-out of the 'Living the Values' sessions, over 1,000 staff had attended or were booked to attend, and positive feedback had been received.
- Robert thanked John Steeds, a public governor for Bristol, for bringing in the commemorative medal of the royal opening of the Bristol Royal Infirmary King Edward Building on 28 June 1912, the centenary of which was today.
- Sybil Moores, who was a Matron at the Bristol Dental Hospital from 1953 to 1975, was awarded a British Empire Medal in the Queen's birthday honours list. Alison Moon and Robert Woolley planned to write to her with congratulations.
- The Trust had received planning permission for the Welcome Centre at the Bristol Royal Infirmary, so building could now proceed.
- Women's Royal Voluntary Service (WRVS) staff at the Bristol Royal Infirmary had expressed their disappointment that the café where they worked in the Queen's Building was set to close at the end of June, when work started on the Welcome Centre. There was some adverse coverage in the press, particularly regarding the decision not to reinstate the facility after the rebuild.

In a joint letter, Deborah Lee and Steven Hargreaves, Head of the Region for the WRVS, highlighted the long-standing relationship between the WRVS and the Trust, pointing out that the charity had recently made generous donations to its work in caring for patients. The Trust and the WRVS were in consultation about plans to expand some of the facilities and alter others across the hospitals, such as introducing hot snacks and light meals at the WRVS outlet in the Bristol Royal Hospital for Children foyer, and said that in order to accommodate work on the Welcome Centre, the WRVS Bristol Royal Infirmary café and shop would close.

Robert Woolley added that maybe there was some shortcoming in communication with WRVS staff, in which case lessons would be learnt.

- On 21 June, the Care Quality Commission visited the Trust, undertaking their planned review of the Outcomes. Robert Woolley reported that we would receive a report in due course. Academic Health Science Networks guidance was issued, and it was also the British Medical Association day of action.

The day of action passed off with minor impact and contingency plans in-place ensured that the impact on patients was minimal. Some cancellations were made and appointments re-scheduled for some elective procedures and in outpatient clinics, which were being re-booked.

- The inaugural 'Green Impact Award Ceremony' was also held on 21 June. Of the 22 teams entered in coalition with the University of Bristol, 11

won awards; this was seen as a good boost to the Trust's internal 'Big Green Scheme', which promoted environmental awareness to staff.

- The British Association of Parenteral and Enteral Nutrition gave an award to the University Hospitals Bristol NHS Foundation Trust Dietetics and Nutrition Services for its work in improving nutritional screening across its hospitals. This was very positive feedback, as nutrition was a major focus of the Board.

The Board discussed the Chief Executive's briefing, including:

- James Rimmer explained to Paul May that the purpose of a visit by the Patient Environment Access Team was to assess the quality of both inpatient and outpatient environment and facilities. Alison Moon explained that money was allocated annually by the Patient Environment Access Team for divisions to focus on specific areas.
- Garry Williams, a governor for patient, carers of 16 years old and over, and Mo Schiller, a public governor for Bristol, both expressed concern that trust governors' had not been provided with information about certain activities at the trust. Robert Woolley planned to check the arrangements in-place, as it was certainly the intention to inform and publicise events to governors.
- Garry Williams asked if any solution had been reached regarding Accident and Emergency access via ambulance. Robert Woolley confirmed that this was under active consideration, and a review had commenced by the Emergency Care and Intensive Support team across Bristol, and at the Trust, with input from Great Western Ambulance Service.
- James Rimmer added that he had recently met with Great Western Ambulance Service, and gave reassurance that shared patient care was a core way of working between the Trust and the ambulance service.
- Iain Fairbairn reassured Garry Williams that from a Non-executive Director point of view, Accident and Emergency performance was of paramount focus. In recent months, the Non-executive Directors had visited the department, and the Quality and Outcomes Committee had received a special presentation in May regarding performance in that area.
- Referring to the closure of the WRVS café in the Bristol Royal Infirmary, Clive Hamilton (a public governor for Bristol), asked if there were any plans for other catering facilities for patients and visitors. Robert Woolley said that food provision facilities at the Bristol Royal Infirmary Welcome Centre would be available next autumn, and in the following year, there would be significant new canteen facilities for patients, visitors and staff when the Bristol Royal Infirmary was redeveloped. It had not yet been decided whether the facilities would offer concessions.

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

Quality, Performance and Compliance

5. 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 item, reporting four areas of deterioration affecting patient experience, which were:

1. Complaints;
2. Pressure sores;
3. Single-sex Accommodation;
4. Healthcare acquired infections, notably Clostridium Difficile.

The report noted that the Trust was showing an 'Amber-green' position against the Monitor governance framework, due to the known position relating to performance of the 4-hour Accident and Emergency standard. As a result of the trajectory being breached for the Clostridium Difficile target, the position would change to 'Amber-red' for the quarter.

- More positively, the Board has shown great interest in practices relating to falls, and there had been very targeted action in an attempt to improve the position, which had gone from 'Red' to 'Green'. This achievement demonstrated that concerted and targeted action has been taken, and the challenge was to sustain and improve the position further.
- Financial position was also 'Red' rated in the barometer, and the Finance Risk Rating was 2, as opposed to 3, which was originally planned. The deterioration in Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA) drove this adjustment in the Finance Risk Rating.

b. Patient Experience

The Chief Nurse, Alison Moon, presented the patient experience report, which recounted the experiences of women who had attended the open access gynaecology service clinic in January and February 2012. Two formal, and several informal complaints had been received from women who had either had to endure long waits to be seen, or were turned away altogether and asked to return the following day. The change in the way care was provided was in part informed by the patient feedback, so this was a very good example of a service being proactive in improving the way patients were cared for.

A number of local learning points were identified and these were documented in the report.

Alison Moon reported that from anecdotal feedback, women were now much happier with the service.

Discussion included:

- Emma Woollett felt that it was a "positive story" as it showed complaints leading to improvements in the organisation.

c. Quality

The Medical Director, Sean O'Kelly, presented the quality element of the quality and performance report, and noted that:

- Improvements across all clinical divisions had been seen in the month, regarding Antibiotic Prescribing performance. Sean attributed this partly to clinical leads being notified of any exceptions in their areas, and being asked to speak to the individuals responsible. The main exception to compliance was regarding incorrect logging of 'stop and review' dates, but Sean reported that new prescription charts had a facility for repeated 'stop and review'

dates, which should help significantly.

- A significant deterioration in the WHO Surgical Checklist Compliance was found to be related to the unfamiliarity of staff with the new computer system. When information was entered into the system adequately, compliance was 97%, as opposed to the 85% reported. Training was being undertaken to enable accelerated familiarisation with the system and an increase in performance.
- Regarding the Reduction in Medication Errors standard, which had slipped into the 'red' this month, Sean explained that the figures involved such small numbers that they suggested a disproportionate increase in percentages. He assured the Board that May numbers would improve, and that the three incidents were not connected, and were in different divisions.

Alison Moon asked the Interim Director of Infection & Prevention Control, Dr Robert Spencer, to explain the reasons for the Clostridium Difficile Exception Report:

- Dr Spencer said that the Trust as a whole was over trajectory by two cases for cases allocated. The yearly target was small, and everything was being done to meet the target. The Antibiotic Compliance Group was trying to ensure that junior doctors prescribed the most suitable antibiotics to patients, and this included front page intranet reminder reminding them when and what appropriate samples to take. In addition, teams were on the wards daily, "drumming home" the message.
- Alison Moon stressed the importance of educating staff, to ensure that good practices regarding Clostridium Difficile were embedded at the Trust. It was noted that 3 or 4 cases had been as a result of inappropriate testing, but Alison assured the Board that this was being focussed on and work was on-going. In addition, weekly operational meetings were held by Deputy Chief Nurse.
- Robert Spencer explained that whilst incidences of Methicillin-Resistant Staphylococcus Aureus (MRSA) were reduced both naturally and within the Trust, Methicillin-Sensitive Staphylococcus Aureus, (MSSA) had often stayed static or increased. Many cases were acquired in the community, but all cases were investigated in the same way.

Alison Moon gave further key points from the exceptions Reports:

- Alison Moon reported that two category 3 and 4 Hospital Acquired Pressure Ulcers had been seen at the Trust, which was "deeply worrying", as they were an important indicator of the quality of care received by patients. Alison assured the Board of the focussed recovery plan in-place, which was detailed in the report. In addition, an intensive teaching programme of education had been instigated. She had also commissioned an external review of the service which would focus on:

  a. Understanding why, despite a continued focus, performance had not improved;

  b) Providing an independent clinical expert view on current clinical actions being taken;

  c) Providing an independent expert view on the current processes and systems regarding procurement and provision of pressure relieving

equipment;

d) Determining if the overall current actions of the Trust were sufficiently robust;

e) Knowing if there were additional action to be taken to increase confidence that the current position could be improved on;

f) Ensuring the governance and assurance processes underpinning this work were operating efficiently;

g) Considering the links between quality of care and patient flow;

h) Identifying best practice in peer trusts;

The expert commissioned to conduct a review of pressure ulcers had previously reviewed ten other tissue viability services in large trusts this year.

- There was increased focus in the Women's and Children's Division to improve the number of women who have Spontaneous Vaginal Births.
- Alison Moon felt that breaches of the Same-sex Accommodation Standard were directly linked to the operational patient flow issues and had occurred in the admissions units. Patients were always informed of changes in their accommodation, and breaches resolved as quickly as possible.
- A 'spike' had been seen in Complaints, and it was noted that 100 of these were regarding missed appointments, and not being able to contact staff to query appointments. There were no other significant themes noted within the increased numbers.

Points of discussion included:

- In response to a question by John Moore, Alison Moon confirmed that it was not clear why there was a Clostridium Difficile spike in May. It appeared to be a seasonal trend. Robert Spencer added that it tended to be found in elderly patients with serious conditions and underlying issues, who required broad-spectrum antibiotics over a prolonged period. Alison Moon informed the Board that attempts were always made to understand why spikes occurred, and in previous years targets had been set according to the season, and when issues were predicted.
- Referring to Clostridium Difficile, Emma Woollett said that detailed reports used to be brought to the Board, and suggested that if any more 'slippage' occurred, these should be reinstated. Robert Woolley agreed with Emma's point, adding that the Trust had seen a massive reduction in incidences of Clostridium Difficile recently, but questioned if conditions were different. He added that the Board would be informed if Clostridium Difficile was going further off trajectory in the future.
- Emma Woollett asked if the trust should screen for Methicillin-Sensitive Staphylococcus Aureus, even though it was not a national recommendation. Alison noted that this was a valid question and assured the Board that the question of screening was regularly reviewed. Robert Spencer confirmed that the Trust worked to distinguish between community and hospital acquired infections.
- Iain Fairbairn suggested that hospital acquired infections were referred to the Quality and Outcomes Committee for detailed analysis, if no improvement was noted, which was agreed.

- Kelvin Blake referred to the incidences of Grade 3 and 4 Pressure Ulcers, saying that it was about culture and embedding nursing standards at the Trust, and using the correct mattresses. He asked what extra could be done to further embed better practices, to decrease ulcer figures. Pauline Beddoes, a Public Governor, added her view that as a nurse, correct equipment was very important. Alison Moon confirmed that this was an important aspect and that equipment would be looked at by the external review.
- Alison Moon responded that the urgency was fully embraced.
- Alison Moon assured John Moore that Grade 1 pressure ulcers would also be 'trended', in addition to Grades 2, 3 and 4.
- Mo Schiller, a public governor for Bristol, asked if research had indicated that certain patients were more prone to hospital acquired pressure ulcers and falls. Alison Moon confirmed that research had confirmed this, and the key was regarding initial and regular assessments of each patient. Diabetes, circulatory problems, and poor nutrition were also thought to be factors contributing to pressure ulcers and falls.
- Clive Hamilton queried whether there was a correlation between incidences of Falls, Hospital Acquired Pressure Ulcers, Clostridium Difficile and other 'Red'- rated indicators and pressures seen in the Accident and Emergency Department.
- The Chair of the Quality and Outcomes Committee, Paul May, said that at the last meeting the Complaints system had been reviewed to see where themes were. Assurances were given regarding the processes in-place.
- Ken Booth, a public governor for Bristol said that some complaints might be due to patients leaving message on answer phones and not being called back. He asked what could be done to improve the communication system and if thought had been given to emailing patients. Paul Mapson confirmed there were no technical issues to report of the new Medway IT system, but that the impact of changing the system had led to pressures of backlogs, which meant there had been delays in responding to patient enquiries.
- James Rimmer recognised the issues regarding complaints and reported the use of additional agency staff and recruiting to vacant posts, which was improving. It was vital that staff responded to patient messages, and these were operational, not technical issues. Paul Mapson added that the use of texts and emails was not an adequate system to inform people of their appointments, and there was no single route to guarantee access to people. Robert Woolley felt that it was a "judgement", but the point was to look at how actively the Trust communicated with its patients.
- John Moore asked if the increase in complaints had been due to the success of advertising the Complaints system, and if patients were encouraged to make a complaint. Alison Moon did not feel that this was the case, and cited the Annual Patient Survey. James Rimmer added that major operational change had probably had a knock-on effect.
- Regarding the issues with Complaints, Deborah Lee gave some positive news that within the new Welcome Centre there would be a patient-facing

outpatient booking centre, which would be located at the front of the hospital. It was due in October 2013.

- Garry Williams explained that he came from a background of family care, and asked if vulnerable people could be flagged-up to those seeing them. Robert Woolley explained that patients with specific needs and conditions were flagged through the patient administration system, but the Trust could look more radically at whether it was possible to use the new system to give more general flags to staff regarding particular needs of patients, including administrative staff.
- Alison Moon said that one of the positives of the new computer system was that the ability to note individual specific requirements for patients was much more comprehensive. Any staff member who had the ability to influence a patient's pathway, whether clinical or non-clinical, would be able to access that person's specific requirements.
- Paul May referred to the Exceptions Report on High-risk Transient Ischaemic Attack (TIA), and was concerned by the delays for two patients, who came from outside of the normal route. Sean O'Kelly was unsure how the patients accessed the service, but the Exception Report referred to how their general practitioners had accessed the service differently. He planned to investigate why the delays occurred.
- Sean O'Kelly responded to Clive Hamilton with regard to his concerns regarding the Queen's Day Unit use of the WHO Surgical checklist, noting that the true figure was 87%, and not 45% as reported, due to problems with the administration of Medway. Paperwork had been re-audited through the Day Surgery unit. 87% was still not good enough, but efforts were on-going with staff training on Medway.

d. Workforce

The Acting Director of Workforce and Organisational Development, Claire Buchanan, introduced the workforce element of the quality and performance report, saying that a number of workforce indicators were below target:

- Workforce costs and numbers had increased against the budget, which was thought to be due to an increase in sickness absence, and the provision of bank and agency staff to cover sickness and vacancies. All divisions had plans in-place to reduce workforce costs and to recruit to vacancies.
- Sickness absence had increased to 4.3% this month, which was significantly higher than a year ago. Nursing and midwifery sickness was also raised in May, and the reasons for this were being investigated. Anxiety, stress, and depression rates seemed to be rising, and Occupational Health were undertaking "stress audits" to determine causes and put in support where possible.
- Appraisal rates had improved to 83%, from last month's score of 78%, although it was still 2% off trajectory. Huge efforts were being made in the divisions and Diagnostics & Therapies, Facilities & Estates and Trust Services were all above 85%.

Comments:

- Emma Woollett requested clarity regarding consultant overspends in Lower GI, Thoracics, Upper GI and Trauma and Orthopaedics, asking if it

was caused by costs in the current job plans exceeding budget, and also if it was being addressed in job planning. Claire Buchanan confirmed that job plans had been looked at in detail. Paul Mapson added that some budgets were overspent and were being reviewed. This could be linked to the financial position and the delivery of additional workloads.

- Iain Fairbairn referred to causes of sickness absence and pressure ulcers, saying that "these were difficult times in the NHS". He asked if any anecdotal feedback had been received that staff were being affected by wider issues. Alison Moon replied that a significant transformational change programme had been undertaken to review numbers of nurses per bed and shift pattern. There had been a consultation with staff over a 3-month period. Vacancies were held throughout this consultation to try to ensure no redundancies within the workforce. This consultation had now ended and there was now a recruitment drive to fully recruit to all nursing vacancies.
- In response to John Moore's question on how well embedded return to work interviews were across the Trust, Claire Buchanan said that the supporting attendance policy was very much focussed on keeping in contact with staff, and reviewing and supporting them following return to work. Also of note, an audit had established that there were very good systems in place in the division of Facilities and Estates for when staff returned to work. Other divisions would also be audited as part of KPIs.
- In response to Paul May, Robert Woolley said that high priority was given to management processes for reducing costs of labour, and the planning was directly related to Cash Releasing Efficiency Savings.
- Lisa Gardner noted an increase in the average turnover of staff, to which Claire Buchanan said that turnover had remained static for some time, and there would be an occasional 'spike'. National data was being looked at in this regard.
- Pauline Beddoes commented that when she worked in the past as a ward sister, if someone was off-sick on a twelve hour shift, other members of staff would encounter problems covering two shifts. Claire Buchanan responded that bank staff were available to fill gaps, along with agency requests for 12-hour shifts when bank staff were unavailable. Alison Moon said that the aim of the transformation programme for nursing shift patterns was to provide more continuity of care, less stress for staff, and less sickness. When there was sickness, covering two shifts was more difficult that covering one 12-hour shift, but nurses might cover different hours rather than a full 12-hour. The ethos of the changes was that they would be better for both patients and staff.

e. Access

The Chief Operating Officer, James Rimmer, introduced the access element of the performance report, and highlighted the following exception reports:

- **Primary Percutaneous Cardiac Interventions (PCIs);**
- **Last-Minute Cancellations;**
- **4-hour accident & emergency standard -** It was on-track to deliver 95% for June, with the help of the Emergency Care Support Team. They had agreed with plans to focus on areas for turnaround, which included:

1. Close working of the Trust with Great Western Ambulance Service (GWAS) regarding the queuing issues at the Department, and additional support to tighten front door procedures.
2. Two issues were identified regarding the "back door", which were: a) social care and b) identifying operations issues leading to discharge delays.

- Of positive note, Referral to Treatment and Cancer standards remained on-track.

Points of discussion included:

- Emma Woollett welcomed the validation and suggestions from the Emergency Care Support Team. She asked how confident the Trust was with regard to the commitment of community partners towards the performance improvement required.
- James Rimmer reported having an initial meeting on 01 June to discuss the Urgent Care Programme. He had a positive view of the enthusiasm of the people around the table. There was no clear action plan as yet, but this was being worked on before winter. James reported that the Social Care team at the council wanted to engage with the Trust around section 2 and section 5 referrals. Internal processes to review patients at 21 days had also been escalated, and this would be brought in operationally.
- Lisa Gardner expressed her concern at the drop in performance of the standard at the Bristol Children's Hospital, from 98% to 95%. James Rimmer explained that the hospital usually had a summer closure plan, but this had not been possible this year. Additionally, winter illnesses have continued into the summer months and there had been an increase in respiratory conditions.
- James Rimmer confirmed to Iain Fairbairn that GP Support Unit abdominal pain pathway was piloted from Monday to Friday, and included some bank holiday shifts.
- Paul May referred to Last-Minute Cancelled Operations, asking if there was any action to ensure operations were not over-booked. James Rimmer responded that the Trust set a target of 0.8%. He added that there was always the potential for booking issues. Some systems had been changed and will take a while to settle, but should see improvement soon.
- John Moore queried the impact of the merger plans of Great Western Ambulance Service. James Rimmer felt that it was likely to be positive, but improvements in service would be needed. Part of the impact would be the issue of both acute trusts working with the ambulance service around front door processes. Emergency Care Intensive Support Team input was helping assist the changes.
- In response to a query by Kelvin Blake regarding changes in Social Services, James Rimmer said that these probably would have an impact on patients waiting for social care packages and assessments.

There being no further questions or discussions, the board resolved to ***note*** *the quality and performance report.*

6. National Inpatient Survey Report

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

Alison Moon introduced the report, saying that it was an annual survey of patients between July and September 2011. The results were known in early May 2012, which represented a significant time delay in responding to any issues raised. The survey compared the trust against itself and other trusts locally and nationally. She noted that the importance of the monthly 'in-house' surveys to our patients was significant in terms of noting good practice and potential issues to resolve in a timely way.

Alison Moon said that it was a "solid report" from which to build, with good highlights:

- 95% of patients who took part in the survey said that their care was "excellent", "very good" or "good", in comparison with the Trust's monthly report, which was around 96%.
- Table 1 in the report highlighted University Hospitals Bristol NHS Foundation Trust results from the survey. The trust was in the higher end of spectrum for patients feeling safe in our care.
- Table 3 showed where the trust had not scored well. 'Quality of care' during hospital stay had provoked debate in a Trust Management Executive meeting, and the action plan was amended as a result of discussion at the meeting. Comparison was also drawn to neighbouring trusts' results to note only.
- Page 112 onwards detailed the action plan, which set high ambitions for Patient Experience targets. Targets were set to be the 'best of the best', but not all were achieved. The Trust had similar high aspirations for this year, although some significant improvements had been seen in 2011/12.

Comments:

- Emma Woollett referred to the Diagnostics and Therapies part of the Divisional Action Plan, asking if it was realistic to expect that 90% of TTAs would be achieved in Quarter 1. James Rimmer responded that it accurately reflected Trust expectation, and was actively monitored.
- In response to a further question by Emma Woollett, James Rimmer said that work to improve food quality at the Trust was underway with the Food Partnership, who operated across the City. There were specifics which the team planned to focus on, which included plans to give food more accurate descriptions (eg. Tomato soup, not just 'soup'), and to look closely at patients with dementia, to see if they could feed themselves better.
- In response to a query by Paul May, James Rimmer confirmed that every outpatient was given the opportunity to 'opt out' of the practice for their GP to receive letters.
- Deborah Lee said it was important to note the value of patient comments, as patient care was more than just an 'administrative task', and noted an additional recommendation from Trust Management Executive to be included regarding being asked about 'Quality of Care'.

*There being no further questions or discussions, the board resolved to **note** the National Inpatient Survey report.*

7. Histopathology Action Plan Update

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

Robert Woolley presented the new action plan, which incorporated the outstanding main item from the previous plan, for the integration of the two cellular pathology departments in Bristol. In addition, it picked up the subsequent report of the Independent Inquiry Panel follow-up review and recommendations.

The final report of the Care Quality Commission (CQC) follow-up review had just been received at the Trust, and they confirmed full compliance with all three outcomes regarding histopathology services.

Points of discussion included:

- Emma Woollett referred to Item 4 of the action plan, and asked if there was a need for a holistic review of effectiveness of Multi-Disciplinary Team process. James Rimmer responded that this was already in train – the Care Quality Commission (CQC) was happy with the functions of the team, an internal audit had also been conducted, and a peer review was planned for September.
- Robert Woolley emphasised the huge progress made regarding the organisation of Cancer Multi-Disciplinary Teams at the Trust. He felt that the monitoring of the teams was exceptional, and this was probably not replicated in "many other hospitals in the country".
- John Savage was impressed with the progress of the Trust since the histopathology review. The Inquiry had taught the Trust the importance of continued checking on the route ahead.

This was noted to be a standing item on Quality and Outcomes Committee agenda.

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

Finance and Governance

8. Committee Chairs' Reports

The board received and considered reports on the activity of board committees by their respective chairs to **note**.

a. Finance committee dated 22 June 2012, including the report of the finance director, as provided in the finance committee report pack.

The chair of the committee, Lisa Gardner, presented a verbal report of the meeting:

1. The income and expenditure summary reported a **deficit of £673k for the first two months** of 2012/13. The results lead to a Financial Risk Rating of 2.35 to date although this was expected to improve when results, supported by further information on clinical activity and income, were available for June.

3 Divisions were currently 'red-rated' i.e. Specialised Services, Surgery, Head & Neck and Women's and Children's services. Executive Directors were working with Divisions to ensure Operating Shortfalls were addressed.

The work to finalise the actual **activity and income performance for March**

2012 (an 'on account' value was agreed in order to close the 2011/12 Accounts) had been completed and the Trust would receive an additional £0.894m to that included in the 2011/12 Accounts. This had been allocated to divisions for use on a 1/12ths basis within their Operating Plans 2012/13.

It was noted that not all the data feeds had been processed for the Trust's April clinical activity. The June report would include activity related income for April and May, together with an estimate for June. Information that was currently available was the subject of detailed validation. Divisions were engaged in a review of their activity and capacity plans.

2. A report on **Cash Releasing Efficiency Savings (CRES)** plans and achievement was received. For 2012/13 the Trust had a Cash Releasing Efficiency Savings Plan of £27.622m. The actual level of savings achieved for April and May totalled £3.924m or 83% of the target for the period. The risk assessed forecast outturn was £23.7m or 86% of the Cash Releasing Efficiency Savings Plan. The Committee recognised the importance of maintaining good progress on the Cash Releasing Efficiency Savings / Transformation programme to ensure satisfactory outturn for this year and for the Trust to continue to be well-placed for 2013/14 and beyond. The principal area of concern for the Committee was that for some clinical divisions there remained a significant element of unidentified recurring CRES schemes.

3. A report was received from the Trust Secretary on the draft revised **Terms of Reference** for the Finance Committee. A number of minor changes were agreed. The Committee also asked that the Chief Executive approved the final draft before consideration by the Trust Board.

4. The Committee were given a presentation of the recently developed in-house financial reporting system. The system, which went live on 21 June, had been developed with input from clinicians and managers in the Trust. Further training sessions are to be provided and users have been encouraged to contribute ideas to further enhance the system. The Committee noted the improvements offered by the system regarding reporting, communication and controls.

Discussion included:

- Paul Mapson acknowledged the adverse position of the trust in month 2. A significant part of the overspend was felt to be due to phased savings plans, but Paul stressed the importance of waiting to understand the full Quarter 1 figures, which would confirm the activity reported through the Medway system, which would give a much clearer picture. The Trust anticipated a Finance Risk Rating of at least 3, and would then decide if further action was required.

- John Savage confirmed that the committee had robust and thorough discussions of the position at the Finance Committee, which he attended as an observer.

Comments:

- From the Finance Committee summary, Iain Fairbairn, was struck that the Division of Surgery, Head and Neck had a significant slippage in expenditure and Cash Releasing Efficiency Savings, and requested reassurance that the division had a "grip" on its finances.

- Robert Woolley responded that the division was already in 'special measures', and would proceed through the Escalation Framework, which was agreed at the Trust Management Executive. The measures allowed for a level of corporate support to address capacity and expertise, as well as restricting the autonomy of the division and "going back to basics" on financial control. The Head of Division was in two-weekly meetings with the Chief Executive, where underlying problems in the division were monitored. The next step in the Escalation Framework would be a direct accountability review of the head of the division with the Chief Executive.
- John Moore expressed his concern at the figures, as they had been bad in both Months one and two. He asked if this was a consequence of the new IT system, or if there had been any changes to accounting practices that could have impacted on them.
- Paul Mapson confirmed that the patient administration system was not at fault, as it only reported activity. There had been no changes to the finance system in recent years, so that was also unrelated. Paul attributed the position of delivery of Cash Releasing Efficiency Savings, which was also an issue at national level in the NHS. He added that it took a lot longer to deliver pay savings than plans assumed, so there was a 'slippage' issue on a regular basis. The question was whether this 'slippage' could be contained and turned into savings.
- John Savage said that the Trust must continue to hit its targets, but acknowledged that the organisation should certainly expect to feel pressure.
- In response to a query by Clive Hamilton, Paul Mapson confirmed that, overall, the trust had a reduced level of income in April. It was speculated that this might have been attributable to the bank holidays in the month, including Easter. James Rimmer also thought it might be due to the phased opening at South Bristol Community Hospital. Although figures had not yet been received for May, they were understood to have improved.

b. Audit Committee dated 18 June 2012

The Chair of the Committee, John Moore, gave a verbal report on the main issues discussed at the Audit Committee meeting in June.

Nothing major to report outside of the minutes, except:

- The sign-off of the Annual Plan;
- Further work was commencing regarding Clinical Audit;
- How the trust could get a good service from its sub-contracting purchasing provider;

It was also noted that this was the last meeting held with our existing external auditor.

There being no further questions or discussions, the board resolved to ***note*** *the committee chairs' reports.*

9. Review of Terms of Reference – Finance Committee

The Board received and considered this report by the Trust Secretary for **approval**.

Comments:

• In response to a query by Emma Woollett, John Savage reassured her that he was currently working on identifying a fourth Non-executive Director member of the Finance Committee. • Referring to section 4.3.e, Deborah Lee suggested that it might be helpful if a trigger value for business cases was clarified in relation to capital and revenue. It was agreed this would be a helpful incorporation. Deborah Lee, referring to 6.1.d, also questioned the status of Chief Operating Officer, in relation to the other two executive officers, and asked if they could send deputies, as part of the quorate. *There being no further questions or discussions, the board resolved to **approve** the Review of Terms of Reference for the Finance Committee.*	
10. Review of Terms of Reference – Audit Committee The Board received this report by the Trust Secretary to **note**. *There being no further questions or discussions, the board resolved to **note** the Review of Terms of Reference for the Audit Committee.*	
11. Annual Review of Foundation Trust Constitution The board received this report by the Trust Secretary to **note**. Charlie Helps informed the Board that the Trust would normally be reviewing the Constitution at this time of year, as part of its annual review. Due to the current changes in the Health and Social Care Act, its legalities, and also the various conditions that existed around the potential integration of the two Bristol trusts, it was appropriate to pause for a couple of months, to gain further clarity of implications of both items. *There being no further questions or discussions, the board resolved to **note** the Annual Review of Foundation Trust Constitution.*	
Monitor Reports	
12. Results of Quarter 4 Monitor Assessment of NHS Foundation Trusts Compliance The board received this report by the Chief Executive to **note**. Robert Woolley explained that this was a routine quarterly report from Monitor, which confirmed the Trust Board's prospective declaration for Quarter 4, of a Finance Risk Rating of 3 and a Governance Risk Rating of 'Amber-green'. This was attributed to decreased performance against the 4-hour accident and emergency target in the quarter. *There being no further questions or discussions, the board resolved to **note** the Results of Quarter 4 Monitor Assessment of NHS Foundation Trusts Compliance.*	
Information and Other	
13. Any Other Business Robert Woolley informed the Trust Board that the Programme Director for the Transforming Care Programme, Jan Bergman, was due to leave the Trust at the end of the week. James Rimmer would be replacing him at same level.	

The Board joined Robert in expressing gratitude to Jan for the work he did as Interim Director in the Medicine Division and as lead for Transforming Care.	
14. Date of Next Meeting **Joint Trust Board and Membership Council Meeting**, Monday 30 July 2012 from 10:30 – 15:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE.	

ID	Entity	Meeting Date	Minute number	Description	Action by	Date to Report Back	Comments
42	Trust Board of Directors	30/04/2012	5	Quality & Performance Report (Workforce) - Governor Ken Booth, who was present, asked whether the Trust would consider a 'staff engagement policy' to oversee appraisals, sickness absences and team briefs. Robert Woolley responded that staff engagement policies were fully addressed in a number of separate policies and procedures. Claire Buchanan planned to make the Trust Board aware of how these documents were related.	Director of Workforce and Organisational Development	31/05/2012	Work was underway to review all current trust policies and procedures for their accessibility to staff and a report could be brought back to the Board, if appropriate.
44	Trust Board of Directors	31/05/2012	5	Quality and Performance Report (Workforce) - At the request of Paul May, Claire Buchanan would provide figures of neurophysiology staff to the trust board, regarding their appraisal compliance.	Director of Workforce and Organisational Development	28/06/2012	
45	Trust Board of Directors	31/05/2012	5	Quality and Performance Report (Workforce) - John Moore referred to the 'performance overview' of staff sickness on page 25 of the pack, and requested a change to the target, as it was misleading in its current form.	Director of Workforce and Organisational Development	28/06/2012	

48	Trust Board of Directors	31/05/2012	7	Equality and Diversity Annual Report - In response to a question by Garry Williams, Claire Buchanan confirmed her belief that engaging younger cohorts in the trust was very valuable; to aid this, the trust had a large schools' programme in-place. She agreed to look into creating apprenticeships at the trust.	Director of Workforce and Organisational Development	28/06/2012	
49	Trust Board of Directors	31/05/2012	10	Monitor Annual Plan 2012/13 incorporating annual compliance declaration - Emma had a query regarding the maternity staffing figure on page 213 of the report. Deborah Lee explained that the figure might be inaccurate, and she would refer back, to check if this was the case.	Director of Strategic Development	28/06/2012	

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

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 – JULY 2012

1. INTRODUCTION

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

2. COMMUNICATIONS

The Trust Management Executive **noted** the monthly report on the activities of the Communications Department. In particular it was noted that the Communications Team was undertaking a LEAN programme and an evaluation of the door drop of leaflets relating to the changes to the patient drop off areas between the Bristol Royal Infirmary and the Bristol Royal Hospital for Children was underway.

3. QUALITY, PERFORMANCE AND COMPLIANCE

The group confirmed the recommendation to the Trust Board to declare an Amber-Red Governance Risk Rating for Quarter 1 2012/2013, reflecting performance in the quarter against the Accident and Emergency 4-hour and Clostridium standards, and the on-going risk to achievement of the Clostridium Difficile trajectory. This decision was reached without the benefit of information about the Trust's application to re-profile the Clostridium Difficile trajectory.

The group received a report on the 4-hour Emergency Access Recovery Plan which identified specific actions to support improving performance against this target, together with the key risk noted by the Emergency Care Intensive Support Team around ambulance queues in the emergency department. It was noted that there had been an improvement in performance in July. Particular actions that had had a positive impact were around patients being seen before 10.00am every morning and targeting length of stay. It was noted that the performance in respect of the Children's Hospital accident and emergency department had deteriorated, mainly due to the fact that patients were presenting with winter related sickness and an increase in dependency of inpatients which impacted on the availability of beds.

There continued to be considerable focus on this issue and the Trust continued to seek advice and guidance from the Emergency Care Intensive Support Team.

Other service pressures were under active management by the Service Delivery Group, including those relating to referral to treatment incomplete pathways, cancer targets and 6-week wait for diagnostics. There was continued focus on MRSA and Clostridium Difficile targets. The group **agreed** that a new approach to Divisional management of staff compliance with essential training standards was required.

The group received and **approved** Adult Emergency Professional Standards which should be applied to the delivery of adult emergency care within the organisation, producing a high standard of both patient experience and patient safety, at the same time as expediting the flow of emergency patients through the Bristol Royal Infirmary.

The group **approved** revised Terms of Reference for the Care Quality Group.

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

- Plans for the British Medical Association industrial action day on 21 June had been implemented successfully, demonstrating that the Trust's processes for dealing with such events were well embedded.
- The internal policy on cancer MDT attendance had been agreed and the group **agreed** that a review of other MDTs should be undertaken, tasking the Care Quality Group to consider how this should be taken forward.
- Medway support call volumes had reduced although there continued to be some post-Medway issues which were being addressed.

4. STRATEGY AND BUSINESS PLANNING

The group **noted** the current position in respect of the proposed model for pathology services and informal feedback from the Second Pathology Advisory Panel that had been held on 9 July 2012.

The group **noted** the progress in the development of an Expression of Interest for an Academic Health Science Network, the deadline for which was 20 July 2012.

The group received an update report on the Patient Information Team's work on Patient Information Leaflets and **agreed** the revised reduction of the number of leaflets in circulation.

5. RISK, FINANCE AND GOVERNANCE

The group **approved** the Trust's response to recommendations of the Internal Audit report concerning the management of Core Payroll Processes.

The group received and **approved** a number of Annual Reports 2011/2012 for onward submission to the Trust Board (Health and Safety, Security, Fire Safety and Information Governance).

The group **noted** the Board Assurance Framework and Corporate Objectives 2012/2013 and Corporate Risk Register, prior to onward submission to the Trust Board.

The group **noted** risk exception reports from Divisions.

6. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
18 July 2012

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

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**' – Claire Buchanan (Acting 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)

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

July 2012

CONTENTS

PERFORMANCE OVERVIEW

SECTION A – Performance Overview

Summary

Overall, the 'health' of the organisation has shown a marked improvement relative to last month, with an increase in GREEN rated indicators by four, and an decrease in RED rated indicators by six. This reflects improvements in a range of indicators, including patient experience and financial performance.

Three of the four measures of 'Being Efficient' are GREEN rated following an improvement in Emergency Length of Stay. The Number of Patient Complaints has reduced but remains RED rated. However, the other two measures of 'Good Patient Experience' are now GREEN rated, following the reduction in Same Sex Accommodation Breaches. Disappointingly, both measures of High Quality Care are now RED rated, following an increase in inpatient falls.

Three of the four measures of financial performance showed an improvement in the month. This included the Monitor Financial Risk Rating and EBIDTA (Earnings Before Interest, Tax, Depreciation and Amortization) moving to an AMBER rating from RED. Cash Releasing Efficiency Savings (CRES) achievement is now GREEN rated. Both measures of 'Delivering our Contracts' have also remained GREEN rated.

The Trust currently has an AMBER-GREEN rating against Monitor's Compliance Framework for Quarter 1. This reflects the achievement of the cancer, infection control and Referral to Treatment Times (RTT) standards for the quarter, but the A&E 4-hour standard currently not being met for the period. However, the A&E 4-hour standard was achieved in June.

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)	77.0	74.7	N/A	Green: >= 73.9 Red: <71.9	↓	Current month is May 2012. Note thresholds have been changed for 2012/13
A02	Number of Patient Complaints	195	148	464	Green: <120 Red: >=135	↓	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	20	0	20	Green: 0 Red> >0	↓	

Delivering High Quality Care

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
B01	Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4)	2	7	10	Green: 0 Red: > 1	↑	No RAG rating for YTD.
B02	Number of Inpatient Falls Per 1,000 Beddays	5.26	5.97	5.94	Green < 5.6 Red: >= 5.6	↑	

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
C01	Number of Serious Incidents (SIs)	7	14	24		↑	
C02	Number of C.Diff cases	8	5	16	Below Trajectory	↓	

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
D01	18 Weeks Admitted Pathways	93.2%	91.5%	92.1%	Green: >=90% Red: <85%	↓	
D02	Number of Cancer Standards Failed	0	0	0	Green: 0 Red: >=2	→	Previous is confirmed Quarter 4 2011/12. Current and YTD is Apr & May 2012.
D03	A&E 4 Hour Standard	91.85%	95.65%	93.58%	Green: >=97.5% Red: <95%	↑	

PERFORMANCE OVERVIEW

Being Effective

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
E01	Hospital Standardised Mortality Ratio (HSMR)	74.2	69.6		Green: <80 Red: >=90	↓	Previous is December 2011 and Current is January 2012. This is the same as reported last month - February's figures are not yet available.
E02	30 Day Emergency Readmissions	334	270	270	Below 11/12 Readmission Rate (3.4%)	↓	Please note, that the target has now been updated with the 2011/12 figures. Previous is March 2012 and Current is April 2012. May's confirmed discharge data should be available for the next report.

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
F01	Elective Length of Stay Reduction	3.62	3.62	3.47	Green: <= 3.64 Red: >= 3.83	→	The Length of Stay targets for the end of 2012/13 are in the process of being finalised, following a refresh of the long-term bed model. Previous is May; Current is June.
F02	Emergency Length of Stay Reduction	5.12	4.68	4.98	Green: <= 5.07 Red: >= 5.34	↓	The Length of Stay targets for the end of 2012/13 are in the process of being finalised, following a refresh of the long-term bed model. Previous is May; Current is June.
F03	Theatre Productivity - Percentage of Sessions Used	95.9%	96.1%	94.9%	Green: >= 90% Red: < 90%	↑	South Bristol Community Hospital (SBCH) theatre sessions are not yet feeding this report. So reported position is up to end of March. Once the appropriate corrections have been made to incorporate the SBCH activity, reporting against this indicator will resume.
F04	Outpatient appointment hopsital cancellation rate	12.2%	12.4%	12.3%	Green: <=6.0% Red: >=10.7%	↑	This is a new efficiency indicator for outpatients. The RED threshold is last-year's cancellation rate. The GREEN threshold is the target that has been set for the Productive Outpatients programme. Current = May; Previous = April.

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
G01	Appraisal Compliance	82.9%	85.6%	N/A	Green: above target Red: below target	↑	
G02	Staff Sickness	4.2%	4.0%	4.0%	Green: above target Red: below target	↓	

Promoting Research

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
H01	NIHR Income (£000s)	£674	£886	£886	Green:>=5% Increase on 10/11 Red: Reduction from 10/11	↑	Data is a Year To Date measure, starting from April. So Previous is Apr-May, and Current (and YTD) is Apr-June. Note that an additional receipt has been received since last month, so Previous has changed from £657k to £674k
H02	Number of Patients Recruited Into NIHR Trials	672	1429	1429	Monthly target of 737 (1/12th of 11/12 annual total)		Current (and YTD) is rolling YTD position to end of May. Previous is to end of April. Please note that the figure quoted last month (915) was an error - screened rather than recruited patients was quoted. So total has been amended. Also note that target has been altered, but is now a "crude measure" as recruitment can vary month-on-month.

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
J01	Monitor Governance Risk Rating	1	1	N/A	Green: < 1 Red: > = 4	→	Previous now shows the confirmed Q4 reported position. Current shows Q1 declared posiiton.

Delivering Our Contracts

The Previous column represents the 2011/12 full year position. Current (and YTD) represents Month 1 2012/13

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
K01	Financial Performance Against CQUINs (£millions)	£6.96	£6.10	£6.10	> 50% Green < 50% Red	↓	YTD and Current is Forecast year-end rewards, assuming BNSSG all payable. Previous is month 1 (April) when a plan=actual assumption was made, Current is month 2 assessment.
K02	Contract Penalties Incurred - Variance From Plan (£millions)	-£0.05	-£0.07	-£0.07	Green: Below Plan Red: Above Plan	↓	Data is variance above (+) or below (-) plan, with a higher negative value representing better performance.YTD and Current is April to May, Previous is YTD for April. Assumption of plan=actual used for Emergency Marginal Tariff Adjustment.

Managing Our Finance

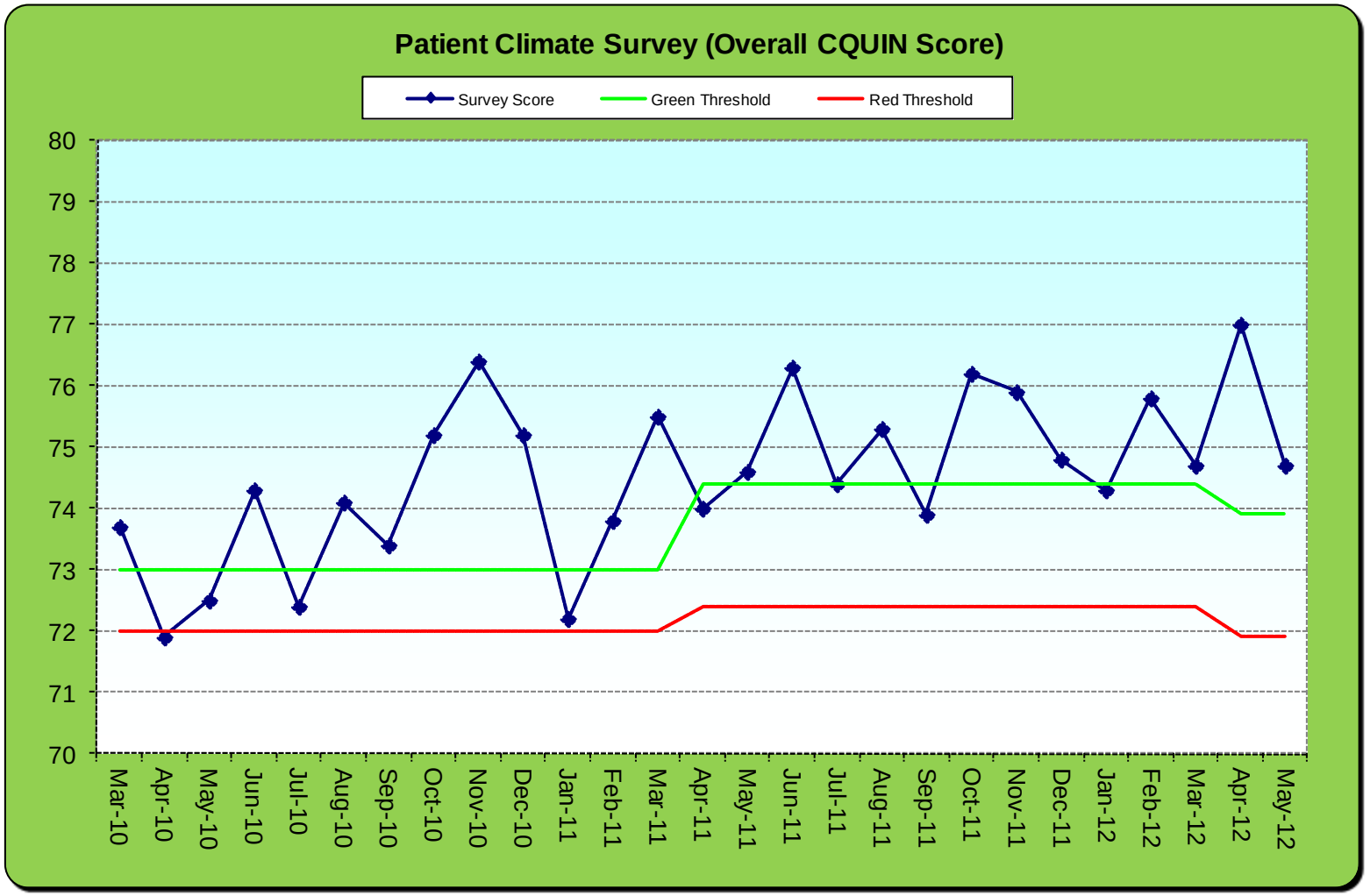
ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
L01	Monitor Financial Risk Rating	2	3	3	Green: >3 Red: <3	↑	For financial measures except CRES, Current and YTD is Current Year To Date. For CRES there is a separate total for latest month and YTD. Previous is previous month's reported data.
L02	EBIDTA (Compared To Plan)	73%	87%	87%	Green: 100% Red: <95%	↑	
L03	CRES Achievement	85%	93%	86%	Green: >=90% Red: <75%	↑	
L04	Liquidity (in Days)	21.2	20.1	20.1	Green: 25+ days Red: <=14 days	↓	

Notes

Unless otherwise stated, Previous is May 2012 and Current is June 2012

YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2012 up to and including the current month

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


Patient Climate Survey (Overall CQUIN Score)
Survey Score
Green Threshold
Red Threshold
80
79
78
77
76
75
74
73
72
71
70
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
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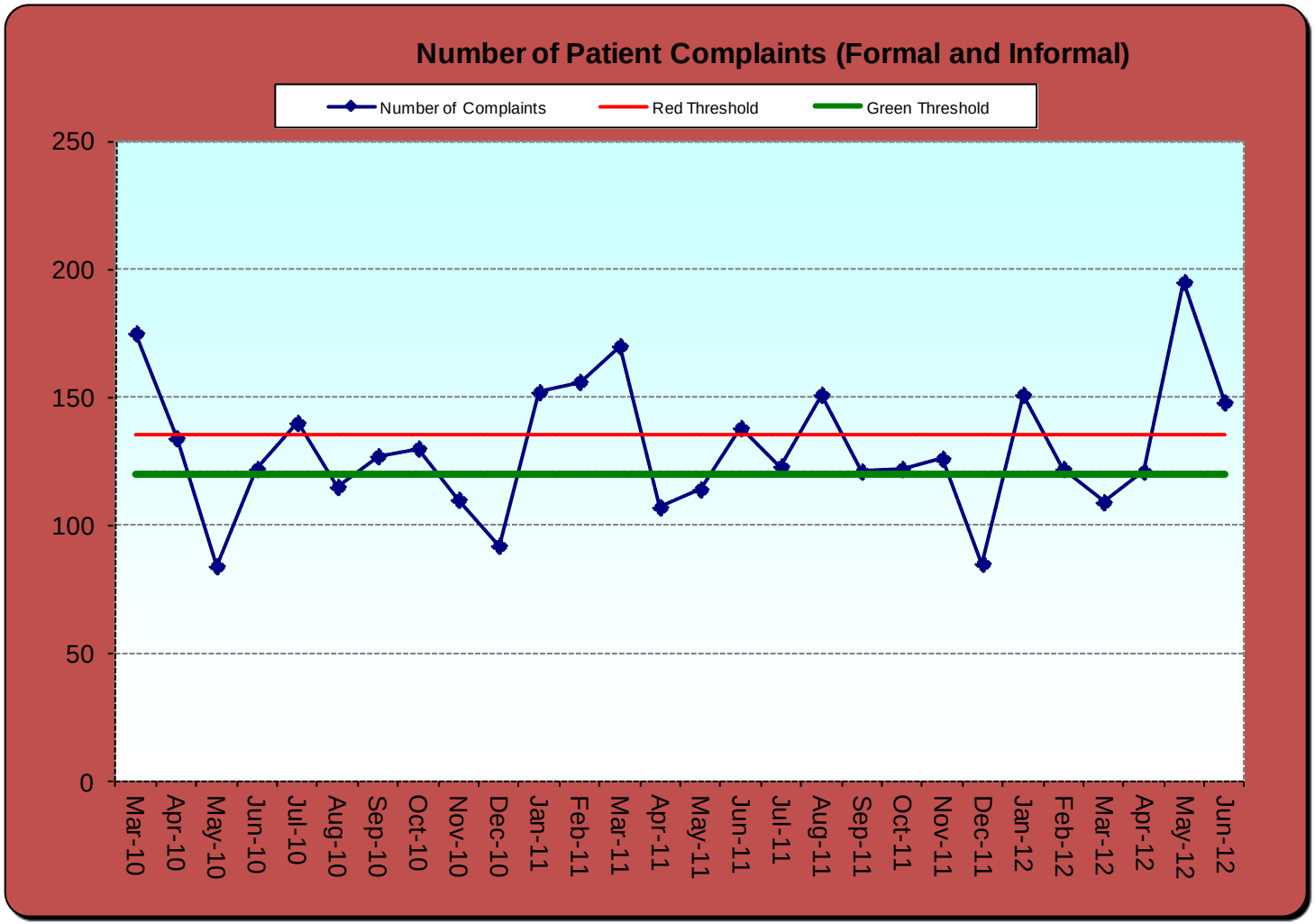
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12


Number of Patient Complaints (Formal and Informal)
Number of Complaints
Red Threshold
Green Threshold
250
200
150
100
50
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
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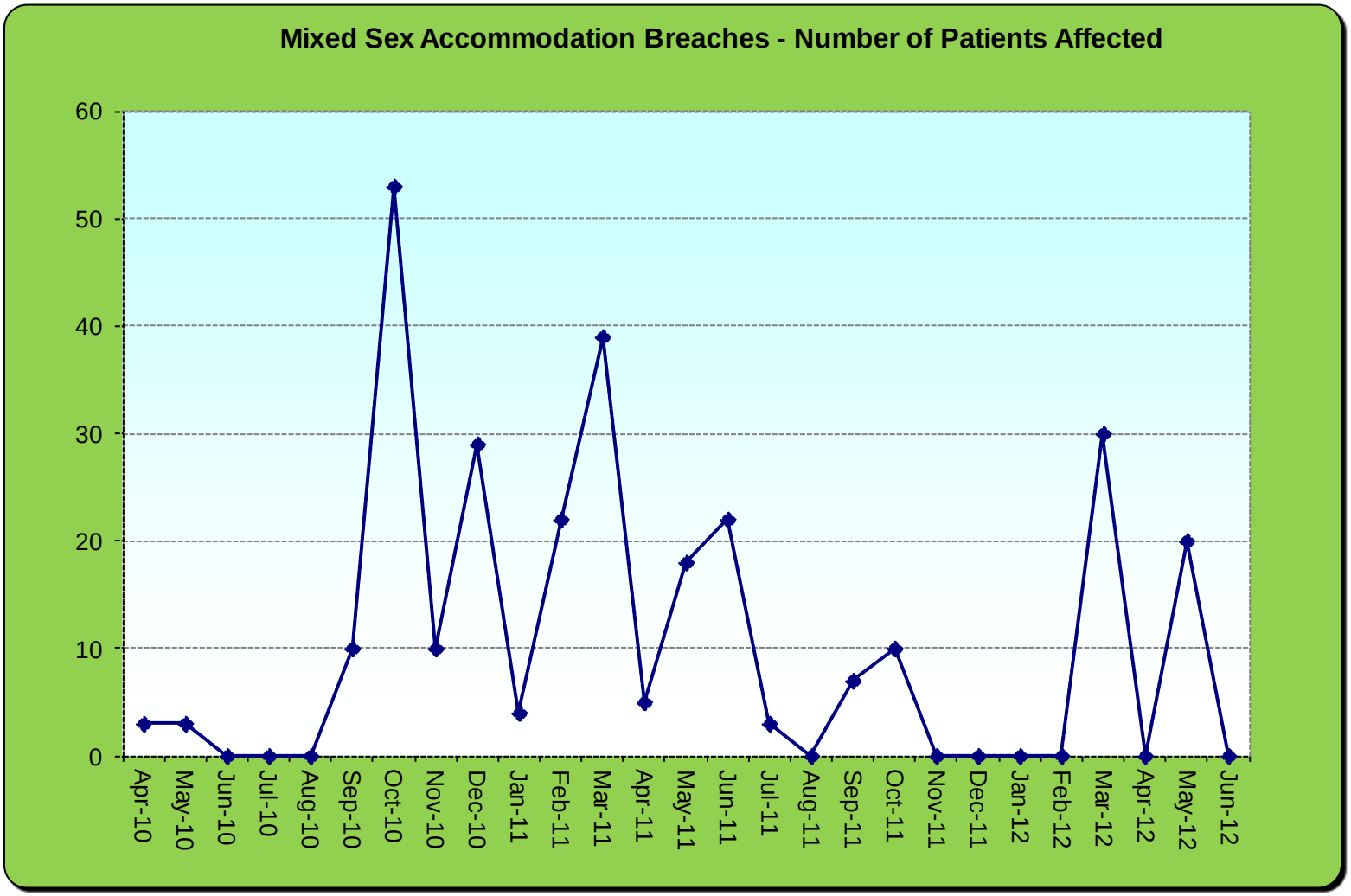
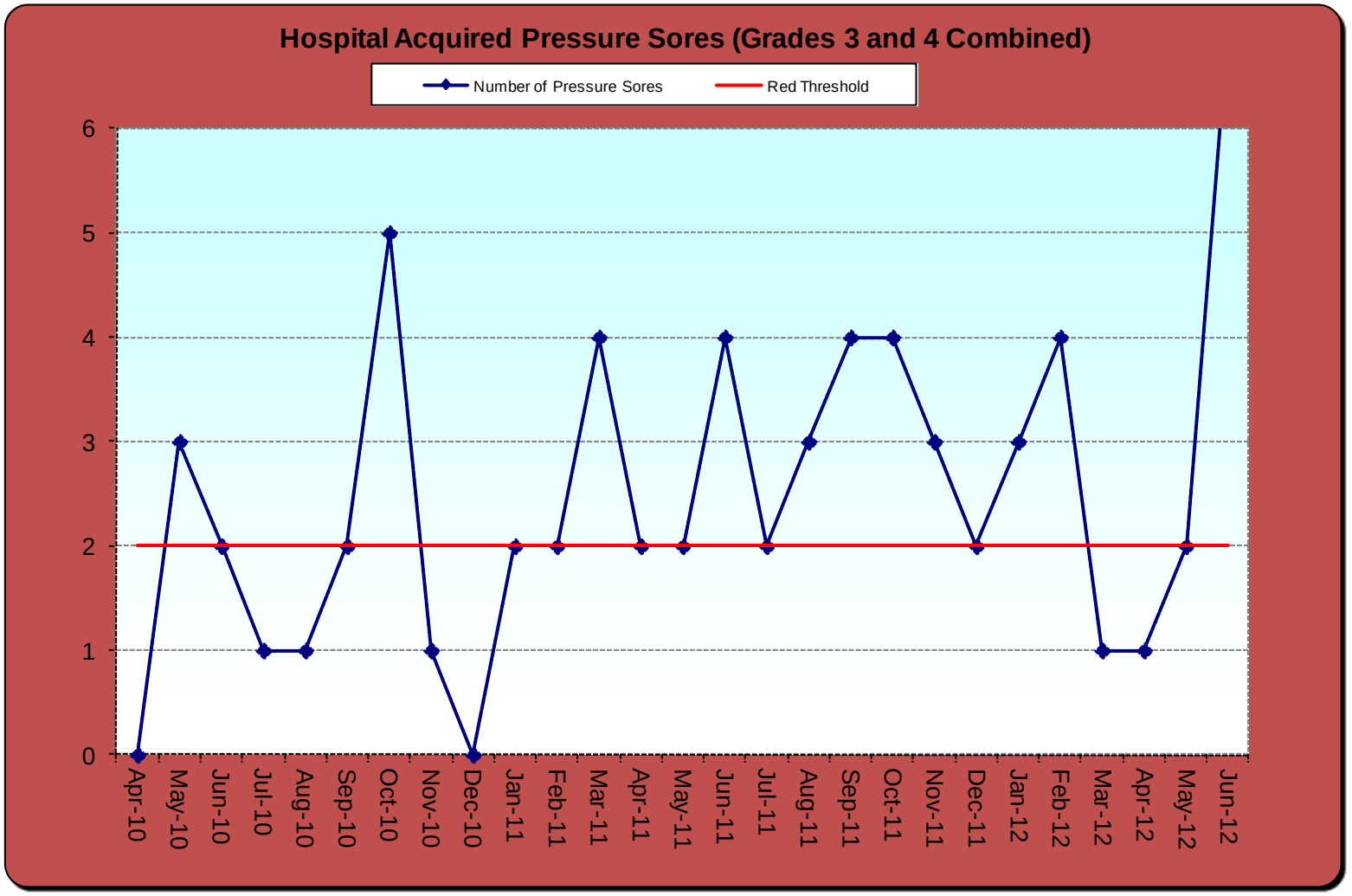
Feb-12
Mar-12
Apr-12
May-12
Jun-12


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
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12


Hospital Acquired Pressure Sores (Grades 3 and 4 Combined)
Number of Pressure Sores
Red Threshold
6
5
4
3
2
1
0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
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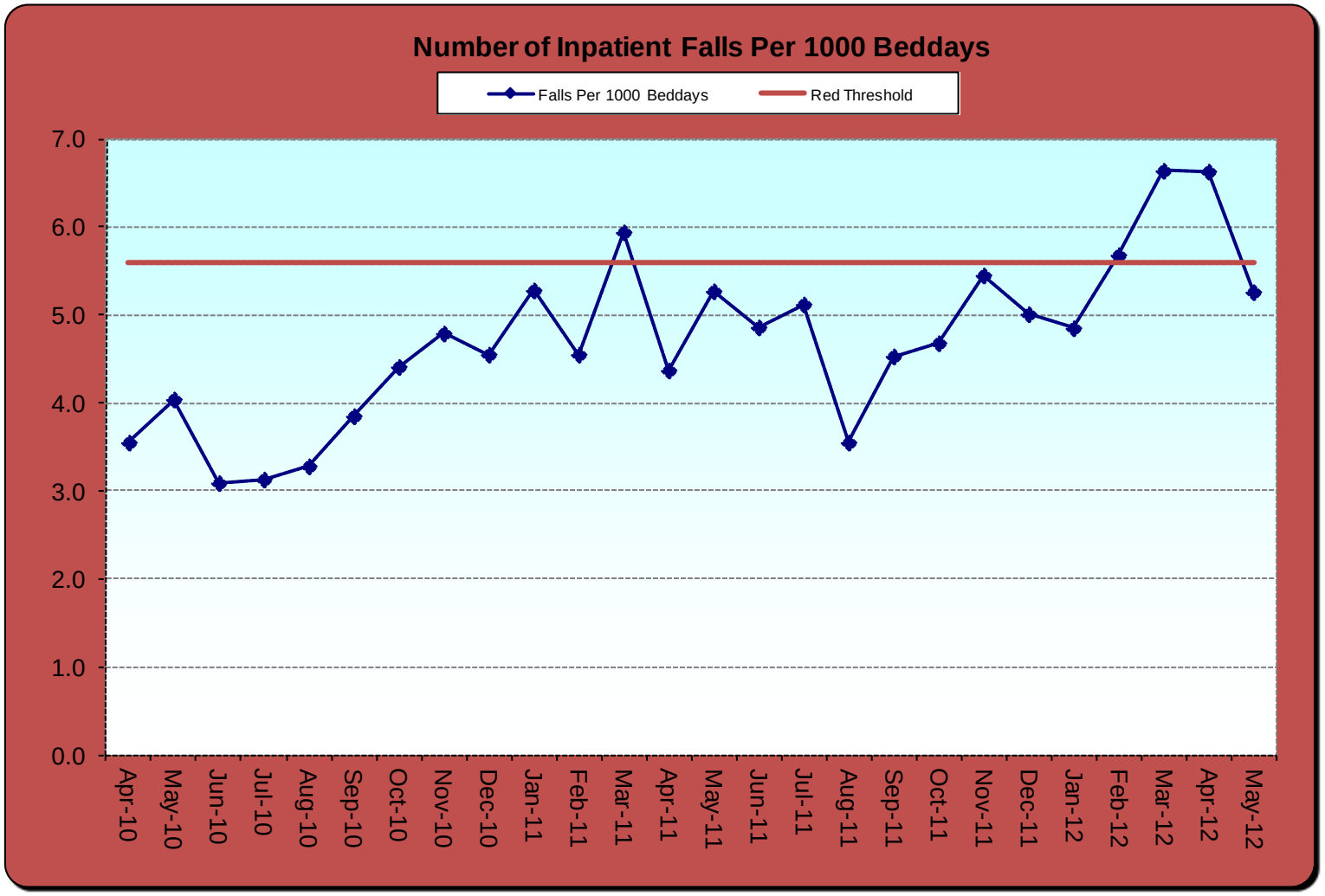
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12


Number of Inpatient Falls Per 1000 Beddays
Falls Per 1000 Beddays
Red Threshold
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
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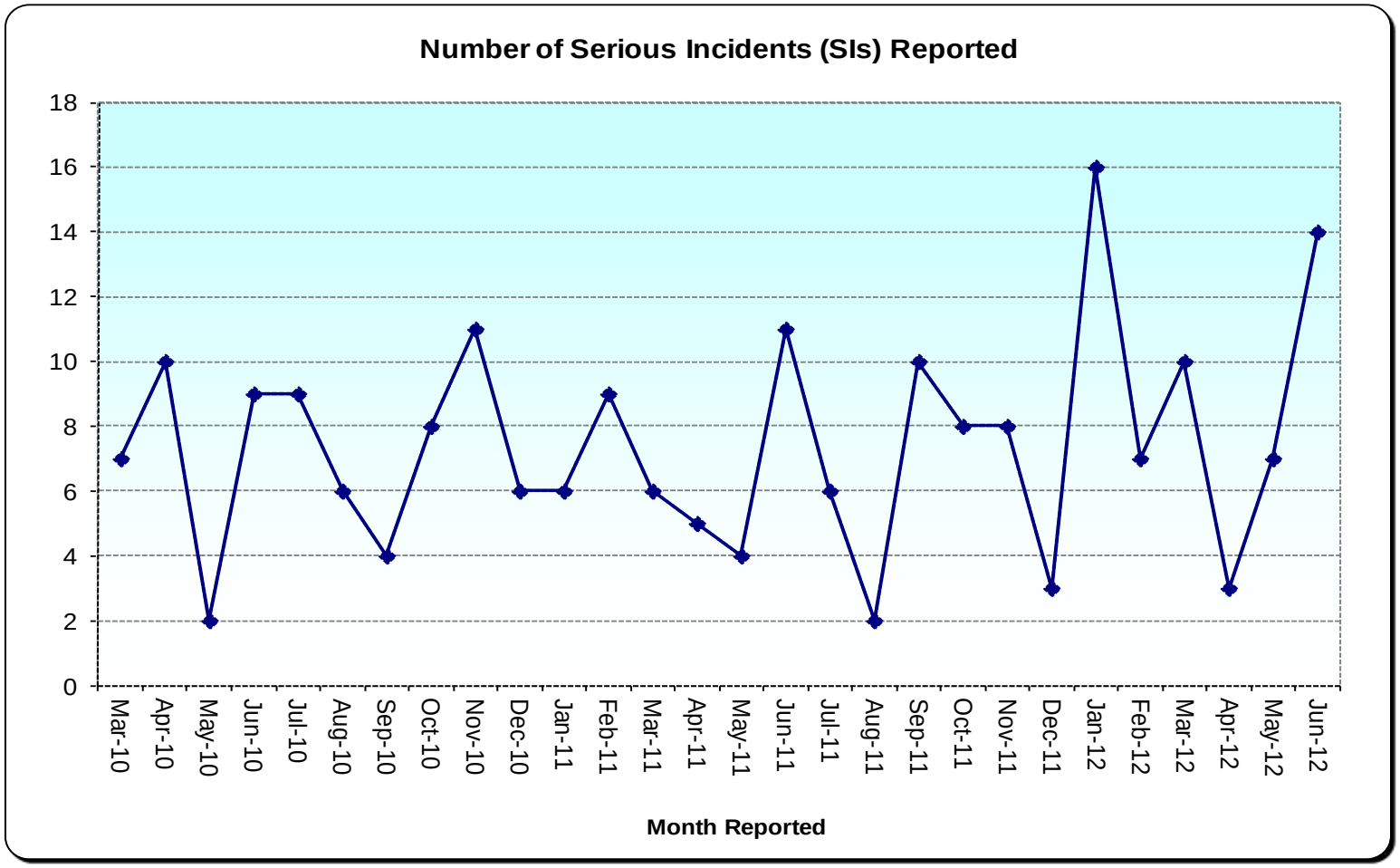
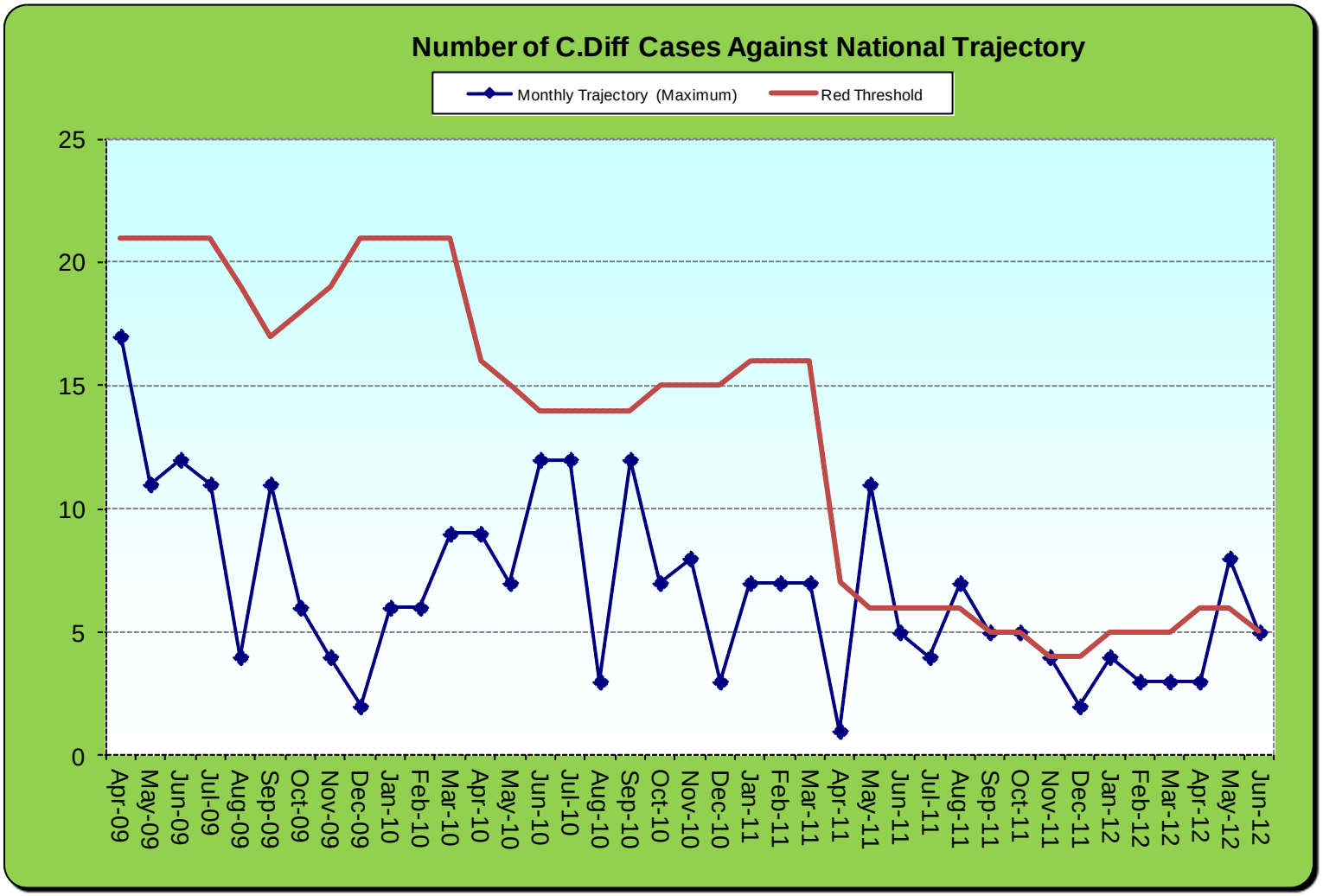
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12


Number of Serious Incidents (SIs) Reported
18
16
14
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
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
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
Apr-11
May-11
Jun-11
Jul-11
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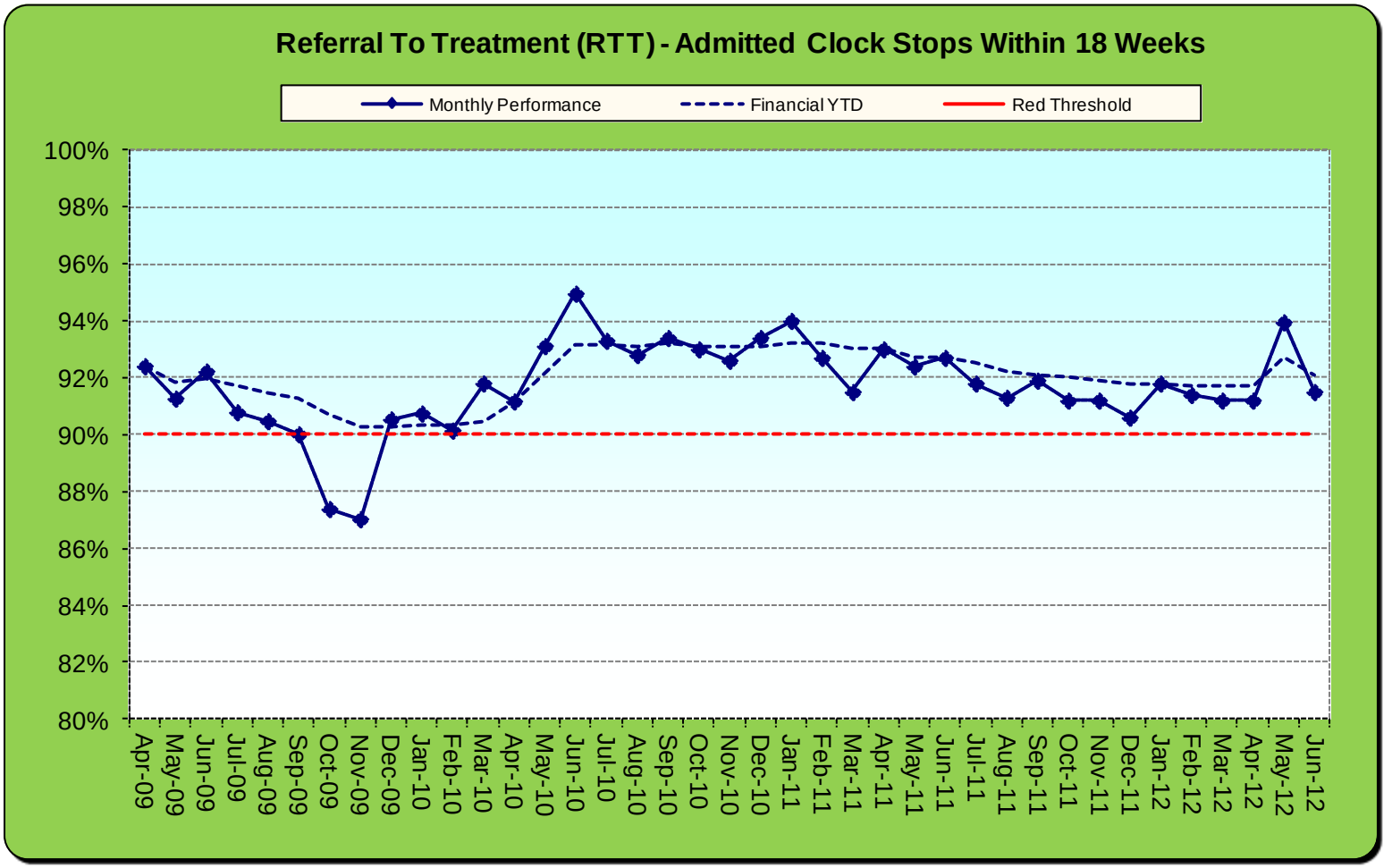
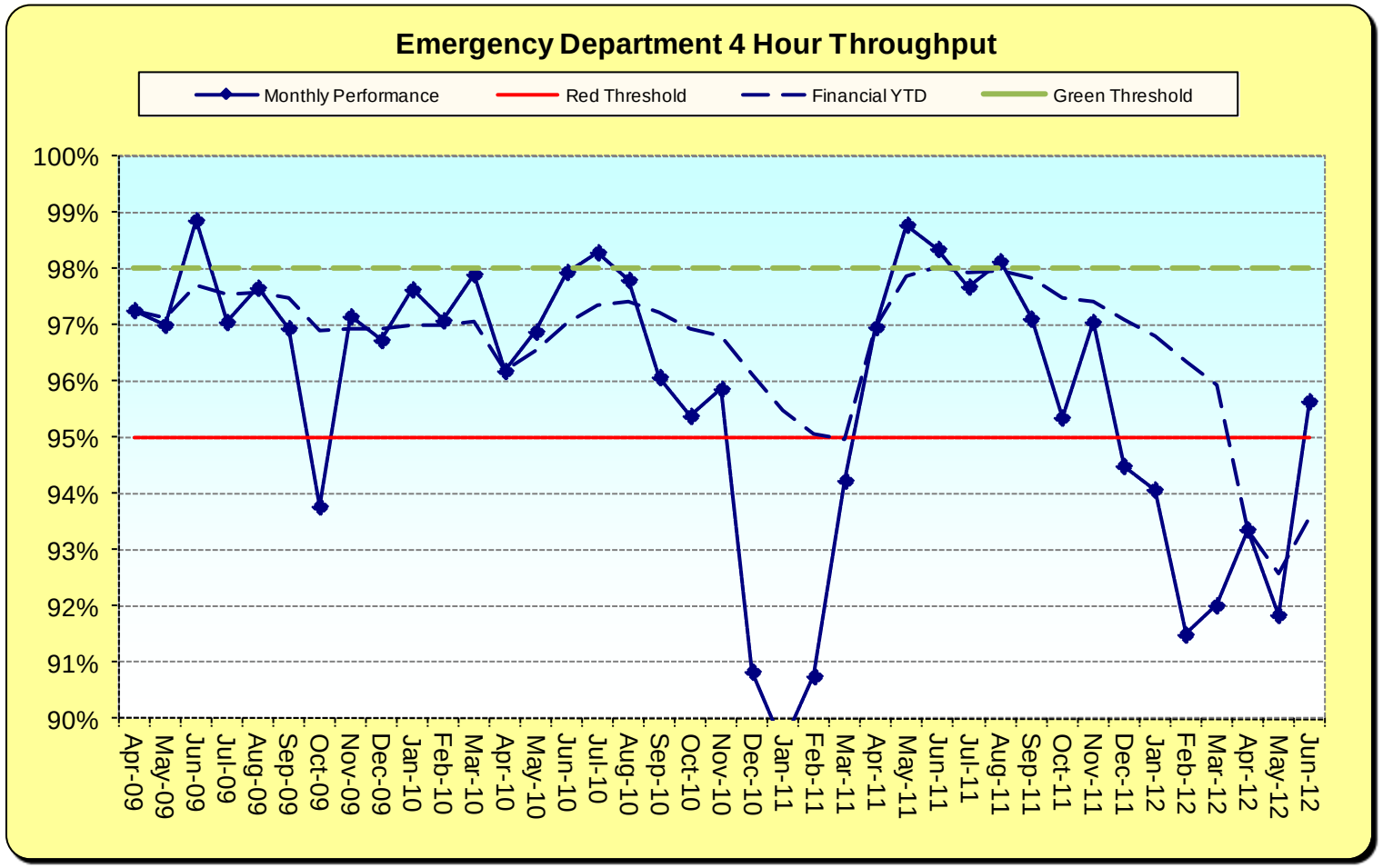
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12


Referral To Treatment (RTT) - Admitted Clock Stops Within 18 Weeks
Monthly Performance
Financial YTD
Red Threshold
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12


Emergency Department 4 Hour Throughput
Monthly Performance
Red Threshold
Financial YTD
Green Threshold
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
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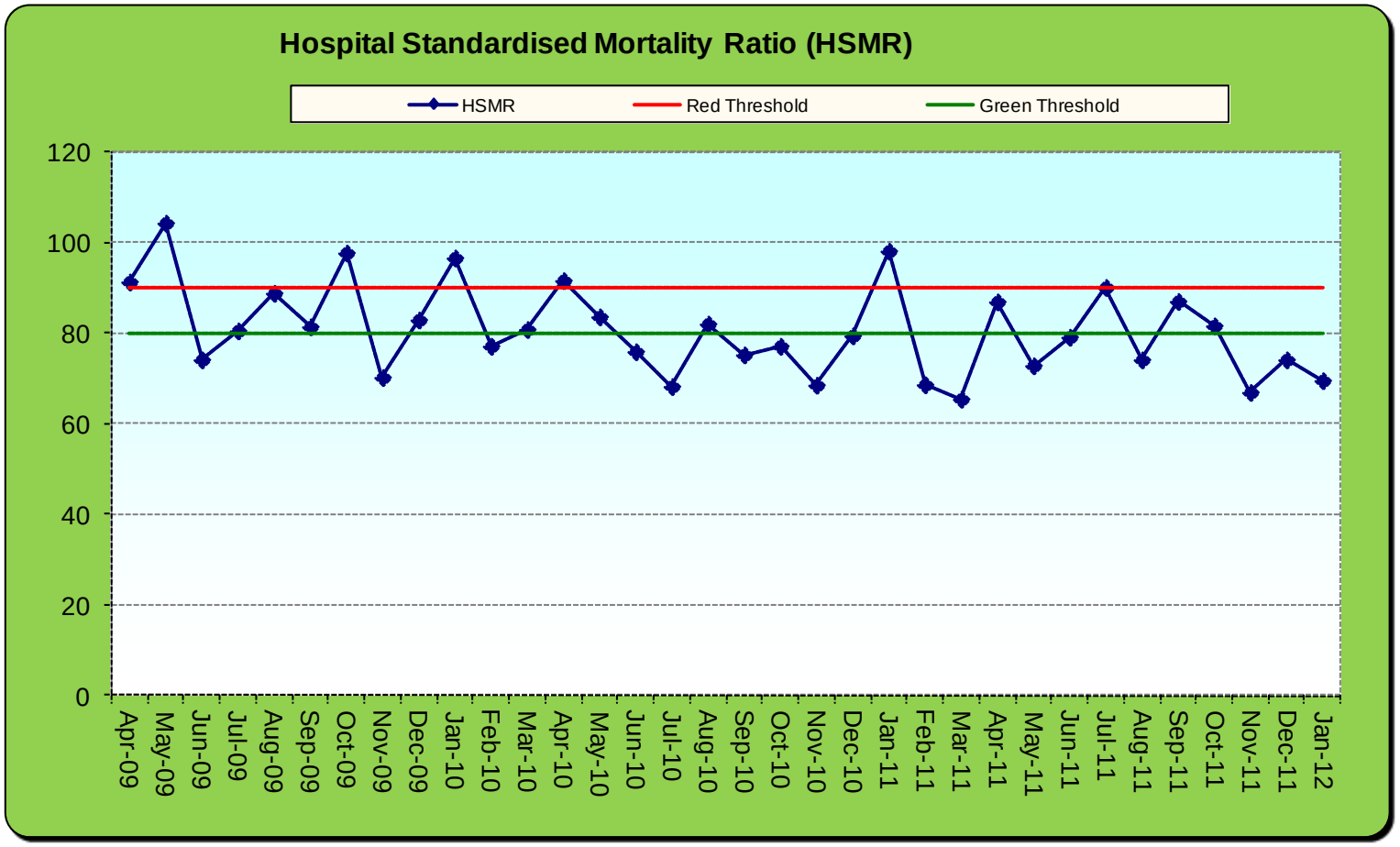
Hospital Standardised Mortality Ratio (HSMR)
HSMR
Red Threshold
Green Threshold
120
100
80
60
40
20
0
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
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Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
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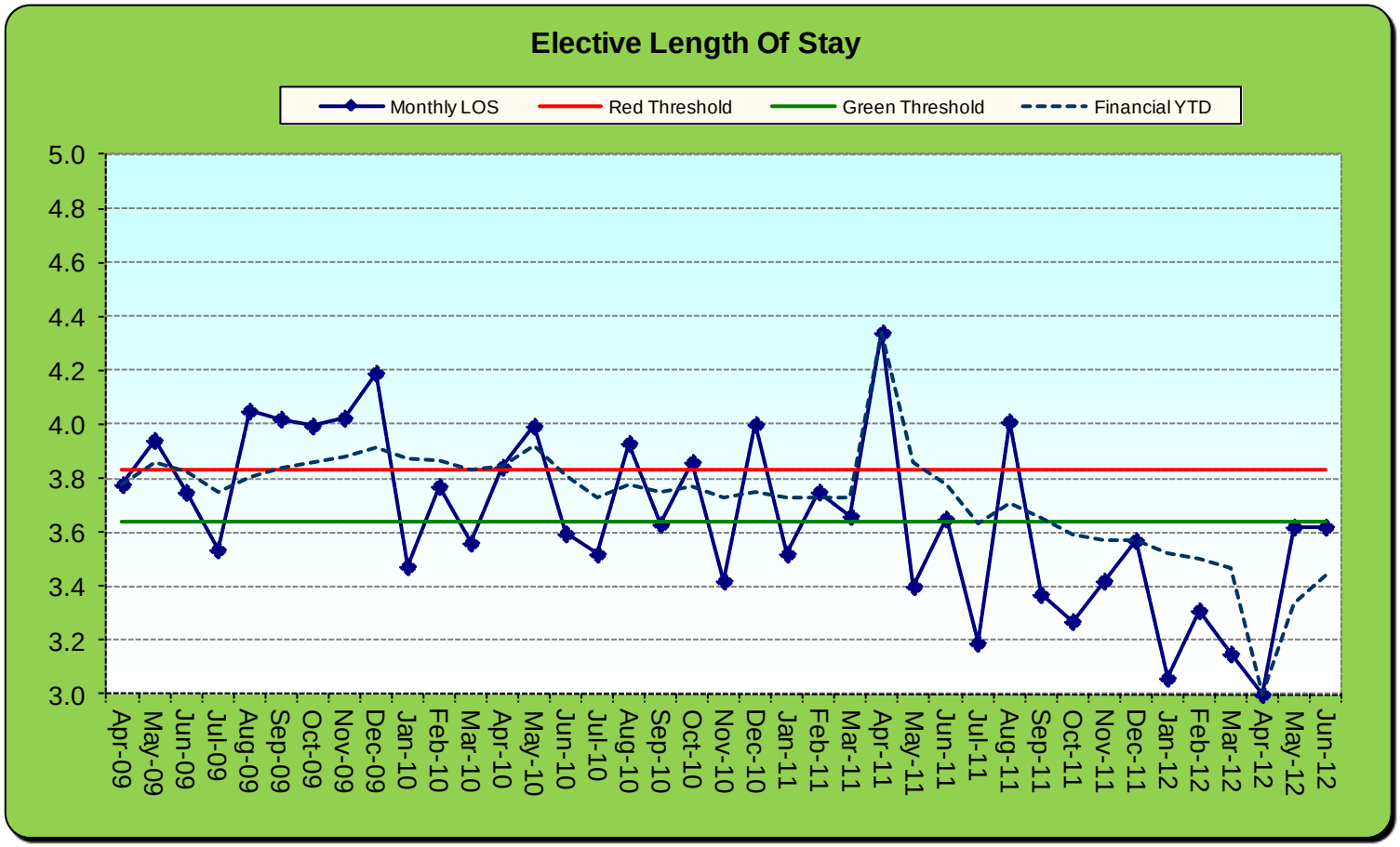
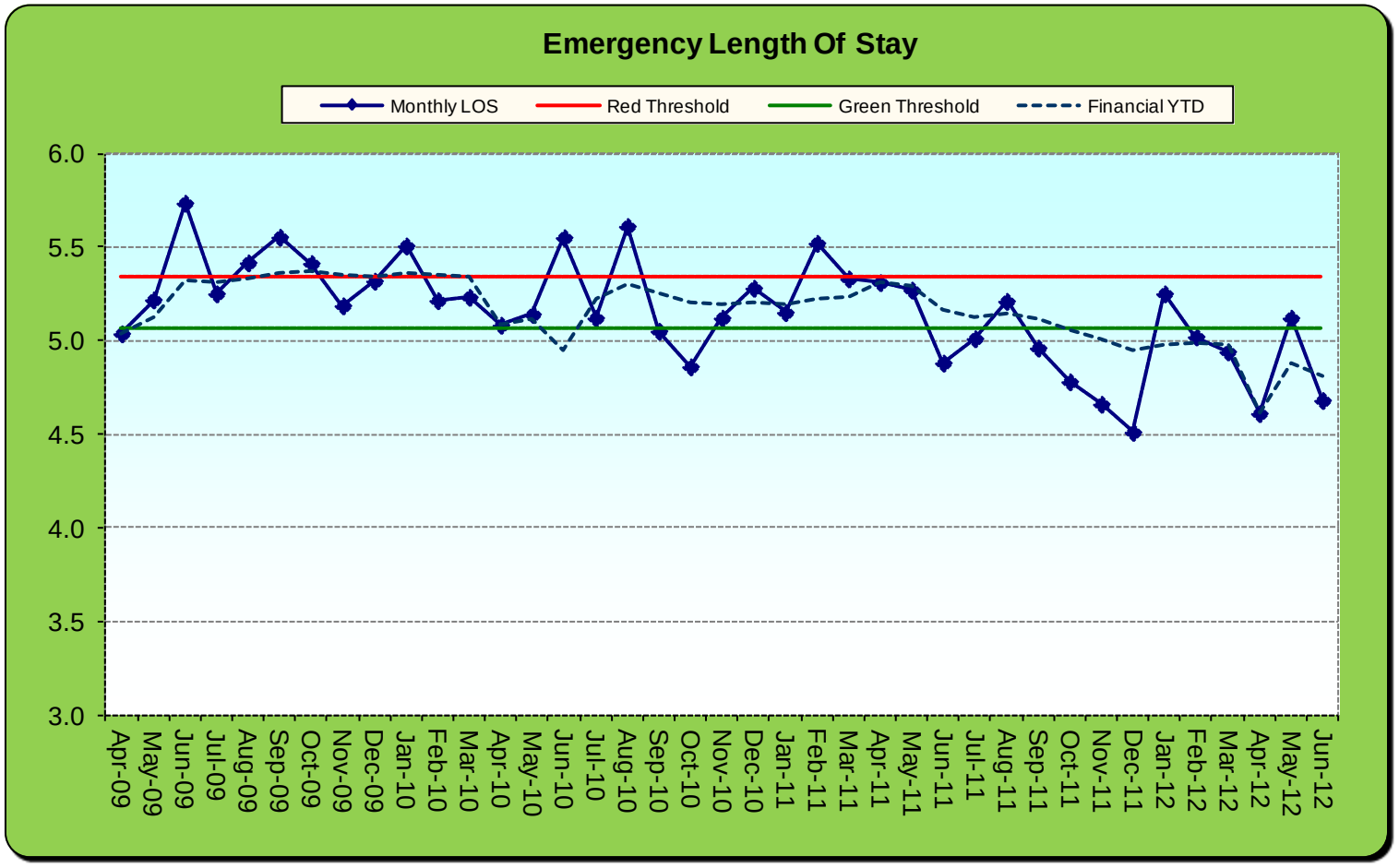
Nov-11
Dec-11
Jan-12

PERFORMANCE OVERVIEW





Please note: a graph showing the new outpatient productivity measure of hospital cancellations of outpatient appointments, will be added to the report next month.

PERFORMANCE OVERVIEW

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Number of Patient Complaints	In the *Quality* section of this report	
Incidence of pressure sores (grades 3 and 4)	In the *Quality* section of this report	
Number of inpatient falls	In the *Quality* section of this report	
Outpatient appointment hospital cancellation rate	See additional information	Hospital cancellation rate is a new measure of the efficiency with which we deliver our outpatient services. An internal target has been set of achieving a 6% hospital cancellation rate by the end of 2012/13. The Productive Outpatients transformation project is developing a programme of work towards achieving this objective.
Staff sickness	In the *Workforce* section of this report	
Number of Patients Recruited Into NIHR Trials	See additional information	The number of patients recruited year to date is marginally below plan. A more detailed exception report will be provided next month if the variance continues.

SECTION C – Monitor's Compliance Framework

At the end of June 2012 the Trust achieved all of the targets in Monitor's 2012/13 Compliance Framework for the quarter with the exception of the A&E 4-hour standard. This position is based upon the draft performance figures against the national cancer standards for June. The final figures will be submitted as part of the national return at the beginning of July.

An Exception Report is therefore provided in the *Access* section of this report for the following indicator:

- A&E 4 –hour maximum wait

The quarter-end declaration to Monitor needs to reflect both performance in the reported quarter, along with performance risks for the quarter to come. The Trust reported achievement of the 95% A&E 4-hour standard for the month of June. This recent improvement in performance against the 4-hour standard performance provides greater assurance of achievement of the standard in the second quarter of the year.

The A&E 4-hour standard is weighted 1.0 in the Compliance Framework. This gives the Trust an AMBER-GREEN Governance Risk Rating for the first quarter of 2012/13. This is the second lowest rating out of four.

Please see the Monitor dashboard on the following page, for details of current reported position for quarter 1 2012/13.

PERFORMANCE OVERVIEW

Monitor's Compliance Framework - dashboard

	Number	Target	Weighting	Target threshold	Reported Year To Date	Q2 11/12	Q3 11/12	Q4 11/12	*Q1 12/13 to date	Q1 Actual*	Notes	Q1 Governance rating forecast
Monitor Compliance Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	16	✓	✓	✓	16	✓	Cumulative trajectory: Q1 17; Q2 33; Q3 44; Q4 54	Achieved
	2	Infection Control - MRSA Bloodstream Cases Against Trajectory	1.0	< or = trajectory	2	✓	✓	✓	2	✖	Cumulative trajectory: Q1 1; Q2 1; Q3 2; Q4 2; Not scored	Not scored
	3a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	100%	✓	✓	✓	100.0%	✓		Achieved
	3b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	99.0%	✓	✓	✓	94.5%	✓		
	3c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	99.4%	✓	✓	✓	99.4%	✓		
	4a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	91.6%	✓	✓	✓	89.0%	✓		Achieved
	4b	Cancer 62 Day Referral To Treatment (Screenings)		90%	100%	✖	✓	✓	95.7%	✓		
	5	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	92.1%	Achieved each month	Achieved each month	Achieved each month	Achieved each month	✓		Achieved
	6	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	96.8%	Achieved each month	Achieved each month	Achieved each month	Achieved each month	✓		Achieved
	7	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	92.2%	Target not in effect			Achieved each month	✓		Achieved
	8	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	0.5	96%	98.9%	✓	✓	✓	96.6%	✓		Achieved
	9a	Cancer - Urgent Referrals Seen In Under 2 Weeks	0.5	93%	96.2%	✓	✓	✓	95.3%	✓		Achieved
	9b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	96.8%	✓	✓	✓	96.5%	✓		
	10	A&E Total time in A&E 4 hours (95th percentile)	1.0	95%	93.6%	✓	✓	✖	93.6%	✖		Not achieved
	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	CQC Actions completed	CQC Actions completed	Not applicable	Not applicable	Not applicable		Achieved
					rating	AMBER-GREEN	GREEN	AMBER-GREEN	AMBER-GREEN	AMBER-GREEN		1.0
												AMBER-GREEN

Please note: If the same 1.0 weighted indicator is failed in three successive quarters, an automatic RED rating is applied. For A&E 4-hours, an automatic RED rating is applied if the target is failed in two quarters in a twelve-month period and is then failed in the subsequent nine-month period or for the year as a whole. The quarterly trajectory for C. diff was amended at the end of quarter 1, in agreement with the Primary Care Trust and Monitor. The year-end target remains 54 cases.

***Q1 Cancer figures based upon confirmed figures for April and May, and draft figures for June.**

QUALITY

1.1 PATIENT EXPERIENCE

Nature of complaint

The Centre Manager for an Extra Care Scheme in Bristol raised a complaint about the discharge of one of the scheme's clients, Mr C. The Centre Manager was concerned that Mr C's discharge from one of the medical wards at the Bristol Royal Infirmary had taken place at a time that the Extra Care Scheme had not agreed to, and therefore they were unaware of this return. Mr C also left the hospital without a discharge summary so they were unaware of any medication changes. There was also concern that the discharging ward was unaware of who was co-ordinating Mr C's care in the community and that the Trust was unaware that his care was Continuing Healthcare funded (CHC) which is a package of care provided outside hospital, arranged and funded solely by the NHS, for people with ongoing healthcare needs.

Investigation

A thorough investigation was carried out, which identified a number of issues:

- Mr C was fit for discharge on a Friday morning (within 48 hours of admission) and the ward nurse contacted the Extra Care Scheme at this time to notify them. The Extra Care Scheme was unable to accept him back into its care without 48 hours notice and therefore Mr C remained an inpatient for the weekend until his services could be re-started on the following Monday.
- Ward staff believed they had agreed a Monday morning discharge (in line with best practice at University Hospitals Bristol), however the Extra Care Scheme believed they had agreed a Monday afternoon discharge.
- Mr C was collected by transport before 10am and at this time his discharge letter was not ready. It had been commenced on the Friday, but there was some concern that his medications may have required review, and therefore it was not completed until the day of his discharge. On the Monday morning, the ward doctor discussed Mr C's medications with his General Practitioner (GP) who agreed that no discharge medication was required and that he had adequate community supplies. Although the GP was reviewing Mr C in his home that afternoon, the nursing team did not communicate this conversation to his care providers, and therefore there was a delay of 24 hours in them receiving his discharge summary.
- Ward staff were unaware of Mr C's CHC funding, although in these circumstances as his care needs had not changed, it did not affect his discharge planning.

Local Learning

- Documentation – poor recording of information regarding the service provider of Mr C's care on admission meant there was some confusion about who the care providers were, and notification of actual discharge time on the day was given to Care Direct rather than the actual care provider.

Actions taken – discussed at a Divisional Clinical Sisters' meeting and asked them to take back to their teams the importance of nursing staff reviewing the details of external care providers with patients/carers for accuracy on admission.

- Documentation of the conversation between the ward nurse and Extra Care Scheme about the discharge plans – the ward nurse was very clear that a Monday morning 10am discharge had been agreed during the Friday phone call, but had not recorded who he had this conversation with. The Extra Care Scheme Manager was clear that the discharge had been agreed for 2pm and therefore there was a discrepancy about discharge times between the ward and the care provider leading to a potential gap in this gentleman's care in the community (the Extra Care Team was able to cover the unexpected gap which meant this gentleman was safe on discharge).

  Actions taken – discussed at a Divisional Clinical Sisters' meeting and asked them to take back to their teams the importance of documenting the date and time of discharge conversations, and the name of the person they had a conversation with.

- Timely completion of discharge summary – communication with the GP by a member of the ward based medical team about discharge medication was an example of good practice. But neither the nurses or medical staff communicated this to the care providers at the time of discharge.

  Actions taken – discussed with the Committee of Physicians at their June meeting to ensure the discharge summary is completed prior to discharge from the Trust.

Organisational Learning

- A Trust wide documentation review is underway to incorporate a single place for recording the care provider's name and contact details and for a single discharge checklist/record to document discharge planning.

  Actions taken – Heads of Nursing are reviewing and updating Trust-wide nursing documentation which is currently with the printers for formatting. A pilot is planned for mid-August. Discharge summary data is captured – we will use this to identify areas of less good practice and speak directly to the teams concerned.

- Building and establishing community partnerships so that we can articulate the expectations across the community about the appropriateness of morning discharges as 'the norm'.

  Actions taken – NHS Bristol is reviewing 7-day working across the health community, and with the support of the Emergency Care Intensive Support Team, are holding a Rapid Improvement Event Workshop on 7-day working on the 31st August 2012.

  On the 30th July 2012 the Emergency Care Intensive Support Team is supporting the Trust and its partner agencies and organisations in an audit of patients in adult inpatient beds, and reasons for this – one of the reasons will be a number of patients awaiting the re-start of a care package. This information will be shared with the health community and opportunities to reduce the numbers of patients occupying hospital beds

when they could have their needs met in a non-acute environment will be considered and this is likely to inform Bristol, North Somerset and South Gloucestershire Urgent Care Plans.

It is also clear that patients discharged from hospital to their homes would benefit from knowing in advance their planned date of discharge and for their discharge to be undertaken on the morning of the planned date. Most patients are still not discharged from hospital until late afternoon, and the Trust is working on this as part of early discharge planning, and the 'yellow' card system in Surgery.

1.2 QUALITY TRACKER

		ID	Title	Green Threshold	Year To Date	Monthly Totals												Quarterly Totals			
						Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Q2	Q3	Q4	Q1
Patient Safety	Infection Control	PS-A1	MRSA Pre-Op Elective Screenings	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		PS-A2	MRSA Emergency Screenings	90%	92.8%	92.7%	93.1%	93.2%	93.4%	94.1%	93.8%	94.1%	94.4%	92.0%	92.2%	93.8%	92.3%	93.0%	93.8%	93.4%	92.8%
		PS-A3	Hand Hygiene Audit Compliance	95%	97.8%	99.1%	98.8%	97.3%	97.2%	96.2%	98.5%	98.3%	98.2%	98.3%	98.0%	98.2%	97.1%	98.4%	97.3%	98.3%	97.8%
		PS-A4	Antibiotic Compliance	90%	83.0%	80.1%	76.3%	76.7%	81.5%	83.3%	82.9%	86.8%	84.2%	83.7%	80.6%	84.7%	84.2%	77.4%	82.7%	84.9%	83.0%
		PS-A5	Matron's Checklist	95%	94.9%	94.2%	93.8%	94.5%	95.2%	94.9%	95.2%	95.5%	96.4%	98.8%	97.3%	95.6%	93.4%	94.2%	95.1%	96.3%	94.9%
		PS-A6	Cleanliness Monitoring - Overall Score	95%		95%	95%	96%	95%	96%	94%	96%	95%	96%	96%	95%	95%				
		PS-A7	Cleanliness Monitoring - Very High Risk Areas	95%		97%	96%	97%	97%	96%	95%	96%	96%	96%	96%	97%	96%				
		PS-A8	Cleanliness Monitoring - High Risk Areas	95%		96%	97%	97%	96%	97%	96%	95%	96%	96%	96%	95%	95%				
		PS-A9	Number of GRE Bacteraemias	<=2	4	0	3	1	0	0	2	0	3	0	2	2		4	2	3	4
		PS-A10	Infection Control - C.Diff Infections Against National Trajectory	<Traj.	16	4	7	5	5	4	2	4	3	3	3	8	5	16	11	10	16
		PS-A11	MSSA Cases Against Trajectory	<Traj.	11	0	8	4	5	2	3	3	3	2	3	4	4	12	10	8	11
	Incidents	PS-B1	Number of Serious Incidents (SIs) Reported		24	6	2	10	8	8	3	16	7	10	3	7	14	18	19	33	24
		PS-B2	Serious Incidents Reported Within 48 Hours	80% (Q3)	92%	83%	100%	50%	62%	75%	33%	69%	86%	80%	67%	100%	93%	67%	63%	76%	92%
		PS-B3	Percentage of Serious Incident (SI) Investigations Completed Within Timescale	80% (Q3)	95%	100%	100%	100%	100%	100%	57%	71%	86%	92%	88%	100%	100%	100%	79%	85%	95%
		PS-B4	Total Never Events	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
		PS-B5	Total Number of Patient Safety Incidents Reported		2750	710	681	688	839	782	778	755	807	892	813	861	1076	2079	2399	2454	2750
	Falls	PS-C1	Number of Inpatient Falls Per 1,000 Beddays	<5.6	5.94	5.14	3.55	4.54	4.68	5.45	5.01	4.84	5.68	6.64	6.63	5.26	5.97	4.42	5.04	5.72	5.94
		PS-C2	Repeat Inpatient Falls		24.7%	21.7%	20.3%	13.4%	28.6%	17.7%	27.9%	23.3%	13.4%	19.6%	12.9%	28.7%	30.9%	18.5%	24.7%	18.6%	24.7%
		PS-C3	Number of Inpatient Falls - Patients Aged 65 And Over		320	94	63	78	87	96	92	98	94	125	116	101	103	235	275	317	320
		PS-C4	Number of Inpatient Falls - Patients With Cognitive Impairment		182	43	26	44	48	47	51	60	43	61	62	57	63	113	146	164	182
	Pressure Ulcers	PS-D1	Total Pressure Ulcer Incidence per 10,000 Bed Days	6.51	14.42	13.65	12.69	14.01	21.21	15.21	14.07	16.41	15.75	15.80	13.50	13.44	16.36	13.45	16.89	15.99	14.42
		PS-D2	Percentage of Hospital Acquired Pressure Ulcers Not Graded	<5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.0%
		PS-D3	Number of Hospital Acquired Grade 2 Pressure Ulcers	<83 yr	97	32	27	29	49	33	32	33	33	39	32	32	33	88	114	105	97
		PS-D4	Number of Hospital Acquired Grade 3 Pressure Ulcers	<1	9	2	3	4	4	3	1	2	3	1	1	1	7	9	8	6	9
		PS-D5	Number of Hospital Acquired Grade 4 Pressure Ulcers	<1	1	0	0	0	0	0	1	1	1	0	0	1	0	0	1	2	1
	Venous Thrombo-embolism (VTE)	PS-E1	Adult Inpatients who Received a VTE Risk Assessment	90%	97.8%	97.5%	98.0%	97.6%	97.5%	98.0%	98.4%	98.2%	98.4%	98.9%	98.7%	93.3%	95.3%	97.7%	98.0%	98.5%	97.8%
		PS-E2	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	90%	98.1%	87.5%	93.3%	89.6%	97.5%	89.7%	97.5%	96.0%	92.5%	97.4%		97.8%	98.4%	90.4%	94.4%	95.3%	98.1%
	Nutrition	PS-F1	Fully Completed Nutritional Screening Within 24 Hours	90%	86.5%			92.0%			83.5%			85.9%			86.5%	92.0%	83.5%	85.9%	86.5%
	Safety	PS-G1	WHO Surgical Checklist Compliance	98%	97.8%	87.3%	96.8%	97.7%	97.0%	97.3%	97.5%	98.7%	98.4%	99.0%	95.4%	98.7%	99.4%	93.9%	97.3%	98.7%	97.8%
		PS-G2	Reduction in Medication Errors	<2.84%	2.23%	0.85%	2.65%	1.05%	2.56%	2.04%	2.22%	1.00%	1.87%	1.63%	3.75%	1.01%		1.54%	2.30%	1.52%	2.23%
	Leadership	PS-H1	Number of Executive Director Patient Safety Walk-arounds	>=6	17	6	5	10	9	5	6	8	6	7	6	8	3	21	20	21	17
		PS-H4	Percentage of Non-Estates Actions Completed Within 2 Months	80%	100%	95%	75%	91%	100%	86%	83%	100%	100%	100%	100%	100%	100%	88%	86%	100%	100%

QUALITY

		ID	Title	Green Threshold	Year To Date	Monthly Totals												Quarterly Totals			
						Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Q2	Q3	Q4	Q1
Clinical Effectiveness	Mortality	CE-A1	Hospital Standardised Mortality Ratio (HSMR)	<=80		90.2	74.2	87.1	81.7	67	74.2	69.6									
	Length of Stay	CE-C1	Average Length Of Stay - Elective	<=3.64		3.19	4.01	3.37	3.27	3.42	3.57	3.06	3.31	3.15				3.53	3.41	3.17	
		CE-C2	Average Length Of Stay - Emergency	<=5.07		5.01	5.21	4.96	4.78	4.66	4.51	5.25	5.02	4.94				5.06	4.65	5.07	
	Learning Disability	CE-D1	Risk Assessment of Patients with Known Learning Disability within 48 Hours	85%		33.3%	42.9%	87.5%	85.7%	81.8%	83.3%	100.0%	100.0%	88.9%				61.1%	83.3%	95.5%	
	Readmissions	CE-E1	Emergency Readmissions Within 30 Days	<411 mth	2.6%	3.4%	2.9%	3.5%	3.7%	3.4%	3.5%	3.2%	2.9%	2.9%	2.6%			3.2%	3.5%	3.0%	2.6%
	Maternity	CE-G1	Percentage of Spontaneous Deliveries Compared to All Births	64.4%	63.9%	64.9%	61.2%	57.8%	63.8%	62.0%	62.5%	65.8%	62.6%	66.7%	67.8%	61.3%	62.3%	61.3%	62.8%	65.1%	63.9%
	Fracture NoF	CE-H1	Fracture Neck of Femur Patients Treated Within 36 Hours			65.4%	58.3%	53.8%	44.8%	57.7%	54.5%	56.2%	58.8%	92.3%				59.2%	52.3%	70.5%	
		CE-H2	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72hours			38.5%	66.7%	84.6%	86.2%	61.5%	87.9%	84.4%	76.5%	79.5%				63.2%	79.5%	80.0%	
		CE-H3	Fracture Neck of Femur Patients Achieving Best Practice Tariff			30.8%	37.5%	46.2%	41.4%	38.5%	51.5%	56.2%	44.1%	53.8%				38.2%	44.3%	51.4%	
	Stroke Care	CE-J1	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	50%	41.8%	42.9%	28.6%	37.9%	28.6%	24.3%	25.7%	33.3%	46.4%	50.0%	41.2%	42.1%		35.9%	26.0%	44.1%	41.8%
		CE-J2	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	80%	67.0%	81.8%	85.4%	97.1%	85.7%	87.8%	81.4%	65.8%	68.3%	64.3%	82.1%	55.1%		87.9%	84.9%	66.1%	67.0%
		CE-J3	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	69.2%	50.00%	63.16%	77.78%	75.00%	64.29%	72.22%	52.63%	59.09%	71.43%	83.33%	57.14%		65.31%	70.45%	60.00%	69.2%
Patient Experience	Single Sex Accom.	PE-A1	Same Sex Accommodation Breaches - Number of Patients	0	20	3	0	7	10	0	0	0	0	30	0	20	0	10	10	30	20
	Patient Experience	PE-B1	Patient Survey - Overall CQUIN Score	73.9		74.4	75.3	73.9	76.2	75.9	74.8	74.3	75.8	74.7	77	74.7		75	76	75	75.6
		PE-B2	Monthly Patient Survey - Noise At Night	84-86		82	83	80	83	82	82	80	81	79	83	81		82	82	80	82
		PE-B3	Monthly Patient Survey - Explaining Medication Side Effects	61-64		52	59	59	59	59	56	59	61	60	59	61		57	58	60	60
		PE-B4	Monthly Patient Survey - Maternity Services	85				82			80			86				82	80	86	
		PE-B5	Monthly Patient Survey - Patients Who Would Recommend The Trust	92%		97%	96%	96%	95%	97%	96%	96%	97%	96%	96%	95%		96%	96%	96%	95%
		PE-B6	Monthly Patient Survey - Local Score	83		86	88	86	88	88	88	87	88	88	88	87		87	88	88	88
	Complaints/Compliments	PE-C1	Number of Patient Complaints	<=120	464	123	151	121	122	126	85	151	122	109	121	195	148	395	333	382	464
		PE-C3	Percentage of Complaints Resolved Within Timeframe (Formal Complaints)	98%	95.2%	97.4%	92.7%	92.6%	90.2%	90.9%	84.2%	81.4%	95.2%	94.3%	96.7%	94.5%	94.7%	93.9%	88.7%	91.2%	95.2%
		PE-C4	Number of Complainants Disatisfied with Response	0-5 mth	20	10	8	4	7	12	7	6	5	8	8	6	6	22	26	19	20
		PE-C6	Complainants Disatisfied with Response (Not Responded In Full)		9				6	1	0	0	0	2	2	3	4		7	2	9
		PE-C7	Complainants Disatisfied with Response (Additional Information Requested)		11				1	11	7	6	5	6	6	3	2		19	17	11

NB: Green Threshold is the threshold for 2012/13. Tresholds in previous years may have been different

Please note: the latest HSMR figure quoted is still for January 2012. The Trust sources these figures from the Strategic Health Authority website. As part of the annual update of the quality indicators the new measure of mortality (SHMI - Summary Hospital Mortality Indicator) figures will be added, which the Trust will source directly from a benchmarking database provided by CHKS. This will improve the timeliness of mortality figures.

1.3 SUMMARY

This month's dashboard includes the Quarter 1 figure for the patients receiving fully completed nutritional screening within 24 hours of admission which shows an improvement on the previous quarter to 86.5%. The number of complaints, largely about appointments and admissions, is reducing following the actions detailed last month and is moving in the right direction, aiming to be below the threshold by August. Stroke and pressure ulcer incidence metrics remain red rated despite significant focussed work in these areas. Exception reports provide further detail on work being completed in these areas.

Achieving set threshold (31)	**Thresholds not met or no change on previous month (5)**
- MRSA (Meticillin Resistant *Staphylococcus aureus*) screening – elective - MRSA screening – emergency - Hand Hygiene Audit - Cleanliness monitoring very high risk areas - Cleanliness monitoring overall Trust score - Cleanliness monitoring high risk areas - Glycopeptide Resistant Enterococci (GRE) Bacteraemias - *Clostridium difficile* cases against national trajectory - Serious Incidents reported with 48 hours - Serious incident investigations completed within required timescales - Never Events - Percentage of hospital acquired pressure ulcers not graded at all - Number of hospital acquired grade 4 pressure ulcers - Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment - Percentage adult in-patients who received thrombo-prophylaxis - WHO surgical checklist compliance - Reduction in medication errors - Number of executive director patient safety walk rounds - Percentage of all actions completed with 2 months of patient safety walk round - Hospital Standardised Mortality Ratio (HSMR) - Stroke Care: Percentage Time on Stroke Unit	- Antibiotic prescribing compliance - Matrons checklist (*C. difficile* dashboard) - Patients receiving fully completed nutritional screening within 24 hours - Monthly patient survey: noise at night - Percentage of complaints resolved within formal timescale

QUALITY

- Risk assessment of patients with known learning disability within 48 hours - Reduction in average elective length of stay - Reduction in average emergency length of stay overall - 30 day emergency re-admissions - Number of breaches of the same sex accommodation standard - Patient experience overall CQUIN score - Monthly patient survey: explain medication side effects - Monthly patient survey: patients who would recommend the Trust - Monthly patient survey local score - Number of complainants dissatisfied with the response (not responded in full)	
Quality metrics not achieved or requiring attention (9)	**Quality metrics not rated (10)**
- MSSA (Meticillin Sensitive *Staphylococcus aureus*) cases against trajectory - In-patient falls incidence per 1,000 bed days - Total pressure ulcer incidence per 10,000 bed days - Number of hospital acquired grade 3 pressure ulcers - Percentage of spontaneous deliveries compared to all births - Stroke care: percentage spending 90% + time on a stroke unit - Stroke care: percentage receiving brain imaging within 1 hour - High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours - Total number of complaints	**Thresholds not yet applicable** - Number of hospital acquired grade 2 pressure ulcers - 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 - Monthly patient survey: maternity services **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 Commissioning for Quality and Innovation (CQUIN) Quality Dashboard Metrics

The Board is asked to note that CQUIN's relating to quality for 2012/13 have been agreed in contracts with commissioners and will be reported in subsequent months in a revised dashboard and in-line with contract timeframes. Thresholds and details relating some CQUINs are in the process of being agreed with commissioners.

- Patient Experience: overall CQUIN score. The final CQUIN will be based on the 2012/13 annual National Inpatient Survey and reported in due course. However, the same basket of questions is monitored locally though our postal surveys. Score in May was 74.7 against a target of 73.9.
- Patient Experience: reducing noise at night. Score for May was 81 against the new 2012/13 target of 86 to be achieved by Q3.
- Patient Experience: explaining medication side effects. This is a new CQUIN for 2012/13. Score for May was 61 against a target of 64.
- Patient Experience: patients who would recommend the Trust. This is a new CQUIN for 2012/13. Score for May was 95% against a target of 92% to be achieved by Q3.

1.4 CHANGES IN THE PERIOD

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

- WHO Surgical Safety checklist compliance up ↑ from 98.7% in May‡ to 99.4% in June.
- Number of Grade 3 pressure ulcers up ↑ from 1 in May to 7 in June
- Same sex accommodation breaches down ↓ from 20 in May to 0 in June.
- Number of complaints down ↓ from 195 in May to 148 in June.

‡ *Please note, compliance with the WHO Surgical checklist was previously reported at 96.5%. However, following validation of these figures, compliance for May has now been confirmed at 98.7%.*

1.5 EXCEPTION REPORTS

Exception reports are provided for eleven indicators in total, nine which are RED rated and a further two* which are amber rated and have been of particular interest to the Board:

1. Antibiotic prescribing compliance*
2. MSSA (Meticillin Sensitive *Staphylococcus aureus*) cases against trajectory
3. In-patient falls incidence per 1,000 bed days
4. Total pressure ulcer incidence per 10,000 bed days
5. Number of hospital acquired grade 3 pressure ulcers
6. Percentage of patient with fully completed nutritional screening with 24 hours*
7. Percentage of spontaneous deliveries compared to all births
8. Stroke care: percentage spending 90% + time on a stroke unit
9. Stroke care: percentage receiving brain imaging within 1 hour
10. High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours
11. Total number of complaints

QUALITY

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

Description of how the standard is measured:

Antibiotic prescribing compliance measures the compliance with three elements of the antibiotic prescribing policy in line with national antimicrobial stewardship initiatives. These are:

1. Antibiotic choice is according to guideline/ microbiology results or microbiologist recommendation
2. The indication is stated on the prescription
3. A stop or review date is included on the prescription.

In order to be deemed compliant, a prescription for an antibiotic must meet all 3 criteria.

Performance in the period, including reasons for the exception:

The overall percentage compliance fell marginally by 0.5% from 84.7% in May to 84.2% in June.

Compliance improved this month in:

- Surgery Head & Neck (88.1%, an increase from 82.3% in May)
- Specialised Services (90.8%, an increase from 83.9% in May). This division meet the 90% target this month. Specialised Services trend is very encouraging and the Division should be congratulated on their improvement.

Compliance fell this month in:

- Medicine (79.2%, a fall from 86.1% in May). This is the first time that the Division of Medicine has failed to achieve 80% since September 2011. A breakdown of the Division of medicine results is available below under reasons for the exception. Gastroenterology and Hepatology achieved the 90% target.
- Women's & Children's (83.3%, a fall from 85.5% in May).

Reasons for the exception:

- 51 of 456 prescriptions audited in June did not include a valid stop or review date. This continues to be the main cause of failure to reach the 90% target.
- Division of Medicine has demonstrated a fall in compliance this month. The breakdown for Division is shown on the next page.
- Sustainability continues to be key to achieving the 90% target in antimicrobial prescribing compliance.

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Sub Division	Number of reviews	Percentage compliant	Number compliant	No. Not Compliant	No. not to guideline	No. with no stop or review date	No. with no Indication
Care of Elderly BRI Total	57	68.4%	39	18	2	13	3
Emergency Dept Total	1	100.0%	1	0	0	0	0
Endocrinology Total	17	76.5%	13	4	0	4	0
Gastroenterology & Hepatology Total	19	94.7%	18	1	0	1	0
Respiratory Total	81	82.7%	67	14	2	12	2

Recovery plan, including expected date performance will be restored:

- Continue with joint Microbiology/Pharmacy review rounds.
- A revised version of the drug chart has gone to print and will be available for use in the near future. The required fields ‘start date’, ‘review date’, ‘stop date’ and ‘indication’ are now in red text and stand out promoting completion. An additional ‘review date’ box has been added to enable annotation of a new review date in an effort to reduce the number of prescriptions failing as the existing review date has past.
- Continue to monitor through Divisional Boards.
- Education of consultants (via consultant away days) on the requirement to adopt antibiotic prescribing as an important issue and the completion of the drug chart fields as mandatory. Consultants to ensure that their juniors are completing the prescriptions in full.
- Attendance on the new F1 ‘Scared to Prepared’ day to ensure that antimicrobial prescribing is explained in detail.
- Plan to speak to all new doctors about antimicrobial prescribing at Trust induction sessions.
- Ask the Division of Medicine to follow up with care of the elderly team the issues that have caused poor prescribing compliance this month.

QUALITY

Q2. EXCEPTION REPORT: Meticillin Sensitive Staphylococcus Aureus (MSSA) cases against trajectory	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The number of MSSA cases for patients in hospital for more than 2 days. The local target is a 25% reduction on 2011/12 outturn figures. This equates to no more than 27 cases in year. This has been allocated across the Divisions over 12 months. This target has no financial penalties and does not contribute to the Monitor compliance framework.

Performance in the period, including reasons for the exception:

There were three Trust apportioned cases of MSSA in June 2012. One over the Trust's target trajectory for June of two cases.
The breakdown of cases by location is as follow.

Division	Monthly Target	Number of Target cases in the month	Location of patients
Specialised services	0	0	
Surgery Head and Neck	1	1	Ward 14
Women's and Children's	0	1	BMT
Medicine	1	1	Ward 23

Actions to prevent MSSA are similar to those for MRSA although at present widespread screening for MSSA is not recommended nationally. The number of people who harmlessly carry MSSA (approximately one third) is far greater than MRSA. The overall trajectory for quarter one is six cases. The actual number of on target cases for quarter one is ten.

Recovery plan, including expected date performance will be restored.

All post-48 hour cases are investigated by the clinical team with learning shared at the Infection Control Operational meeting chaired by the Deputy Chief Nurse. These investigations inform the recovery plan below.

- Practice for insertion and management of intravenous lines is to be reviewed by the Divisions. Ward Sisters (in their supervisory role) will use the Saving Lives care bundle tool for insertion of peripheral intravenous cannula to assess compliance with best practice standards and identify areas to focus on for improvement.
- The current screening policy for MSSA is for cardiac patients only, this continues.

QUALITY

- Microbiologist to discuss if appropriate to extend the screening of MSSA patients in critical care areas.
- Current position and actions to prevent further cases continue to be included in the Divisional quarterly reviews with the Executive team.
- Focused training of staff of management and insertion of peripheral lines and cannulae.

Delivery of the plan is being monitored and managed through the weekly Infection Control Operational meeting and through exception reporting to the Service Delivery Group fortnightly.

QUALITY

Q3. EXCEPTION REPORT: Inpatient falls incidence per 1,000 bed days	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The number of inpatient falls per 1,000 bed days compared with national benchmark data from the National Patient Safety Agency (NPSA) of 5.6 falls per 1,000 bed days.

Performance in the period, including reasons for the exception:

Performance in the month was 5.97 falls per 1,000 bed days against the national benchmark of 5.6. There were 148 inpatient falls in June. The degree of harm, based on NPSA guidance, arising from the falls in June was:

Degree of Harm	April	May	June
Near Miss	3	8	6
Negligible	141	92	93
Minor	17	32	47
Moderate	1	2	0
Major	1	1	2

2 patients sustained hip fractures as a result of their fall on wards 23 and 200. Both were un-witnessed and a root cause analysis is underway for both cases.

Breakdown of Falls by Division

Division	April	May	June
Diagnostics & Therapies	2	1	1
Medicine	98	78	97
Specialised Services	29	26	20
Surgery Head & Neck	30	21	27
Women's & Children's	4	8	3

Recovery plan, including expected date performance will be restored:

QUALITY

Matrons meet cross divisionally to review each and every fall to share experience and learning, which is reviewed at the Falls Steering Group to gain understanding of the Trust-wide themes emerging from the reviews, and to develop plans that need to be put in place. It is clear from themes emerging that a high number of falls occur at night. They also occur when patients are behind curtains or in toilets (with staff just outside). Ill fitting footwear has also been identified as a contributory factor. A number of actions are in place to address this.

1. Discussion with patients and or carers and documentation regarding patients need to get up in the night. Plans to wake in the night to be agreed.
2. Posters advising patients not to risk falling, but to wait for help, have been produced and are displayed in ward bays and toilets.
3. A pilot is planned on ward 7 where patients at risk of falling will wear a green wristband to alert all staff to this risk. Progress and reporting will be via the Falls Steering Group.
4. Whilst slipper socks are available, they are not always suitable or offered to patients. This is under review and information will be included in a new patient leaflet
5. A patient and carer information leaflet is being developed, to ensure patients are fully informed of the risks and what they can do to prevent falls.
6. Multi-disciplinary care rounding is underway, led by Hazel Moon (Head of Nursing) and new Clinical Leads for falls, Natalie Godfrey (Lead Dementia Nurse) and Scott Allan (Occupational Therapist)
7. One year's funding for a fall support band 4 worker has been agreed. The post will support the Clinical Leads and the roll out of teaching and audit work in all ward areas.

QUALITY

Q4-Q5 EXCEPTION REPORT: Pressure ulcer incidence per 10,000 bed days + Number of hospital acquired grade 3 pressure ulcers	RESPONSIBLE DIRECTOR: Chief Nurse

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).

Performance in the period, including reasons for the exception:

The rate of hospital acquired pressure ulcers grade 2 and above was 16.36 per 10,000 bed days in June 2012, an increase from May's figure.

Division	June 2012	May 2012	April 2012
Medicine	22.20	21.51	12.85
Specialised Services	23.87	6.91	16.71
Surgery Head and Neck	22.27	21.47	28.95
Women and Children's	1.39	2.68	2.78
Trust	**16.36**	**13.44**	**13.50**

There were seven grade 3 pressure ulcers which developed in hospital in June.

Division	**Ward/Unit**	**Site**
Medicine	12 and 54.	Heel and sacrum
Surgery Head and Neck	Intensive Care (ITU) x 2	Heel and sacrum
Specialised Services	52 and Cardiac Intensive Care Unit (CICU)	Heels
Women's and Children's	Neonatal Intensive Care (NICU)	Nasal (from nasal specs)

QUALITY

Recovery plan, including expected date performance will be restored:

- Specific pressure ulcer prevention training is being targeted to areas where pressure ulcer incidence is high. This includes all critical care areas, where four of the seven grade 3 pressure ulcers occurred in June.
- A review of mattresses in Critical Care areas is underway, with a specific focus on protection of heels.
- A benchmarking exercise is underway, which aims to identify incidence in Neonatal Intensive Care Units and to share best practice.
- A Trust-wide programme of teaching is in place. All nurses and healthcare assistants will receive training in pressure ulcer prevention by the end of September 2012.
- Weekly meetings are established with Heads of Nursing and Tissue Viability in attendance. These meetings monitor Divisional prevalence, focus on practice and ensure any agreed changes are implemented promptly.
- A trial of a prophylactic silicone-based dressing has now started within Surgery Head & Neck Division for patients with fractured neck of femur.
- All Divisions are required to complete and submit detailed recovery plans to the current Divisional Quarterly Reviews, where quality indicators are not achieved. The plans will be monitored at the monthly performance meeting which either the Chief Nurse or the Deputy Chief Nurse will attend. Divisions who fail to make progress against their recovery plan may go into escalation.
- An external review of tissue viability is being carried out at the beginning of August. The reviewers will meet with a variety of staff across the Trust and will focus on systems and processes, clinical practice, availability and use of equipment and governance arrangements.
- Root Cause Analysis investigations of Grade 3 and 4 pressures ulcer incidents are reviewed regularly and where appropriate, action taken with individual staff where avoidable measures could and should have been put in place.

QUALITY

Q6. EXCEPTION REPORT: Percentage of adult in-patients who received nutritional screening with 24 hours	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

This is a case note audit for adult patients who have been admitted to the Trust for over 24 hours. The audit is conducted in adult in-patient areas over each quarter and a Trust-wide figure is therefore reported quarterly. The target is 90%.

Performance in the period, including reasons for the exception:

The average figure for completion of nutritional screening in adults admitted over 24 hours for Quarter 1 2012/13 was 86%, and shows no change from Q4 2011/12. However, fortnightly results during quarter 1 showed a gradual improvement from 82% at the beginning of the quarter to 87% at the end of the quarter.

A nutrition CQUIN for 2012/13 has been agreed to include the completion of nutritional screening within 24hours, the use of the cutlery sign, protected mealtimes Trust-wide and the appropriate use of STAMP (Screening Tool for Assessment of Malnutrition in Paediatrics) for patients where it is applicable in paediatrics.

Recovery plan, including expected date performance will be restored:

- Nutrition paperwork audits will continue on a fortnightly basis. Feedback will continue to be given verbally following each audit, followed up by a ward report summarising findings sent to Heads of Nursing, matrons and ward managers.
- 'Microteaches' covering 'how to' complete nutritional screening have been updated and now include an overview of the nutrition care plan. They are being provided all wards, with specific targeting to underperforming wards.
- As requested by the Nutrition Steering Group, matrons and ward managers will check the completion of nutritional paperwork on their ward on a daily basis.

QUALITY

Q7. EXCEPTION REPORT: Percentage of spontaneous vaginal deliveries compared to all births	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the target is measured:

This Commissioning for Quality and Innovation (CQUIN) incentive has been carried over for 2012/13 and is designed to increase the proportion of normal births. The standard is a further 1% improvement in the proportion of spontaneous vaginal deliveries, compared with the number of all births including caesarean sections based on 2011/12 performance. The target for 2012/13 is being confirmed, but will be higher than the 64.4% target for 2011/12. The deliveries include patients of all Primary Care Trusts and home births supervised by a UH Bristol employed community midwife.

Performance during the period, including reasons for exception:

In June the percentage of spontaneous vaginal births was 62.3% of all births. The publication of National Institute for Clinical Excellence (NICE) guidelines for caesarean section towards the end of 2011 appears to have impacted on the number of women requesting a caesarean section with no clinical indication.

Recovery plan, including expected date performance will be restored:

In addition to the medium to long term actions previously reported to the Board we are:

- Continuing with work via normal birth working party to achieve the target.
- Continuing to promote vaginal births after caesarean section (VBAC) and are obtaining patient stories from women who have successfully achieved this to promote this as a positive experience with other mothers.
- Reviewing ante-natal education and preparation for women for labour.
- We have also placed a bid for funding to improve the birth environment (awaiting outcome) and for funding for Aromatherapy Midwife time in order to write guidelines, a patient information leaflet and to teach staff (awaiting feedback).
- We have planned a “Latent phase of labour” study day.

QUALITY

Q8-Q10. EXCEPTION REPORT: Stroke care	RESPONSIBLE DIRECTOR: Medical Director
• **percentage receiving brain imaging within an hour** • **percentage of patients spending at least 90% of their stay on a stroke unit** • **High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours**	

Description of how the target is measured:

Percentage receiving brain imaging within an hour: The percentage of patients suspected as suffering from a stroke that are scanned within 1 hour of arrival in the hospital. The national standard is for at least 50% of suspected strokes to be scanned within 1 hour. Scanning helps to ensure patients requiring thrombolysis are appropriately identified. This is based upon the finding that around 50% of suspected strokes have clinical indications that warrant a scan.

Percentage of patients spending at least 90% of their stay on a stroke unit: The percentage of stroke patients spending at least 90% of their stay on a designated stroke unit. Stroke patients are identified on the basis of their primary diagnosis being one of stroke. Patients' length of stay on a stroke unit is reported in the month of their discharge. The target is for 80% of patients to spend at least 90% of their stay on a designated stroke unit.

High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours: The percentage of High Risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours of referral. Only those patients treated in an outpatient setting count as a treatment.

Monitor measurement period: There are no Stroke indicators in Monitor's 2012/13 Compliance Framework.

Performance during the period, including reasons for exceptions:

Percentage receiving brain imaging within an hour (target 50%):

Performance against this standard was 42.1% in May. This represents an improvement on Q4 2011/12 performance, but is still below the national 50% standard. The national standard is based upon the assumption that 50% of stroke patients have symptoms that suggest braining imaging is required to assess their condition. The Trust's own figures suggest that the percentage of patients with symptoms that would indicate scanning is required, is well below 50%, and all patients receiving thrombolysis are scanned within an hour of arrival.

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

ensure we continue to scan patients promptly are focused on these two areas.

Percentage of patients spending at least 90% of their stay on a stroke unit (target 80%):

The 80% national standard was achieved in April (82.1%). However, May's performance was well below this, at 55.1%. Patients suspected as suffering from a stroke patients should be directly admitted to the Stroke Unit from the Emergency Department. This helps to ensure that even patients that only require short stays in hospital spend at least 90% of their stay on a designated stoke unit. No stroke beds being available to admit a patient to remains one of the main causes of failure to achieve this standard. During May there were significant pressures on beds for emergency admissions. It remains difficult under these conditions to maintain empty beds in the Stroke Unit to enable a stroke patient to be admitted if one arrives in the Emergency Department. In some cases patients are only identified as suffering from a stroke once they have been admitted to the Medical Assessment Unit (MAU) or an inpatient ward. The protection of stroke beds, and possible ways of earlier identification of stroke cases, are the primary focus of an ongoing action plan.

Please note: the figures reported for May (55.1%) will be the subject of further clinic validation as the commissioners have excluded some patients included in our May exception report.

High risk TIA (Transient Ischaemic Attack) patients starting treatment within 24 hours (target 60%):

Performance in May was 57.1%, as reported last month. However, overall performance against this standard remains above the 60% national target year-to-date (69.2% against the 60% standard). The main reasons why patients are not treated within 24 hours include:

- Patients not being referred promptly by their GPs (the 24-hour standard starts from the time of the decision to refer, not referral receipt)
- Patients being incorrectly referred by their GP to North Bristol Trust
- Patient choice to defer treatment
- Clinic capacity

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*:

- A written protocol for the Clinical Site Team is being developed, for keeping one stroke bed empty for direct stroke admissions whenever the Bristol Royal Infirmary is on a green escalation status and there aren't emergency patients queuing for beds in the Emergency Department (end August)
- Ways of identifying patients sooner that may be suffering from a stroke are being explored, such as considering the direct admission of patients that have collapsed and have at risk symptoms (end August)
- There will be monthly reviews of all cases where stroke patients did not spend at least 90% of their stay on the stroke unit; this will be supported by detailed recorded keeping by the Clinical Site Management team of the reasons why stroke patients were admitted elsewhere (end

August)

- The stroke nurse practitioner is undergoing IRMER (Ionising Radiation Medical Exposure Regulations) training, to enable her to request brain scans (end October)
- Incidents of GPs referring late or via the wrong route are being feedback to individual GPs via the Primary Care Trust (ongoing)
- The Trust is actively engaged in the Stroke Network project called Stroke 90. This is a sponsored project which has the aim of improving response times for stroke thrombolysis, including brain scanning. University Hospitals Bristol has bid for support to pilot a direct to CT (brain scan) pathway in-hours in Sept 2012, and out of hours by the end of the year for emergency patients identified as suffering from a stroke. This should help to maintain prompt access to a brain scan for all applicable patients showing risk symptoms.

Progress against the recovery plan:

Despite a deterioration in performance over the last two months, performance remains above the national standard year-to-date for the 24 hour TIA treatment standard. Performance against the 90% stay standard is expected to improve with the improvements in emergency access, as demonstrated by the 4-hour performance for June.

Performance against the one hour scan standard remains below 50%, although ongoing audits carried-out by the Division provide assurance that those patients requiring a scan are receiving it within an hour, as required.

QUALITY

Q11. EXCEPTION REPORT: Number of Patient Complaints	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The number of complaints received by the Trust and managed by either a formal or informal resolution process in agreement with the complainant. This excludes concerns raised and immediately dealt with by front line staff.

Performance in the period, including reasons for the exception:

In June, the Trust received 148 complaints against a threshold of 120 set as an average number received each month in 2010/11. This is a decrease on the 195 complaints received by the Trust last month.

Compared to May's figures, there was a slight decrease seen in the Division of Surgery, Head & Neck, where the number of complaints decreased from 86 to 79 and in the Division of Medicine where they decreased from 52 to 36. The remaining divisions were fairly consistent, with differences of one or two complaints compared to May.

Within the Division of Surgery, Head & Neck, 44% of the 79 complaints were in the category of Appointments & Admissions and a further 37% came under Attitude & Communication. The majority of the communication complaints were in respect of cancelled and delayed appointments and an inability to get through to departments, or for departments to respond to telephone messages. Complaints have continued to be prevalent in certain departments, as was the case in May. For example, 22% of the Division's complaints were about the Bristol Eye Hospital; 20% about the Trauma & Orthopaedics Department; 14% about the Bristol Dental Hospital; and 13% about the Ear, Nose & Throat Department. Across the Division, 18% of the complaints received were in respect of cancelled appointments and operations; 22% were about a failure to answer phones, or respond to telephone messages and 25% were about delayed appointments and operations.

Within Medicine, 22% of the 36 complaints received were in the category of Appointments & Admissions, and a further 31% were in relation to the category of Attitude & Communication. No particular trends in complaints have been identified in other Divisions.

The areas in the Division of Surgery, Head & Neck where the majority of complaints about appointments are occurring had some existing backlogs of work due to staff vacancies and some processes which were in need of review. In particular, we have set-up our new Patient Administration System (Medway) to require staff to select which cancellation letter they wish to send to the patient. But this is not always being done, so no letter is being sent with the result that we have seen an increase in the number of complaints from patients who have turned up for appointments only to find their appointment/clinic has been cancelled. The Trust's IM&T (Information Management & Technology) Department is looking at how we can change this process, so that a default option will be automatically triggered unless the user selects an alternative.

Recovery plan, including expected date performance will be restored:

The staffing issues in the Ophthalmology and Trauma & Orthopaedics Outpatient Departments identified during the outpatients review are currently being addressed through normal management processes. The Divisions are working to ensure that gaps in staffing are filled and some currently have temporary staff in place. In Ophthalmology all vacancies have now been recruited to, and the vacant posts should be filled by the end of July.

An intensive support team, comprising Medway staff and transformation staff working on the Productive Outpatients project, is in place and is working with local teams to review outpatient processes and the Medway interface to put in place process improvements and clear any backlog. The team has prioritised their review in the following outpatient departments:

1. Women and Children - *complete*
2. Ophthalmology
3. Trauma and Orthopaedics
4. Dental

A system is now in place in Ear, Nose and Throat Outpatients whereby people can now contact someone who is able to help them resolve their queries relating to their appointments.

Performance is expected to be restored by August 2012.

1.6 SUPPORTING INFORMATION

1.6.1 QUALITY ACHIEVEMENTS - Division of Medicine

- The Division led the opening of the South Bristol Community Hospital in April offering services locally, in a purpose built environment
- The Bridge Sexual Assault Referral Centre (SARC) is a unit hosted by sexual health on behalf of the police and NHS Bristol, to provide counselling and forensic investigations to victims of sexually motivated crime. The service is recognised nationally as a model of good practice which is reflected in a tenfold increase in clients accessing this supportive service in the past year.
- Achievement of 90% of Genito-Urinary Medicine patients attending the appointments they have been offered within 48 hours of contacting the service, following the introduction of patient-friendly Saturday morning and walk in clinics; currently, 100% of patients are offered an appointment within 48 hours
- Appointment of fracture liaison nurse for Division of Medicine and a Trust-wide Dementia post from within Division
- The stroke thrombolysis service has been extended to a seven day service, providing more equitable treatment for patients
- Established MAU (Medical Assessment Unit)/SSU (Short Stay Unit) model in place as the first phase towards development of an Integrated Assessment Unit
- An Ambulatory Care Unit has opened, moving all existing non-specialist medical day case services into one location as the first phase towards full ambulatory care services in 2013
- Ward Manager roles have been reconfigured as supervisory roles across all inpatient medical wards to improve clinical leadership and quality of care.
- Compliance with venous thrombo-embolism (VTE) risk assessments remains above 90% within the Division

1.6.2 EXAMPLE OF LEARNING FROM COMPLAINTS

Summary of complaint

Following a fall at home, the patient was admitted to the Bristol Royal Infirmary. Her niece visited daily and was generally impressed with the level of care her aunt was receiving. However, the patient was isolated in a small side room, where there was no stimulation until her niece brought in a radio from home.

The patient's niece had been in close contact with the social work team and together they identified a nursing home. It was arranged that a care worker from the nursing home would visit the patient in hospital, to assess her needs and confirm they could be met by the nursing home. This visit took place and the care worker confirmed that the nursing home could meet the patient's needs.

A discharge date and time was agreed with the patient's niece. However, the day before discharge, this was brought forward at short notice by the hospital. The nursing home agreed to take the patient that same day, provided she did not arrive too late in the day. The patient's niece asked the ward if the discharge could take place after 1pm to allow her enough time to make the necessary arrangements.

The ward called the patient's niece at 2.30pm to say that the patient was about to leave. So she called the nursing home to advise them of this and that she was on her way so she would be there to greet her aunt when she arrived. However, the nursing home advised the niece that her aunt had in fact already arrived.

Due to this last minute change of plans, the patient's room at the nursing home was not ready for her, there was no bed in it and she had to spend the night in a different room.

When the patient's niece raised these concerns with the social work team, they confirmed that they had not been advised of the sudden change of plan and that they would be raising this with the hospital.

Investigation

The investigation found that:

- The patient was placed in a side room for infection control purposes. It was recognised that older patients do not do particularly well in single rooms, but this was superseded by a need to maintain patient safety.
- Discharge was brought forward at short notice due to the capacity for beds across the Trust being outweighed by demand. All patients were therefore reviewed by the Multi-Disciplinary Teams in order to progress discharge and to ascertain which patients were fit to be discharged earlier than planned, without compromising patient safety. As the patient was deemed fit to be discharged, the ward contacted the nursing home, who confirmed they would be able to take the patient a day earlier than planned, so long as she arrived by no later than 4pm.
- The patient's niece was called after the patient had already arrived at the nursing home as the call from the ward was delayed.

Departmental Learning

- The issue of the delayed call from the ward (when the patient had already arrived at the care home) was raised with the Ward Manager and nursing team, emphasising the importance of prompt communication and the consequences for the person they have been caring for (i.e. in this case, the patient's niece was unable to be at the nursing home to meet her aunt and support her in her transition from hospital to her new care environment).

Organisational Learning

- The Trust recognises that there is a significant lack of occupational activities, particularly for older adults, and are actively in the process of addressing this in conjunction with charitable organisations. It is anticipated that televisions, radios and activities will be provided and embedded into daily routine on the older adult care wards, through the use of volunteers, by the end of this year.
- Televisions were recently installed on the older adult care wards and stroke wards at the Bristol Royal Infirmary, to facilitate the viewing of the jubilee celebrations; however this has not as yet encompassed all of the cubicles/side rooms.
- The Trust is reviewing the discharge information provided to patients, families and carers, to include information on transport and the constraints in terms of supplying definitive arrival home times.

QUALITY

WORKFORCE

2.1 SUMMARY

The Trust has selected a range of key workforce indicators. The indicator below target this month is sickness absence.

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

2.2 EXCEPTION REPORTS

Exception reports are provided for the red-rated indicators, which in June 2012 were as follows:

- Sickness absence – red rated against Divisional targets

WORKFORCE

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

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

Performance in the period, including reasons for the exception:

Absence has reduced to 4.0% in June compared with 4.2% in the previous month, but remains over the June target of 3.3%. All Divisions are above target except Diagnostic and Therapies. Reasons for absence are now included in the supporting information, see 2.3.

	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Estates and Facilities)	Estates & Facilities
Absence June 2011	3.8%	3.0%	4.9%	3.6%	3.3%	3.9%	3.5%	4.9%
Target June 2012	3.3%	3.0%	3.7%	3.2%	2.8%	3.5%	2.8%	4.4%
Absence June 2012	4.0%	2.6%	4.6%	4.4%	4.0%	3.7%	2.9%	5.8%
Cumulative absence June 2012	4.0%	2.7%	4.5%	4.4%	4.0%	3.7%	3.2%	6.1%

Recovery plan, including expected date performance will be restored:

Amendments to the Supporting Attendance Policy were shared and discussed with the Unions recently and the rationale accepted in principle. The changes will now go to Industrial Relations Group for formal sign off and additional support and training will be cascaded to managers to help them understand and implement the changes. **Review: August 2012**

In the longer term, the sickness pilot being run within Medicine and Women's & Children's Divisions will be reviewed to assess the potential for other Divisions including Specialised Services and Facilities & Estates.

Recovery plans in those Divisions which are furthest from their targets are as follows:

Surgery, Head & Neck (SHN)

Members of the Safety Team attended the SHN Management Meeting to discuss ways of supporting managers with staff affected by stress/anxiety/depression, as well as back and other musculoskeletal problems. Specific sickness absence data has been sent to the areas worst affected, and the Safety Team is working with some areas already to tackle the issues and encourage prevention of further injury. **Review – August 2012**

18 areas with high sickness have been identified and each manager will be required to submit written evidence of management of cases in their area

within a week of the information being requested. This will enable managers to demonstrate the support they offer to their staff and how they apply the Supporting Attendance Policy in their areas. **Review – August 2012**

Medicine

Sickness remains high across many of the wards, with significant increases being seen within Ward 12, Ward 54, Ward 11 and Ward 100 (SBCH).

Human Resources Business Partner (HRBP)/Senior Management continue to review departments with highest sickness each month and provide support and escalation as appropriate.

The Staff Wellbeing Pilot has been in place for 6 weeks, with initial figures showing 34 referrals to end of May for the Division. There will be an assessment of the pilot in August and any gaps in the system will be resolved. To support this initial evaluation, two email surveys are also being conducted: one to those who opted out of being contacted to establish why; and one about the process, which will go to managers. Also the need to refer all staff to the Staff Wellbeing Advisors is highlighted in management meetings, and additional communication material is also to be distributed across the Division, to raise awareness about the pilot.

The dashboard providing sickness/appraisal/budget Key Performance Indicators for all nursing areas is in place. This enables the Divisional Management team to track individual line manager performance more effectively. Matrons are now copied in on all ward sister sickness returns. Employee Services continues to review all sickness cases within the Division and the use of the percentage attendance calculation is being more routinely used resulting in escalation through the policy as appropriate.

Specialised Services

Employee Services have arranged regular meetings with key managers to review all workforce metrics, including sickness absence. This will next be reviewed in advance of Divisional Board on 27th July 2012 and key themes will be shared with the Board for action. **Review: August 2012.**

The Division has identified the top 5 highest areas for sickness absence, which include Cardiac Intensive Care Unit (CICU), Bristol Haematology & Oncology Centre (BHOC) outpatients and Patient Services within the BHOC. An action plan for each of these areas will be developed with each individual manager as part of the ongoing Human Resources review meetings process and will then be presented at Divisional Board in August 2012. **Review: September 2012**

HRBP will undertake a full investigation of causes for sickness absence within the Division to understand whether there is an identifiable reasons for the recent increases. This work will be taken to the July Divisional Board for further action where necessary. **Review: September 2012.**

HRBP to remind all managers of dates for training on managing sickness absence and encourage those who are non-compliant with this training to attend within the next 8 weeks. Communication to go out by **Friday 20th July.**

Estates & Facilities

Detailed reports are now being sent to managers in Estates & Facilities to ensure that all cases of absence are being managed in line with the Supporting Attendance policy. This information enables managers to check all absence and ensure that they are managing each case appropriately, with support

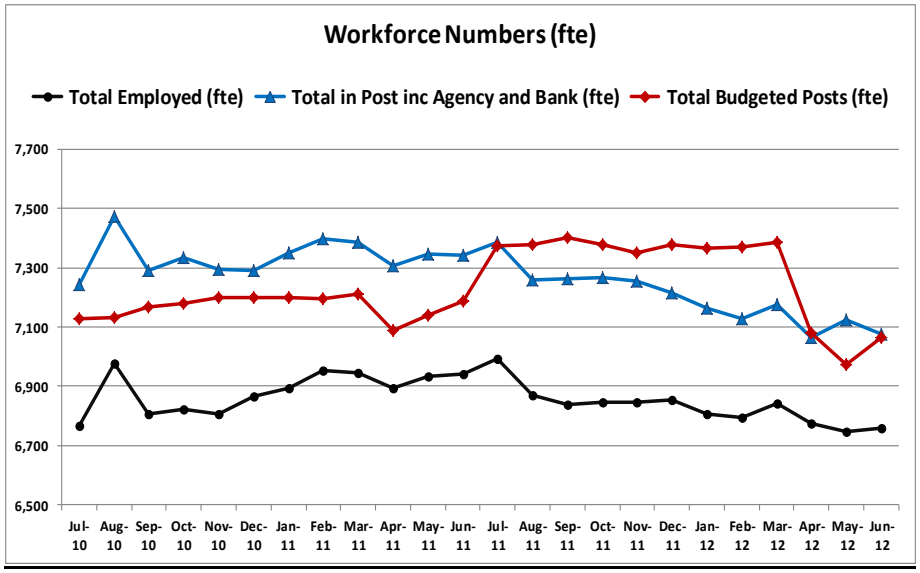
from Employee Services. The information received back from managers shows that cases are indeed being managed appropriately and July's figures show a reduction in absence of 1.1% and it is hoped this will continue.

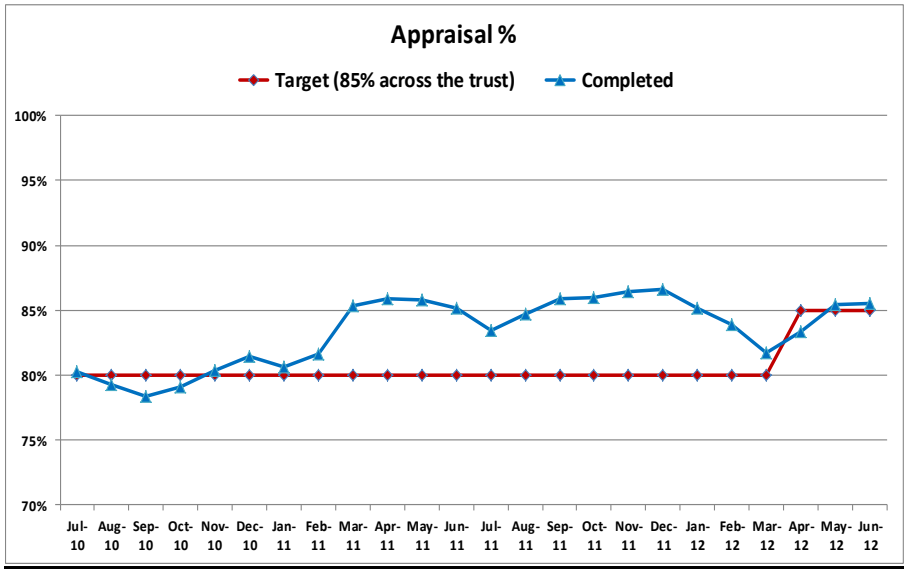
Progress against recovery plan: See above.

2.3 SUPPORTING INFORMATION

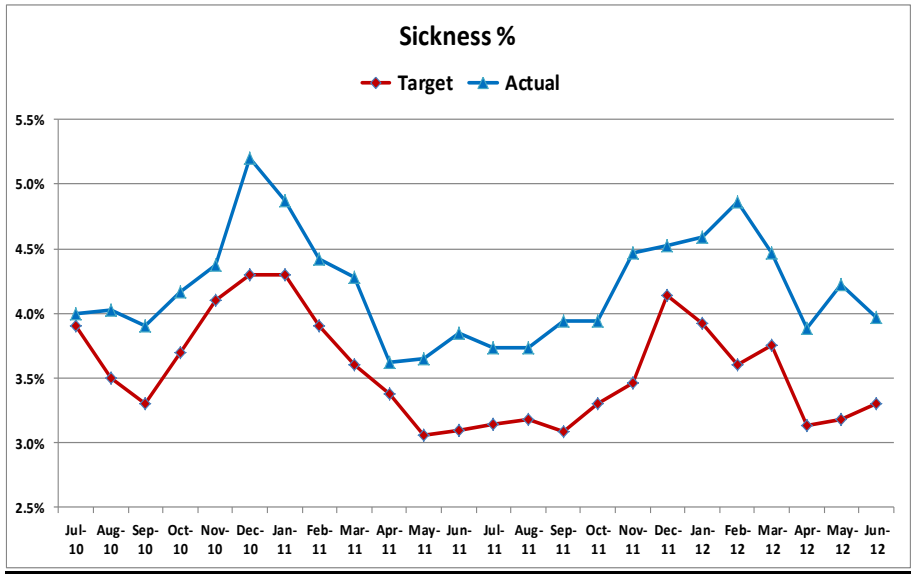
2.3.1 Summary

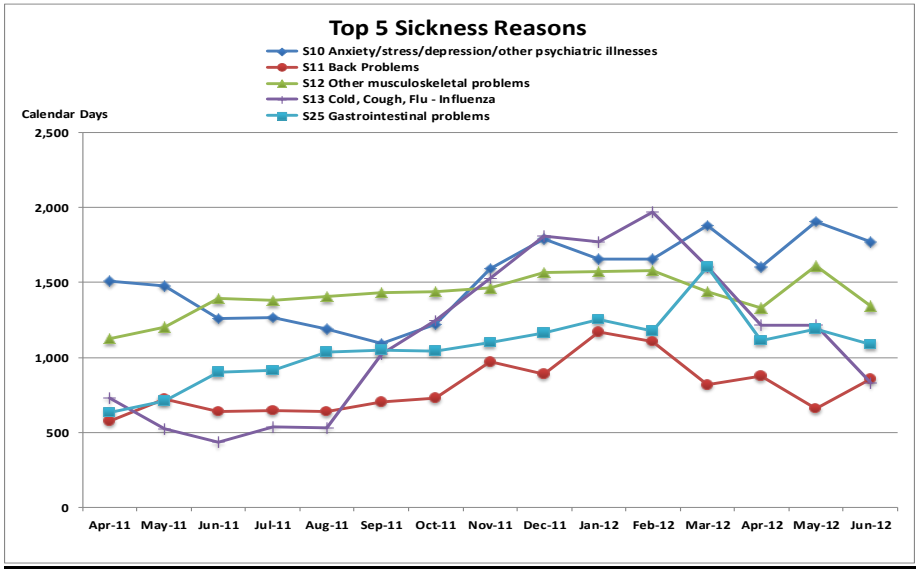
This report provides an outline of the Trust's position against key workforce standards for the month of June 2012 and year to date performance for 2012/13 for workforce numbers, sickness, top five causes of sickness absence, bank and agency.

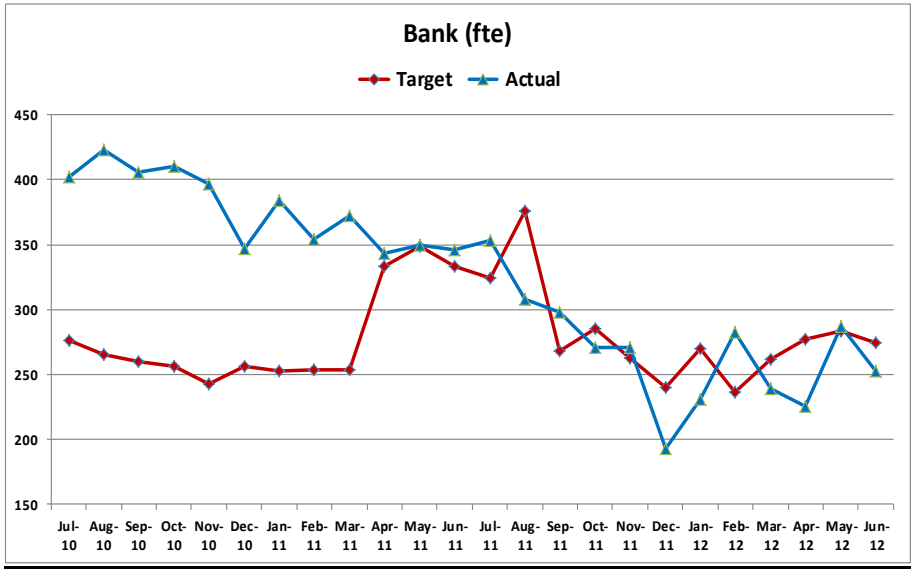


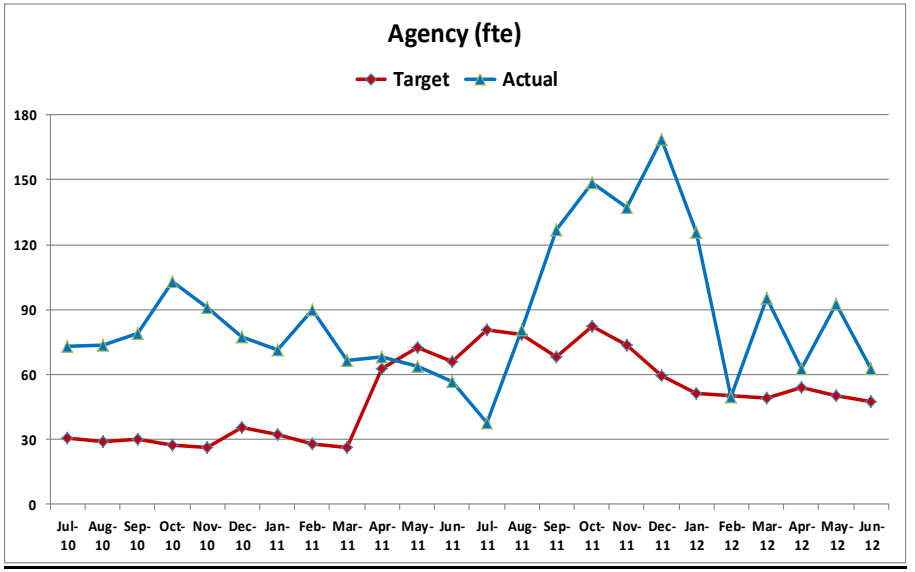


WORKFORCE


Sickness %
Target
Actual
5.5%
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
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 Jan-12 Feb-12 Mar-12 Apr-12 May-12 Jun-12

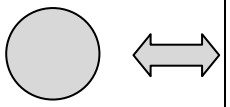
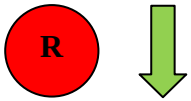

Top 5 Sickness Reasons
S10 Anxiety/stress/depression/other psychiatric illnesses
S11 Back Problems
S12 Other musculoskeletal problems
S13 Cold, Cough, Flu - Influenza
S25 Gastrointestinal problems
Calendar Days
2,500
2,000
1,500
1,000
500
0
Apr-11 May-11 Jun-11 Jul-11 Aug-11 Sep-11 Oct-11 Nov-11 Dec-11 Jan-12 Feb-12 Mar-12 Apr-12 May-12 Jun-12


Bank (fte)
Target
Actual
450
400
350
300
250
200
150
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 Jan-12 Feb-12 Mar-12 Apr-12 May-12 Jun-12


Agency (fte)
Target
Actual
180
150
120
90
60
30
0
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 Jan-12 Feb-12 Mar-12 Apr-12 May-12 Jun-12

2.3.2 Changes in the period

Performance is monitored for workforce costs, workforce numbers, bank and agency usage, turnover, sickness and appraisal numbers. Indicators on a rolling reporting programme are: Statutory and mandatory training (August 2012), European Working Time Directive (EWTD) (October 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 Numbers		Workforce numbers reduced by 0.7% compared with May 2012, 0.2% above budgeted workforce numbers. This compares with May 2012, when workforce numbers were 2.1% above budget.	See summary
Turnover		Rolling turnover (with exclusions) remains static at 10.4%.	See summary
Sickness		Sickness reduced by 0.2 percentage points compared with May 2012 across the Trust, 0.7 percentage points above the monthly target for 2012/13.	See exception report and summary
Bank/Agency		Bank and agency reduced by 64.2 FTE compared with the previous month, 2.4% below the target for June 2012, compared to 11.9% above in May.	See summary
Appraisal		Trust wide appraisal rates for all staff were 85.6%, and therefore achieved the stretch target of 85% which was introduced in April 2012. Junior doctor appraisal has now reached a level above 85% and will no longer be reported separately. Divisional rates were: Diagnostic & Therapies, 86.3%, Medicine 84.3%, Specialised Services 83.7%, Surgery Head and Neck 85.1%, Women's & Children's 85.7%, Trust Services 89.1%, and Estates & Facilities 85.7%.	See summary

Note: RAG (Red, Amber, Green) rating reflects whether the indicator has achieved the target, or is within defined tolerance limits. 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 and bank and agency targets are set by Divisions.

2.3.3 Monthly forecast and overview

Measure	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	June 12 Planned
Budgeted Posts (FTE)	7189.1	7374.1	7379.3	7401.1	7378.4	7351.1	7376.8	7365.3	7368.1	7384.3	7081.2	6973.2	7063.9	7293.5
Total Employed (FTE)	6940.7	6993.0	6868.9	6836.4	6846.4	6845.8	6853.7	6806.7	6795.7	6841.0	6776.8	6745.7	6760.1	6731.5
Sickness Rate (%)	3.8%	3.7%	3.7%	3.9%	3.9%	4.5%	4.5%	4.6%	4.9%	4.5%	3.9%	4.2%	4.0%	3.3%
Bank (FTE) Admin & Clerical	77.8	79.2	67.3	99.3	60.7	71.8	50.6	60.8	70.1	61.4	54.1	68.3	55.3	73.8
Bank (FTE) Ancillary Staff	19.1	17.4	13.6	23.5	81.7	10.2	12.9	15.0	15.5	12.9	12.8	14.9	12.9	10.8
Bank (FTE) Nursing & Midwifery	230.8	239.7	225.4	163.4	118.3	177.6	123.3	152.1	197.3	164.7	158.2	203.6	184.3	173.9
Agency (FTE) Admin & Clerical	3.2	2.6	6.4	6.9	7.4	4.6	5.5	13.5	4.5	5.2	6.4	11.8	5.4	3.0
Agency (FTE) Ancillary Staff	34.3	18.1	62.1	78.6	95.1	84.8	110.2	63.4	36.3	34.6	30.0	20.0	22.9	18.3
Agency (FTE) Nursing & Midwifery	7.4	8.4	7.6	9.7	24.6	22.2	30.0	26.7	0.0	37.6	32.4	40.3	30.8	14.0
Overtime	78.8	61.5	40.4	65.3	62.7	81.1	64.9	72.2	76.6	89.1	83.8	70.0	70.9	75.5
Appraisal (%)	85.1%	83.4%	84.7%	85.9%	86.0%	86.5%	86.6%	85.2%	83.9%	81.7%	83.4%	85.5%	85.6%	85.0%
Rolling Average Turnover (all reasons) (%)	15.0%	14.8%	14.4%	15.2%	15.1%	15.3%	15.7%	16.5%	16.2%	16.8%	17.0%	17.0%	17.2%	
Rolling Average Turnover (with exclusions) (%)	9.0%	8.6%	8.6%	8.8%	8.8%	9.1%	9.3%	9.5%	9.7%	10.2%	10.3%	10.4%	10.4%	
Vacancy Rate (%)	3.5%	5.2%	6.9%	7.6%	7.2%	6.9%	7.1%	7.6%	7.8%	7.4%	4.3%	3.3%	4.3%	

- '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 June 2012**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 1)***, and/or the ***year to date***. The standards include those used in Monitor's Compliance Framework, as well as key standards included within the NHS Operating Framework and NHS Constitution.

 **Achieving (14)**	 **Underachieving (1)**
- 31-day diagnosis to treatment cancer standard - *first* - 31-day diagnosis to treatment cancer standard – *subsequent surgery, drug & radiotherapy* - 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 - Referral to Treatment Time for non-admitted patients - Referral to Treatment Time for incomplete pathways - Genito-Urinary Medicine (GUM) 48-hour access - A&E Left without being seen rate - A&E Unplanned re-attendance - Access to healthcare for patients with learning disabilities - Infant health – breastfeeding rate - Reperfusion times (door to balloon time of 90 minutes)	- Reperfusion times (call to balloon time of 150 minutes)
 **Failing (5)**	 **Not reported/scored (0)**
- Last-minute cancelled operations - 28-day readmission – *a date for re-admission within 28 days of cancellation* - A&E Maximum waiting time (4-hours) - A&E Time to Treatment - A&E Time to Initial Assessment (ambulance arrivals) (95th percentile)	

*Please note: Performance for the cancer standards is reported by all trusts in the country two months in arrears. Indicators are shown as being **failed** where the required standard is not achieved for the quarter to date, and/or the current month has been failed. Indicators are shown as being **underachieved** if there has been a failure to achieve in a previous month, but the quarter is currently being achieved.*

3.2 ACCESS DASHBOARD

Access Standards - dashboard

	Target	Thresholds Green	Thresholds Red	Previous YTD	Year to date (YTD)	Month Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Quarterly performance Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	88%	95.9%	96.2%	95.4%	96.4%	93.4%	94.2%	96.7%	98.1%	94.0%	96.6%	97.1%	96.4%	96.0%	Cancer standards report two months in arrears	95.1%	97.0%	96.1%	96.2%
	Cancer - Symptomatic Breast (cancer not suspected) in Under 2 Weeks	93%	88%	99.2%	96.8%	97.7%	97.0%	100.0%	93.6%	95.3%	97.7%	100.0%	98.4%	95.7%	96.1%	97.3%		98.1%	96.8%	97.7%	96.8%
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	93%	97.4%	98.9%	97.2%	99.1%	99.1%	98.1%	97.5%	98.1%	99.1%	98.4%	99.2%	99.5%	98.4%		98.5%	97.9%	98.9%	98.9%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	93%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	99.7%	100.0%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	89%	99.1%	99.0%	97.8%	94.0%	98.3%	93.6%	94.5%	100.0%	93.3%	96.4%	98.2%	100.0%	98.1%		96.5%	96.0%	95.9%	99.0%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	89%	99.7%	99.4%	99.4%	100.0%	98.9%	99.0%	99.5%	100.0%	99.5%	96.9%	99.1%	99.5%	99.4%		99.4%	99.5%	98.5%	99.4%
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	80%	86.9%	91.6%	85.4%	85.1%	87.7%	88.1%	88.2%	89.3%	89.3%	87.7%	87.4%	92.7%	90.6%		86.2%	88.4%	88.1%	91.6%
	Cancer 62 Day Referral To Treatment (Screenings)	90%	85%	98.3%	100.0%	85.3%	86.1%	95.2%	88.1%	100.0%	100.0%	96.2%	100.0%	92.9%	100.0%	100.0%		89.3%	95.3%	96.2%	100.0%
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	100.0%	100.0%	92.6%	100.0%	94.9%	94.4%	94.7%	87.0%	91.9%	93.6%	93.8%	100.0%	100.0%		95.2%	91.7%	93.1%	100.0%
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	85%	92.7%	92.1%	91.8%	91.3%	91.9%	91.2%	91.2%	90.6%	91.8%	91.4%	91.2%	91.2%	93.2%	91.5%	91.7%	91.0%	91.4%	92.1%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	90%	98.4%	96.8%	98.0%	97.6%	97.7%	97.8%	97.2%	98.0%	97.6%	97.6%	98.0%	97.9%	96.8%	95.9%	97.7%	97.6%	97.7%	96.8%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	87%	Not applicable	92.2%	Target not in effect									92.2%	92.2%	92.1%	Target not in effect			92.2%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	98.0%	93.6%	97.7%	98.1%	97.1%	95.4%	97.1%	94.5%	94.1%	91.5%	92.0%	93.4%	91.9%	95.7%	97.6%	95.6%	92.5%	93.6%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	55	151	15	12	13	14	12	13	12	48	30	120	196	15	13	13	24	151
	A&E Time to treatment decision (median) - in minutes	60	60	20	53	18	15	18	19	17	21	19	24	26	30	69	62	17	19	23	53
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	1.8%	2.0%	1.1%	1.8%	1.9%	2.0%	1.9%	1.8%	1.8%	1.5%	1.6%	1.1%	2.1%	2.6%	1.6%	1.9%	1.6%	2.0%
	A&E Left without being seen	5%	5%	1.2%	3.3%	0.9%	0.9%	1.1%	1.3%	0.6%	0.9%	0.8%	1.1%	1.3%	2.2%	5.0%	2.4%	1.0%	0.9%	1.1%	3.3%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	0.97%	1.22%	1.13%	0.89%	0.31%	0.90%	0.89%	0.85%	0.88%	0.96%	0.76%	1.08%	1.59%	0.94%	0.77%	0.88%	0.87%	1.22%
	28 Day Readmissions	95%	85%	93.9%	86.7%	93.0%	93.2%	96.1%	100.0%	92.0%	93.9%	95.2%	92.0%	86.8%	84.4%	88.2%	87.0%	94.0%	94.0%	91.0%	86.7%
	GUM Offer Of Appointment Within 48 Hours	98%	95%	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%	100.0%
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	85.2%	86.5%	78.4%	85.2%	97.1%	85.7%	77.3%	70.4%	86.1%	90.4%	81.1%	89.7%	81.8%	88.2%	86.9%	81.4%	86.4%	86.5%
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	89.0%	92.7%	89.2%	88.9%	94.3%	90.5%	86.4%	100.0%	88.9%	94.2%	91.9%	96.6%	84.8%	97.1%	90.9%	91.2%	92.0%	92.7%
	Infant Health - Mothers Initiating Breastfeeding	76.3%	74.5%	75.1%	78.8%	77.0%	78.1%	73.8%	78.2%	77.1%	76.5%	77.3%	74.7%	76.0%	74.2%	80.7%	81.7%	76.2%	77.3%	76.0%	78.8%

Please note:
Where the threshold for achieving the standard has changed between years, the latest threshold for 2011/12 has been applied in the Red, Amber, Green ratings
The Rapid Access Chest Pain standard and the Infant Health: mothers not smoking have now been withdrawn from national
Infant Health breast feeding rates have a GREEN threshold of being above last-years performance, and a RED threshold of the national average.
The standard for Primary PCI 150 Door to Balloon Times has been added to the above dashboard.
The standard for Primary PCI 150 Call to Balloon Time now only applies to direct admissions - the local target is shown as the
All CANCER STANDARDS are reported nationally two months in arrears. Monthly figures are indicative, until they are finalised at the end of the quarter.
There are data quality issues with the A&E Clinical Quality Indicators following the Medway implementation, especially for Time to Initial Assessment and Time to Treatment. So the reported figures shown should be treated as interim.

3.3 CHANGES IN THE PERIOD

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

- A&E Maximum wait (4 hours) ↑ (up from 91.9% in May to 95.7% in June)
- A&E Time to Initial Assessment (15 minutes) – 95th percentile ↓ (down from an average of 196 minutes in May* to 15 in June)
- Last-minute cancelled operations ↓ (down from 1.59% in May to 0.94% in June)
- Reperfusion times (Door to Balloon time of 90 minutes) ↑ (up from 84.8% in May to 97.1% in June)

*Please note the above performance figures only show the final reported position and do not include the draft June performance against the cancer standards.*Please note there are still data quality issues with the A&E Clinical Quality indicators following the Medway Patient Administration System (PAS) implementation.*

3.4 EXCEPTION REPORTS

Exception reports are provided for the five RED rated performance indicators.

1) Last-minute cancelled operations + 28-day readmission
2) A&E Maximum wait (4 hours) + A&E Time to Treatment + A&E Time to Initial Assessment

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 49 last-minute cancellations of surgery in **June** (0.94% of operations) which is outside of the national standard of 0.8%. The main reasons for cancellations in the month were as follows:

- 22% of cancellations (11 cancellations) were due to an emergency patient being prioritised on the day
- 14% (7 cancellations) were due to no ward bed being available
- 14% (7 cancellations) were due to no critical care bed being available
- 12% (6 cancellations) were due to another elective patient having to be prioritised on the day – this is usually due to pressures on critical care beds

Of the 49 cancellations, 15 were day-cases and 34 were inpatients (31% day cases). On average, seventy percent of the Trust admissions in a month are day-cases. The higher rate of inpatient cancellations reflects the high cancellation rate due to emergency patients and the lack of a critical care bed, both of which are more likely to impact inpatient than day-case procedures. In June the level of cancellations due to no critical/high care bed being available, was very high, as it was in May.

87.0% of patients were re-admitted within 28 days of the cancellation of surgery at last-minute in June, which was below the 95% national standard. Twelve patients were not re-booked within 28 days. The reasons for not re-admitting within 28 days were as follows:

- 3 patients could not be re-dated due to broken equipment at the Bristol Eye Hospital
- 1 patient was rebooked within 28-days but cancelled again (showing erroneously as two failures to re-admit within 28 days)
- 3 patients needed to have their procedure performed by a specific surgeon, but theatre availability and the need to treat more clinically urgent patients prevented them being readmitted in the period.
- 3 patients were readmitted within 28-days but not signed off correctly
- 1 patient was signed off as an last-minute cancelled operation in error

The above has highlighted potential over-reporting of last-minute cancelled operations and failures to re-admit within 28 days. This has largely been due to delays in finalising the data following the changes made to reporting from our new Medway Patient Administration System (PAS). Full validation of last-minute cancelled operations and the failures to re-admit within 28 days will be re-established for future months.

Recovery plan, including expected date performance will be restored:

The following actions continue to be taken to reduce last-minute cancellations and sustain achievement of the 0.8% standard (*please note: actions completed in previous months have been removed from the following list*):

- Theatre staffing is being reviewed by the Division of Specialised Services, as this is a leading cause of cancellations for Cardiac Services; bank and/or agency scrub and other theatre staff will be arranged to reduce theatre staffing related cancellations (Action complete).
- Outputs of the weekly scheduling meeting to be reviewed by Surgery, Head & Neck team, to be clear on the accountability for making sure theatre lists are appropriately booked (i.e. will not over-run), and the necessary equipment/staffing are available (*ongoing*)
- The new elective scheduling policy will be implemented within Surgery, Head & Neck (end June 2012); *policy drafted and now scheduled for ratification by the Surgery, Head & Neck Divisional Board.*
- Weekly reviews of future week's operating lists will continue, to ensure the demand for critical care beds is spread as evenly as possible across the week; daily reviews of current demand for critical care beds, and flexible critical care bed-usage across Divisions to minimise cancellations will also continue (*ongoing*)
- The validation process will be re-established, to ensure we are not inappropriately reporting last-minute cancelled operations, or failures to re-admit within 28 days (end August)
- Productive Operating Theatres has commenced a programme of work in Cardiac Theatres
- Implementation of the Optimising Use of Beds work-steam will continue – with the aim of balancing bed capacity and demand for beds
- Please also see actions listed under the 4-hour exception report, which should reduce cancellations related to bed availability

Progress against the recovery plan:

The Trust achieved the 0.8% national standard in March, and all the milestones in the performance trajectory agreed with the PCT. However, the outbreak of *norovirus* and emergency pressures resulted in a deterioration in performance against this standard in April and May. The number of cancellations related to the lack of a ward bed being available, dropped from 28 in May to 7 in June, and overall performance improved from 1.59% to 0.94%. However, the number of critical care bed-related cancellation remained high. For this reason, the 0.8% standard was not achieved. Efforts continue to be focused on improving patient flow and ward bed availability, through which reductions in last-minute cancellations will be realised. However, high levels of demand for critical care beds pose risks to the achievement of the 0.8% national standard.

A reduction in overall last-minute cancelled operations should result in an improvement in 28-day readmissions, with fewer patients needing to be re-booked. It is expected that performance against the 28-day readmission standard will improve in July, following a reduction in last-minute

cancellations in June.

A2. EXCEPTION REPORT: A&E maximum wait 4 hours + A&E Time to Initial Assessment – 15 minutes (95th centile) + A&E Time to Treatment	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

A&E maximum wait 4 hours

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

A&E Time to Initial Assessment – 15 minutes (95th centile)

The time of arrival in the department through to initial assessment of the patient's condition. The assessment will involve both pain scoring and other physiological assessments. The 15 minute target for initial assessments only applies to ambulance arrivals.

Monitor measurement period: Not applicable – this is a quality standards trusts are working to achieve

A&E Time to Treatment – 60 minutes (median)

The time from arrival in the department through to the start of the treatment. Treatment is defined as when a clinician who is able to take a decision to discharge, defines the treatment plan.

Monitor measurement period: Not applicable – this is a quality standards trusts are working to achieve

Performance during the period, including reasons for exceptions:

Performance against the 4-hour standard in June was 95.7%, and above the national standard. This was a significant improvement on May's performance of 91.9%.

As reported in previous months, analysis of quarter 4 and the first two months of quarter 1 has identified the following reasons for the deterioration in performance in recent months:

- Patients being discharged later in the day (this is supported by evidence from the Pharmacy Department, which is experiencing late requests for discharge medication)
- An increase in over 14 days length of stays, including delayed discharges (i.e. patients medically fit for discharge but awaiting input from an

external agency, for example a patient awaiting placement in a residential home)

- An increase in the number of patients being admitted that are over 75 years old (age is an indicator of patient acuity and expected length of stay), with particular increases in the over 90 age group.

The above patterns have persisted into quarter 1. In addition, in May there was a significant increase in levels of BRI emergency admissions, to levels similar to that seen in December, when performance against the 4-hour standard started to fall. But unlike in December, performance against the 4-hour standard for patients with minor injuries/illness, not requiring an admission, dipped significantly. This is attributed to the higher number of patients that were awaiting a bed to become available, being managed in the BRI Emergency Department.

The Trust has had additional 'flex' bed capacity open since performance against the 4-hour standard deteriorated in January, half of which has now been closed (see actions below). The Emergency Care Intensive Support Team's experience from other sites is that opening additional bed capacity often results in a lengthening of patient stays in hospital and a deterioration in patient flow if this extra bed capacity is not supported by comparable increases in staffing (for all types of healthcare professionals) to make sure patients' stays in hospital continue to be actively progressed. The increases in over 14 days stays and overall length of stay in quarter 4 coincided with the opening of the additional bed capacity.

The Bristol Children's Hospital's (BCH) has continued to experience an increase in emergency demand, with high levels of respiratory illness only usually seen in winter months. This pattern has been seen in other Children's Hospitals in the country. The BCH plans its bed capacity on the basis of historical patterns of demand, which vary by season. Performance in June was 96.0%, which is below the normal standard of performance of 98%. There has been a further deterioration in July, with performance dropping to 93.5% for the month to date. Despite this, the Trust continues to achieve the 95% standard overall. Additional bed capacity is now being opened where possible, to meet this heightened demand.

The focus of the action plan to sustain the 95% standard for the coming quarters continues to be on those areas identified in the recent analysis:

- Reducing over 14 days stays, via escalation of delayed discharges and the closure of flex bed capacity to increase the clinical input into patients
- Improving bed availability early in the day
- Protecting the throughput of minor injury/illness patients, to ensure these continue to be treated and discharged within 4 hours
- Understanding changing patterns of demand for beds by different groups of patients

Recovery plan, including expected date performance will be restored:

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

- Over 14 day stays escalation will be enacted by all Divisions, and plans put in place to reduce the number of over 14 day stays by 5 patients per week from the beginning of June (Action completed) – *reductions not yet delivered at anticipated pace - Reviews put in place with Lead Doctor / Head of Division leadership; Medical Director undertaken review of >28 day stays; data validation of all patients with a length of stay of over 14 days on the 18th July, to be completed for 20th July 2012.*

ACCESS STANDARDS

- Ten BRI inpatient beds (seven Medicine; 3 Surgery) will be made available by 10:00 each day from the beginning of June (Action completed) - *process in place and working, but achieving 10 routinely has been challenging. Awareness raising around the importance of this is continuing.*
- Levels of admission and discharges by time of day, ward and Division will be reported on and managed against (Action completed).
- Once in post, supervisory ward sisters will work to achieve safe and timely patient discharge to match emergency demand, and ensure appropriate patients are pro-actively admitted from the Medical Assessment Unit (MAU) (Action completed).
- The two 'Flex' wards (30 beds in total) will be closed over a two-week period during the middle of June; contingency options for halting or reversing the closure are in place, if the removal of these excess beds does not drive the expected rapid improvement in length of stay. *Not achieved due to continuing emergency pressures. 50% of flex capacity closed 19 July (16 additional unfunded beds remain in use)*
- Flexible trolley spaces will be used on wards to accommodate patients awaiting a bed, where a clinical risk assessment has been completed, and there are confirmed discharges on those wards. Where there are breaches of the 4-hour standard that are due to a lack of an available bed, breach reports will confirm whether the use of a flexible trolley space or "sitting out" of patients expected to be discharged that day had already been utilised (Action completed).
- The numbers of Emergency Nurse Practitioner (ENP) resource dedicated to the management of minor attendances will be increased; a business case it being developed for putting in place additional ENPs, with the aim of these new posts being in place by the end of August. (Action completed) - *recruitment timescale end September 2012 (first advertisement unsuccessful). Short term arrangements for existing staff to work extra hours/shifts now being put in place, pending recruitment.*
- There will be close monitoring and trouble-shooting of patients in the Emergency Department that have reached a 3-hour wait, with appropriate escalation utilised throughout the day/week (Action completed).
- Delays in Social Services assessment will be escalated to the Director of Social Services (as at the 1st June there were 17 patients that had been awaiting a Social Services assessment for between 1 and 3 weeks) (Action completed) - *Emergency Care Intensive Support Team audit of hospital patients will take place on 30th July 2012.*
- The frequency with which 4-hour emergency access reports are opened and read will be monitored, with the aim of determining whether different routes of getting information out to staff are required (Action completed) - *Divisions now regularly reporting emergency access performance to all specialties.*
- The abdominal pain pathway, which was piloted over the bank holiday, will be supported by the GP Support Unit. *Action reviewed and due to minimal impact agreed to be considered as part of new Ambulatory Care Unit.*
- The cubicle (infection control rooms) tracker at the BCH will be updated more regularly, to support patient flow, and will be fully utilised by the Emergency Department (Action completed).
- Residual operational issues associated with the Medway implementation will be resolved at the BCH (Action completed - *in relation to 4*

hour standard, for completeness of all clinical indicators awaiting next phase of Medway Development in December to address 15 minute assessment data issues).

Actions for quarters 2 and 3.

- Creation of a 'Hospital Hub' and creation of a dedicated BRI Discharge Team Dedicated discharge team and leadership in place from 1 August. Hospital hub (intermediate care in-reach) due to start September
- Increased scope of Ambulatory Care supported by the GP Support Unit (end September); *failure of CQUIN bid jeopardises extending ambulatory care but new unit occupied and staffed for existing pathways*
- Full recruitment to ward staff posts (Ongoing and to be completed at the end of July). *Almost complete in Medicine.*
- The number of direct emergency admission pathways will be increased (end July) - *work to agree improved cardiology pathways underway and multi-agency group to review and improve pathways established to increase direct admits during Q2*
- Following the completion of a review of readmissions at the end of June 2012 by the Commissioning Team and Primary Care Trust, specific aims and objectives of the following work-streams will be developed by the end of July *(review of readmissions completed – the percentage of avoidable readmissions 9%, most of which could only be avoided by the provision of additional community based services; Divisions reviewing feedback to identify any potential areas where pathways could be improved).*
- The physical capacity to review paediatric Emergency Department (ED) patients will be increased following the creation of new observation area in July 2012. This will improve ED performance in the short term with the utilisation of 2 additional spaces from July 2012 **(**on track)
- A start date for pilot of weekend social work input will be agreed, with agreed evaluation of outcomes (end of August) - *pilot at North Bristol Trust; outcomes awaited for consideration of transfer to UH Bristol in September*
- Draft standards for inter-professional referrals and associated response times have been produced and commented upon; standards to be in place by the end of quarter 2 (end September) - *Professional standards for emergency care agreed at Trust Management Executive in July*
- Further analysis is continuing to be undertaken to understand the reasons why recent 4-hour performance is well below historical performance. The output from this will be an operational planning tool that will model the impact of the size of the BRI bed-base, length of stay, and changes in levels of patient acuity (*first part of the model completed, with key factors having been identified*). Along with this planning tool a monitoring report will be developed. This will alert the Divisions to potential changes in patient acuity and other key factors that put pressure on the BRI bed-base, to allow operational teams to manage potential changes in demand in a more pro-active way, especially during the winter (July; *work ongoing*)
- Review utilisation and operational policy of discharge lounge to ensure it is fit for purpose and fully supports patient discharge/flow (to be completed by the end of July).
- Review utilisation of South Bristol Community Hospital (SBCH) and operational policies to ensure optimal and timely access to SBCH and

patient flow (to be completed by mid August).

- Prepare plan to support timely discharge from hospital (to be completed by the end of July).
- Ensure commitment of specialty leads in Medicine to early discharge is enacted through practices at ward level, using opportunity of change of house in August (to communicate this by 3rd August 2012).

Progress against the recovery plan:

In June the 95% standard was achieved. As of the 19th July performance for the month remains above the 95% national standard, at 95.5%. This is despite the Bristol Children's Hospital experiencing a much higher than normal level of demand due to the unseasonal weather. June and July's performance to date provides greater assurance of achievement of the standard in the second quarter of the year, ahead of the quarter 1 declaration of compliance to Monitor.

The BRI's Time to Initial Assessment and Time to Treatment, which is directly related to how busy the Emergency Department is, are both expected to improve along with the improvement in achievement of the 4-hour standard and bed-related patient flow. It is known that there are some data quality issues associated with the capturing of Time to Initial Assessment and Time to Treatment, related to the Medway Patient Administration System (PAS) implementation. An enhancement to Medway will be available in December to address this. The data quality issues in particular impact the Bristol Children's Hospital. The figures now reported exclude timings where the time to initial assessment was unknown. Local monitoring at the BCH continues to provide assurance that Time to Initial Assessment remains below the 15-minute standard for 95% of patients.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 06a – Infection Control Annual Report

Purpose

To brief the Board on the Infection Control Annual Report**.** For compliance with the Hygiene Code the Director of Infection Prevention and Control is required to produce a report and release it publicly annually. The content of the report is dictated by expectations from the department of health and the care quality commission and summarises performance in infection prevention and control matters for the year.

Abstract

The report outlines progress against compliance with the hygiene code, in which full compliance was achieved. The corporate objective to further reduce rates of infection was achieved. The annual infection control programme was, overall achieved. We have also :

- Maintained a clean and appropriate environment. The standard has been set at 95%. Eleven months of the year this standard was met.
- We have continued to develop entrance signage and patient information.
- Plans and funds are in place for the provision of a specialist isolation room.
- Updated policies and achieved monthly hand hygiene audits.
- Ensured our staff are suitably educated in the prevention and control of infections.

More detailed objectives for 2011/12 are included in the report.

We will continue for the year 2012/13 to :

- Comply with the Code of Practice and related guidance in the prevention and control of infections.
- We will reduce further the incidence of infections, specifically MRSA and MSSA blood stream infections and *Clostridium difficile.*

Statistics on specific infections and outbreaks are included as are standing sections on decontamination, cleaning services and the Matrons report. The objectives for 2012/13 are outlined.

Recommendations

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

Executive Report Sponsor and Other Author

Sponsor – The Chief Nurse, Alison Moon.

Author – The Director of Infection Prevention and Control, Christine Perry. Dr Robert Spencer, Acting Director of Infection Prevention and Control. Joanna Hamilton-Davies, Senior Infection Control Nurse.

University Hospitals Bristol NHS
NHS Foundation Trust

Infection Control Report 2011/12

I am pleased to introduce the University Hospitals Bristol NHS Foundation Trust Annual Report on Infection Control for 2011/12.

One of the most important aspects of caring for our patients and working with our staff, is to keep everyone safe and free from harm. Patients tell us how important this is to them. The Trust Board are full committed to supporting staff in their aspirations to do their best for our patients. You will see through the report evidence of much work undertaken every day by our staff to minimise the risk of infections for all patients who we serve. It is very heartening to note that incidence of both C.Difficile and MRSA bacteraemias have significantly reduced during this year. Throughout the report there are also many other examples of good practice and improvement.

It is important to note that there is no complacency within the Trust and our objectives for 2012/13 are to continue our improvement in this area. We know that there is always much to do and I would like to thank all the staff, whatever their role for the very important part they play. Special thanks also to Chris Perry, the Director of Infection Control, who played a key role during this year.

With best wishes

Alison Moon
Chief Nurse
Executive Lead for Infection Prevention and Control

CONTENTS

1. OVERVIEW OF PROGRESS FOR 2011/12

Last year, we based our infection control compliance and delivery programme on two specific objectives. In the pages which follow, you will be able to read a detailed account of how we got on. All areas have been assigned a 'traffic light' (Red/Amber/Green) rating to give the reader an idea of the progress we have made. Table 1, below, provides an overview.

Table 1

We said we would…	How did we get on?
Comply with the Code of Practice on the Prevention and Control of Infections and Related Guidance (Hygiene Code)	Green/ Amber
We will report and investigate cases of healthcare associated infection as mandated	Green
We will reduce further the incidence of infections (specifically MRSA and MSSA blood stream infections and C. difficile)	Green
We will establish an in-house infection prevention and control masterclass training programme	Amber
We will revise and re-launch the High Impact Interventions (Saving Lives)	Green
We will undertake an audit programme using national Infection Prevention Society Quality Improvement Tools	Green
We will implement a programme for sharps injury prevention	Amber

2. COMPLIANCE TO THE HYGIENE CODE

We said we would…

Have systems in place to manage and monitor the prevention and control of infection, using risk assessment to consider individual and environmental risks

How did we do?

- We have a fully established infection control team that consists of an infection control doctor, seven infection control nurses, an antimicrobial pharmacist, an analyst and administration support.
- The Director of Infection Prevention and Control leads the team and reports directly to the Chief Nurse and Chief Executive.
- The Chief Nurse is the Executive Lead and chairs the Infection Control Group, which has met four times in 2011/12 and includes Governor and partner organisation representatives.
- The Trust Board has received infection control reports within the quality report monthly and a detailed report quarterly

- The Infection Control Group has monitored all relevant risks at each meeting
- We have assessed our compliance to the hygiene code quarterly at each Infection Control Group meeting

We said we would…

Provide and maintain a clean and appropriate environment

How did we do?

- We have achieved our standard of 95% for cleanliness monitoring scores in 11 months of the year
- We have continued to monitor and improve instrument decontamination processes
- We have continued to participate in the National Patient Safety Agency 'Clean your Hands' campaign focusing on alcohol hand gel being used by staff and visitors to clean their hands as near to the point of care delivery as possible
- We have reviewed the alcohol hand gel supplied and we are in the process of changing to a new supplier which will enable hand gel dispensers to be placed at the immediate entrances to wards and departments
- Results of the staff survey continued to show poor scores for staff reporting that hand washing facilities were always available (52%). These lower scores were from staff who work in administration areas and not patient areas and Nurses cleaning their hands between touching patients
- Hand hygiene practice monitoring scores achieved 97.7% against our 95% standard over the year

We said we would…

Provide suitable and accurate information to service users and their visitors

How did we do?

- All patient and visitor information leaflets have been reviewed and updated
- We have continued to develop entrance signage that provides up to date information on current ward closures

We said we would…

Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care

How did we do?

- We implemented system of writing to patients and their family doctors who have been screened for MRSA but are discharged before the sample result is available

- We have started an audit of the information that is shared with doctors and nurses in the community when patients with infections are discharged and will complete this in summer 2012

We said we would…

Ensure that people who develop an infection are identified and receive appropriate care and management

How did we do?

- An assessment for risk of infection is carried out for all patients when they are admitted
- *Audit results from QICT:*

	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
MRSA Pre-Op Elective Screenings	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
MRSA Emergency Screenings	91.5%	93.3%	92.5%	92.7%	93.1%	93.2%	93.4%	94.1%	93.8%	94.1%	94.4%	92.0%

We said we would…

Ensure that staff are fully involved in preventing and controlling infection

How did we do?

- All Divisions have leadership for infection control through the Heads of Nursing (for the Division of Diagnostics and Therapies it is the Divisional Manager), a designated medical lead and Matrons. Divisions all have effective link nurse systems

We said we would…

Provide or secure adequate isolation facilities

How did we do?

- We audited practice for isolating patients monthly with the 95% standard achieved in five months
- We made plans to fund the provision of a specialist isolation room for infections such as multi-drug resistant tuberculosis and this conversion work will take place in 2012.
- We have planned sufficient single rooms and specialist isolation rooms into the new Bristol Royal Infirmary build to increase availability of isolation beds from the current 12% to 33% of beds

We said we would…

Secure access to laboratory services

How did we do?

- Laboratory services are provided by the Health Protection Agency who have delivered laboratory services in line with the expected contract
- During times of high influenza and norovirus activity the laboratory implemented additional weekday and weekend testing

We said we would…

Have and adhere to policies that help to prevent or control infection

How did we do?

- We have reviewed and updated all necessary policies within the year
- We have audited hand hygiene monthly with the standard of 95% achieved each month
- Audits of glove and apron use have shown an improvement with the 95% standard achieved in February 2012

We said we would…

Ensure that staff are free from and protected from infection and are suitably educated to prevent and control infections

How did we do?

- All staff are screened for infection when they begin work at the Trust and are offered appropriate vaccinations against infectious disease
- We have worked with our occupational health service to review health screening and in 2012 we are introducing additional health screening for staff that spend long periods in specific countries abroad for either work of personal reasons.
- We have continued to place specific focus on providing infection control induction and update training for all staff with 88% of staff having attended within the three-year agreed timeframe

3. STATUTORY AND NATIONAL REQUIREMENTS

We said we would…

Report and investigate cases of healthcare associated infection and outbreaks as mandated

How did we do?

- We strengthened our management of Norovirus following a review by the Health Protection Agency of our management of Norovirus in 2010/11
- We have had less complete ward closures due to Norovirus in 2011/12 following the relocation of wards from the Old Building
- We have reduced the number of number of complete ward closures and patients affected by Norovirus. From January to March 2012 there were 10 full and seven partial ward closures where Norovirus was detected, seven less than in 2010/11, with 49 patients confirmed to have the infection, 74 less than the previous year
- We investigated a member of staff in the Neonatal Intensive Care Unit who was diagnosed with respiratory TB. The investigation included neonates outside the Bristol area. Contact tracing and treatment of these neonates was instigated as appropriate. No harm came to any neonate in relation to this outbreak
- We restricted admissions to the neonatal intensive care unit for five days in March 2012 whilst we investigated a potential diarrhoea and vomiting outbreak and managed this as a major outbreak of infection due to risk of infection to neonates; no harm came to any neonate in relation to this outbreak
- For some infections (e.g. chickenpox) staff or patients are infectious before they show any sign of the infection. When a staff member or patient develops such infections we look carefully at any patients or staff they have been in contact with, and may be at risk of getting the infection. In 2011/12 we did this twice for chickenpox, once for mumps and once for TB. In all these cases no patients were at risk and did not develop the infection

We said we would…

Further reduce the incidence of infections (specifically MRSA and MSSA blood stream infections and *C. difficile*)

How did we do?

- We have reduced the number of MRSA blood stream infections in patients who are in hospital for more than two days from 5 cases in 2010/11 to 4 cases in 2011/12
- For 2 of the four quarters our rate of MRSA blood stream

infection was below the national rate, for 2 out of the four quarters it was below the regional rate.

- We maintained the number of patients who were tested for MRSA at pre-operative assessment clinics at 100%
- We have screened 93.3% of emergency patients for MRSA
- We have reduced the number of MSSA blood stream infections in patients who are in hospital for more than two days from 45 cases in 2010/11 to 38 cases in 2011/12; this reduction was 16%, slightly less than the 20% local target for reduction
- Women & Children's Division reduced the number of MSSA blood stream infections by 59% and Medical Division by 42% in 2011/12
- We have reduced the number of GRE (glycopeptides resistant Enterococci) blood stream infections in patients who are in hospital for more than two days from 15 cases in 2010/11 to 10 cases in 2011/12
- We have reduced the number of C diff (*Clostridium difficile*) infections in patients who are in hospital for more than three days from 94 cases in 2010/11 to 54 cases in 2011/12
- We took part in a European survey of hospital infection rates. This showed there was an overall drop in HCAI prevalence from 8.2 per cent in 2006 to 6.4 per cent in 2011.

4. DEVELOPMENTAL OBJECTIVES

We said we would…

Establish an in-house infection prevention and control masterclass training programme

How did we do?

- In response to the Health Protection Agency's report on our management of Norovirus outbreak, we focused masterclass training on Norovirus for different staff groups
- As a result of this we did not run the number of masterclass training sessions we had originally planned and we plan to run those now in 2012/13

We said we would…

Revise and re-launch the High Impact Interventions (Saving Lives)

How did we do?

- The Saving Lives programme allows wards to check that patients who have devices that put them at risk of infection (drips/lines and catheters) are being cared for correctly
- We reviewed the way that wards currently carry out this check

and found that no changes to this process were needed

- The standard of 95% for care of intravenous lines was met for eight months in 2011/12 with no months being below 92% for the care carried out by staff
- The standard of 95% for care of peripheral lines was met for six months in 2011/12 with no months being below 93% for the care carried out by staff
- The standard of 95% for care of urine catheters was met for 11 months in 2011/12 with no months being below 93% for the care carried out by staff

We said we would…

Undertake an audit programme using national Infection Prevention Society Quality Improvement Tools

How did we do?

- We had planned to carry out this audit programme using new national quality improvement tools; as these were not available until early 2012 we carried out audits of the ward environment and equipment using existing national audit tools
- The Infection Control Nurses have carried out 20 ward/department audits to date and will carry out audits of the remaining wards in 2012/13
- For the wards audited to date the average score of 86% for the environment and 90% for equipment show a need for improvement and individual ward sisters have produced plans to address this

We said we would…

Implement a programme for sharps injury prevention

How did we do?

- We carried out an audit of needle and syringe disposal with the company who supply us with disposal bins. The following areas identified in this audit are being addressed: use of temporary closures; assembly and labelling of bins; location of bins; and use of sharps bins for disposal of general waste.
- We did not undertake the additional staff training and awareness as we had planned; this will now take place in 2012/13

5. CLEANING SERVICES

The facilities department has made continual improvements to performance and working strategy to ensure the best patient environment experience. Actions and initiatives during 2011/12 included:

- In January 2012, successful completion of the transformation of the night cleaning team , where we aligned 37% of the night cleaning hours to the evening to carry out the cleans of corridors, stairwells and lifts, thus providing more supervision and management to the team in the evening. The night cleaning team continue to clean the following key areas: Emergency Department, Heygroves Theatres, and Deep cleans.
- Review and restructure of the cleaning arrangements in Emergency department at Bristol Royal Infirmary to more appropriately reflect activity and this has resulted in the area consistently achieving 95% and above.
- A detailed rolling programme for top up cleans performed by the Deep Clean cleaning staff.
- Introduction of new staff appraisal form including generic objectives for the cleaning team which encompass the cleanliness standard and performance of the area they work in.
- Carrying out supervisory audit checks of ward kitchens and cleanliness of the wards on a daily basis
- Reinforcing to all Hotel Service Assistant staff through team brief and appraisal process cause and effect of cleaning standards, cleanliness audit process and trust values.

During 2011/12 Facilities have provided a prompt response to outbreak situations , appropriate management of high level cleaning and ward decontamination programmes together with meeting a growing expectation of our patients and staff to enjoy an environment that is always clean, well organised and cared for. There is now evidence to support more appropriate cover at all times of the day and week to support the delivery of a prompt response to cleaning services. Changes to cleaning service rotas, to more appropriately meet clinical activity trends, has had significant positive effect. An example of this is within the Emergency Department where changes have resulted in the area achieving consistently high cleanliness scores. The Patient Environment Operational group oversees the standards and protocol development and implementation and senior facilities representatives attend relevant infection control strategic and operational meetings.

As set out in the NHS Cleaning Manual guidance cleaning schedules and frequencies are agreed and publicly displayed in each area. Regular audits of cleanliness are undertaken by facilities management and supervisory staff which are reported to the Ward Sisters and matrons with remedial actions agreed where needed.

A programme of induction and ongoing training is in place for Hotel Services Assistants with all new staff completing a programme of competencies.

The facilities team continue to support infection prevention and control with deep cleans of bedspaces, cubicles, rooms and whole ward areas. This cleaning is in addition to regular cleaning and is carried out in response to

individual cases of infection as well as outbreaks. The number of deep cleans performed in 2011/12 totalled 4,220 a reduction of 6% from the previous year. During 2011/12 the deep clean team have used Hydrogen Peroxide Vapour machines for disinfection of an area 308 times, averaging up to 6 usages per week.

Independent cleanliness monitoring audits are carried out around the trust and a summary report tracks the scores achieved throughout the year. Ward areas of the trust are audited on a monthly basis with weekly audits taking place in areas where patients are more vulnerable to infection, such as intensive care units. A green rating is applied when audit scores are 95% or over. When individual scores fall below 88% a remedial action plan is completed by the Hotel Services Management Team. During 20011/12 the average cleanliness score across all risk categories (very high, high , significant and low) for the Trust was 95%, achieving and average score of 96% for very high and high risk category areas across the Trust.

The 2011/12 Patient Environment Action team (PEAT) inspections included Trust governors, members, members of the Youth Council and an external validator in attendance at St Michaels's Hospital and the Bristol Royal infirmary/ Bristol Heart Institute. Over a number of years now there has been steady increase in the outcome if the focus on cleaning and all hospital sites achieved a "good "rating for the environment aspects of these assessments.

During 2012/13 in line with the trust cleaning strategy we plan to build further on the improvements made in the standard of cleanliness achieved trust wide. We will do this by:

- Reviewing the departmental and clinical area cleans in the Old Building and King Edward building of the Bristol Royal Infirmary, to provide a more efficient and consistent level of service.
- Complete the transfer of Cleaning Services at Bristol Royal Children's Hospital's, Bone Marrow Transplant department from clinical to facilities ownership.
- Build on the implementation of the new appraisal form, embed cleaning standards and performance into all cleaning roles.
- Review alternative models of the Hydrogen Peroxide Vapour machines to provide a more efficient and cost effective service to the clinical teams by considerably reducing the turnaround time of the room after the use of the Hydrogen Peroxide Vapour machine. Trial currently underway.
- Introduce an electronic cleaning management and audit tool.
- Review and update the Cleaning Strategy Document for the Trust to meet review timeline of October 2012.

6. ANTIBIOTIC PRESCRIBING

Antimicrobial stewardship within the trust has progressed under the guidance of the anti-infectives steering group which have met quarterly over the year. The group, which is chaired by the medical director have identified and implemented strategic changes over the year to further improve antibiotic prescribing compliance.

Antibiotic review rounds conducted by a consultant microbiologist and antimicrobial pharmacist now occur once a week on thirteen wards within the trust. The antimicrobial pharmacists audit antibiotic prescribing compliance in all other wards within the Bristol Royal Infirmary, Bristol Children's hospital, Bristol Haematology and Oncology Centre and St Michael's hospital at least twice a month and the Bristol General Hospital (now South Bristol Community Hospital) at least once a month.

There has been a steady but continuous improvement in antibiotic prescribing compliance over the last year. In March 2011, the trust wide figure for antibiotic prescribing compliance was 76%. The figure for March 2012 is 84% with the highest ever trust wide score having been achieved in January 2012 of 88%. We have identified that sustainability of achieving high antibiotic compliance scores is the major obstacle for the antimicrobial stewardship programme to overcome and this will be the focus of the work of the anti-infective steering group in 2012-2013. We have identified that the weakest area of antibiotic prescribing compliance is the inclusion and update of review or stop dates of antibiotics on the prescription chart and this is the area that the antibiotic pharmacists will focus on improving in the forthcoming year.

In 2012-2013 we will further improve our antibiotic prescribing compliance. We will do this by:

- Ensuring that sustainability of antibiotic prescribing compliance is achieved.
- Ensuring that Consultants have ownership of antibiotic prescriptions written for patients in their care.
- Ensure that each clinical division monitors antibiotic prescribing compliance within their division.
- Ensure that the inclusion of a stop or review date on the antibiotic prescription improves.

We will also continue to produce and review antibiotic guidelines for clinical specialties within the trust and ensure that our practice is in line with recommendations contained within the antimicrobial prescribing initiatives published by the Department for Health.

7. DECONTAMINATION

Annual Accreditation Audit	CSSD underwent its 1st surveillance audit of the 3 year audit process in February. Overall a good audit with 1 major and 6 minor corrective action notices and 10 recommendations being awarded. An action plan has been drawn up in response to the points raised and staff are working through these and plan to close them all down by end of July.
Installation of RO water plants across site.	RO plant in stalled in BHI and is still awaiting connection – full chemical sanitisation of the system occurs regularly but we are experiencing very high TVC counts on water testing. Working closely with Purite who installed the system to resolve problem – various pipes and valves have already been changed at cost to the company. RO plant in HGT has now been fully installed and is working fine. Additional monies have been sourced to support the expansion of RO water in QDU – capital monies approved and work is commencing re procurement of this system.
Clean Steam Installation	The installation of clean steam into CSSD has been stopped and was removed from the capital bid following discussion between finance, estates and the division. It is thought to be more sensible both in terms of finance and service delivery to install clean steam when a refit/rebuild of CSSD occurs. AG checked with the auditors the implications of not installing clean steam at the moment in terms of department accreditation and has been told it is not a problem as the governing legislation does not currently stipulate it as a must have.
Automatic Endoscopic Reprocessors at SBCH	These machines have not been installed as there are major difficulties with obtaining acceptable water results. Micro-bacteria and high TVC counts are a constant issue despite frequent sanitisation of the whole water system. A completely different water pipe, independent of the main system is now being explored. The non-installation of this machinery has meant a delay to the opening of endoscopy services at SBCH – this is impacting upon SHN service plans.
Annual and quarterly testing and validation of washer disinfectors and autoclaves in CSSD.	Annual and quarterly testing by Audare continues to be on schedule. Dental have also engaged Audare to provide the same service for the community equipment. Individual departments that undertake local decontamination continue to seek their own quotes with respect to annual and quarterly validation and are moving across to Audare as contracts are due for renewal.

CSSD air handling unit and ventilation compliance	Despite improvements to the air handling unit for CSSD the manometer readings continue to be low for the air flow in the clean room. Inspection of the filters in the clean room has shown that these are very likely to be blocked (having never being changed since installation 10 years ago) and thus affecting the effectiveness of the system as a whole. Plans are in place to replace a total of 9 filters. Once this has been done it is hoped that the air pressure coming into the room will significantly increase to reading above 10PA as required by HTM 2030. It is possible work may be needed on the 'flaps' that regulate the air pressure in and out of the room but this will be determined once the filter work is complete.
Age of equipment and risk register	The age and life span of decontamination equipment across the Trust is now known and understood. Items considered to be at risk are now on divisional risk registers and this has helped the allocation of capital monies for replacement.
CSSD	Service being delivered to end users by CSSD has stabilised overall. The department continues to experience quite a high staff turnover and is again recruiting. A drop in personnel available to work has a demonstrable effect upon the department's ability to process equipment in a timely manner. Monies for the Band 7 operational manager have yet to be identified as available by the division SHN and absence of this post does impact upon the Head of CSSD post as AG is absorbing this work in amongst her other roles and responsibilities. Until band 7 post is filled further management restructure is not possible. First draft of the CSSD refurbishment/replacement business case has been written but some changes need to occur. Current building and facilities are over 20 years old and capacity is at a premium. In order to remain compliant and maintain accreditation going forward refit is necessary. Whether this will be on the existing site or a new site is yet to be determined. Currently there is a capital pot of £3 million set aside for some of these improvements.
Authorised Engineer for Decontamination	Bob Kingscote has recently undertaken his annual audit of all decontamination equipment managed by the Trust. His report is with end users for their perusal. End users have been asked to comment upon the report at April's decontamination group meeting and there will be a presentation of both Bob's report and end users comments at June's Decontamination Board meeting. Overall his report is favourable in terms of decontamination compliance across the patch. Recommendations have been made in terms of replacement of machinery, and adherence to/understanding of good decontamination practice in certain areas.

Decontamination Incident Reporting and CSSD Dashboard	Clinical incidents forms that are completed with relation to CSSD continue to be monitored. Collation of these reports continues to show the following themes: • Holes in tray wrap • Damaged instrumentation • Contaminated set/instrument • Wrong/missing/extra item on set • Equipment unavailable when required. CSSD dashboard shows monthly CSSD performance against certain KPI's. Significant progress has been made by the department in terms of appraisal compliance and the department can now report being green for this measure.
Service disruption at BEH TSSU and potential future impact for CSSD Kingsdown.	It was necessary to stop the TSSU service at BEH in March when the RO water tank (over 10 years old)supplying the washers and sterilisers sprung a leak. Service was transferred to CSSD Kingsdown and the service to BEH theatres was not significantly impacted. New water tank has now been installed and service now running at TSSU. The RO tank problem has led us to review the age profile of the RO plant at CSSD Kingsdown – this is also now over 10 years old. A quote is being obtained for replacement and this will be presented to the division of SHN for consideration of replacement works. A risk assessment has been completed and is sitting on SHN divisional risk register as highly rated. Should the RO water tank fail at CSSD Kingsdown significant Trust wide service disruption would occur – impact upon services reliant upon CSSD services could be catastrophic.
Containerisation of instrument sets	Division of SHN has recently been successful in purchasing 1000 containers for the sterilisation of surgical instruments. Use of these items will mean sets will no longer be wrapped in tray wrap and thus eliminate the incidence of tray wrap breaches. A planned, systematic roll out of the trays is scheduled for May with usage of trays across all appropriate sites by Christmas. The purchase has been made through spend to save monies supported by Paul Mapson. It is anticipated that a 60% reduction in expenditure of tray wrap and associated consumables can be achieved.

Decontamination service at SMH ENT OPD	ENT OPD finally went live with their automated decontamination service in February. This service has taken 3 years to procure, install, commission and go live following a number of issues on all sides. Since go live, the team have worked hard to adjust to the new ways of working. Support to the team is being provided by the decontamination engineers in terms of water and weekly testing as well as any machinery trouble shooting issues as the staff become more familiar with the machines and safe practice. Mary Alderson, who is relatively new in post as lead in out-patients is to be congratulated on her and her teams achievements with the new practice in addition to the running of very busy ENT OPD clinics.

8. MATRONS REPORT

The Trust Matrons remain an effective part of the infection prevention and control programme. They have worked tirelessly to over achieve the *Clostridium difficile* targets for 2011/12. The introduction of a Quality in Care Tool (QiCT), allows the matrons to cross audit areas and ensure that high standards are maintained. An integral part of this process is the feedback given to Ward Sisters about improvement or areas of outstanding practice and sharing this both in Divisions and at the Trust wide forum. Monitoring of cleanliness, use of protective clothing, correct isolation techniques and using lessons learned from the last Norovirus outbreak in 2011 assisted in halving the length of time wards needed to remain closed during the early part of 2012. The Matron focus for 2012/13 will be the reduction of MSSA bacteraemias.

The matrons also take a wider view and act as divisional links for infection control, chairing the divisional meetings and working to enforce policy. The matrons are delighted to have been involved in the new linen tender ,which has improved the quality of linen and reduced daily frustrations at ward level. The environmental operational group ensures matrons have a role in the PEAT visits and a voice to estates and facilities about environment issues. The. Matrons knowledge and expertise have allowed the trust to move forward and continually improve the standard of care given to all patients and has allowed the nursing to be well represented at a corporate level.

9. OBJECTIVES AND NEXT STEPS FOR 2012/13

Our goal in 2012/13 remains to ensure that patients who receive care within the organisation are assured that every effort is taken to reduce their risk of infection as well as to ensure the Trust meets statutory and national requirements related to healthcare associated infection. To achieve this we have identified the following five objectives:

1. We will comply with the Code of Practice on the Prevention and Control of Infections and Related Guidance (Hygiene Code)
2. We will report and investigate cases and outbreaks of healthcare associated infection as mandated
3. We will reduce further the incidence of infections (specifically MRSA and MSSA blood stream infections and *C. difficile*)
4. We will further develop the infection prevention and control masterclass training programme
5. We will implement a programme for sharps injury prevention to meet requirements of Directive 2010/32/EU - prevention from sharp injuries in the hospital and healthcare sector
6. To develop a system in conjunction with Occupational Health and HR for identifying members of staff who have been visiting (on annual leave/secondment) a high risk TB country for more than 3 months or who have worked and lived with TB patients for more than one month

APPENDIX A

Additional information

Figure 1 – Infection Control Structures

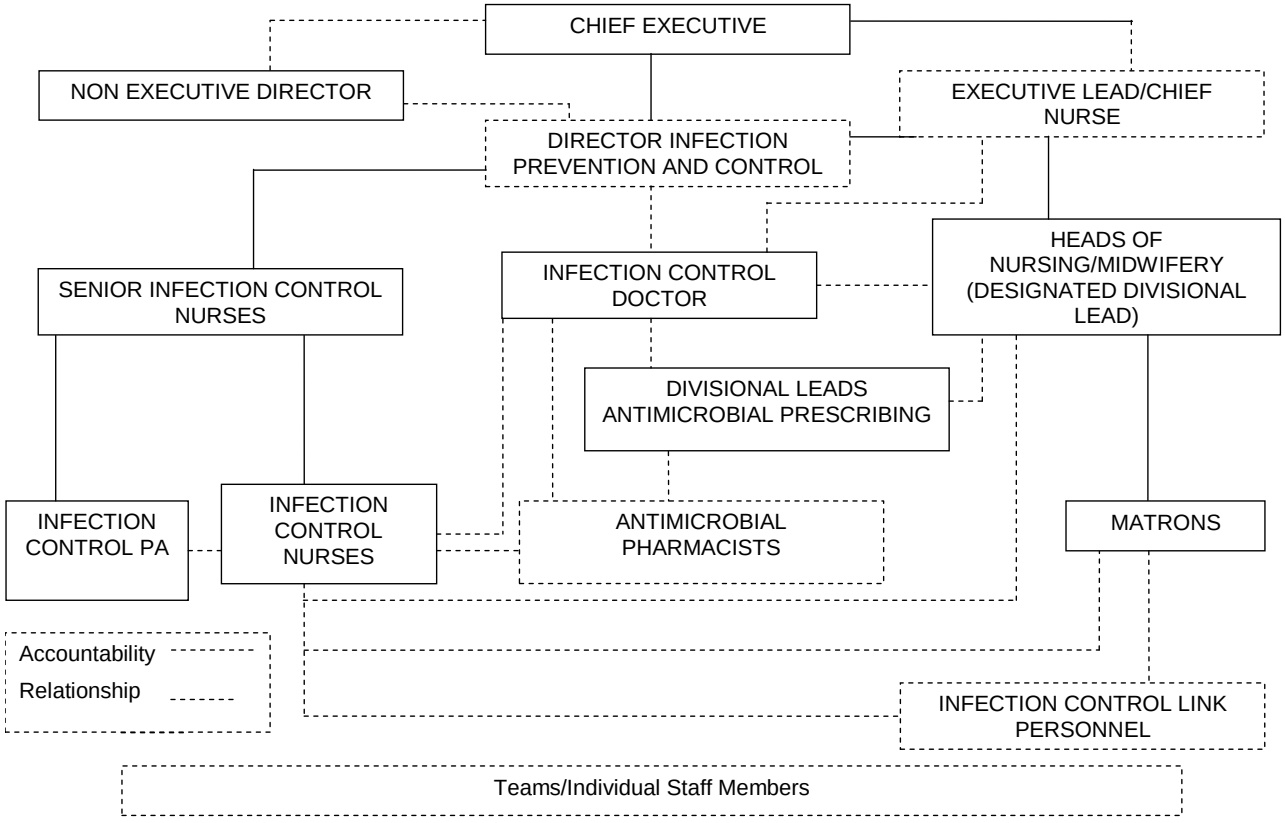


Figure 2 – Infection Prevention and Control Governance Structures

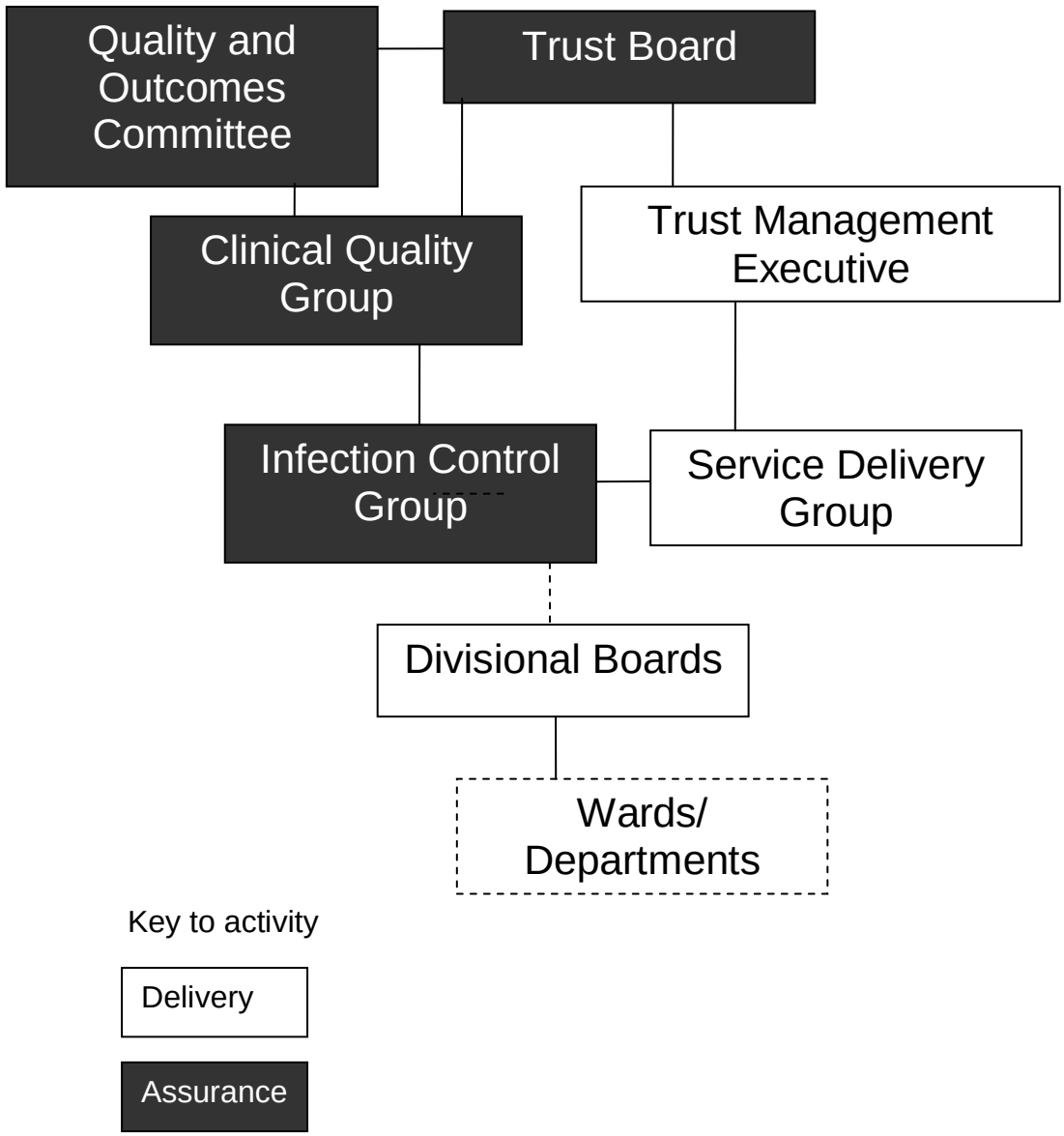


Figure 3 – Quarterly rate of MRSA blood stream infections compared to the national and regional rates.

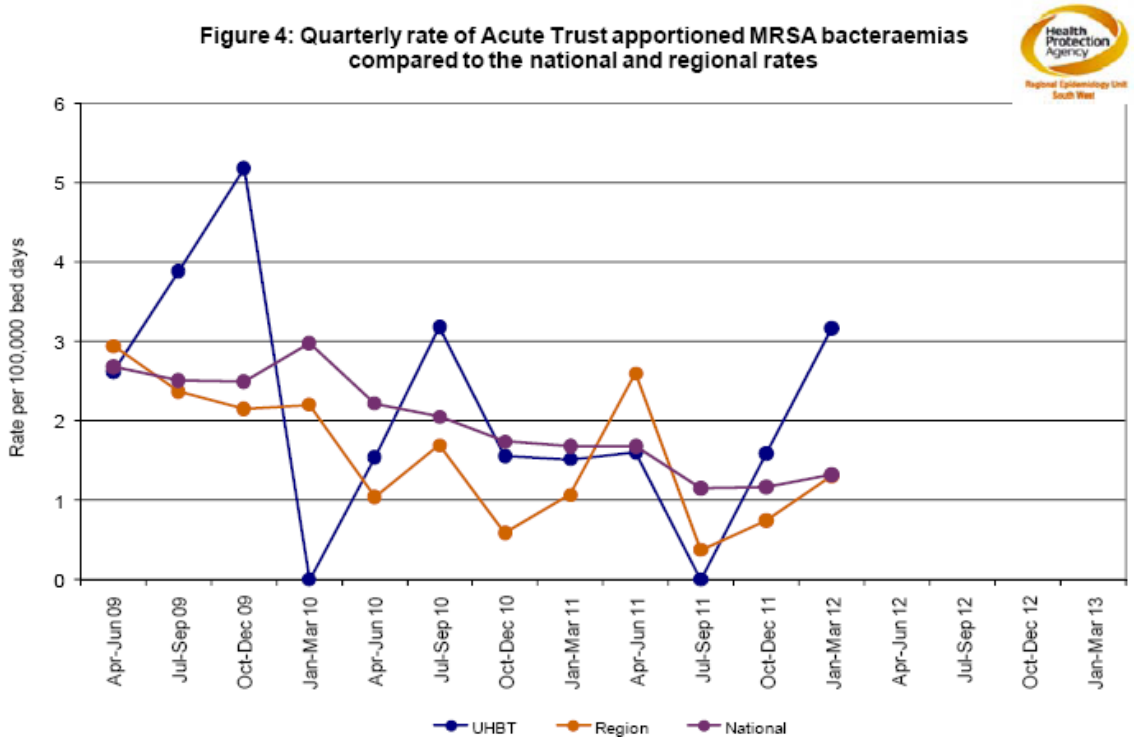


Figure 4 – Quarterly rate of *C difficile* infections compared to the national and regional rates.

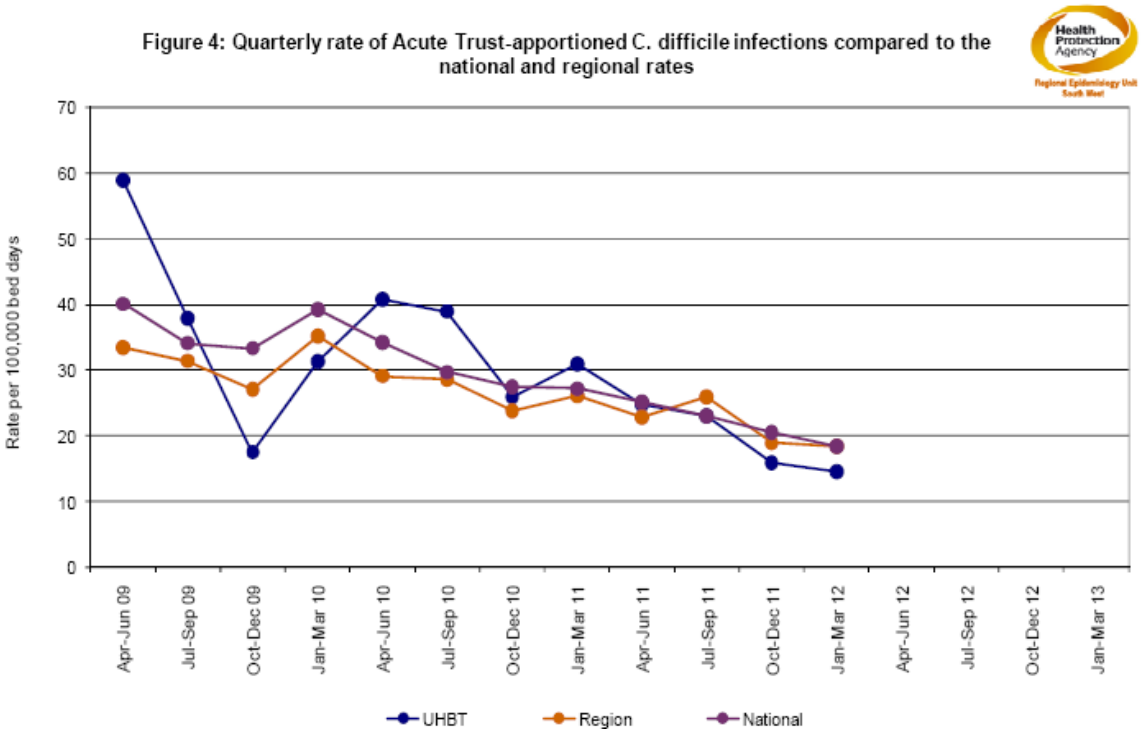


Figure 5 – Norovirus Outbreak Activity

Ward	Date closed	Bed days lost	Patients affected	Staff affected	Number of specimens sent	Number of specimens positive	Comments
26	03/04/2012		4	0	2	2	
21			2	0	1	1	Ward partially closed
10a	28/03/2012	5	4	0	4	1	
10			2	0	2	2	Bay only closed
54			3	1	2	1	Bay only closed
15	05/03/2012	51	8	6	7	6	
23	29/02/2012		13	14	12	7	
Brunel (80)	26/02/2012		12	6	8	4	
4	27/02/2012	20	13	6	9	7	
12	18/02/2012	64	16	6	12	5	
10a	16/02/2012	9	4	0	3	1	High Care only closed
23	14/02/2012	22	8	2	7	2	Ward closed
20	11/02/2012	26	8	1	7	1	Ward closed
18	09/02/2012	24	10	0	4	1	Ward closed
10			1	1	1	1	Bay only closed
31			1	0	1	1	Bay only closed
23 & 23a	25/05/2011	126	9	1	8	6	
Brunel	23/05/2011	9	7	2	5	1	
27	27/04/2011	46	10	2	8	4	
52	23/04/2011	11	6	2	7	1	
52	19/04/2011	0	5		9	3	Bay only closed
38	01/04/2011	10	6	3	6	1	

Figure 6 – Overall Cleaning Index by Hospital

	Bristol Eye Hospital	Bristol General Hospital	Bristol Haematology and Oncology Centre	Bristol Royal Hospital for Children	Bristol Royal Infirmary	St Michaels Hospital	Bristol Dental Hospital
2008	92%	87%	95%	88%	85%	86%	92%
2009	92%	94%	97%	93%	Including Bristol Heart Institute 89%	93%	91%
2010	96%	98%	99%	97%	91%	96%	95%
2011	97%	99%	99%	96%	91%	97%	95%

Figure 7 – Patient Environment Action Team (PEAT) Scores

Site Name	Environment Score					Food Score					Privacy and Dignity				
	2008	2009	2010	2011	2012	2008	2009	2010	2011	2012	2008	2009	2010	2011	2012
BRI	Acceptable	Acceptable	Good	Good	Good	Good	Excellent	Good	Good	Excellent	Good	Good	Good	Good	Good
BCH	Good	Good	Good	Good	Good	Good	Excellent	Good	Excellent	Excellent	Good	Good	Good	Good	Good
BHOC	Acceptable	Good	Good	Good	Good	Excellent	Excellent	Excellent	Excellent	Excellent	Good	Excellent	Excellent	Excellent	Good
BEH	Good	Good	Good	Good	Good	Excellent	Excellent	Excellent	Excellent	Good	Excellent	Good	Good	Excellent	Good
STM	Acceptable	Acceptable	Good	Good	Good	Good	Excellent	Good	Excellent	Excellent	Good	Excellent	Good	Good	Good
BGH	Good	Good	Good	Good	N/A	Excellent	Excellent	Excellent	Excellent	N/A	Good	Excellent	Excellent	Excellent	N/A

Figure 8 – Antibiotic prescribing compliance Trustwide 2010/11

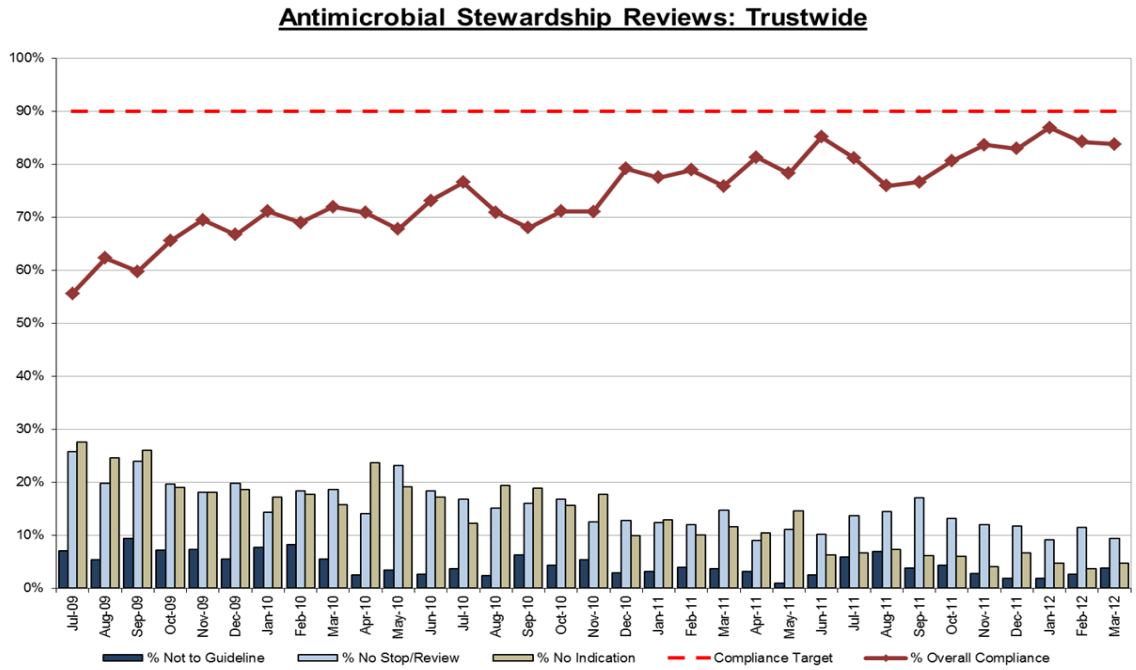


Figure 9 – Antibiotic prescribing compliance Medicine 2010/11

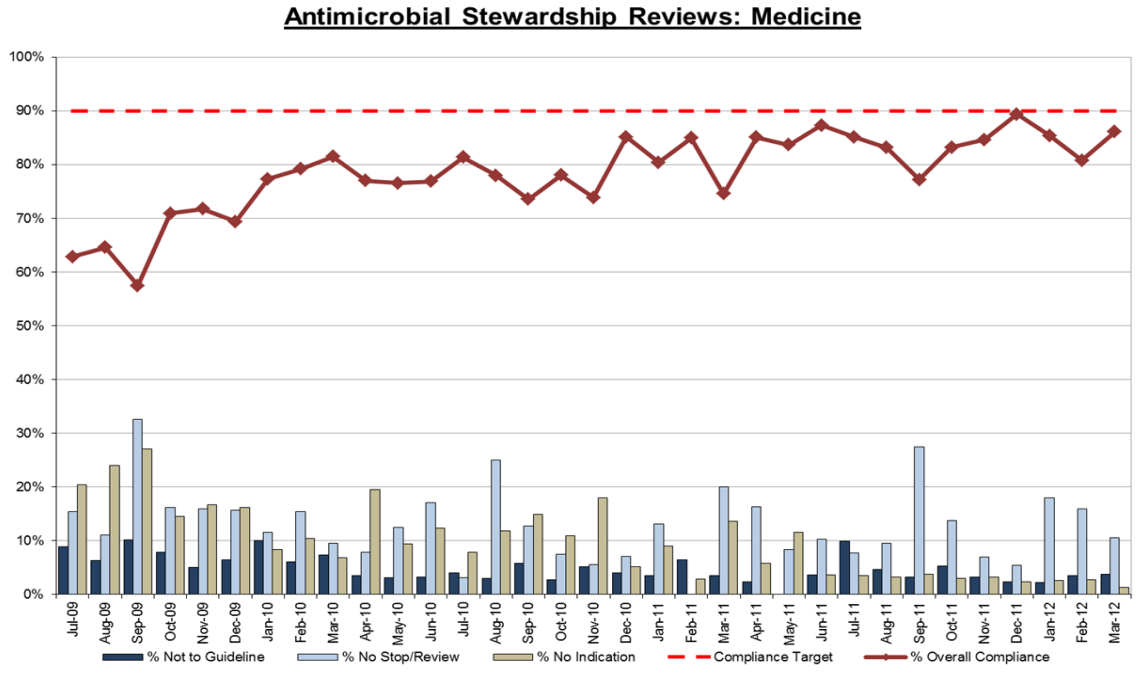


Figure 10 – Antibiotic prescribing compliance Specialised Services 2010/11

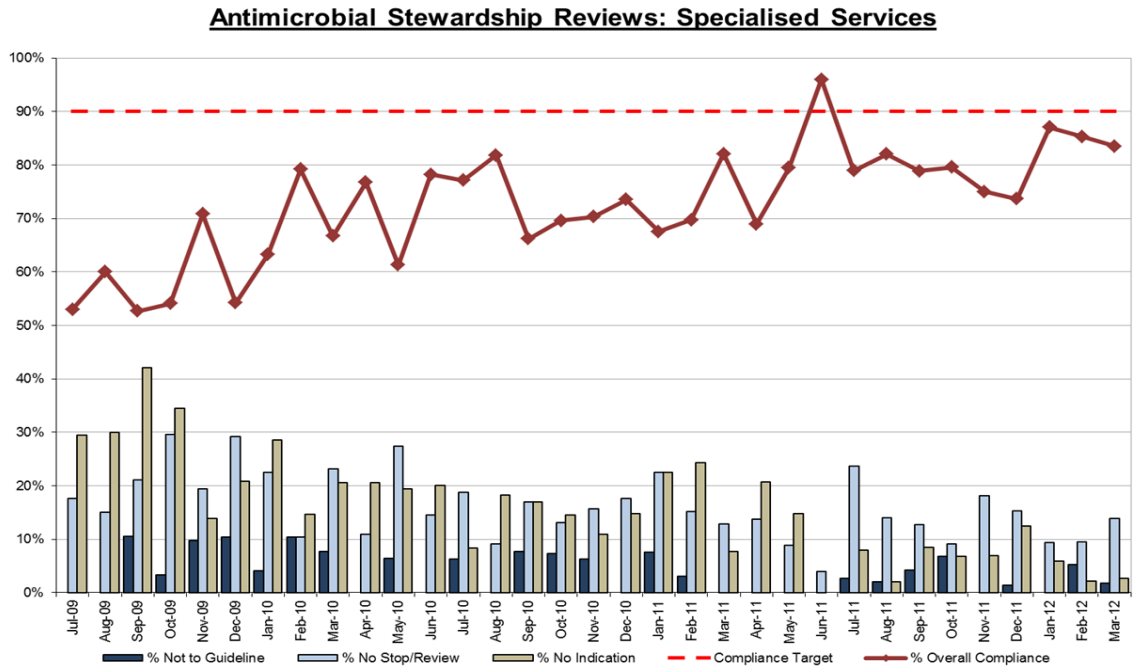


Figure 11 – Antibiotic prescribing compliance Surgery Head and Neck 2010/11

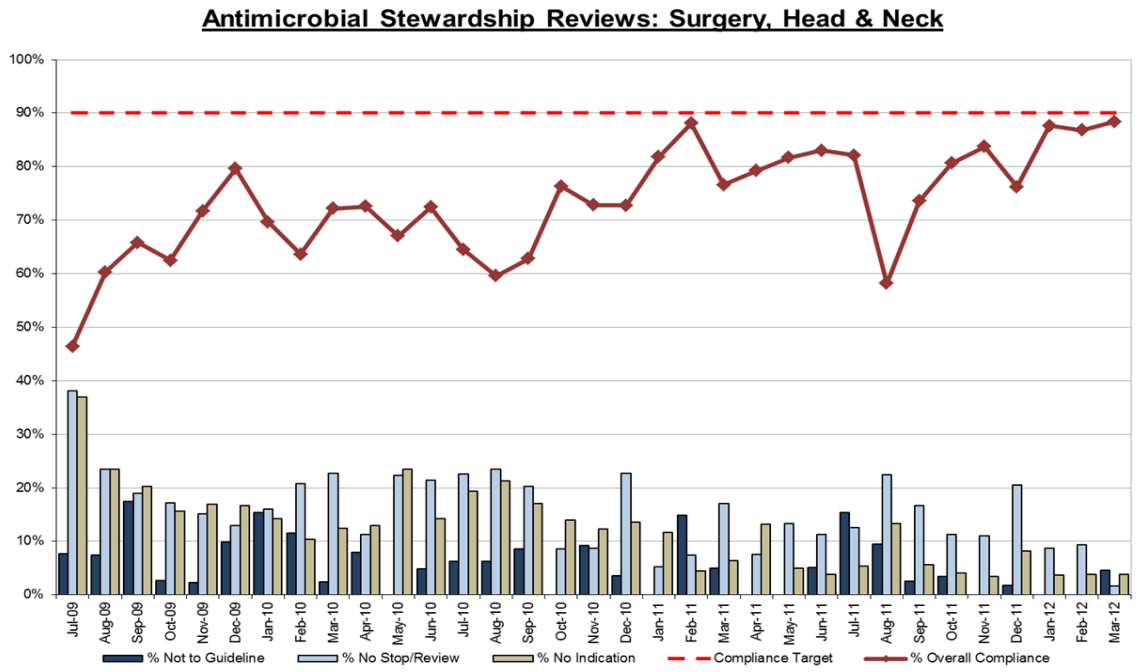


Figure 12 – Antibiotic prescribing compliance Women and Children 2010/11

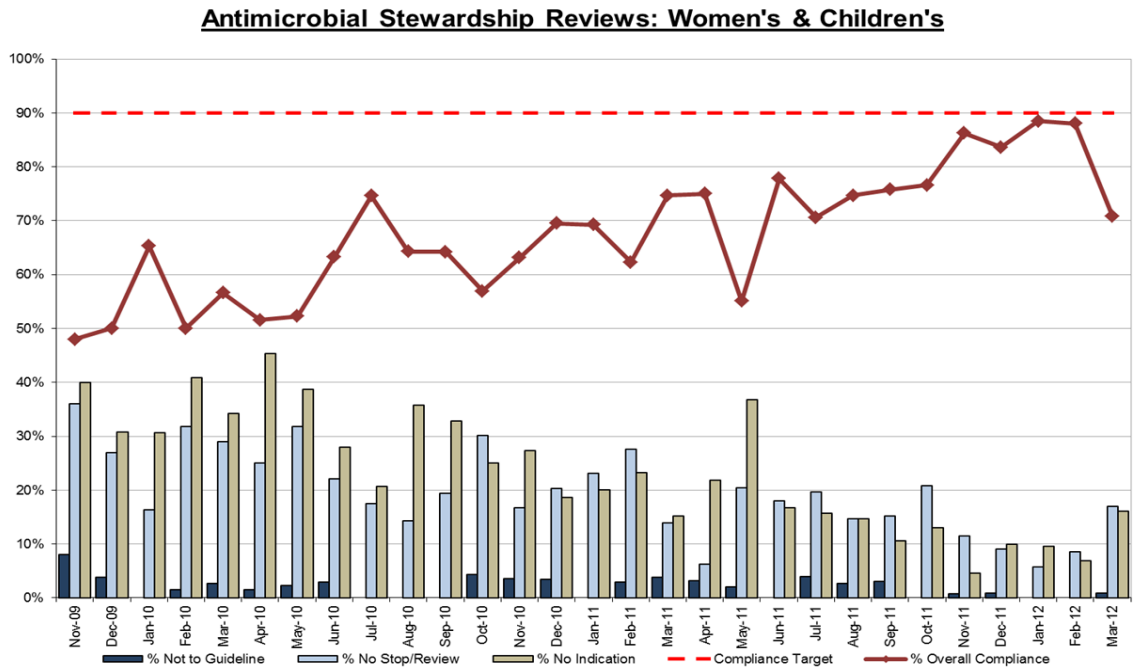


Figure 13 – Decontamination Programme 2011/12 Report

Action	Lead	Target date	Progress report
1) Standardise policies and procedures for all endoscope areas: St Michael's Queens Day Unit Bristol Heart Institute Main BRI (Heygroves) Theatres Community Urology Service BCH	**Annette Giles to co-ordinate:** Carole Tookey, Christine Marshall Martin Nelson Jennifer Pollock Christine Marshall Lotty Jones	Sept 2011	Ongoing
2) Finalise SOP for self disinfection and water sampling of all AER locations, through completion of appendix D of policy presented to May 2011 committee	Christine Marshall & Pete Harris	June 2011	Completed Autumn 2011
3) Installation of R/O water plants: • HGT • BHI • QDU	Dave Holder Dave Holder Dave Holder	June 2011 June 2011 July 2011	Fully Completed March 2012 On going due to instillation difficulties. New machine being installed July 2012. Additional capital monies applied for and approved. Instillation plan to have occurred by end of 2012.
4) Installation of clean steam in CSSD	Nigel Phillips	October 2011	Project on hold and to be part of the wider CSSD future refurbishment plan.
5) Complete options appraisal for future of CSSD and agree strategy via strategic estates steering group	Andy Headdon & redevelopment team	August 2011	Business case has been written. However NBT and UHB now working in partnership to engage an external consultant to review future Sterile service provision across the city.
6) Implement CSSD service review recommendations	Annette Giles & Maureen Hornsby	Ongoing	Ongoing.

Figure 14 – Decontamination Programme 2012/13

The 2012/13 Decontamination plan will be drawn up conjunction with the new publication CFPP 01/01. This new publication will change the ways of working within sterile services, and particularly endoscopy departments.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 06.b – Health and Safety Annual Report

Purpose

To brief the Group on Health & Safety in 2011/2012.

Abstract

This report summarises the main health and safety issues for 2011/12 and progress achieved by the trust in this area. It incorporates all aspects of Health and Safety relating to University Hospitals Bristol NHS Foundation Trust including Manual Handling. There is also a separate Annual Security Report and Annual Fire Safety Report and Summary report of incidents reported under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.

Recommendations

The Board is recommended to **Note** the report which has been received at Trust Management Executive via Trust Health & Safety and Fire Safety Committee.

Executive Report Sponsor and Other Author

Sponsor – Acting Director of Workforce and Organisational Development, Claire Buchanan
Author – Head of Health & Safety Services, Melanie Fewkes.

Appendices

- Appendix 1 – Health and Safety Annual Report

University Hospitals Bristol NHS
NHS Foundation Trust

Annual Health and Safety Report

Introduction

This report summarises the main health and safety issues for 2011/12 and incorporates all aspects of Health and Safety relating to University Hospitals Bristol NHS Foundation Trust including Manual Handling. There is also a separate Annual Security Report and Annual Fire Safety Report.

Revitalising Health and Safety – Health and Safety Executive targets

We continue working with the Health and Safety Executive and Occupational Health and Safety standards guidance from the NHS council updated in 2010. This is subject to further review to align with Health and Safety Guidance (65) 'Successful Health & Safety Management' in the coming year.
The work plan for the Health and Safety Executive 2011/12 covered:

Specific topics

- Stress at an organisational level as individual cases should be captured within management of staff with input from Human Resources. Stress and Musculo skeletal disorders as a reason for sickness absence which are in the top three categories of reporting and also feature in the referrals made to Occupational Health.
- Sharps and Needle stick – European directive consultation process will conclude in spring 2013.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 Consultation of these regulations by the government facilitated by the Health and Safety Executive led to a change in the law as regards work related injury. As of 6 April 2012, the reporting requirement for over-three-day injuries has changed. The trigger point has increased from over three days' to over seven days' incapacitation (not counting the day on which the accident happened). Incapacitation means that the worker is absent or is unable to do work that they would reasonably be expected to do as part of their normal work. The deadline by which the over-seven-day injury must be reported has also increased to 15 days from the day of the accident.

Risk management areas

- Management of Dermatitis
- Management of Asbestos

Health and Safety Executive contact with UHBristol.

In 2011 six Health and Safety Executive inspection visits occurred in this trust, topics covered were:-

- Slips, Trips, Falls to staff resulting in time off work reported under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations,
- Management of Health and Safety in general and control and Management of Legionella,
- Implementation of Ionising Radiation Regulations
- Implementation of the Construction (Design and Management) Regulations 2007 for the new build in the demolition phase, design and more recently initial enabling works and construction

All of which the Trust responded to with action plans where required post inspection that were produced and delivered to their satisfaction.

NHS Litigation Authority/ Care Quality Commission
In addition to statute we are required to meet regulatory requirements under NHSLA and in June 2011 we achieved 10/10 in the safe environment standard and Level 2 overall. We are intending as a trust to achieve Level 3 in 2013 which is recognised by other agencies including Care Quality Commission who have a similar requirement within Outcome 10.

Management of risks – 'Health & Safety Guidance (65) – Successful health and safety management' is the model used by the trust in achieving the requirements of the Management of Health and Safety at Work Regulations 1992/99. The revised Risk Management Strategy and Training Plan (2010-13) are in place and the annually reviewed training needs analysis has been developed into an Essential Training Matrix which has all the requirements formally under Health and Safety and Patient Safety for all staff groups. In addition the Risk Management Prospectus and

Training topic	May-11	Mar-12	June-12
Violence & Aggression Level 2	87%	89%	89%
Infection Control	94%	88%	90%
Manual Handling	78%	75%	72%
Fire Safety Training	84%	58%	57%
Health & Safety	89%	91%	92%

Key
under 60%
60% to 79%
above 80% to 89%
above 90%

training delivery plan for 2011/12 has been reviewed in line with NHS Litigation Authority requirements. This sets the standard for each level of training required to ensure risk is managed effectively across the trust. This was the subject of an annual audit in 2011/12 which also demands an 80% compliance rate in all training topics. Each area of high risk has a policy and also procedures, standards and guidelines to assist implementation of each policy. This can be accessed via Health and Safety web pages

Essential training
In September 2009 we set the training standard compliance target of 80% and a stretch target of 90% in all areas under statutory & mandatory training. The table below shows the position within the Health & Safety topics as of June 2012. Fire safety training became an annual frequency hence the reduced compliance. This is to be subject to further streamlining and a recovery plan to ensure the highest risk groups are covered annually. The NHS Litigation Authority has placed an additional requirement to achieve 95% training compliance in 14 criterions that have a training element for example manual handling training, which is challenging.

Independent Audits that covers Health & Safety Guidance (65) – Successful health and safety management'

Safety Management Systems are subject to annual audit which is validated by Willis the Trust insurers. Willis has permitted self assessment for the last 3 years with validation by them. This year a revised model was utilised as the trust had reached a plateau. The generic issues identified have been incorporated into the overall priorities for the Trust such as risk assessment and inspection programme rather than risk assessment on an ad hoc basis.

Service / Division	Diagnostics & Therapies	Facilities & Estates	I,M&T	Medicine	Specialised Services	Surgery, Head & Neck	THQ/ Trust Services	Women's & Children's
Total score	515	867	594	768	892	703	455	672
Percentage	48%	77%	64%	71%	83%	65%	63%	62%

Key

	Does not comply with the standards/ guidelines and requires minor alterations/ improvement
	Does not comply with the standards and requires substantial improvement

To assist momentum on achieving further compliance this is now a section within the Divisional operating plans and their reviews. The audit is repeated each year and a key performance indicator has been set to achieve 5% increase in compliance year on year. Diagnostic & Therapies has the added task of achieving the 'green' category achieved by all other clinical divisions. Due to the diverse nature of the services within Diagnostic & Therapies this is challenging to achieve. Willis felt that 'further commitment to effective health and safety is required from this division' which has been demonstrated since the audit took place.

Health and Safety/ Manual Handling Work programme

The ongoing Health and Safety work programme continues with progress, against an agreed list of priorities with investment from the capital budget as allocated.

In 2011/12 the following investment was made to reduce identified high risk activities:

- We continue to use the on line chemical management system – Sypol which standardises the quality of assessments whilst providing a pictorial safety assessment as well as written;
- We continue to use the eLearning training methods from Cardinus which have been customised to UHBristol requirements;
- We continue to deliver training courses in First Aid, Health and Safety for senior executives and Clinical holding training which we completed in partnership with North Bristol Trust so that the cost for external training providers was shared. Health and Safety for department managers/ supervisors, e learning in safe handling of liquid nitrogen, and medical gas training to ensure legislative compliance is also delivered as per risk management role/ department matrix.
- The Trust has invested in scoops and hover jacks to assist patients who have fallen in the wards and departments so they can be safely moved by staff trained in their use.
- The Trust has invested an additional £42,000 for anti-ligature curtain rails in high risk areas based on risk assessment of patients.

– Cat ladder protection has been improved so that estates staff only can access the Old Building Level 5 following a member of the public gaining access to this area.
– Eye test reimbursement to staff equated to £2539.40 which is a reduction from 2010's expenditure by £1568.50 due to a free eye test service delivered as part of the well-being initiative in partnership with North Bristol Trust in the summer.

Health & Safety and Manual Handling – Progress in 2011/12

- Substantial increase in advisory visits to clinical and other work areas with much success. Particularly with patient handling guidance and advice but also general advice in a variety of other settings (i.e. office, diagnostic facilities, external (mobile) services, etc). Of particular note (due to the unusual nature of situation), advice and assistance given on moving of Category 3 facilities for Pathology labs.
- Use of the HSE stress process and management standards which has increased and is identified through Occupational Health, Employee Services and department managers.
- Continue to provide examination and written advisory reports for specific situations, problems and environments in order to inprove staff and patient experience, reduce incident and increase statutory compliance.For example site visit requested by ward sister who had noted increased number of staff sustaining back injury. An observational visit was conducted by a member of the manual handling team who worked with staff and then recommendations were made to enhance practice and thus reduce injury.
- Increased instances of observation, advice and reporting for return to work situations, in the main requested by and in partnership with Occupational Health Service.
- Programme of 'in-loco' and tailored / targetted Manual Handling training continues, most notably bespoke courses devised for portering staff and theatres. This will continue (as resources permit) with the aim to move away from the 'blanket' generic, classroom training where appropriate and possible, in order to make training more significant and streamlined for staff with more specific moving and handling needs.
- Investigation and comparison of new products via multi-disciplinary demonstartion including Bariatric beds, fallen patient lifting equipment, office chairs, specialist patient chairs, clinical examination couches.
- Researching a greater number of external events in order to investigate and potentially introduce new / improved practice to the Trust. Also, literature search / research via usual methods for continued improvement to practice and knowledge base.
- Formulation of new Trust Bariatric policy (shared with other Trusts) and promotion of Bariatric interest group with a view to creating a multi-disciplinary approach to the improvement in care of the larger framed patient and safety of those providing care.
- Negotiation for cost neutral installation of new hoisting equipment in the Manual Handling Training facility in the Education Centre; in order to train staff in use of hoisting equipment due to be placed in Centralisation of Specialist Paediatrics redevelopment – with a view to managing risk.

- Safer sharps devices **-** The Control of Substances Hazardous to Health Working Party has been extended to include needle stick concerns due to continued high numbers of clinical sharps incidents resulting in injuries to staff. Incident details have been reviewed to establish causes and identify where use of a safer sharps device is likely to have prevented the injury. Trials of safer sharps devices are to take place for evaluation purposes with an aim of widespread availability and use. Additional clinical skills 'drop-in' training sessions have also been introduced and have received good attendance.

- Hazardous substances **-** Risk Assessor training for hazardous substances currently stands at 92% coverage across departments. Incidents involving exposure to cleaning substances have significantly reduced in the year 2011/12. This is believed to be partly due to increased training and awareness at the point of use for Support Service staff and that cleaning products in use are under continuous review to ensure the least hazardous products are chosen. The majority of exposure incidents relate to biological exposure, most often when a needle stick type injury occurs. Further actions stated above in relation to safer sharps devices is expected to reduce these numbers

Health and Safety incident reports

A 5 year comparison summary of reported health and safety incidents/ near misses is illustrated below:

Table 1 Health & Safety incident/ near miss - total per annum which have decreased by 6% so met the internally set key performance indicator and incidents reported under Reporting of Injuries Diseases and Dangerous Occurrences Regulations have decreased by 11% in the last year which is 6% above the target set by the Health & Safety Executive of 5% reduction year on year.

- Chart 1 Health and Safety incident by the type
- Chart 2 & 3 Health and safety incident total reported in cause group comparing the last 5 years

Table 1

Year	2007/08	2008/09	2009/10	2010/11	2011/12
Total number of incidents	2478	3209	3025	1886	1765
Reportable incidents to the Health and Safety Executive	69	52	50	60	53

The Safety department instigate all Reporting of Injuries Diseases and Dangerous Occurrences Regulations follow up investigations. The department intends to close the loop further by providing a synopsis of each incident and trends found on root cause analysis so that lessons can be learnt in order to prevent recurrence. Reporting of incidents and near misses has however increased across patient safety and health and safety as we have raised awareness by instigating fortnightly induction and update training plus specific accident investigation training. We are now wholly an on line reporting system which means reporting is much more timely and investigation is instigated earlier to stop recurrence. A separate annual report on the detail of those reported under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 is also available on the Incident Reporting page and we have implemented 'learning from incidents' section on this page as a result of feedback from the NHS Litigation Authority.

Chart 1 Type of incident (excludes Fire, Violence and Aggression and Security as included in separate annual reports)

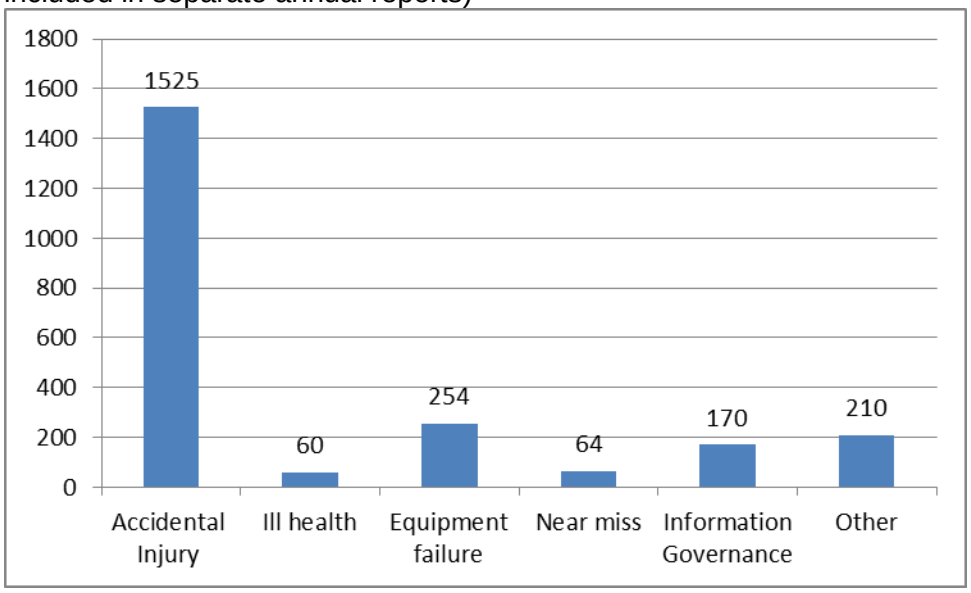


Chart 2: Health and Safety incidents reported by main Cause Groups in 2011/2012 (1)

(Excluding Fire Safety and Security/ Managing Violence and Aggression as in separate annual reports)

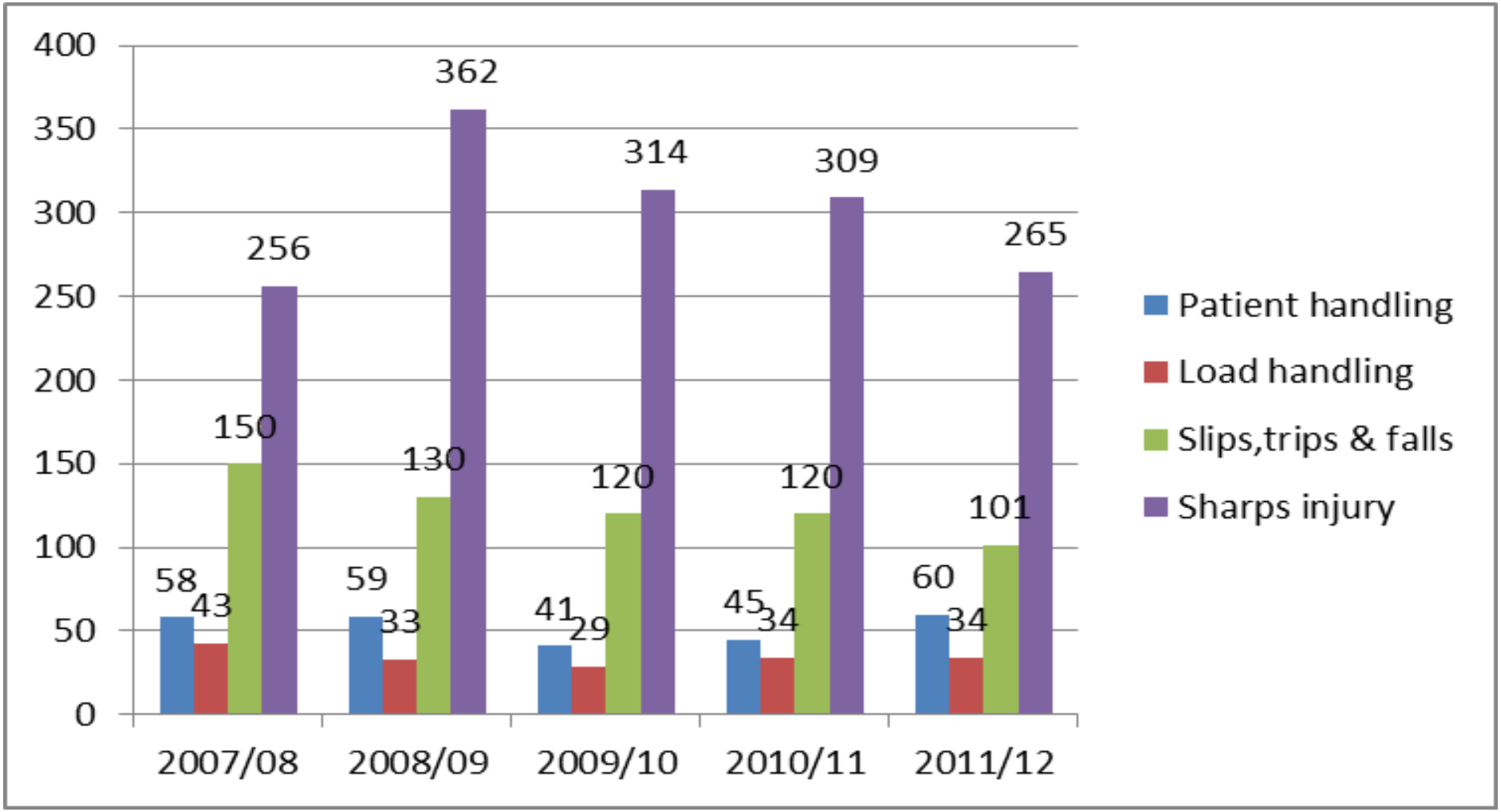
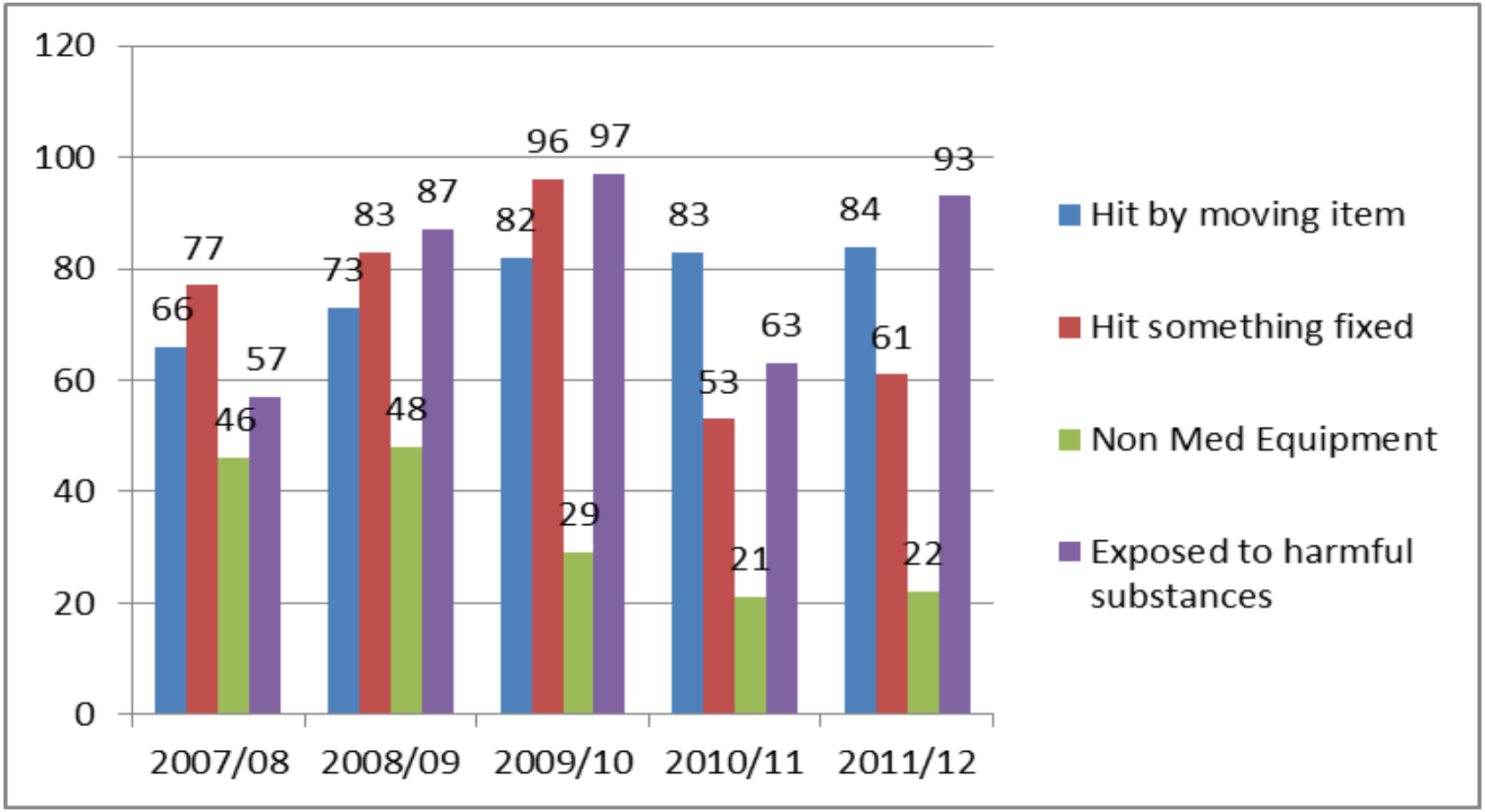


Chart 3: Health and Safety incidents reported by main Cause Groups in 2011/2012 (2)

(Excluding Fire Safety and Security/ Managing Violence and Aggression as in separate annual reports)



University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 06.c - Information Governance Annual Report
Purpose
To brief the Board on the content of the Annual Information Governance Report.
Abstract
This report highlights progress made against version 7 of the Information Governance Toolkit and the Trust's self-assessment against version 8. This assessment shows that progress is needed in three chief domains; Information Governance training, Confidentiality audits and the Pseudonymisation project. This report outlines plans designed to secure this improvement. The Report provides information concerning Information Governance incidents and shows that there were no incidents categorised as Serious Information Governance Incidents during the year.
Recommendations
The Board is recommended to **note** the report.
Report Sponsor
The Medical Director, Dr Sean O'Kelly.
Other Author
Liz Nasey, Information Governance Lead.

Previous Meetings

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

Information Governance Report for March 2012

Information Governance (IG) is an overarching approach which helps University Hospitals Bristol to ensure that personal information is handled legally, securely, efficiently and effectively to support the best possible healthcare.

The Information Governance Framework is evidenced by the Trust having key staff roles filled (Executive Information Governance Lead, Senior Information Risk Owner, Caldicott Guardian), key Information Governance policies in place, with a governance body (the Information Governance Management Group) that meets regularly. Training and Guidance to support all Trust Staff in the expected working practices, combined with Incident Management processes and procedures to document any breaches and provide learning from incidents.

The Information Governance Toolkit is a national framework that brings together statute and national guidance in one place to support the process of achieving good governance and that the Trust uses to evidence its position with regard to those requirements.

The purpose of this report is to describe the Information Governance successes achieved over the last 12 months.

Information Governance Toolkit

The Trust published its evidence for Version 9 of the Information Governance Toolkit on the 31st March, 2012. The score was 68% compared with last year's score of 65%. However, the Trust is still red-rated with 1[1] requirement at Level 1 (requirement 324 – The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate) and 1 at level 0 (Requirement 209 – All person-identifiable data processed outside of the UK complies with the Data Protection Act 1998 and DOH guidelines).

Information Governance Staff Survey

During April 2011 the Information Governance Team carried out a staff survey, to which 109 staff replied, in line with recommendations of the Audit Commission. A more effective communication plan will be created this year in an effort to receive replies from more staff.

Information Risk Management

The new Medical Director attended external face to face training for the Senior Information Risk Owner role. A training event, facilitated by the Avon IM&T Consortium Information Governance Manager, was held at the Trust for staff in the Information Asset Owner Role, some Information Asset Administrators attended the session as well. A second session was delivered by the Trust's IG team for those that did not attend the first one.

Contracts with third party organisations have been reviewed and a contract schedule is being created to cover Information Governance aspects for Information Systems.

A Privacy Impact Assessment, based on the Information Commissioners documentation has been developed, currently in draft it is out for consultation. The intention is that it will be used by staff in the Trust to access confidentiality risks caused by changes in working practices, particularly those that relate to information systems.

[1] The Trust uploaded a report showing 60% of staff having done Information Governance Training, which marks the requirement at Level2, whilst not achieving the 95% target for training in year.

Information Governance Training

Much effort has been concentrated this year on achieving the annual training requirement. Gloucester Acute Hospitals' Trust shared a mini-teach booklet with us which was adapted for use at UHBristol. Copies of the booklet have been distributed to Divisions for them to hand out to staff. The booklet contains a short test which staff return to the IG team. This is all recorded on AtLearning, which is updated with details of training, which is either delivered face to face, via e-learning or the booklet. As at 31th March 2012, 60% of Trust staff had received some form of IG training, either on-line via the IG training tool, face to face or through the booklet. Work is being focused on those Divisions with low compliance and an action plan is in place to achieve the annual target of 95% trained.

Internal Accountability / Responsibility

The revised Information Governance Management Group is scheduled to meet 2 monthly. The Group is chaired by the Medical Director, who is also the Senior Information Risk Owner and attended by representatives of the Divisions, the Head of I M & T, the Caldicott Guardian and FOI/Data Protection Lead. The group oversees the development and approval of core Information Governance activities and the toolkit.

The SIRO verifies the score as 68%, a slight rise from last year, with 4 more requirements being scored at level 3 this year.

Internal Audit carried out an audit of the Information Governance Toolkit in February 2012 and the final report is included. Many of the issues raised have subsequently been addressed. The outstanding ones relate to those requirements not scored at Level 2.

Information Governance Incident Reporting.

The Trust reported one serious IG incident to the Information Commissioner, which related to an encrypted laptop that went missing, but the encryption password was kept with the device. The ICO was reassured that the Trust gave appropriate messages to staff and did not take any further actions. A root cause analysis was undertaken by the Trust and corrective actions taken. Two other incidents have been followed up internally, but were lower ranked incidents not needing reporting outside the Trust.

Historically incidents were recorded as either Health and Safety or Patient Safety, changes have been made to the on-line incident reporting system within the Trust, which will allow staff to categorise incidents specifically as Information Governance Incidents.

Conclusion

The Trust is maintaining its position with regard to Information Governance and this year has improved its overall score slightly. Work continues with system managers to assure the Trust that Information risks are identified and managed. Staff information governance awareness is improving with a resultant rise in enquiries and incidents reported.

A separate Freedom of Information Report is produced by the FOI lead.

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 06.d – Fire Safety Annual Report 2011 / 2012

Purpose

To report to the Board on the activity of the Fire Safety function.

Abstract

This Report summarises the main fire safety issues for 2011/12 and incorporates all aspects of fire safety relating to the Trust. The key issues being addressed are:

- non-compliance notices issued to contractors
- reduction of Unwanted Fire Signals
- installation of enhanced fire detection systems to ensure continued safety and compliance
- completion of departmental fire risk assessments
- staff training in fire safety
- proposed programme of works 2012 / 2013

Recommendations

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

Executive Report Sponsor and Other Author

Sponsor – James Rimmer, Chief Operating Officer

Authors –Derek Pearce, Fire Safety Officer, and Jeff Bluck, Estates Quality & Systems Manager

Appendices

- Appendix A – Analysis Of The Locations Of Unwanted Fire Signals
- Appendix B – Week-By-Week Monitoring Of Unwanted Fire Signals
- Appendix C – Fire Incidents
- Appendix D - Annual Statement of Fire Safety 2011

Previous Meetings

Date the paper was presented to the relevant Group or Committee:

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	11.7.2012				Facilities & Estates Divisional Management Board 17.7.2012

Fire Safety Annual Report January 2011 – March 2012 (covering a 15-month period)

1. Introduction

1.1 This Report summarises the main fire safety issues for 2011/12 and incorporates all aspects of fire safety relating to the Trust. The report covers 15 months from 1 January 2011 to 31 March 2012 to bring the reporting dates in line with other reports. In future the reporting period will be 1 April – 31 March.

1.2 The original Fire Safety Policy, Procedures and Guidelines was approved in 1996 and revised in 2007. This has now been further revised, updated and encompasses all relevant legislation to fire safety and is due for review in 2015.

2. Inspections and Risk Assessments

2.1 Fire Risk Assessments (FRA) have been reviewed for the Trust's hospital buildings, and the assessments for the thirty associated buildings are part of an ongoing annual programme.

2.2 Avon Fire & Rescue Services (AF&RS) carried out a re-inspection under the requirements of the Regulatory Reform (Fire Safety) Order 2005 (FSO) at the Bristol General Hospital on 24 November 2011, and were satisfied with the quality of the Departmental FRAs and declared them to be suitable and sufficient, and confirmed that they were satisfied with the standard of fire protection and management within the building. The building has now closed.

2.3 During the period covered by this report, 9 Non-Compliance Notices have been issued by the Trust Fire Safety Advisor to contractors who are not complying with the Trust's Fire Safety Policy.

JPS	1
Laing O'Rourke	5
Melluish & Saunders	1
Oakland Construction	1
Stone BCI	1

2.4 In the forthcoming year, Fire Safety Audits will be carried out by the Fire Safety Officer in accordance with Section 6 of the Trust Fire Safety Policy, the results of which will be reviewed by the Health, Safety and Fire Safety Committee.

3 Reducing Unwanted Fire Signals (UWFS) in Healthcare Premises

3.1 All fire signals are received at the Estates Office on a fire alarm terminal and are responded to by the Fire Safety Advisor and members of the Estates team. Reports of alarm activations are also received electronically through the on-line reporting system. These are recorded on Ulysses; trends are monitored and acted upon (see Appendices A & B).

3.2 The number of unwanted fire signals during 2010 was 140, and in 2011 the number increased to 161. For the fifteen month period covered by this report, the number of unwanted fire signals totals 200. 31 (16%) of these were caused by contractors not effectively isolating alarms prior to carrying out work likely to affect detector heads. Due to the amount of building works being carried out over this period, some unwanted fire signals could be expected, but as a result of this, the Trust Fire Safety

Advisor has implemented a new procedure which has been circulated to all interested parties with a view to reducing these unwanted signals in the future.

3.3 Continued liaison with AF&RS has taken place with regard to reducing unwanted fire signals.

3.4 Firecode HTM05-03 Part H – Reducing false alarms in healthcare premises, sets standards which Trusts are expected to meet. The unwanted fire signals received during the period covered by this report have been examined against these standards, and the following table outlines the Trust's position.

Building	No of calls 2011	No of calls extended period	Remedial Action Required Reduce by:
BRI Old Building	6	11	None
Bristol Homeopathic	0	0	None
Central Health Clinic	0	0	None
Dental Hospital	7	10	None
Education Centre	0	0	None
Facilities and Estates	0	0	None
Trust Headquarters	0	0	None
Tyndalls Park Children's Centre	0	0	None
BRI Queens Building	33	45	10%
Bristol Heart Institute	11	12	10%
Bristol Oncology Centre	11	11	10%
Bristol Royal Hospital for Children	16	18	10%
King Edward Building & Dolphin House	8	10	10%
St Michael's Hospital, IM&T and Boiler House	25	33	10%
Bristol General Hospital	15	16	40%
Dermatology and Sterile Services	6	7	40%
Eye Hospital	19	23	40%
King David Offices	4	4	40%
Total	**161**	**200**	

The remedial action is determined by dividing the number of fire alarm devices in a building by the number of unwanted fire signals. The resulting figures are compared to the standard within the HTM. This being:

>100 = none
<100 & >50 = reduce by 10%
<50 = reduce by 40%

Four sites are required to reduce by 40% their unwanted fire signals (UWFS). The number of UWFS are mainly due to the amount of construction works being carried out in the Trust, and the age of the fire detection system in some buildings.

3.5 The number of UWFS received during the year average just over 3 per week. Performance targets for the forthcoming year are to reduce the number of UWFS to 130 which averages at 2.5 per week. This should be achievable due to the ongoing fire alarm replacement/upgrading programme and the time spent with contractors advising them of the precautions needed to be taken during their high risk work activities.

4. Serious Incidents and Fires

During the period covered, there have been 13 small fires (Appendix C).

5. Fire Strategy

A Fire Strategy Document has been prepared for the Trust which all future projects will follow. Individual buildings will have a FSD prepared specific to it, taking into account the individual needs of the building.

6. Schemes carried out during 2011 which have resulted in enhanced fire precautions and reduced fire risks

- **St Michael's Medical Records Department** - a fire suppressant system has been installed, awaiting commissioning, in the first of two phases, the worst having been installed first.
- **Queens and King Edward** - upgraded fire alarm system to L1 standard
- **BHOC** – Fire door and compartmentation survey completed

7. Schemes to be carried out during 2012 in the rolling programme of fire precautionary works

- **Haematology and Oncology**
  - provision of fire breaks in ceiling voids
  - provision of fire dampers in ductwork in ceiling voids
  - upgrading of fire doors
  - removal of waste bins from means of escape corridors
  - provision of Evac+Chair and AlbacMat for use in emergency evacuation

- **BRI Queens**
  - upgrading of glazing in fire doors and on corridors
  - removal of waste bins from means of escape corridors
  - provision of Evac+Chair and AlbacMat for use in emergency evacuation

- **King Edward Building**
  - removal of waste bins from means of escape corridors
  - provision of Evac+Chair and AlbacMat for use in emergency evacuation

- **Old Building**
  - upgraded fire alarm system to L1 standard
  - removal of waste bins from means of escape corridors
  - provision of Evac+Chair and AlbacMat for use in emergency evacuation

- **Eye Hospital**
  - upgraded fire alarm system to L1 standard
  - removal of waste bins from means of escape corridors
  - provision of Evac+Chair and AlbacMat for use in emergency evacuation

- **Dental Hospital**
  - upgraded fire alarm system to L1 standard
  - upgrading of fire doors
  - removal of waste bins from means of escape corridors
  - provision of Evac+Chair and AlbacMat for use in emergency evacuation

- **South Bristol Community Hospital**
  - formulation of fire risk assessment
  - formulation of fire and evacuation strategy
  - formulation of fire safety policy

8. Fire Safety Training & Awareness

Fire safety awareness training has continued to be a priority within the Trust to meet the requirements of Firecode HTM 05-03, the Care Quality Commission and the Trust standard of 90%.

Due to mandatory training now being carried out annually, instead of two yearly, the Trust level of 90% compliance has fallen back. At May 2012 this was showing as 57% compliance across the Trust.

Training provided includes: Induction, Fire Safety Awareness, Evacuation Procedures, Fire Extinguisher, Evacuation Equipment, Fire Risk Assessments, Fire Marshall's and Ward Evacuation. To facilitate the Ward Evacuation training, a ward and training facilities has been set up within the old Children's Centre, Tyndalls Park for these exercises, and has involved the AF&RS who use the training sessions for training of their fire fighters.

The online training facility is ongoing, and can be used by staff in alternate years, as an alternative to attending a formal training session.

9. Departmental Fire Risk Assessments

A review of Departmental Fire Risk Assessments shows currently 57% being in place. Service Delivery Group have now escalated this and are now facilitating and monitoring action by Divisional Managers and H&S leads to move this to 95% compliance.

10. Annual Statement of Fire Safety 2011

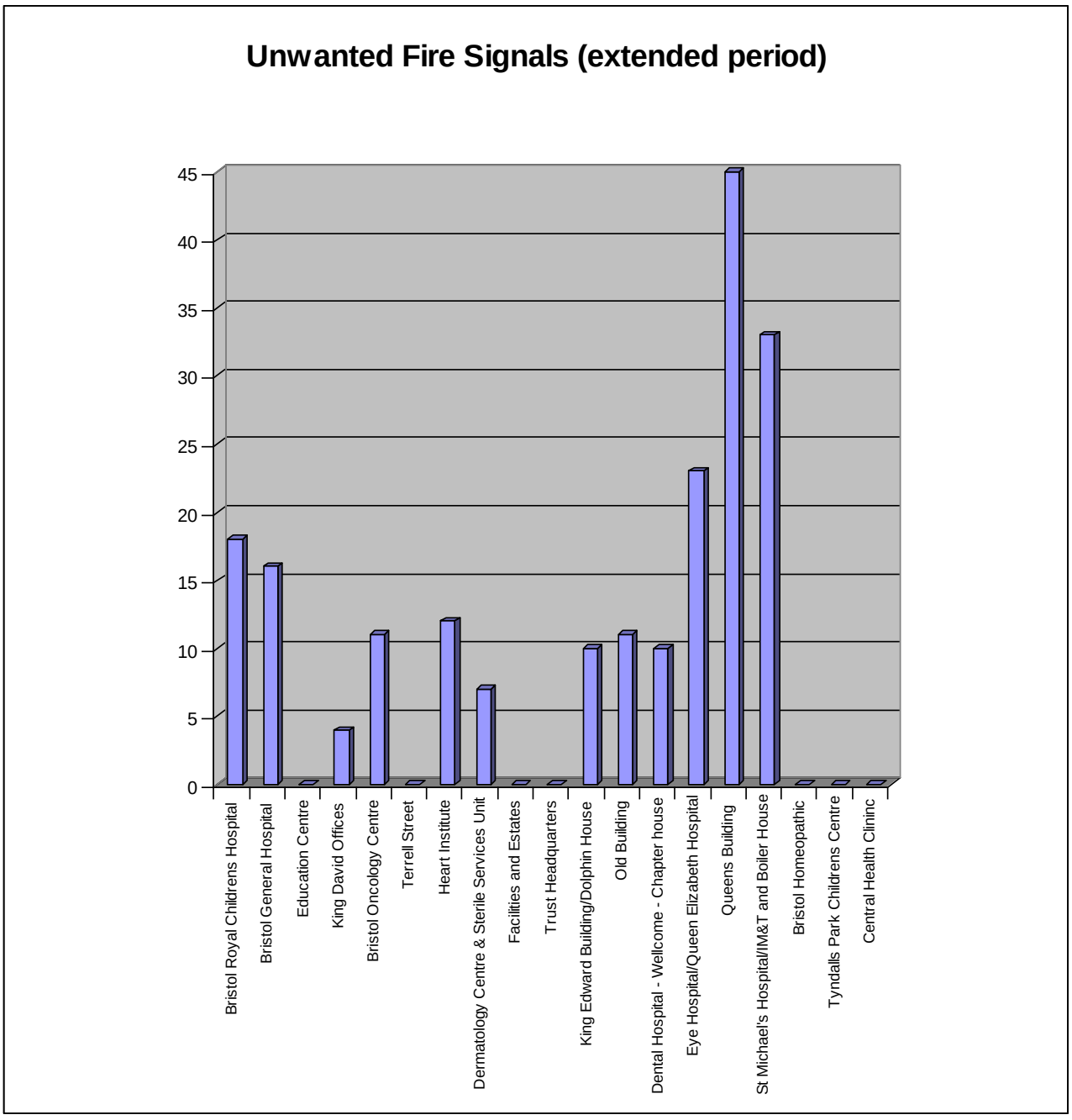
The Annual statement of Fire Safety, signed by the Chief Executive, was forwarded to the Health & Social Care Information Centre on 18 January 2012. It is not expected that this process will be required next year.

11. Overall Fire Risk Assessment

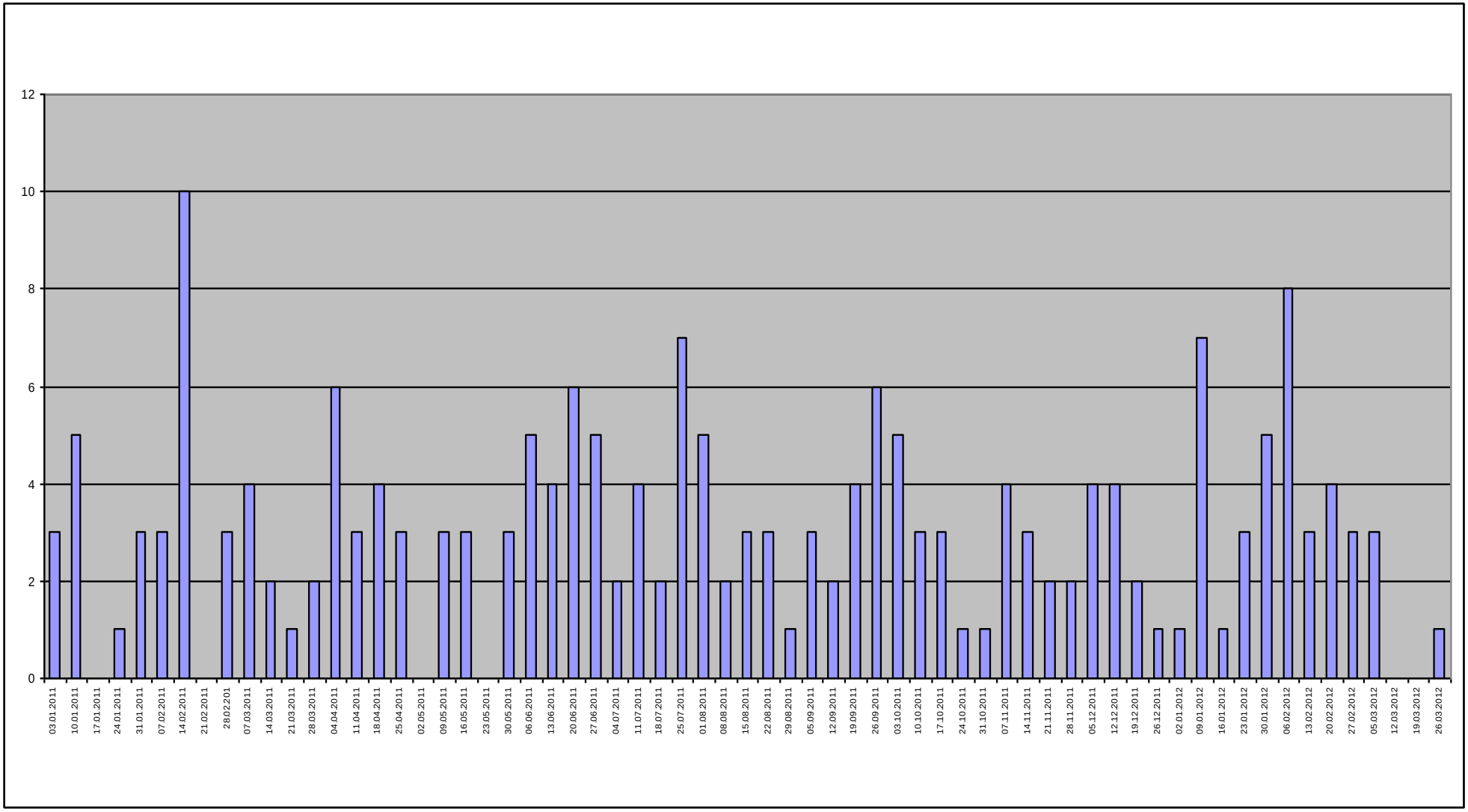
11.1 The overall programme of Fire Safety Improvements has now run for two years and there is now a L1 Standard (the highest standard available) installed in all our hospitals. The materially improves the overall risk profile from two years ago.

11.2 At this time the further programme of works (see 7 above) has been prioritised by risk and is awaiting further capital funding. The residual risk relating to this non-compliance is 16 (High/Red) and Capital Programme Steering Group are reviewing the priorities to agree a sequence of work, so remedial measures can take place as capital is released in an appropriate manner. In the meanwhile the two major mitigations, Fire Training and Departmental Risk Assessments, are both below the planned level of compliance.

Appendix A: ANALYSIS OF THE LOCATIONS OF UNWANTED FIRE SIGNALS



Appendix B: WEEK-BY-WEEK MONITORING OF UNWANTED FIRE SIGNALS



Appendix C - Fire Incidents

1. Female patient from ward 24 found in a secure area of Queens L1 Physiotherapy Department tearing up paper and setting fire to it. This is the third such incident with this patient. Awaiting transfer to secure unit.

2. KEB Ward 9 Light fitting overheated and cables/ electrical components smoking giving off strong smell of burning. Nurse activated alarm by using manual call point. Contractor working on alarm system nearby switched the lights off and removed fuse. AF&RS attended and used thermal imaging camera and declared the area safe. Estates removed light fitting and replaced.

3. KEB L2 Facilities/Security Rm equipment left switched on and camera wiring overheated and burnt out.

4. Queens L8 University Lab CL3. A small paper fire in CL3 lab while a member of staff was flaming a slide for a particular test (something which unfortunately cannot be excluded or avoided), shortly after the paper on the wall set alight.

5. Kitchen in Children's Hospital canteen L5 – 13amp plug top overheating and smoking. The inside had burnt out and the neutral pin was welded into the socket. To turn the appliance off, the kitchen attendant had to lean over the deep fat fryer to switch it off at the socket behind. This type of appliance should be fitted with a Commando plug on a separate supply and also should have an emergency switch adjacent the door. This was brought to the Management's attention some 18 months ago but not acted upon due to cost and the closure in 12 months of this unit.

6. Ward 15 KEB – Patient smoking in bed and hid the cigarette under the pillow when ward staff came in after smelling smoke (small singe to pillow).

7. St Michael's Level A – light fitting is store overheating and smoking. Light isolated ready for replacement/repair.

8. St Michaels Level B washing machine used for cleaning mops overheating and smoking. Brigade called and gave the ok to re-enter the floor concerned. Machine taken out of service and to be repaired/replaced

9. St Michaels Level A air conditioning motor overheating and smoking. Brigade called and gave the ok to re-enter the floor concerned. Motor to be repaired/replaced

10. Ward 9 L4 of KEB staff broke manual call point due to strong burning smell in stock room. Found to be extract fan controller burnt out.

11. Queens L3, 4 & 5 reporting strong smell of burning plastic and broke manual call point. Found to be air conditioning fan bearing burnt out in L6 plant room.

12. Dental Hospital Welcome Building. Lift motor overheating and emitting smoke. Lift maintained by University of Bristol. No access to motor room for fire service. Key now made available.

13. Children's Hospital. Fire in car park due to contractor carrying out hot works without proper inspection and permits being issued. Contractor used a powder extinguisher and water extinguisher to try to extinguish fire. Fire service attended and extinguished fire with hose reel jet.

Specific Action arising from the above:
Items 2 & 7: To mitigate the light fittings causing further problems, a regime has been implemented so that when lamps are replaced, a physical check is carried out to the wiring. This work is being carried out on a rolling program.

Items 9 & 10: To mitigate the ventilation system motors from overheating, inspection frequency has increased from 12-weekly to 6-weekly. In undertaking more frequent checks we anticipate that any incurred defects can be attended to without the system going into fault.

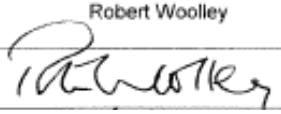
Item 12: To alleviate future problems within the lift motor room in the BDH we are in discussions with the University of Bristol (the present lift maintainers) to hand over the maintenance contract to the Trust (along with the necessary funding); we will the carry out the necessary checks all as per the other lifts within the Trust.

APPENDIX D
Annual Statement of Fire Safety 2011

ROCR ID: ROCR/OR/0139/002

Annual Statement of Fire Safety 2011

NHS Organisation Code: RA7	NHS Organisation Name: University Hospitals Bristol NHS Foundation Trust	
I confirm that for the period 1st January 2011 to 31st December 2011, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and (*please tick the appropriate boxes*):		
1	There are no significant risks arising from the fire risk assessments.	N/A
OR 2	The organisation has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessments.	YES
OR 3	The organisation has identified significant fire risks, but does **NOT** have a programme of work to mitigate those significant fire risks.*	N/A
*Where a programme to mitigate significant risks **HAS NOT** been developed, please insert the date by which such a programme will be available, taking account of the degree of risk. Date:		
4	During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire & Rescue Authority? **(Delete as appropriate)** If Yes - Please outline details of the enforcement action in Annex A – **Part 1**.	NO
5	Does the organisation have any unresolved enforcement action pre-dating this Statement? **(Delete as appropriate)** If Yes Please outline details of unresolved enforcement action in Annex A – **Part 2.**	NO
AND 6	The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method.	NO

Fire Safety Manager	Name:	Bob Pepper
	E-mail:	bob.pepper@uhbristol.nhs.uk
Contact details:	Telephone:	0117 3422994
	Mobile:	07747 048940
Chief Executive Name:		Robert Woolley
Signature of Chief Executive:		

ANNEX A

Part 1 – Outline details of any enforcement action during the past 12 months and the action taken or intended by the organisation. Include, where possible, an indication of the cost to comply.
None
Part 2 – Outline details of any enforcement action unresolved from previous years, including the original date, and the action the organisation has taken so far. Include any outstanding proposed action needed. Include an indication of the cost incurred so far and, where possible, an indication of costs to fully comply.
None

NHS Organisation Code:	RA7
NHS Organisation Name:	University Hospitals Bristol NHS Foundation Trust
Date:	January 2012

2

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 06.e – Security Annual Report
Purpose
To brief the Board on the Trust's Security initiatives and achievements for the reporting year 2011-2012.
Abstract
This report contains a review of Security activity and issues during the 2011/12 financial year. It cites evidence of a system that is in place to identify and eradicate or mitigate risks associated with Security.
Recommendations
The Board is recommended to **note** the report.
Executive Report Sponsor and Other Author
The Chief Operating Officer, James Rimmer The Head of Security and Transport, Paul Wood.
Appendices
• **Appendix A** – Security Annual Report.

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	11 July 2012				Health & Safety Committee - 11 July 2012 Facilities & Estates Divisional Management Board - 17 July 2012.

Annual Security Report 2011/2012

1. Introduction

1.1 The security and safety of patients, staff and property is a Trust priority for the delivery and development of quality patient focused services. Security is the responsibility of everyone. For security to be effective everyone must take an active role to assist in preventing, deterring and detecting security incidents and losses. The year 2011/12 has been a successful year for the security team but also a challenging year.

1.2 The Head of Security spent a considerable amount of time contributing to the re-development of the Trust hospitals including the new ward block, A&E, Children's extension and Oncology. Prior to the opening of the new South Bristol Community Hospital the Local Security Management Specialist (LSMS) helped out with the familiarization induction training whilst the Head of Security worked with stakeholders on security provision.

1.3 2011/12 has seen the retention of the National Security Inspectorate (NSI) Guarding Gold Scheme Award consisting of BS ISO9001, BS7499 and BS7858 by successfully passing our 6-monthly external audit inspections.

1.4 There were **860** security related incidents in 2011/12 in comparison to **896** in 2010/11. The incidents ranged from attending wards to help manage violent patients, restraining patients who were a danger to themselves and others, alarm activations, thefts, escorting confused patients back to their ward and providing a presence to maintain a safe environment.

1.5 Recorded crime within the Trust reflects the findings of the British Crime Survey and any changes in the levels of crime do not show any statistical significance. Major progress has been made in the number of sanctions achieved against offenders. There has been an increase in the number of prison sanctions from **11** in 2010/11 to **25** in 2011/12. The length of sentences has also increased with one offender being sentenced to 1 year in prison whereas in 2010/11 the longest sentence was 18 weeks.

1.6 The new Police Liaison Officer has significantly improved the levels of accurate information available to the Security department. The Liaison Officer has also placed great importance in developing pathways for intelligence gathering to help prevent and detect crime. The work undertaken has resulted in a reduction in those on the Safe Treatment list from **62 to 47**. The Liaison Officer also has intelligence on all those on the scheme making the work undertaken by Security Officers safer.

1.7 NHS Protect, formally NHS Counter Fraud and Security Management Service centrally mandate the security management function within the NHS. NHS Protect audit security performance and report at Risk Summits to the Care Quality Commission (CQC), NHS Litigation Authority (NHSLA), Health and Safety Executive (HSE) and Monitor. Compliance in 2010/11 required the submission of a work-plan, annual security report, violence against staff (VAS) statistics and quarterly attendance of the Local Security Management Specialist (LSMS) to NHS Protect quarterly. In 2012/13 NHS Protect will expand the audit process to include 45 formal security management standards.

2. Crime Reduction Strategy

2.1 The Crime Reduction Strategy was launched in 2003 and has produced significant reductions in vehicle crime and theft within the Trust. The levels have remained relatively static over the last four to five years. In line with the new NHS Protect standards for security management a review will take place to revitalize the strategy.

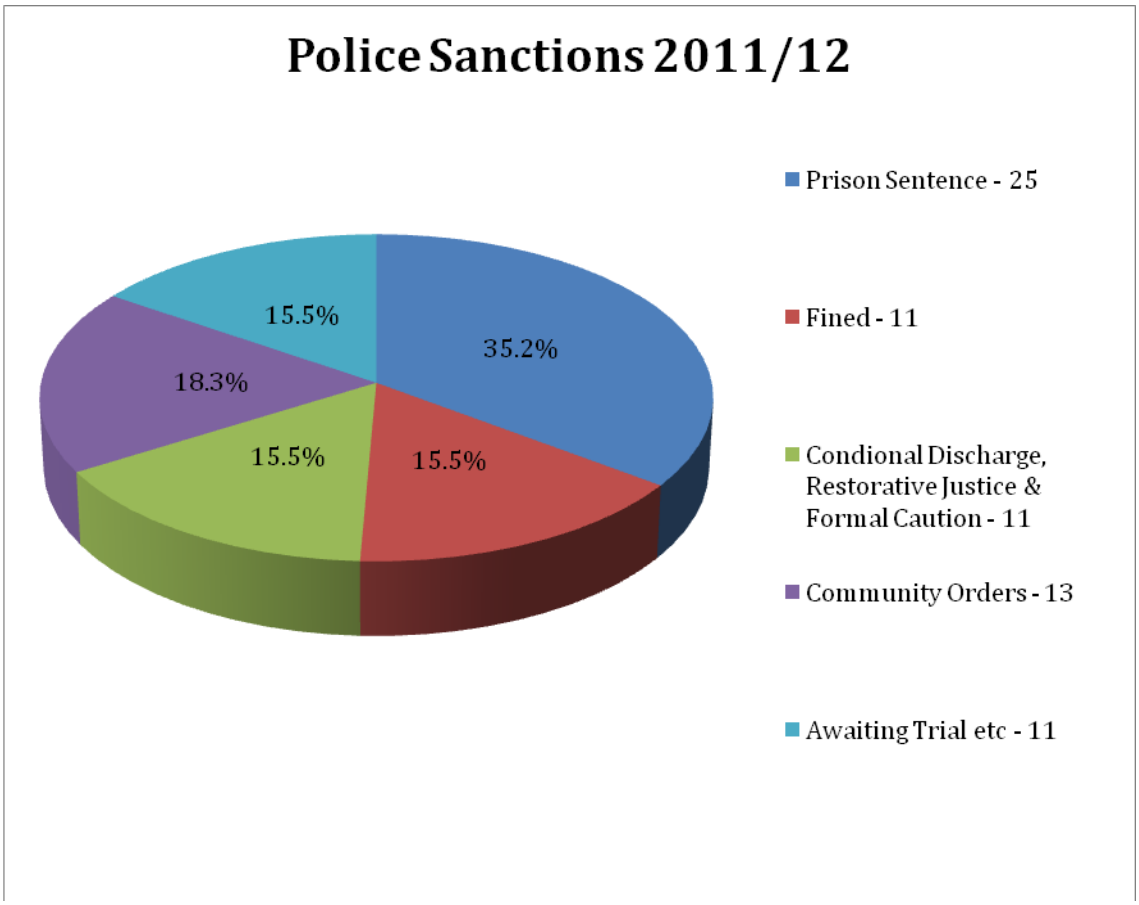
Offence Type	2001 to 2006 Average	2007/08	2008/09	2009/10	2010/11	2011/12
Violence and Aggression	650	323	423	426	501	449
Burglary	37	4	5	4	6	8
Vehicle Crime	52	3	3	3	4	2
Theft	91	65	22	22	48	30
TOTALS	**830**	**395**	**453**	**455**	**559**	**489**

2.2 NHS Protect no longer require the Trust to submit physical assaults to NHS staff by the Personal Assault Reporting System (PARS). However, the information is still required for the annual violence against staff submission. In 2011/12 there were **172** reported physical assaults to Trust staff. This compares to **168** in 2010/11 and **181** in 2009/10. Of the reported physical assaults in 2011/12 in 145 (**80%)** of the incidents, clinical factors played a part in the behaviour of the offender. Where sanctions were available **19** offenders were successfully prosecuted.

2.3 The Security department works closely with the Health and Safety department to encourage Trust staff to report all acts of violence and aggression. At Induction a significant effort is made to encourage staff to report incidents and data is presented to show how reporting can make a difference. One such development has been the introduction of training in clinical holding. The LSMS contributed data and expertise in risk assessment to establish the need for the training and the benefit to the Trust in its introduction.

2.4 The LSMS has also undertaken a number of security risk assessments and carried covert security audits to test security awareness. An on-going issue raised by the security audits is the problem of tailgating. Tailgating remains a significant area of concern within the NHS which criminals exploit. Nationally a gang called the ‘Coventry Falcons’ are targeting NHS premises and using tailgating to gain access to restricted areas. Articles have been published in Newsbeat to raise awareness of the problem of tailgating and the ‘Coventry Falcons’.

2.5 Vehicle crime remains very low and continues the trend of recent years. The continued presence of the uniformed car-parking patrolman from Total Parking Solutions, our contracted car parking management service, acts as a visible deterrent to criminals.



3. Training

3.1 The Security department continues to invest in its staff. The security officers attend refresher training every six months in the use of restraint techniques including the use of mechanical restraints to both hands and legs. Accreditation is maintained with the Northern College of Further Education (NCFE) in Managing Conflict for Enforcement Personnel via our external trainers Niton.

3.2 The LSMS attended and obtain accreditation as a Trainer in the Criminal Justice and Immigration Act 2008, section 119-120 (CJIA). The act allows for the removal of those who cause a nuisance or disturbance to NHS staff on NHS premises. Subsequently all security officers and managers attended the three-day CJIA course and are using the powers to maintain a safe environment for clinical delivery. An annual return to NHS Protect will be made on the use of CJIA to monitor its effectiveness. All the security officers and managers received dementia awareness and Safe-guarding training.

3.3 The LSMS has also started to attain a suite of training courses facilitated by the Centre for the Protection of National Infrastructure (CPNI). The courses and exams are anti-terrorism related and included security risk assessment, personnel risk assessment, and CCTV. The LSMS will continue to attend the courses in 2012/13. The LSMS is also working towards a degree in Risk and Security Management from the University of Portsmouth.

4. Police Liaison

4.1 The Trust continues to invest in a Police Liaison Officer. In 2011/12 there were successful prosecutions of **45** offenders resulting in **72** sanctions. This has resulted in gaining sanctions ranging from fines ranging from **£25** to **£235** for public order offences. **25** offenders received prison sentence of **8** weeks to **52** weeks. Other sanctions include community orders, restorative justice and conditional discharge. One offender was return to prison within a week of release after the theft of a staff members' bicycle and the Police recognizing the offender from CCTV images from the Trust CCTV system.

4.2 The Liaison Officer works closely with the security officers in managing the patients attending the Safe Treatment Facility and works with the LSMS on crime prevention tours of the Trust hospitals. The Liaison Officer also acts as a conduit between the Police and the Security department to hence intelligence and contributes to a safer environment.

5. Safe Treatment Facility

5.1 The Trust continues to operate its Safe Treatment Facility in support of Local PCTs and mental health organizations. The facility provides treatment for patients who are categorized as 'high-risk' and have been excluded from GP surgeries. The same facility has also been extended to similar Trust patients as an alternative to exclusion from receiving high quality care. Avon and Wiltshire Partnership and the Prison Service use the facility on a regular basis. The security team and police liaison have dealt with **360** high-risk patients this year at the facility.

6. Baby and Child Abduction

6.1 The Security department has played an active role in abduction exercises at both the Children's Hospital and St Michaels. Staff vigilance remains very high and the exercises showed how quickly both hospitals could be locked-down. The exercise debriefs play a vital learning environment for understanding the issues that arose and adding to the next exercise. The LSMS will continue to test security in both hospitals and raise any issues with the appropriate body whilst security officers place high importance in responding to incidents in these environments.

7. Lost and Found

7.1 The Lost Property Store is operated in line with procedures audited by NSI and in line with British Standards. The Security Manager completes internal audits to maintain compliance.

8. Lone Worker Devices

8.1 There were no serious incidents where the activation of the lone worker device was required. The issuing devices and training continues for staff members new to the Trust or moving into a role where the device is required. Newsbeat has been used to highlight the Trust investment in the device and the requirement of staff to use the device if allocated but usage remains low. The usage level within the Trust reflects national usage levels.

8.2 As the Trust is now in the last year of the contract for the requirement of a lone worker device is being reviewed by the LSMS and the Head of Health and Safety.

9. Access Control

9.1 The Security department has been under considerable strain due to a software update to the access control system, at the behest of the supplier TDSI. The update resulted in periodic outage of the system and individuals dropping off the system. The department has invested in new hardware to counter these developments and continues to actively manage access control for the safety of staff and patients.

10. Summary

10.1 Encouraging all staff to engage and share in the responsibility for security and developing a pro-security culture continues to be a major part of the duties for the security department. Security Officer's, Police Liaison Officer, CCTV and access control are the visible manifestation of the investment by the Trust in creating a pro-security culture. Whilst the Head of Security, the Security Manager and the LSMS all work to facilitate the environment where security remains a high priority for the Trust in delivering patient centred outcomes.

10.2 Looking forward to 2012/13 significant work will be required by the Security department to meet the requirements of the new standards for security management from NHS Protect, contributing to the Trust achieving Level 3 NHSLA compliance, working for CQC compliance and maintaining NSI Gold accreditation.

11. LSMS work plan for 2012-13

Please refer to Appendix A.

APPENDIX A: WORK PLAN FOR 2012/13

Domain 1 Creating a Pro-Security Culture	Security walkabouts by LSMS to test tailgating, security systems and security awareness. Report of findings to be communicated to department head and Head of Security and Transport. Regular articles in Newsbeat and H&S Department webpage.
Domain 2 Deterrence of Security Incidents and Breaches	Publicise internally to staff positive prosecutions and sanctions to offenders following security related incidents twice a year. Walkabout of site with Police Liaison Officer and Security Officers to provide a visible deterrence.
Domain 3 Prevention of Security Incidents and Breaches	Undertake crime reduction surveys and produce security risk assessments. Review security related incidents reports and management actions to identify areas of weakness requiring preventative action. Attendance of LSMS at Trust committees as mandated by NHS Protect; Health and Safety Committee & Risk Management Committee and other committees, groups to advise on security management related issues.
Domain 4 Detection/ Reporting of Incidents	Carry out crime pattern analysis of incident reports to establish 'hot spots' and use data to target offenders. Liaise with Police Liaison Officer to build data profile for Trust and improve police response to wards.
Domain 5 Investigation of Incidents	Investigate reported incidents, which result in the loss/harm or potential loss/harm to the Trust, its employees and patients, in accordance with the NHS Protect guidance. Develop process following the recording of incidents on Ulysses to communicate to staff that the LSMS is aware of the incident and actions to be taken or available to the staff and Trust to seek redress or sanctions.
Domain 6 Sanctions	Work with Police Liaison Unit to identify sanctions resulting from incidents on Trust premises. Information used for annual report and creating pro-security culture publicity.
Domain 7 Redress	Identify incidents, review and develop the required Trust actions to be taken to ensure that the Trust, its staff, patients and others that suffer harm or loss are supported and potential redress for loss, harm or damage are sort from the offender, statutory compensation scheme, criminal and civil justice systems.

Objectives
Attendance of regional NHS Protect LSMS meetings at various locations across South West
Preparation of annual UHBristol LSMS work-plan for 2013/14 for submission to NHS Protect
Review progress of LSMS work-plan and production of reports
Introduction of NHS Protect standard for providers – 45 strategic security standards
Security report to summarize achievements in 2011/12
Collate and verify physical assault incidents on Ulysses and completion of VAS submission to NHS Protect for year 2010/11.
On-going attendance at CPNI training courses
Review the introduction of new guidance issued by the NHS Protect to meet NHS Protect standards.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 7a - Committee Chairs' Reports – 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 £0.185m for the three months to 30 June 2012. The Trust's Financial Risk rating is 3 (actual 2.90) for the quarter.

Good progress has been on the validation of in patient data feeds from the Medway system. Work continues on the validation of out-patient activity with the expectation that next month's report will include an assessment of actual out-patient performance.

Cash releasing efficiency savings total £5.984m to date and equate to 86% of plan for the period. Slippage to date totals £0.951m with a forecast outturn of savings at £23.890m being £3.732m less than Plan. The position, with a significant net Divisional overspending, is of concern as CRES delivery is the primary driver of the 2012/13 overall Trust financial position.

Recommendations

To note the financial position for the 3 months to 30th June 2012.

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
			25 July 2012		

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £0.185m for the three months to 30th June 2012, an improvement of £0.858m in the month. The Annual Plan projected surplus for the quarter is £0.935m so the results represent slippage against the Plan of £0.750m. The operating surplus (EBITDA[1]) at £7.199m equates to 87% of the Annual Plan projection for the quarter. The impact of the results to date is reflected in the Trust's Financial Risk Rating which stands at 3 (actual 2.90), further information on this is given in section 6 below.

The two key challenges which need to be addressed are the delivery of the cash releasing efficiency savings programme and to complete the validation of data from the Medway system (primarily out-patients). Further information on the CRES programme is summarised in section 3 below with a more detailed commentary provided to the Finance Committee (see Agenda item 6).

Clinical services activity is currently reported a month in arrears. There are plans to report on a more timely basis later in 2012/13. Good progress has been made in the validation of in-patient data with the principal area of outstanding work to be completed relating to out-patient services. For this month's report it has been assumed that out-patient activity is in line with Plan. Information specialists are currently working with divisional managers to review data pathways and validate data. It is anticipated that next month's report will include an assessment of actual performance for all out patient activity. The improvement in the Trust's financial performance follows the higher level of income in May, a small element of which relates to the correction of validated data for April activity.

The table below shows the in-month movement on the Trust's income and expenditure position. The table sets 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. The overspending against divisional budgets now totals £1.523m. Detailed information and commentary for each Division is to be considered by the Finance Committee (report included under agenda item 5.3 below).

	Variance to 31st May	Variance this month	Variance to 30th June	Memorandum CRES Variance
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(1,039)	(234)	(1,273)	(532)
Non Pay	(498)	(397)	(895)	(1,401)
Operating Income	79	202	281	6
Income from Activities	100	264	364	(110)
Totals	**(1,358)**	**(165)**	**(1,523)**	**(2,037)`**

[1] Earnings Before Interest Depreciation Taxation and Amortisation

It can be seen that the non achievement of savings within the CRES programme is a significant feature on the expenditure lines to the extent that the underachievement on the CRES programme is greater than the net overspending on Divisional budgets.

Pay budgets have a cumulative overspending of £1.273m with CRES slippage accounting for £0.532m of this adverse variance. In addition, the Division of Surgery, Head and Neck services has within the June report a shortfall on its pay budget heading of £0.366m relating to prior years non achievement of pay CRES schemes. Further information is given on these adverse movements in the Divisional commentary below with more detail provided in Divisional financial commentaries for the Finance Committee. Maintenance on the control of pay budgets and the delivery of pay CRES schemes is an essential element in the recovery of a satisfactory financial position for 2012/13.

Non pay budgets show a cumulative adverse variance of £0.895m. Slippage on non-pay CRES schemes of £1.401m to date is embedded within this position. Significant overspendings are reported this month against Diagnostic and Therapies (£0.168m) and Women's and Children's (£0.294m).

Operating Income budgets show a favourable variance of £0.281m. A significant favourable variance (£0.157m) this month has been reported against the Diagnostic and Therapies Division as a result of a detailed piece of work carried out to review goods and services provided to external organisations and the recovery of income for those services.

Income from Activities shows a cumulative over performance of £0.364k, an improvement in the month of £0.264m.

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

	£'000
Medway maintenance costs	589
Clinical Systems Implementation Programme	248
South Bristol Community Hospital – Nursing and AHP costs	180
Trauma and Orthopaedics out patients	130
European Working Time Directive	114
Energy Inflation	94

3. Cash Releasing Efficiency Savings

The achievement of cash releasing efficiency savings headline message is that June has seen delivery of CRES savings of £5.984m to date. This equates to 86% of the Plan for the first quarter. Planned savings assume a pick-up in the rate of savings to be achieved over the later part of the year. To counter the risk that the CRES programme poses in having a disproportionate volume of savings phased in this way the CRES target to date has been reprofiled to reflect the position based on savings targets being phased evenly over the year. This will require careful monitoring throughout the year. The delivery of actual savings against the CRES programme will allow for the unwinding of this phasing adjustment as we progress through the year. The June report reflects an adverse variance of £2.037m year to date on the CRES programme. Actual savings of £5.984m represents slippage of £0.951m when compared with profiled planned savings for the first three months of £6.935m. The adjustment to bring CRES plans on to a 1/12ths basis adds a further £1.086m to the reported non achieved CRES to date.

This position is of real concern as CRES delivery is the primary driver of the 2012/13 overall Trust financial position.

The table shown below summarises divisional CRES performance for the first quarter together with the current projections for the year.

	Diagnostic and Therapies £'000	Medicine £'000	Specialised Services £'000	Surgery, Head and Neck £'000	Women's and Children's £'000	Estates and Facilities £'000	Trust Services £'000	Totals £'000
Plan for Quarter	875	1,336	1,159	2,053	1,435	422	741	8,021
Actual	800	905	835	1,249	1,243	331	621	5,984
Variance – Fav / (Adverse)	(75)	(431)	(324)	(804)	(192)	(91)	(120)	(2,037)
Represented by:								
Slippage etc	7	(34)	(290)	(493)	(55)	(4)	(82)	(951)
/12ths Phasing	(82)	(397)	(34)	(311)	(137)	(87)	(38)	(1,086)

Plan for Year	2,605	4,590	4,588	7,086	4,830	1,377	2,546	27,622
Forecast Outturn								
Recurring	1,891	3,825	2,546	3,816	2,635	1,069	2,120	17,902
Non Recurring	727	752	1,028	1,153	1,935	309	84	5,988
Totals	2,618	4,577	3,574	4,969	4,570	1,378	2,204	23,890
Variance – Fav / (Adverse)	13	(13)	(1,014)	(2,117)	(260)	1	(342)	(3,732)

Full Year Effect of Forecast Outturn	2,333	4,923	2,763	4,444	3,057	1,388	2,232	21,140
Recurring shortfall c/fwd into 2013/14	(272)	-	(1,825)	(2,642)	(1,773)	-	(314)	(6,826)
Recurring savings for 2013/14 CRES Plan	-	333	-	-	-	11	-	344

As can be seen the slippage year to date is £1m whereas the forecast for the year end is £3.7m. The level of pick-up in CRES delivery is vitally important.

The main area of concern is in Surgery, Head & Neck which accounts for 57% of the Trust shortfall on CRES.

4. Income

For the months of April and May contract income is £0.011m higher than plan with higher income in May offsetting the lower income in April. In addition the SLA contract reward / penalties heading has a favourable variance of £0.07m. The balance of the 2011/12 over-performance against the Month 12 estimate provides additional income of £1.07m.

Clinical Income by Worktype	**Plan**	**Actual**	**Variance**
	£'m	£'m	£'m
Accident & Emergency	2.00	1.90	(0.10)
Emergency Inpatients	12.05	12.00	(0.05)
Day Cases	4.98	5.03	0.05
Elective Inpatients	7.81	7.69	(0.12)
Non-Elective Inpatients	4.97	4.85	(0.12)
Excess Bed days	1.27	1.23	(0.04)
Outpatients	10.87	10.88	0.01
Bone Marrow Transplants	1.38	1.08	(0.30)
Critical Care Bed days	6.09	6.11	0.02
PbR Exclusions / NICE	6.44	6.92	0.48
Contract Penalties / Rewards	0.21	0.28	0.07
Other	8.62	8.90	0.28
Sub-Totals	**66.69**	**66.87**	**0.18**
2011/12 Estimate v Actual	-	1.07	1.07
Totals	**66.69**	**67.94**	**1.25**

5. Expenditure

In total, Divisions are shown as overspent by £1.523m for the three months to 30th June. The position for each Division, together with comparable results with CRES accounted for on the Divisional Phased Plan basis, is summarised below:

Division	**CRES on 1/12ths profiling**		**CRES on Phased Plan**	
	Variance to 30th June Favourable / (Adverse)	Memorandum CRES Variance to 30th June	**Variance to 30th June Favourable / (Adverse)**	**Memorandum CRES Variance to 30th June**
	£'000	£'000	£'000	£'000
Diagnostic and Therapies	299	(75)	381	7
Medicine	(142)	(431)	255	(34)
Specialised Services	(183)	(324)	(149)	(290)
Surgery, Head and Neck	(889)	(804)	(578)	(493)
Women's and Children's	(481)	(192)	(344)	(55)
Facilities and Estates	(39)	(91)	48	(4)
Trust Services	50	(30)	88	8
Other Services	(138)	(90)	(138)	(90)
Totals	**(1,523)**	**(2,037)**	**(437)**	**(951)**

This position is after additional support of over £2.5m for the year has been issued from reserves as follows:

	2012/13 £'000	Year to date £'000
Diagnostics and Therapies	86	21
Medicine	355	89
Specialised Services	794	198
Surgery, Head & Neck	1,050	263
Women's and Children's	272	68
Totals	**2,557**	**639**

Two divisions are red rated[2] for their financial performance to date.

The Surgery, Head and Neck Division has a cumulative adverse variance on its income and expenditure position of £0.889m. The table shown below provides a summary of the principal factors which contribute to the reported position.

	Pay	Non Pay	Operating Income	Income from Activities	Totals
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Operating Services Variance	(597)	315	22	(184)	(444)
CRES Slippage	(129)	(268)	-	(97)	(494)
/12ths phasing	-	(311)	-	-	(311)
Sub Totals	**(726)**	**(264)**	**22**	**(281)**	**(1,249)**
Adj re Non Recurring Support	-	263	-	-	263
March 2012 Income	-	-	-	97	97
Variance to 30th June	**(726)**	**(1)**	**22**	**(184)**	**(889)**

Pay budgets have a cumulative overspending of £0.726m. Within the overspending is the impact of CRES slippage of £0.129m, the prior year shortfall of £0.366m relating to non achieved CRES on pay headings and other cost pressures and net overspendings on management budgets of £0.231m. The management budget overspendings reflect higher than planned expenditure on nursing bank, agency and specialist mental health staff and medical agency staff.

Non pay budgets are overspent by £1k to date. The non pay column in the above table shows that this includes management budget underspendings to date of £0.315m are offset by an adverse CRES variance and a proportion of the £1.05m non recurring central support. The underspendings reported to date are likely to be taken up by higher costs on clinical supplies as activity picks up over the remainder of the year.

Income from Activities shows an adverse variance of £184k. The under-performance is a combination of lower than planned activity for services directly managed by the Division and a loss of income on under-performing specialties managed by other Divisions e.g. cardiac surgery, obstetrics and gynaecology. The division is developing plans to catch-up on the slippage against elective activity service agreements. Operating Income budgets have a favourable variance of £22k to date.

[2] Division has an annualised cumulative overspending greater than 1% of approved budget.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £0.481m, an overspending of £0.175m in the month. The table shown below provides a summary of the principal factors which contribute to the reported position.

	Pay	Non Pay	Operating Income	Income from Activities	Totals
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Operating Services Variance	(366)	(398)	(25)	309	(480)
CRES Slippage	(2)	(60)	7	-	(55)
/12ths phasing	-	(137)	-	-	(137)
Sub Totals	**(368)**	**(595)**	**(18)**	**309**	**(672)**
Adj re Non Recurring Support	-	68	-	-	68
March 2012 Income	-	-	-	123	123
Variance to 30th June	**(368)**	**(527)**	**(18)**	**432**	**(481)**

Pay budgets are overspent by £0.368m. Overspendings have continued on nursing and midwifery budgets. Medical specialty rotas saw increased sickness leading to additional locum and agency use.

Non pay budgets show a cumulative overspending of £0.527m. Drugs and other clinical supplies including 'pass through' costs are the principal areas of overspending – these are offset by additional income recorded against Income from Activities budgets (favourable variance of £0.432m). Slippage and phasing adjustments on the CRES programme of £0.192m to date is a significant factor in the Division's reported financial position.

The Specialised Services Division is now 'amber / red[3]*' rated an improvement on the assessment at the end of May as 'red'.*

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £0.183m, an improvement of £92k in the month. The table shown below provides a summary of the principal factors which contribute to the reported position.

	Pay	Non Pay	Operating Income	Income from Activities	Totals
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Operating Services Variance	(227)	204	71	(118)	(70)
CRES Slippage	-	(277)	-	(13)	(290)
/12ths phasing	-	(34)	-	-	(34)
Sub Totals	**(227)**	**(107)**	**71**	**(131)**	**(394)**
Adj re Non Recurring Support	-	198	-	-	198
March 2012 Income	-	-	-	13	13
Variance to 30th June	**(227)**	**91**	**71**	**(118)**	**(183)**

Pay budgets are reported as having a cumulative overspending of £0.227m. The overspending relates mainly to the timing of savings from the nursing staff review, non-achievement of the vacancy factor and payments to consultants for additional sessions. Non pay budgets show a net underspending of £91k to date. The results include the proportion of the non- recurrent Trust support (£0.198m) together with underspendings on blood products (£113k), drugs (£88k) and clinical supplies (£0.293m). This is partially offset by slippage on CRES schemes (£0.249m), use of the Spire Hospital (costs covered by income receivable from commissioners) and other structural

[3] Division has an annualised cumulative overspending of between 0.5 and 1% of approved budget.

funding issues linked to the cardiac surgery contract changes in previous years. Operating Income budgets show a favourable variance to date of £71k. Income from Activities shows an adverse variance of £0.118m with the significant adverse variances relating to underperformance on cardiac surgery and continuing under-performance on private patient income.

The remaining four divisions are green rated.

The **Diagnostic and Therapies Division** reports a cumulative underspending of £0.299m. Pay expenditure is marginally less than Plan with a £16k favourable variance. Non pay budgets are in line with Plan with a small overspending of £3k to date.

The significant issue is the overperformance on the Division's income budgets with Operating Income £80k ahead of Plan and Income from Activities being £0.206m greater than Plan. The higher than planned income from activities relates to more activity having been undertaken through direct access arrangements in Radiology (£0.15m) and Pathology (£0.066m).

The **Division of Medicine** reports an adverse variance of £0.142m for the three months to 30th June, an improvement of £66k when compared with the adverse variance to 31st May of £0.208m. Within this total for June is the CRES phasing adjustment which contributes an adverse variance of £0.397m and slippage on CRES schemes to a value of £34k to date.

The Division has significant overspendings on pay (£0.158m) and non-pay budgets (£0.164m) which have been partially offset by the underspendings on income from activities (£42k) and operating income budgets (£0.138m).

The Facilities and Estates Division reports a cumulative overspending to date of £39k, an adverse movement of £14k in the month. The phasing of the CRES plan contributes £91k to this adverse position.

Trust Services report an in-month underspending of £18k and a cumulative underspending of £50k.

6. Financial Risk Rating

The Trust's overall financial risk rating, based on results to 30th June is 3. The actual financial risk rating is 2.90 (May = 2.35) which rounds up to 3. The improvement in the financial performance for June has resulted in positive changes to the EBITDA and Net Return on Financing metrics with all three headings moving up one category. The actual value for each of the 5 metrics is given in the table below together with the bandings for each metric.

	30th June 2012		
Metric	Metric Result	Metric Score	Weighted Average Score
EBITDA			
Margin	5.5%	3	0.75
Plan achieved	87%	4	0.40
Net Return on Financing	0.23%	3	0.60
I&E surplus margin	0.14%	2	0.40
Liquidity ratio (days)	20.1 days	3	0.75
			2.90

Weighting	Rating categories				
%	5	4	3	2	1
25	11	9	**5**	1	<1
10	100	**85**	70	50	<50
20	3	2	**-0.5**	**-5**	<-5
20	3	2	1	**-2**	<-2
25	60	25	**15**	10	<10

Overall Financial Risk Rating	**3**

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

7. Quarter One Review

A details forecast out-turn assessment is not yet complete. This will include:

- Divisional forecasts including recovery plans – to be reviewed in monthly / quarterly review meetings in July;
- Validation and correction of out-patient data to assess real income position post Medway; and
- Assessment of reserves in the light of wider discussions re various transactions being considered in BNSSG (e.g. integration, Pathology, service transfers).

However, as can be seen the current Divisional adverse position of £1.5m year to date raises the possibility of a £5 – 6m year-end overspend (unless corrective action is taken). This is after £3.5m has already been funded for costs pressures and non-recurring support. There is unlikely to be sufficient cover for this Divisional position leading to the Trust's financial plan of £5.7m surplus not being achieved. The run-rate going into 2013/14 also needs to be considered.

8. Capital Programme

A summary of income and expenditure for the three months to 30th June is given in the table below. Expenditure for the period of £12.899m is £1.461m less than the current Plan.

Plan for Year		**3 Months Ended 30th June 2012**		
		Plan	**Actual**	**Variance Favourable / (Adverse)**
£'000		£'000	£'000	£'000
	Sources of Funding			
238	Donations	238	-	(238)
18,125	Retained Depreciation	4,287	4,287	-
49,950	Prudential Borrowing	-	-	-
7,695	Sale of Property	-	-	-
5,112	Cash balances	9,834	8,612	(1,222)
81,120	**Total Funding**	**14,359**	**12,899**	**(1,460)**
	Expenditure			
(54,524)	Strategic Schemes	(9,644)	(8,940)	704
(9,063)	Medical Equipment	(936)	(681)	255
(5,515)	Information Technology	(2,430)	(2,044)	386
(1,911)	Roll Over Schemes	(147)	(169)	(22)
(3,229)	Refurbishments	(270)	(335)	(65)
(9,744)	Operational / Other	(932)	(730)	202
2,866	Anticipated Slippage	-	-	-
(81,120)	**Total Expenditure**	**(14,359)**	**(12,899)**	**1,460**

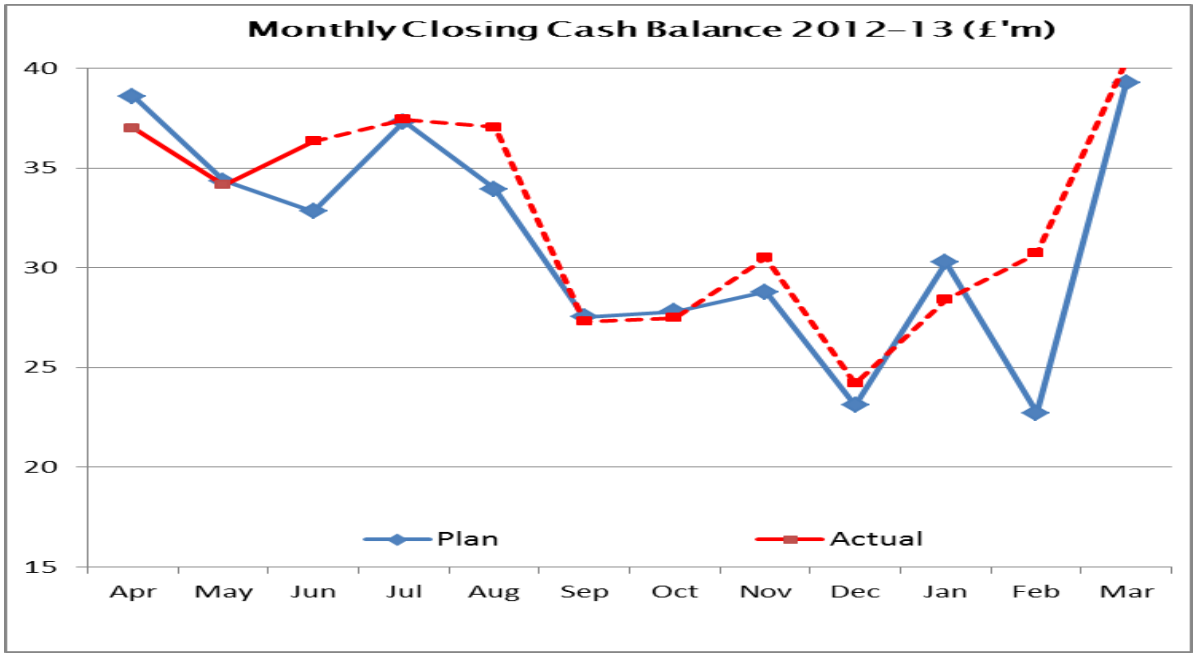
The favourable variance on Strategic schemes is a combination of slippage (£0.25m) and projected underspendings (£0.45m). The slippage on medical equipment expenditure has recently been addressed. The spending plans for information technology are currently subject to review. This includes reconciling the final costs of phase I and profiling the costs of subsequent phases. The Finance Committee is provided with further information on this under agenda item 5.4.

The Monitor capital expenditure performance target is to deliver the programme within 75% -125% of the Annual Plan. At quarter 1 actual expenditure to 30th June totals £12.899m, which represents

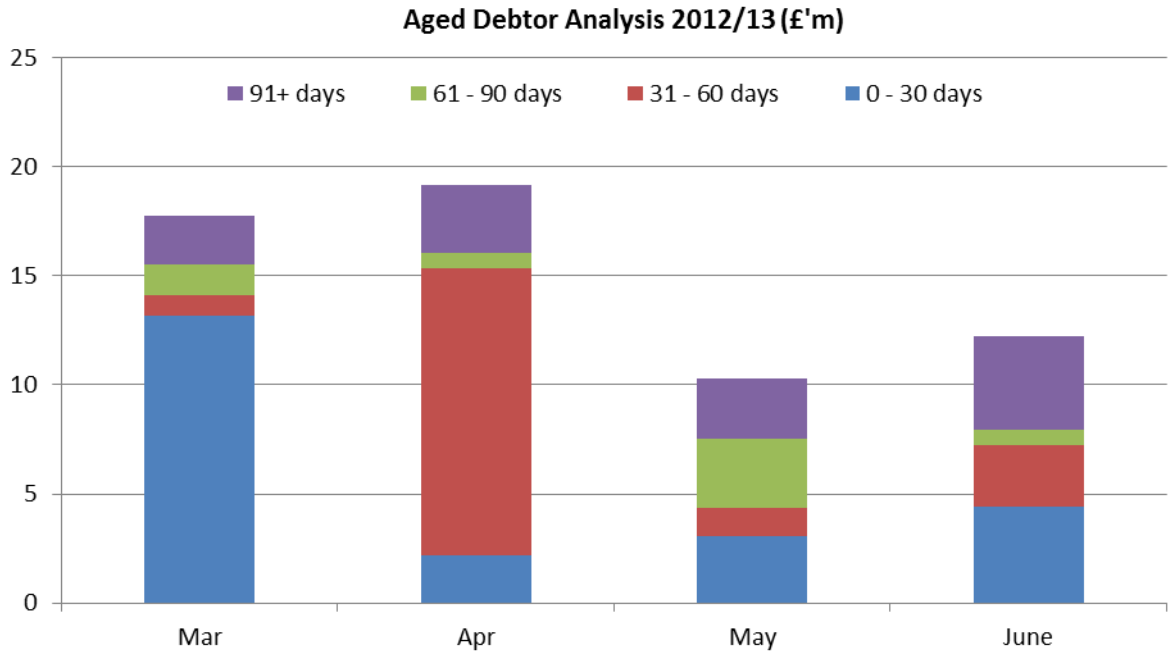
77% of the Annual Plan assumption of £16.857m. The forecast outturn of £75.402m is equivalent to 93% of the Annual Plan forecast of £81.514m. The Trust is currently operating within Monitor's Potential Financial Risk Indicator thresholds.

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

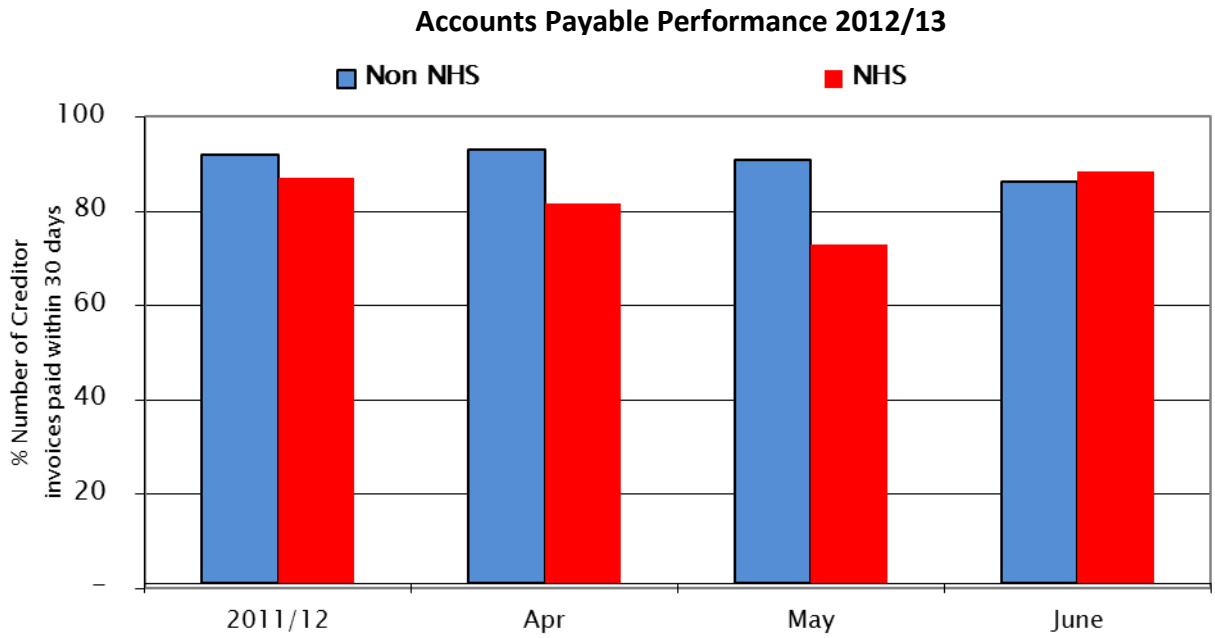
Cash - The Trust held a cash balance of £36.336m as at 30th June. The graph, shown below, sets out the current forecast for month end cash balances to March 2013.



Debtors - The total value of invoiced debtors has increased by £1.929m during June to a closing balance of £12.233m. The principal changes relate to a minor dispute with a commissioner (£0.576m - now resolved) and an increase in moneys owed by a local NHS trust (£0.383m). The total amount owing is equivalent to 9.4 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In June the Trust achieved 88% and 86% compliance against the Better Payment Practice Code for NHS and Non NHS creditors. Delays in the receipt of invoice authorisation required to pay invoices is the principal reason for the drop in recent performance. Processes are currently being reviewed to deliver secure improved payment performance.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Monthly analysis of pay expenditure 2012/13
Appendix 4 – Executive Summary
Appendix 5 – Financial Risk Matrix
Appendix 6 – Financial Risk Rating

Appendix 1

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 2012- Summary Income & Expenditure Statement

Approved Budget / Plan 2011/12	Heading	Position as at 30th June Plan	Actual	Variance Fav / (Adv)	Actual to 31st May	Forecast Outturn
£'000		£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)					
409,044	From Activities	101,322	101,698	376	67,930	414,944
111,352	Other Operating Income	28,254	28,676	422	17,835	112,820
520,396	Sub totals income	**129,576**	**130,374**	**798**	**85,765**	**527,764**
	Expenditure					
(296,098)	Staffing	(75,513)	(76,817)	(1,304)	(51,275)	(305,061)
(173,699)	Supplies and services	(45,384)	(46,358)	(974)	(30,483)	(187,861)
(469,797)	Sub totals expenditure	**(120,897)**	**(123,175)**	**(2,278)**	**(81,758)**	**(492,922)**
(15,003)	**Reserves** Reserves	(432)	-	432	-	-
(15,003)	Sub Total Reserves	**(432)**	-	**432**	**-**	**-**
35,596	**EBITDA**	**8,247**	**7,199**	**(1,048)**	**4,007**	**34,842**
6.84	**EBITDA Margin - %**		**5.52**		**4.67**	**6.60**
350	Fixed asset impairments	-	-	-	-	350
(83)	Reserves	(55)	-	55	-	-
-	Profit/ loss on sale of asset	-	-	-	-	-
(19,451)	Depreciation & Amortisation	(4,577)	(4,577)	-	(3,051)	(19,457)
226	Interest Receivable	55	48	(7)	27	226
(387)	Interest payable on leases	(97)	(97)	-		(387)
(1,000)	Interest payable on loans	(250)	-	250	(64)	- 323
(9,551)	PDC Dividend	(2,388)	(2,388)	-	(1,592)	(9,551)
5,700	**NET SURPLUS / (DEFICIT)**	**935**	**185**	**(750)**	**(673)**	**5,700**

Appendix 2

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report June 2012- Divisional Income & Expenditure Statement

Approved Budget / Plan 2012/13	Division	Total Net Expenditure / Income to Date	Position as at 30th June [Favourable / (Adverse)] Pay	Non Pay	Operating Income	Income from Activities	Total Variance to date	Memorandum CRES Variance to Date	Cumulative Variance to 31st May	Forecast Outturn Variance
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements									
403,534	Service Agreements	98,830	–	–	–	2	2	–	–	–
–	Overheads	28	–	–	–	28	28	–	(186)	
39,847	NHSE Income	9,984	–	–	22	(18)	4	–	3	–
443,381	**Sub Total Service Agreements**	**108,842**	**–**	**–**	**22**	**12**	**34**	**–**	**(183)**	**–**
	Clinical Divisions									
(42,731)	Diagnostic & Therapies	(10,319)	16	(3)	80	206	299	(75)	43	281
(57,558)	Medicine	(14,550)	(158)	(164)	138	42	(142)	(431)	(208)	(500)
(64,208)	Specialised Services	(16,237)	(227)	91	71	(118)	(183)	(324)	(275)	(1,539)
(87,199)	Surgery Head & Neck	(22,458)	(726)	(1)	22	(184)	(889)	(805)	(606)	(1,580)
(86,254)	Women's & Children's	(21,871)	(368)	(527)	(18)	432	(481)	(192)	(306)	(800)
(337,950)	**Sub Totals (1)**	**(85,435)**	**(1,463)**	**(604)**	**293**	**378**	**(1,396)**	**(1,827)**	**(1,352)**	**(4,138)**
	Corporate Services									
(6,016)	Trust Hq	(1,547)	59	(42)	18	–	35	8	21	30
(5,185)	Human Resources	(1,221)	53	(14)	(31)	–	8	(9)	7	–
(6,366)	Imt	(1,930)	84	(88)	8	–	4	(2)	2	–
(5,001)	Finance	(1,247)	30	(13)	(14)	–	3	(26)	2	–
(30,598)	Facilities And Estates	(7,942)	(23)	7	(23)	–	(39)	(91)	(25)	–
(53)	Community	(7)	–	6	–	–	6	–	4	–
(6,248)	Misc Support Services	(3,643)	60	(223)	52	(14)	(125)	(90)	(111)	–
(29,002)	Capital Charges	(6,965)	–	–	–	–	–	–	105	–
4,824	Research & Innovation	1,280	(73)	76	(22)	–	(19)	–	(10)	16
(83,645)	**Sub Totals (2)**	**(23,222)**	**190**	**(291)**	**(12)**	**(14)**	**(127)**	**(210)**	**(5)**	**46**
(421,595)	**Sub Totals (1) and (2)**	**(108,657)**	**(1,273)**	**(895)**	**281**	**364**	**(1,523)**	**(2,037)**	**(1,357)**	**(4,092)**
–	**Skills for Health**	–	**(31)**	(87)	119	–	1	–	12	–
(421,595)	**Totals I & E**	**(108,657)**	**(1,304)**	**(982)**	**400**	**364**	**(1,522)**	**(2,037)**	**(1,345)**	**(4,092)**
	Reserves									
(16,086)	General	–	–	738	–	–	738	–	232	4,092
(16,086)	**Sub Total Reserves**	**–**	**–**	**738**	**–**	**–**	**738**	**–**	**232**	**4,092**
5,700	**TRUST TOTALS**	**185**	**(1,304)**	**(244)**	**422**	**376**	**(750)**	**(2,037)**	**(1,296)**	**–**

Analysis of pay spend 2011/12 and 2012/13

Appendix 3

Division		2010/11	2011/12					2012/13						2009/10	2010/11	2011/12
		Total £'000	Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Apr £'000	May £'000	Jun £'000	Q1 £'000	Total £'000	Mthly Average £'000	Mthly Average £'000	Mthly Average £'000	Mthly Average £'000
Women's and Children's	Pay budget	65,891	16,638	16,716	16,901	17,553	67,808	5,822	5,634	5,740	17,196	17,196	5,732	5,238	5,491	5,651
	Bank	2,076	496	524	521	514	2,055	176	209	190	575	575	192	162	173	171
	Agency	654	182	128	162	315	786	71	125	126	322	322	107	31	55	66
	Waiting List initiative	304	73	42	16	27	158	18	2	5	25	25	8	42	25	13
	Overtime	91	14	11	7	12	45	6	4	3	13	13	4	8	8	4
	Other pay	62,798	16,219	16,274	16,333	16,736	65,562	5,627	5,494	5,509	16,630	16,630	5,543	5,087	5,233	5,464
	Total Pay expenditure	65,923	16,984	16,979	17,039	17,604	68,606	5,898	5,834	5,833	17,565	17,565	5,855	5,329	5,494	5,717
	Variance Fav / (Adverse)	(32)	(346)	(263)	(138)	(51)	(798)	(76)	(200)	(93)	(369)	(369)	(123)	(91)	(3)	(66)
Medicine (inc Central Services for 11/12)	Pay budget	41,745	11,034	10,900	10,938	11,340	44,213	3,720	3,763	3,671	11,154	11,154	3,718	3,396	3,479	3,684
	Bank	3,434	845	758	689	775	3,067	276	305	293	874	874	291	314	286	256
	Agency	559	157	141	113	309	720	1	93	61	155	155	52	43	47	60
	Waiting List initiative	315	30	4	26	43	103	2	17	9	28	28	9	30	26	9
	Overtime	69	25	15	16	15	70	5	6	5	16	16	5	4	6	6
	Other pay	38,883	10,318	10,094	10,041	10,162	40,616	3,470	3,399	3,369	10,238	10,238	3,413	3,110	3,240	3,385
	Total Pay expenditure	43,260	11,375	11,012	10,884	11,305	44,576	3,754	3,820	3,737	11,311	11,311	3,770	3,501	3,605	3,715
	Variance Fav / (Adverse)	(1,515)	(341)	(111)	54	36	(363)	(34)	(58)	(66)	(158)	(158)	(53)	(104)	(126)	(30)
Surgery Head and Neck	Pay budget	66,148	16,416	16,947	17,045	17,710	68,118	5,876	5,196	5,633	16,705	16,705	5,568	5,189	5,512	5,676
	Bank	2,100	450	525	497	497	1,969	158	193	177	528	528	176	216	175	164
	Agency	1,206	121	95	175	189	580	39	79	65	183	183	61	144	101	48
	Waiting List initiative	1,209	304	50	220	140	714	30	26	10	66	66	22	180	101	60
	Overtime	152	22	35	40	46	142	10	17	17	43	43	14	23	13	12
	Other pay	61,071	15,784	16,096	15,921	16,682	64,482	5,619	5,518	5,475	16,612	16,612	5,537	4,856	5,089	5,374
	Total Pay expenditure	65,738	16,681	16,801	16,853	17,554	67,888	5,856	5,833	5,743	17,432	17,432	5,811	5,419	5,478	5,657
	Variance Fav / (Adverse)	410	(265)	146	192	157	230	20	(637)	(110)	(727)	(727)	(242)	(230)	34	19
Specialised Services	Pay budget	33,790	8,635	8,613	8,641	9,456	35,345	2,947	2,792	2,926	8,664	8,664	2,888	2,694	2,816	2,945
	Bank	1,049	230	265	241	208	945	68	73	67	208	208	69	85	87	79
	Agency	654	243	293	245	382	1,163	60	31	74	165	165	55	30	55	97
	Waiting List initiative	537	138	86	127	72	423	42	32	19	93	93	31	49	45	35
	Overtime	20	3	4	6	14	27	3	3	3	9	9	3	10	2	2
	Other pay	32,290	8,283	8,362	8,219	9,212	34,077	2,814	2,772	2,831	8,417	8,417	2,806	2,579	2,691	2,840
	Total Pay expenditure	34,550	8,897	9,011	8,839	9,888	36,635	2,987	2,912	2,993	8,892	8,892	2,964	2,754	2,879	3,053
	Variance Fav / (Adverse)	(760)	(262)	(398)	(198)	(432)	(1,290)	(40)	(120)	(68)	(228)	(228)	(76)	(60)	(63)	(108)

Analysis of pay spend 2011/12 and 2012/13

Appendix 3

Division		2010/11	2011/12					2012/13						2009/10	2010/11	2011/12
		Total £'000	Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Apr £'000	May £'000	Jun £'000	Q1 £'000	Total £'000	Mthly Average £'000	Mthly Average £'000	Mthly Average £'000	Mthly Average £'000
Diagnostic & Therapies	Pay budget	36,929	9,121	9,280	9,371	9,487	37,259	3,096	3,229	3,213	9,538	9,538	3,179	2,944	3,077	3,105
	Bank	544	144	108	129	130	510	38	38	33	109	109	36	45	45	43
	Agency	389	73	46	63	101	284	(3)	32	23	52	52	17	58	32	24
	Waiting List initiative	156	37	27	28	41	133	0	31	12	43	43	14	11	13	11
	Overtime	264	68	49	67	96	280	20	31	27	77	77	26	14	22	23
	Other pay	35,515	8,915	9,029	8,965	8,954	35,863	3,060	3,079	3,101	9,240	9,240	3,080	2,786	2,960	2,989
	Total Pay expenditure	36,868	9,237	9,258	9,253	9,322	37,070	3,115	3,211	3,196	9,522	9,522	3,174	2,914	3,072	3,089
	Variance Fav / (Adverse)	61	(116)	22	119	165	189	(19)	18	17	16	16	5	30	5	16
Facilities & Estates	Pay budget	18,706	4,657	4,807	4,655	4,874	18,993	1,533	1,545	1,548	4,626	4,626	1,542	1,476	1,559	1,583
	Bank	483	93	75	72	84	323	28	31	27	86	86	29	48	40	27
	Agency	1,300	351	380	312	364	1,407	91	118	119	329	329	110	108	108	117
	Waiting List initiative	7	2	0	0	0	2	0	0	0	0	0	0	2	1	0
	Overtime	1,160	286	250	308	294	1,138	120	87	84	292	292	97	98	97	95
	Other pay	15,591	3,912	4,021	3,906	3,989	15,828	1,304	1,326	1,312	3,942	3,942	1,314	1,245	1,299	1,319
	Total Pay expenditure	18,541	4,644	4,726	4,598	4,730	18,699	1,543	1,563	1,543	4,648	4,648	1,549	1,501	1,545	1,558
	Variance Fav / (Adverse)	165	13	80	57	144	294	(10)	(18)	5	(22)	(22)	(7)	(25)	14	24
Trust Services	Pay budget	26,763	6,369	7,248	7,127	6,138	26,882	2,217	2,042	2,134	6,393	6,393	2,131	2,182	2,230	2,240
	Bank	609	115	157	(11)	13	275	0	(2)	(14)	(16)	(16)	(5)	52	51	23
	Agency	209	9	53	83	96	240	7	18	6	30	30	10	16	17	20
	Waiting List initiative	7	(1)	0	0	0	(1)	0	0	0	0	0	0	0	1	(0)
	Overtime	108	16	17	23	83	139	17	29	13	59	59	20	7	9	12
	Other pay	26,087	6,532	6,832	6,617	5,890	25,871	2,150	1,908	2,050	6,108	6,108	2,036	2,093	2,174	2,156
	Total Pay expenditure	27,020	6,671	7,059	6,711	6,083	26,524	2,174	1,952	2,054	6,180	6,180	2,060	2,168	2,252	2,210
	Variance Fav / (Adverse)	(257)	(302)	189	416	55	358	43	89	80	212	212	71	13	(21)	30
Trust Total	Pay budget	289,972	72,870	74,510	74,678	76,559	298,617	25,211	24,200	24,865	74,276	74,276	24,759	23,118	24,164	24,885
(excl Skills for Health)	Bank	10,295	2,373	2,413	2,137	2,221	9,144	744	846	774	2,364	2,364	788	921	858	762
	Agency	4,971	1,136	1,136	1,154	1,755	5,181	266	498	473	1,237	1,237	412	431	414	432
	Waiting List initiative	2,535	583	209	417	323	1,532	92	108	55	255	255	85	313	211	128
	Overtime	1,864	434	380	466	560	1,841	181	176	152	509	509	170	164	155	153
	Other pay	286,411	69,963	70,708	70,003	71,626	282,299	24,044	23,496	23,646	71,186	71,186	23,729	22,904	23,868	23,525
	Total Pay expenditure	291,900	74,489	74,845	74,177	76,486	299,997	25,327	25,125	25,099	75,551	75,551	25,184	23,585	24,325	25,000
	Variance Fav / (Adverse)	(1,928)	(1,619)	(335)	502	73	(1,380)	(116)	(925)	(234)	(1,275)	(1,275)	(425)	(467)	(161)	(115)

Key Issue	RAG	Executive Summary	Table
Service Level Agreement Income and Activity	G	Data from the new PAS system (Medway) is currently the subject of a detailed validation exercise. Good progress has been made recently on the validation of the in-patient activity. Further work is planned to continue on out-patient activity in the coming weeks. For the months of April and May contract income is £0.11m greater than plan. In addition SLA contract reward / penalties show a favourable variance of £0.07m and the balance of the 2011/12 over-performance against the Month 12 is £1.07m. A&E Attendances at 19,104 are 499 **lower** than planned. The average number of daily attendances is 313. Emergency activity at 5,980 is 4.6% or 289 spells **lower** than planned. Non Elective activity at 2,420 is 8.9% or 235 spells **lower** than planned. Elective activity at 2,445 is 4.3% or 100 spells **higher** than planned. Day case activity at 6,473 is 4.0% or 266 spells **lower** than planned. Outpatient Procedure activity at 4,575 is as per Plan New Outpatients activity at 22,050 is 0.2% or 46 attendances **higher** than planned. Follow up Outpatient activity at 52,285 is 0.1% or 32 attendances **higher** 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	A	The reported surplus for the 3 months to 30th June is £0.185m. This is £0.750m adverse to Plan. The EBITDA surplus of £7.199m equates to 87% of the Annual Plan target for the period. Total income to date of £130.374m is £0.798m greater than Plan. This includes a proportion (3/12ths) of the residual over performance relating to 2012/13 at £0.894m. Expenditure at £123.175m is greater than Plan by £2.278m, 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 £298k.	I&E 1 I&E 2 I&E 3a I&E 3b

Key Issue	RAG	Executive Summary	Table
Cash Releasing Efficiency Savings	A	The 2012/13 CRES programme totals £27.622m. Actual savings achieved for the first quarter total £5.984m, a shortfall of £0.951m (May £0.794m) against divisional plans. The shortfall comprises the proportion to date of unidentified CRES at £0.977m offset by savings ahead of plan on identified schemes at £0.026m. The 1/12th phasing adjustment adds a further £1.086m to the total cumulative shortfall to date of £2.037m.	I&E 4a – 4b
Statement of Financial Position & Treasury Management	G	The cash balance on 30th June was £36.336m. This is £5.018m higher than planned as a result of a lower than expected payments for capital expenditure and to traders. The rate of payments is expected to pick up in the next quarter. The balance on Invoiced Debtors has increased by £1.929m in the month to £12.233m. The invoiced debtor balance equates to 9.4 debtor days. Creditors and accrual account balances total £69.993m although £5.716m relates to deferred income. Invoiced Creditors - payment performance for the year to date for Non NHS invoices and NHS invoices within 30 days was 90% and 81% respectively.	BS 1 BS 2 BS 3 BS 4
Capital	G	Expenditure for the three months to 30th June totals £12.899m - this is £1.46m less than profiled for the period. The significant variances reflect slippage on Strategic Schemes (£0.704m), Medical Equipment (£0.255m), Information Technology (£0.386m) and Operational Capital (£0.28m. Actual expenditure for the quarter equates to 77% of the forecast included in the Trust's Annual plan submission to Monitor – this level of spending falls within the 75 – 125% threshold which would otherwise trigger a potential financial risk indicator under the Monitor performance review regime. The forecast outturn is that expenditure will equate to 93% of the Annual Plan projection.	
Financial Risk Rating	A	The Trust's overall financial risk rating using the results for the three months to 30th June has been calculated to be 3 (actual score 2.90). The Trust's ratings under the Prudential Borrowing Code are satisfactory with all ratios well within the Monitor thresholds.	
Private Patient Cap	G	Private patient income for the period is £0.398m or 0.39% of total patient related income. This is well below the Trust's Private Patient Cap of 1.1%.	

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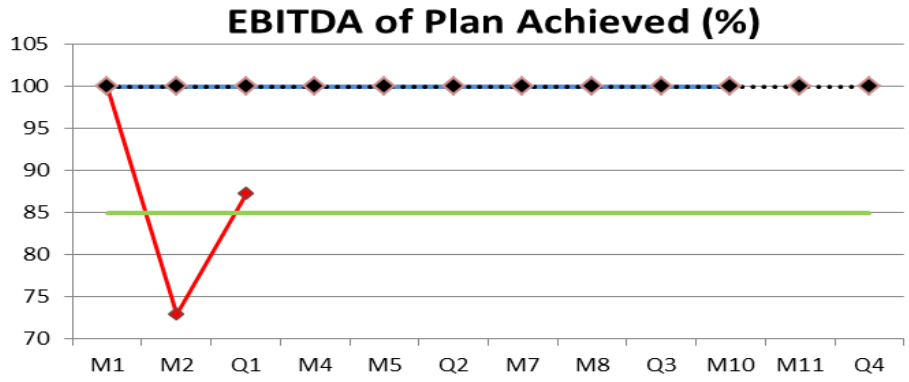
Finance Report June 2012 - Risk Matrix

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	8.0	Mitigated by Trust Reserves to ensure financial plan delivered.
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	-	
1240	SLA Performance Fines	Low	1.0	Infection Control plan implemented. Regular review of performance.	DL	Low	-	Mitigated in 2012/13 Service Level Agreement
	PCT Income challenges	Medium	2.0	Maintain reviews of data, minmise risk of bad debts	PM	Low	1.0	Position being managed.
1418	Breach of Private Patient Income Cap	Low	-	Monitoring and reporting to Finance Committee.	PM	Low	-	Private patient income @ 0.39% of patient related income remains well within the Trust's Cap of 1.1%.
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	-	
1858	Non receipt of pledges of charitable moneys to partly finance capital expenditure	Medium	2.0	Monitoring of capital expenditure. Maintain dialogue with respective trustees.	PM	Low	1.0	Firm pledges not yet available.

Financial Risk Ratings – June 2012 Performance

1. Financial Risk Rating

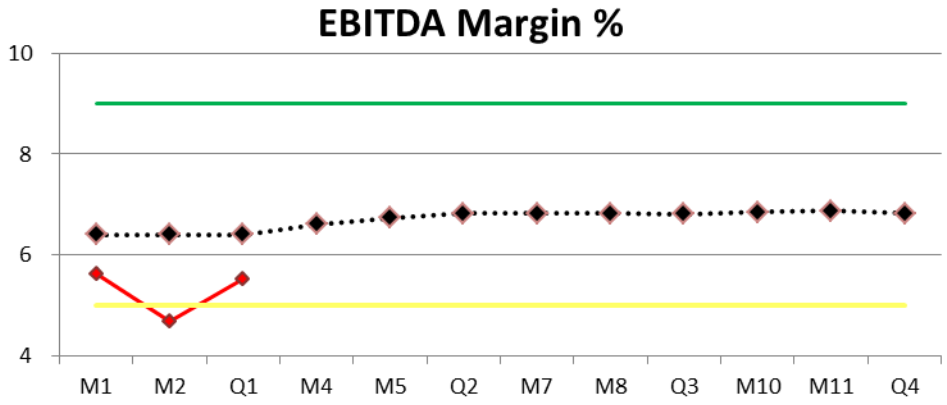
The following graphs will show performance against the 5 Financial Risk Rating metrics. The 2012/13 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 5 (blue line)**; **FRR 4 (green line)** and **FRR 3 (yellow line)**. A comment for the June performance is given alongside each graph.

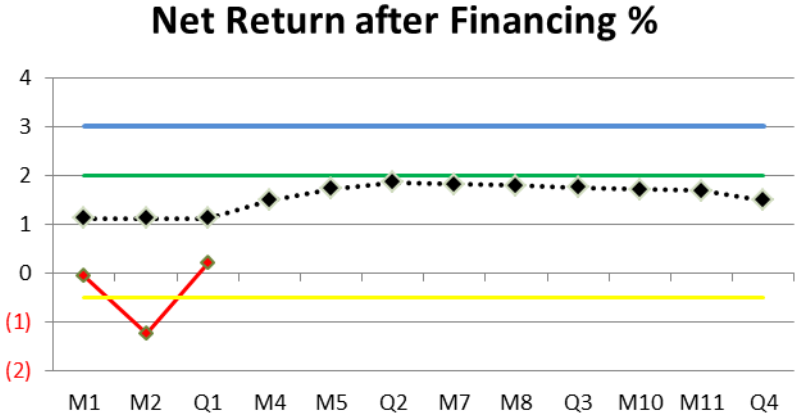


An EBITDA of £7.199m was achieved. This equates to 87% of the Annual Plan projection of £8.247m.

EBITDA Achievement of 87% of Plan earns a metric score of 4.

The EBITDA Margin of 5.52% for the 3 months to June achieves a metric score of 3. This is less than the Annual Plan forecast of 6.40%.



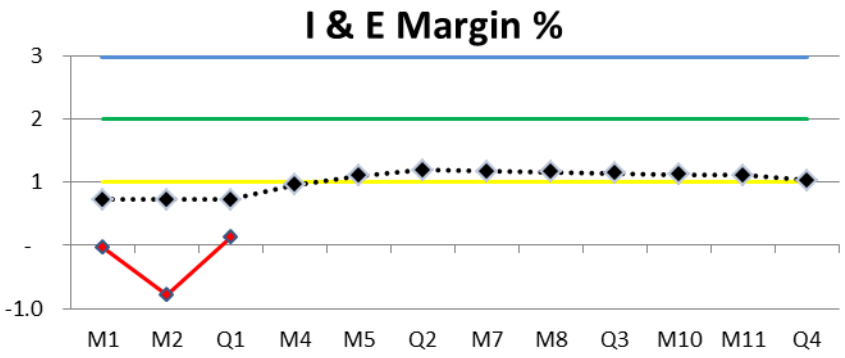


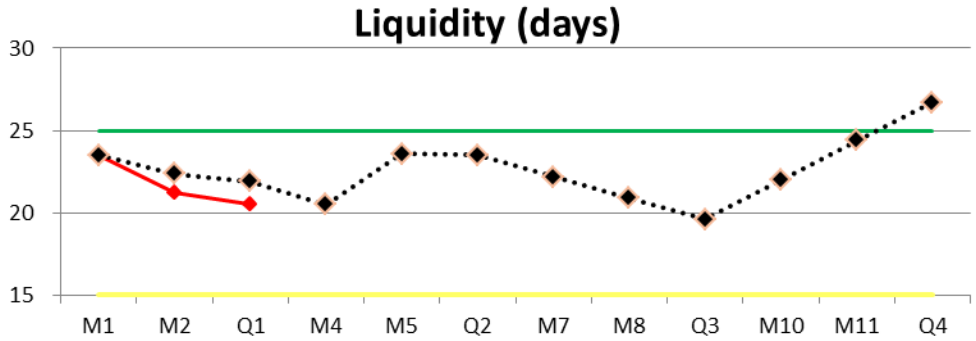
The Net Return on Financing for the 3 months is 0.23%. The result earns a metric score of 3.

Annual Plan = 1.13% to date.

The 2012/13 Annual Plan Income & Expenditure surplus margin is 0.73% to date.

The Income and Expenditure surplus margin for the period is 0.14%, a metric score of 2.





The 2012/13 Annual Plan liquidity ratio for the year is 26.7 days.

The actual liquidity ratio for June is 20.1 days, a metric score of 3.

The Trust's Financial Risk Rating is calculated by using a weighted average score to determine the overall rating. The weighted average score is 2.90. The Trust has therefore achieved a Financial Risk Rating of 3 for the three months to 30th June.

2. Prudential Borrowing Limit

A summary of the Trust's performance for June 2012 is given in the table below.

Prudential Borrowing Limit Performance	Monitor Ratio Tier 1	30th June 2012	Projection – March 2013
Minimum Dividend Cover	>1x	3.4x	3.6x
Minimum Interest Cover	>3x	80x	25x
Minimum Debt Service Cover	>2x	55x	22x
Maximum Debt Service to Revenue	<2.5%	0.1%	0.31%

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

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 09 – Report from the Transformation Programme Board

Purpose

To report to the Board on the progress of the *Transforming Care* programme inside the Trust.

Abstract

This report is a quarterly progress report to the Board describing the status of the *Transforming Care* programme as at Q1 (30 June) 2012/13. An additional degree of contextual information has been provided in this report.

This report includes a review of progress during Q1 compared to objectives, a performance review of key work streams for the period and a summary of Q2 objectives.

Recommendations

The Trust Board is recommended to **note** progress with key programme-level activities for the period April to June 2012 and activities planned for the current quarter.

Report Sponsor

Robert Woolley, Chief Executive

Appendices

- Appendix A – Report from the Transformation Programme Board

Transforming Care – Update for Trust Board 30th July 2012

Introduction

This paper reports the status of the Transforming Care programme to the Trust Board at the end of Q1 2012/13.

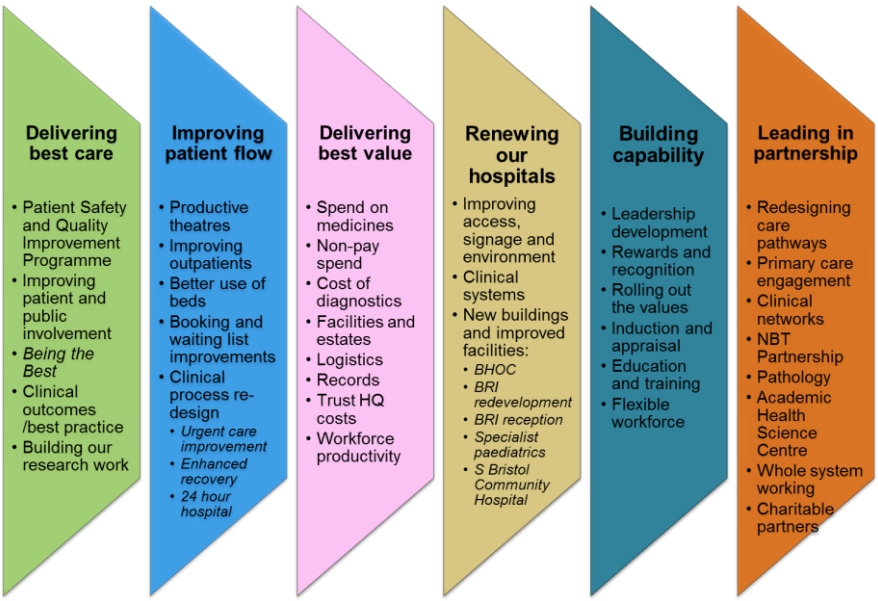
This report concentrates on progress in developing the programme at corporate level and a brief update on key work streams within the 6 constituent themes.

Background

As previously reported, the main organisational arrangements for governance of the programme are:

- The Chief Executive is senior responsible officer for the programme.
- The Chief Operating Officer is responsible for a dedicated programme management office which is run by a programme director role (position vacant since 1st July) and a programme manager.
- Oversight by an executive programme board, reporting to the Trust Management Executive.
- Co-ordination of activities and benefits realisation by a steering group reporting to the programme board.
- Establishment of six constituent themes, each overseen by a pair of Executive Directors.

Figure 1 – Transforming Care: programme overview



The interim Director of Transformation departed on 30th June as agreed, having successfully supported the drive to realise CRES savings from the Transforming Care work streams. The opportunity is being taken to review our requirements and recruit a suitable candidate with broader change management and service redesign experience who is able to provide greater direction on the trust wide transformation of services.

Progress Review Q1 – 2012/13

Progress continues to be achieved toward building a solid structure for the programme. Reviews of specific corporate led activities and constituent theme activities are provided below, the headlines are:

- 450 staff have attended the Living the values sessions (at 30 June) – on target to achieve 1000+ staff by the end of September
- A centralised outpatient booking centre commenced in July with the planned migration of all services over the next 13 months
- A comprehensive resource pack has been designed and made available to support staff undertaking change and improvement activities

However, CRES delivery as at the end of Q1 is £5.98m against a target of £6.93m (shortfall of £0.95m) with a year-end forecast now 86.5% of the £27.6m target - projected shortfall of £3.7 million. Work streams with a financial target are subject to individual monthly 'accountability' reviews between the respective senior responsible officer, finance and transformation team, where on-going focus will be on mitigating the risk of further slippage in performance and closing the current shortfall.

Figure 2 – Progress Review Q1 2012/13 of Corporate Level Activities

Activity	Deliverables	Comment
Programme Office Support	Establish financial targets and appropriate patient safety/quality/experience KPI's for key work streams delivery.	Complete
	Re launch Operational Intelligence Group to provide information that supports Divisions and identifies potential corporate led initiatives.	Complete
	Introduce a bespoke consultancy model approach to support Divisions and Clinical teams to assist implementation and sustainability of local initiatives.	Complete
	Launch a resource pack of project tools and techniques to support delivery of local initiatives.	Complete
	New Programme Manager joins 14 May.	Complete
Staff Engagement	Living the Values sessions designed and launched – with supporting poster campaign across the trust and intranet pack.	450 staff attended with all workshops booked until September.
	Launch Trust wide recognition scheme aligned to Transforming Care priorities.	Approach agreed by TME – completing funding arrangements.
	Transformational Leadership Development – on-going support to Top 150 leaders.	Review of scheme underway in order to design the next phase.
	Develop a staff engagement strategy to embed Transforming Care as 'the way we do business at UH Bristol.'	Strategy approved by Transformation Board

Figure 3 – Progress Review of Key Work streams Q1 2012/13 (KPI data delayed re Medway implementation).

Theme	Work stream Review
Delivering Best Care	All work streams report good progress with clinical outcomes/best practice work focused on the trust Dementia strategy and Stroke pathway
Improving Patient Flow	**Productive Theatres** – 'enabler work stream' with no direct CRES target. Focus is on improving theatre efficiency in BHI and emergency admissions (36 hour CQUIN target) **Improving Outpatients** – 'enabler work stream' so no direct financial target, but supports delivery of Medical Staff efficiency and Nursing productivity work. Centralising of Booking phase 1 to commence July 2012. Current focus is on aligning Medway to improve operational efficiency of outpatient's admin responsibilities. **Bed Optimisation –** forecast CRES out turn for the year – 79%. Slippage against target as plans to close ward 23 has been delayed. Forecast being revised.
Delivering Best Value	**Medicine Spend** – forecast CRES out turn – 109%. Good progress on a number of schemes – outsourcing planning has also progressed, due 2013/14. **Non Pay Spend –** forecast CRES out turn 89%. **Estates and Facilities** – forecast CRES out turn – 86%. **Medical Staff Costs** – forecast CRES out turn – 49% is of concern. Focus is on evaluation of consultant job plans against required capacity. **Nursing Productivity** - forecast CRES out turn – 82%. Some slippage as new ward staffing levels has been implemented. Under close monitoring. **AHP/HCSt Productivity** - forecast CRES out turn – 78%. Outputs from a cross division workshop are being reviewed to prioritise further activities. **Admin and Clerical Staff Productivity** - forecast CRES out turn – 97%. **Trust HQ costs** - forecast CRES out turn – 102%.
Renewing Our Hospitals	Good progress is being made to improve the hospital environment. Phase 1 of the new clinical system (Medway) was successfully implemented. The BRI redevelopment remains on track (Welcome centre and BHOC extension commence in July) and plans have been developed to transform the model of patient care in the upgraded facilities. South Bristol Community Hospital opened and a 'lessons learned' review is underway.
Building Capability	**Leadership Development** – programme review underway following study day on 22 June, in order to inform design of the next phase of the programme. **Rewards and Recognition** – staff consultation trust wide harmonisation of on call arrangements scheduled for July. A consortium approach to T&C review across south west has been agreed. KPI's and timeline to be developed. **Education and Training** – all work streams making good progress **Flexible Workforce** – scoping for this initiative has commenced.
Leading in Partnership	Programme focus is on redesigning care pathways (outpatient diabetes, Obstructive jaundice, and Clinical genetics).

Key Risks

The major risk to the success of the programme remains the engagement of clinical staff to support and drive activities. This is evident from the Medical Staff work stream which is the only one where financial performance is significantly short of target. Mitigating this risk is a clear focus of our staff engagement strategy.

Programme Objectives Q2 - 2012/13

Figure 4 – High level Objectives Q2 2012/13

Deliverable	Detail
Programme support to Divisions and other teams	Further develop the consultancy style approach of support from Transformation team, Organisation Development, Finance and Communications. Quarterly Division reviews to include a review of Transforming Care activity/progress. Deliver more 'thinking different' sessions (launched in Q1).
Staff Engagement	Continue to deliver the trust values sessions (Living the values). Encourage adoption of the Transformation Tuesday afternoons – the protection of diary time for business change activity, with a significant reduction in email traffic. Launch a trust wide 'ideas' scheme to encourage more staff involvement. Allocate specific 'Newsbeat' slots for Transforming Care and Living the values updates. Review other engagement ideas that have been collected from staff.
Staff Recognition Scheme	Launch trust wide recognition scheme aligned to programme priorities.
Transformational Leadership Development	Design and plan delivery of the next phase of this initiative.
Patient and public involvement	Define desired approach to involvement of patients and the public at programme, theme and work stream level
Programme Reporting	Review and enhance current reporting processes of theme work streams and the overall programme, including 'lower level' successes where there is an opportunity to share best practices.

Conclusion

This report has outlined recent further progress made in developing and embedding the Transforming Care programme across the trust, with plans for the current quarter.

Future reporting arrangements will be enhanced to provide the board with more relevant information at a programme and constituent theme level, in subsequent quarterly reviews.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 10 – Pathology Services Review – Advisory Panel Findings and Recommendations

Purpose

To inform the Board of the findings and recommendations arising from the recent Pathology Advisory Panel and to describe the next steps for both Severn Pathology and UH Bristol.

Abstract

The Pathology Services Review was established more than two years ago and is the local health community's response to the Lord Carter Review into the future of pathology services. Lord Carter's Reviews of 2006 and 2008 noted the fragmented nature of pathology provision in the UK and advised that the future quality and on-going development of pathology services was at risk without significant consolidation of the sector. The key benefits that are attributed to consolidation are quality gains, associated with a greater concentration of pathology expertise and improved cost effectiveness derived from the establishment of economies of scale.

After careful consideration of the strategic options open to the Trust, the Board determined that it was not well placed to host and develop the local vision of a single pathology centre of excellence, particularly when compared to other neighbouring organisations. However, the Board gave its full support to North Bristol NHS Trust (NBT) to develop a proposal that would see UH Bristol transfer its service to NBT and become a commissioner of pathology services. Weston Area Health NHS Trust also agreed to support NBT in such a venture through the transfer of their service and the Health Protection Agency (HPA), who provide microbiology services to both UH Bristol and Weston, agreed to partner NBT in the future provision of a comprehensive pathology service. This NBT proposition, partnering HPA, has been subsequently branded Severn Pathology.

An important part of the process to assess the appropriateness of this strategic direction for pathology services is the consideration of the Severn Pathology proposal by an Advisory Panel comprising local stakeholders and independent experts in the pathology field. A first panel in November highlighted a number of areas where the Severn Pathology proposal needed to be developed further to respond to the agenda facing local pathology services. The attached report describes the findings of the second Advisory Panel, which met in early July, and presents a number of recommendations for Severn Pathology and the wider health community; there are no specific recommendations for UH Bristol within the report.

The report notes that much progress has been made since the last panel and that in principle the panel believes the model for pathology provision being considered by this health community is the right one. However, it notes that key elements of the financial work remains incomplete and that the level of savings identified to date is not as great as they would have expected to see (given the scale of consolidation taking place) nor does it come close to the 20% goal for cost reduction set out by current and future potential commissioners.

Given this context, the next steps are for Severn Pathology to complete the outstanding work on the financial case and to conclude discussions with the Strategic Health Authority regarding transitional support; these two activities will allow UH Bristol to undertake an assessment of the financial impact of the proposed transaction, alongside other service considerations.

Subject to a positive outcome of this assessment, a divestment business case will be put to the Board in Autumn 2012; this case will also compare the Severn Pathology proposal to the alternative option(s) identified alongside the Severn Pathology proposal.
Recommendations
The Board is recommended to **note** the report and the next steps.
Executive Report Sponsor and Other Author
Sponsor – Chief Executive, Robert Woolley Author – Director of Strategic Development, Deborah Lee
Appendices
• Appendix A – Advisory Panel Report

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	25` July 2012				Divisional Board (Diagnostics & Therapies) July 2012

Advisory Panel Report for the Pathology Review

Version no.	1.0
Status	Approved
Author	Elizabeth Williams
Approver	Richard Smale, the Advisory Panel and the Pathology Review Project Board
Date for approval/ Date approved	13th July 2012
Agreed circulation of this version	Draft – internal Advisory Panel and Pathology Review Project Board Approved – publicly available

Version	Date	Reviewer	Comment
0.1	4th July 2012	Hayley Burton	Template creation
0.2	10th July, 2012	Elizabeth Williams	Initial draft`
0.3	10th July, 2012	Richard Smale	Review
0.4	12th July, 2012	Elizabeth Williams	Amendments from Deborah Lee, Michael Wells, Stephen Shiel, Ian Danks, Ian Barnes, Alastair Smith, Chris Price, Ian Danks and David Lloyd
0.5	13th July, 2012	Elizabeth Williams	Amendments from the Dick Whittington, Wolf Woltersdorf, Ian Danks and Marie-Noelle Orzel
1.0	13th July, 2012	Elizabeth Williams	Final amendments from the Pathology Review Project Board

13th July 2012

Elizabeth Williams, Project Manager

Sponsored by Richard Smale, Programme Director

Contents

1. Purpose

The purpose of this paper is to describe the recommendations of the second meeting of the Pathology Review Advisory Panel and to describe the next steps that the Review will follow. The Advisory Panel was chaired by Dr Ian Barnes, the National Clinical Director for Pathology, at the Department of Health England and included lay representation, commissioners and leading pathology experts.

The aim of the second Advisory Panel meeting was to enable the Panel members to review key elements of the Business Case for the formation of a new pathology service (which is to be known as Severn Pathology) and decide whether to recommend acceptance of it to the Pathology Review Project Board.

2. Introduction

In 2008, the Department of Health issued the 'Report of the Second Phase of the Review of NHS Pathology Services in England' chaired by Lord Carter. The first review of Pathology Services was published in September 2006. Both national reviews argue for the consolidation of services into managed pathology networks which reflect patient flows.

In 2010 a Healthy Futures Pathology Review was established to explore opportunities to reconfigure the pathology services provided at North Bristol Trust (NBT), University Hospitals Bristol Foundation Trust (UH Bristol), Weston Area Healthcare Trust (WAHT) and the Health Protection Agency (HPA). The pathology services currently provided by these organisations are located across five locations, employing over 750 staff, processing in excess of 16 million tests per year and with a combined annual operating budget of approximately £53m.

Following the first meeting of the Pathology Advisory Panel in November 2011 the concept of Severn Pathology has been developed, which brings together the pathology services currently operating across these four organisations. Severn Pathology will be lead by North Bristol Trust in partnership with the HPA. The vision for Severn Pathology is to create a patient-centred innovative service which is regarded as excellent by staff, patients and peers.

3. Proposed Service Configuration

Severn Pathology plan to provide services from a Central Laboratory at Southmead Hospital supported by two Essential Services Laboratories (ESL) based at Weston General Hospital and the Bristol Royal Infirmary (BRI). Although not the preferred option, the business case also includes a "virtual centralisation" option with Cellular Pathology located at the BRI in addition to an ESL.

All tests that do not require a turnaround time of less than 120 minutes will be processed at the Central Laboratory. This means that the Central Laboratory will process all primary care work unless identified at point of sampling as urgent and requiring processing at an Essential Services Laboratory in order to meet turnaround time targets of less than 120 minutes.

The Essential Services Laboratories will manage urgent samples with turnaround times of less than 120 minutes. Where appropriate there will also be local support for one stop

clinics, a frozen section service, support for infection control teams and clinical support at multidisciplinary team meetings and ward rounds.

In respect of specialist tests, paediatric and adult metabolic specialist services, haemato-oncology diagnostic service (HODS) and haemoglobinopathies will be consolidated at the central laboratory. Specialists Haemostasis will be consolidated on the BRI site.

Severn Pathology will be structured around broad service groupings where similar technologies or methods are being used. Based on an analysis of current technologies, sample types, skills requirements and workflow, existing laboratory functions have been grouped into six functional departments:

- Blood Sciences, including a centralised specimen reception;
- Specialist Testing (formerly Chromatography);
- Bacteriology;
- Virology;
- Cellular Pathology and
- Molecular Testing.

4. Feedback from the Advisory Panel

The Panel were extremely impressed by the quality and quantity of the work that had been achieved in response to the issues raised at their first meeting in November 2011. They acknowledged how far the work to develop Severn Pathology had come and the level of commitment and joint working from all those involved.

During this second meeting, the Advisory Panel were asked to specifically evaluate the Business Case for the creation of Severn Pathology using the following four key questions. Their feedback on these questions is described below:-

4.1. Will the clinical operating model presented deliver a high quality, safe and efficient service?

The Advisory Panel agree that the clinical operating model is well placed to deliver a high quality, safe and efficient service and they made the following observations:-

- The Advisory Panel are in agreement with Severn Pathology and felt strongly that the preferred option is full centralisation at Southmead Hospital to future proof the service by ensuring Cellular Pathology is co located with all the other pathology disciplines, particularly genetics and molecular pathology. Nationally and internationally, this is the direction of travel for the majority of consolidated pathology services and is considered to be the best option.
- The Advisory Panel felt Severn Pathology had not highlighted the outward facing role of pathology in respect of its extensive and varied clinical interfaces. Severn Pathology needs to make this more prominent in their description of the service model as well as providing more detail about how the clinical interface between pathology and other clinical services would operate, be

sustained and enhanced. Active, robust clinical interfaces are crucial to the effectiveness of a pathology service.

- The Advisory Panel admire the commitment from Severn Pathology to developing research, innovation, education and training. The Panel emphasised how important these aspects would be to the success of Severn Pathology in the future and recommended that further opportunities for academic appointment were considered with the University. The Panel also noted how important it was that commissioners recognise the added value of research, innovation, education and training undertaken by Severn Pathology when assessing the relative value for money of the service.
- The Panel recommend Severn Pathology examine further the opportunity presented by telepathology, particularly to facilitate the reporting of frozen sections undertaken at the Essential Services Laboratories. The Panel noted the recent improvements to digital imaging and suggested Severn Pathology learn from other Cellular Pathology departments such as the one in Sheffield (who are installing telepathology to facilitate frozen sections at the Northern General Hospital) and Coventry and Warwick who are piloting a telepathology system.
- The Panel recommend that the whole health community own and try and solve any estate issues at the Bristol Royal Infirmary that result from full consolidation to enable the local health community to achieve the preferred option for pathology services for the future.
- The Panel had concerns that Severn Pathology has not fully identified the scope of the IM&T challenge (e.g. Weston legacy data) that they face and may have underestimated the resource needed to implement the IM&T plan. They were also concerned about the simultaneous delivery of phase 1 and elements of phase 2 of the IM&T plan as both would draw on the same human capacity. Severn Pathology are encouraged to revisit the IM&T plans to ensure they are comprehensive and deliverable.
- The Panel welcomed the emphasis being placed on performance management and improvement and the creation of the Commissioning Framework and Key Performance Indicators. The Panel recommended that further KPIs are developed which measure the impact of pathology interventions on the wider patient pathway/clinical outcomes and the clinical interface between Clinicians within the Pathology service and the primary and secondary care clinicians who use the service.
- The Panel endorsed the proposed model for specialist testing presented by Severn Pathology whilst noting the merit in an incremental approach to these changes, testing at each step the impact and benefits of changes agreed.

4.2. Will the financial aspects of the business case enable the pathology service in Bristol, North Somerset and South Gloucestershire to be efficient, make the necessary cost savings and be competitive?

- The Advisory Panel recognised the effort in producing the detailed financial work produced as part of the business case. However, they were disappointed that not all the financial/pricing work was complete in time for the meeting which had significantly constrained the Panel's ability to test the

competitiveness of the Severn Pathology offer to prices emerging elsewhere. They noted the need to have this work completed as a matter of urgency to enable UH Bristol and Weston Area Healthcare Trust representatives to produce their own business cases which would enable their Trust Boards to evaluate the option of divesting in Pathology services.

- Based on the financial information presented to the Panel it was evident that the reconfiguration of pathology services as currently modelled would not come close to achieving the savings targets that had been specified by the current and future commissioners at the outset and throughout this Review.
- The Panel suggest additional savings will need to be found over the next five years to enable the local acute trust providers and commissioner to commission pathology services from Severn Pathology. This included a recommendation to do further work to identify savings in those areas where consolidation has already occurred.
- In addition to seeking further internal efficiencies, Severn Pathology is encouraged to identify opportunities for savings in other areas of patient pathways as a result of pathology interventions through pro-active engagement with system and organisation transformation programmes. For example, pathology units offering Troponin testing have changed hospital pathways and pathology units which robustly link and support anticoagulation services within primary care have minimised the risk of adverse events which in turn can prevent emergency admissions to hospital.
- The Panel identified the risk in the financial modelling being based on managing demand to an annual increase of only 1%, although they recognised the value of Severn Pathology working with their clinical partners in primary and secondary care to achieve effective demand management approaches. The Panel observed that an integrated service covering a wide area has the most potential to achieve robust demand management.
- The Panel note the fundamental importance of working with the SHA to secure financial support for the capital and transitional costs and they recommend Severn Pathology produce the financial information needed to facilitate this process as soon as possible.
- The Panel feel there are more saving opportunities available from:-
    - Reviewing medical staffing, which shows minimal change in the proposed operating model.
    - The services which are already consolidated, the Panel observed that opportunities for savings should be examined from the Regional Genetics Centre and Cytology service.
    - Closer working with NHS Blood Transfusion to improve the cost effectiveness of the blood transfusion service.
    - The Panel suggest there are more opportunities to ‘sweat the assets’ by extending the working day and moving to 7 day working where cost effective to do so, although they recognise this will result in the need for improved systems for dealing with abnormal results out of hours.

The panel suggest the remaining financial work is finished as soon as possible and a further due diligence exercise is conducted on the complete set of financial data prior to presentation to the Trust and PCT Cluster (CCG) Boards.

4.3. Are all the key stakeholders aligned and in agreement sufficiently for this new consolidated service to work?

The Panel observed that the majority of key stakeholders were aligned and in agreement sufficiently for the new consolidated service to work. They noted that there appears to be a great deal of commitment to the principles and vision set out for Severn Pathology from all stakeholders.

The Panel noted that further cost savings will need to be identified and the detailed pricing model completed to enable current and future commissioners of pathology services to sign up to this new model.

The individual organisations will also need to compare the updated financial position with any alternative “do nothing” or “plan B” options that they wish to develop. These alternatives should be developed as robustly as the models developed for Severn Pathology and should consider the risk of withdrawal of the GP Direct Access work which the panel considered to be a key risk if individual organisations determined to proceed alone.

The Panel commended the work that had been undertaken on lay engagement, recognising that it surpassed the levels achieved in many other pathology reviews across the Country.

4.4. What further work is required to make the development of Severn Pathology successful?

In addition to the activities described above the Panel observed the following work should be under taken:-

- Severn Pathology need to be more outward facing and prioritise involvement in the transformational work within the local health community to improve care, reduce admissions and support self care. Pathology has an important contribution to make to improve patient pathways and must become a key partner in the Healthy Futures Transformation Programme for Bristol, South Gloucestershire and North Somerset. Pathology staff have a key clinical partnership role, shown in their involvement in Multi-disciplinary team meetings and in the large volume primary care work for Haematology and Chemical Pathology.
- The Panel noted the commitment of Severn Pathology to focus initially on its existing customer base. However they highlighted the importance of the service finding the right balance between growth and delivery of local services.

5. Recommendations from the second Advisory Panel meeting

The Panel believe that the approach being adopted by all organisations participating in the development of Severn Pathology is the best option for the future provision of pathology services within Bristol, North Somerset and South Gloucestershire. They

encouraged all of the organisations to continue to work together to make Severn Pathology successful.

The specific recommendations from the second meeting of the Advisory Panel are:-

- A decision on which option to take forward should be made as soon as possible, with a strong recommendation to proceed with Option 1 if possible.
- Severn Pathology to complete the outstanding financial work and find additional savings.
- Severn Pathology to provide the financial data necessary to work with the SHA to secure financial support for capital and transitional costs.
- The Healthy Futures Pathology Review to conduct a further due diligence exercise on the complete set of financial data once available.
- The whole healthy community to own and try to solve any estate issues at the Bristol Royal Infirmary that result from full consolidation.
- Severn Pathology to explore options for greater use of telepathology to facilitate the reporting of frozen sections undertaken at the Essential Services Laboratories
- Severn Pathology to review the scope, resourcing and phasing of the IM&T plan
- Severn Pathology to work closely with NHS Blood Transfusion to improve the quality and cost effectiveness of the blood transfusion service
- Severn Pathology and local commissioners to develop key performance indicators relating to the clinical interface between Clinicians working in Severn Pathology and primary and secondary clinicians using the service
- Severn Pathology and local commissioners to develop key performance indicators relating to the clinical interface between Clinicians working in Severn Pathology and primary and secondary clinicians using the service, together with a robust mechanism for utilising these indicators in the performance management of the use of the service.
- There needs to be a greater recognition amongst all stakeholders that the benefits of Severn Pathology are best seen across the whole patient pathway, and that the service should be commissioned and operated with this in mind.
- Severn Pathology to become more involved in the Healthy Futures Transformation Programme to support the redesign of patient pathways.

6. Next Steps

Following completion of the recommendations set out above the Pathology Review will enter into the Recommendation and Approval phase. During this phase the proposal for the implementation of Severn Pathology will be presented to the following groups:-

- Bristol Clinical Commissioning Group
- North Somerset Clinical Commissioning Group
- South Gloucestershire Clinical Commissioning Group

- Bristol, North Somerset and South Gloucestershire PCT Cluster Board
- North Bristol Trust Board
- University Hospitals Bristol Foundation Trust Board
- Weston Area Healthcare Trust Board
- Health Protection Agency Executive Group
- Health Protection Agency PAM Board
- Bristol Overview and Scrutiny Committee
- North Somerset Overview and Scrutiny Committee
- South Gloucestershire Overview and Scrutiny Committee

As described above, the outstanding financial work must be complete to enable this next phase to take place.

After completion of the NHS approval process the outcomes and the impact assessment will be presented to the Bristol, North Somerset and South Gloucestershire Overview and Scrutiny Committees on the 12th December, 2012 for them to assess if the changes are a substantial variation.

Whilst the process to secure approval is underway, North Bristol Trust in partnership with the Health Protection Agency will commence planning for implementation.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 11 – Quarterly Capital Projects Status Report

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 achieving planning permission for the Welcome Centre, the completion of the second phase of the Bristol Royal Infirmary Emergency Department and the approval of the Bristol Haematology Oncology Centre (BHOC) Full business case. The planning application for the BHOC scheme is expected to achieve permission on the 25 July. Within the first two weeks of August three phases of the Centralisation of Specialist Paediatrics (CSP) scheme will achieve handover of Emergency Department and Levels 6 & 7 of the new extension. This will make way for the commencement of the new burns department.

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

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
					Clinical Strategy Group – 11 July 2012

					Governors' Strategy Group – 17 April 2012

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT

1. Introduction

This status report provides a summary update for Quarter 1 on the Trust's 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**	Project on programme with some small changes to phasing of the works. Contract end date is still maintained. Handover dates agreed as follows • Level 7 Adolescent ward - 10th August • Level 6 medical records -3rd august • Level 3 emergency department - 3rd August	
3	**Budget**	A capital allocation of £36.9m is in the capital programme including charitable funding support of £5.83m. The scheme remains within budget and the 2012/13 cash flow has been re-projected and incorporated within the Trusts capital programme. HMRC have now authorised the level of VAT reclaim allowable and this risk is now eliminated.	
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 but progress needs to be expedited.
		Transfer of Adult BMT not achieved.	BHOC Full Business Case approved, but scheme still subject to outcome of planning process and final negotiation of the contract price. Planning and cost will be resolved by the end of July.

		Charitable funding target not achieved.	Regular meetings with The Grand Appeal (TGA) established, TGA developing robust plans with a number of major grant making bodies. Contingency plan developed which prioritises major equipment provision and phases non-critical investment as funds are secured. Any residual shortfall will be a call on future years' operational capital.
		Additional revenue costs materialise as future designation standards and operational service models become clearer	All future costs will need to be accommodated within the agreed FBC revenue envelope and investments re-prioritised to reflect any additional "must do" items arising from designation standards. Finance tracker now established to monitor material changes with regular reports to Project Board.
		Income assumptions do not come to fruition in response to changed commissioner intentions and designation impacts; key risk areas are scoliosis care and paediatric neurosurgery activity.	Robust designation bid being developed for neurosciences following successful outcome in paediatric epilepsy. Strengthened links with S Wales and Peninsula provider for scoliosis provision though these risks are increasing. Finance tracker process in place to monitor material changes with regular reports to Project Board.

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**	Level 3 ground slab complete and level 4 floor slab under construction. Lift cores and stairwells progressed beyond these levels. Successful ambulance diversion to facilitate installation of protection works. New lifts to ED completed and handover of the Observation and Minors phase of the ED refurbishment achieved on 20th July. Site Wide Generators installed in early July, services connections on-going with commission planned for later in the year.	
3	**Budget**	A capital allocation of £86.3m is in the capital programme including assumed charitable funding support of £3m. Allocation of £86.3m includes funding for the Helipad and Site Wide Generators, which is now part of the target price agreement. The scheme remains within budget and the scheme has been reforecast to reflect minor changes in phasing and is now incorporated in Trust capital programme. HMRC have now authorised the level of VAT reclaim allowable and this risk is now eliminated.	
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. Services currently located in old Building cannot be re-provided for within future estate.	Detailed enabling works and decant programme developed. Space Allocation Project continuing to mature to ensure all services are mapped to a future location and affordable accommodation plan is being developed to ensure delivery.
		Charitable funding target not achieved.	Above and Beyond have pledged this level of support. Any residual shortfall will be a call on future years' operational capital.

		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	
2	**Progress**	Planning permission decision received. Retailer selection is nearer completion with the production of Agreements to Lease with each of the retailers. The Community Pharmacy retailer selection process has also concluded. Rentals have exceeded those assumed at Business Case.	
3	**Budget**	£4.95m has now been secured by the Trust. Final design solution completed and final contract target costs currently under negotiation. Following advice from Ernst & Young the centre will operate under election to tax rules to ensure the maximum benefit of any available VAT recovery to be achieved.	
4	**Programme**	On programme, construction due to commence July 2012. WRVS and GP Support Unit areas vacated and destructive asbestos surveys on-going.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Scheme costs exceed budget and acceptable Guaranteed Maximum Price (GMP) cannot be agreed.	Construction partner fully aware of cost envelope and working closely with design team to ensure final design and works plan is affordable.
		Operational disruption to front entrance during construction.	Two phased construction programme to retain current front entrance at all times. Operational policies to support flows through all trust entrances, including specific consideration of patient drop off (including ambulance). Temporary café and shop being planned to retail facilities during works.
		On-going adverse publicity in relation to commercial retail	Pro-active media strengthened with clear articulation of benefits

		offer.	secured for patients through commercial model. Continued close working with WRVS senior team.
BRISTOL HAEMATOLOGY & ONCOLOGY CENTRE			
1	**Decisions required**	None.	
2	**Progress**	Full Business Case approved. Planning Committee on 25th July expected to approve slightly modified scheme required to address planning issues. Marlborough Hill Car Park alterations and the Woodland Walkway are under way. Drop off access for patients will be maintained during construction. Shuttle service, on pilot basis, being explored.	
3	**Budget**	Capital cost identified at £15.996m (incl. £2m for Linac replacement) supported by £6.5m of charitable funding pledged by Above and Beyond, Teenage Cancer Trust and the Friends of BHOC. Final contract negotiations to agree contract price underway, challenges remain evident.	
4	**Programme**	On programme, construction due to commence July 2012 and conclude December 2013.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Business continuity during construction.	Ensure robust site logistic co-ordination through principle supply chain to provide continuity.
		Unable to identify acceptable decant for inpatient ward during construction phase.	Solution agreed with BRHC, final issue of accommodation for EEG to be resolved.
		Adverse operational impact on radiotherapy service during Linac construction phase.	Robust construction logistic planning in place. Close working between operational and strategic development teams.
		Dust from construction impacting on immunosuppressed patients, possibly leading to a delay if works must be stopped.	Agree weekly review of works and dust mitigation measures with contractor. Closed window policy agreed with Division. Implement full decant solution for ward 62 patients. Funds to support necessary prescribing prophylaxis included in

			transitional revenue.

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: 16/07/2012

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 12 – Proposal for the Clinical Reconfiguration of Urology Services

Purpose

The purpose of this paper is to bring before the Board proposals for reconfiguring urology services to create a single centre of excellence in urology in Bristol, which will deliver improved clinical outcomes for patients and provide for a better patient experience.

Abstract

Currently, North Bristol NHS Trust, and University Hospitals Bristol NHS Foundation Trust both provide and manage inpatient, daycase and outpatient urology services, with complex urology cancer surgery consolidated into Southmead Hospital.

The proposal is to consolidate all of the surgical inpatient and day case urology services into Southmead Hospital (the 'Hub'), with 'spoke' sites providing routine outpatient appointments and some diagnostic services at locations across Bristol, North Somerset and South Gloucestershire (BNSSG). The reconfigured service would be managed and operated by North Bristol NHS Trust.

Recommendations

The Board is recommended to:

1. Approve in principle, subject to resolution of financial impact;
2. Support the proposal through authorisation at the three Health Overview and Scrutiny Committees, and then through the process of implementation.

Executive Report Sponsor and Other Author

Sponsor – Chief Operating Officer, James Rimmer

Appendices

- Appendix A – Proposal for the Clinical Reconfiguration of Urology Services.

Proposal for the clinical reconfiguration of Urology Services

July 2012

1 Purpose of this paper

The purpose of this paper is to bring before the Board proposals for reconfiguring urology services to create a single centre of excellence in urology in Bristol, which will deliver improved clinical outcomes for patients and provide for a better patient experience.

Currently, North Bristol NHS Trust, and University Hospitals Bristol NHS Foundation Trust both provide and manage inpatient, daycase and outpatient urology services, with complex urology cancer surgery consolidated into Southmead Hospital. The proposal is to consolidate all of the surgical inpatient and day case urology services into Southmead Hospital (the 'Hub'), with 'spoke' sites providing routine outpatient appointments and some diagnostic services at locations across Bristol, North Somerset and South Gloucestershire (BNSSG). The reconfigured service would be managed and operated by North Bristol NHS Trust.

The paper will outline the key service changes proposed, the mechanism through which these proposed changes are being developed, and the improvements for patients that are intended to be delivered.

This proposal has been considered by the Bristol, South Gloucestershire and North Somerset Clinical Commissioning Groups at their June and July meetings and is brought forward with their support. It is anticipated that following Trust Board approvals in July, the proposal will be presented to the three BNSSG Health Overview and Scrutiny Committees for consideration in September 2012, with a current planned service transfer in December 2012.

2 Proposed changes

The specific proposal being considered in this paper is to consolidate all of the surgical inpatient and day case urology services into Southmead Hospital (the 'Hub'). In support of this, the intention is to transfer the management of the whole urology service to North Bristol NHS Trust. The changes proposed will also result in:

- The establishment of a single point of referral for urology patients, ensuring fair and equitable access and efficient use of resources;
- Many outpatients being seen in one stop clinics at Southmead Hospital and the newly opened South Bristol Community Hospital, leading to a reduction in follow up appointments;

- The number of outpatient clinics provided at peripheral 'spoke' sites increasing; and
- The appointment of an Outpatient Clinic Coordinator to better manage the flow of patients through the department.

Oncology services for patients with urological cancers under this proposal will continue to be provided via the Oncology Centre (BHOC) located on the BRI campus. Furthermore these changes do not directly impact the urology services that are provided at Weston General Hospital, nor the Community Urology Services provided by GP Care (the latter being subject to a separate review process currently taking place to decide future commissioning intentions).

To ensure adequate support for emergency and inpatient services at the BRI, Consultant Urologists will be on site each week day on a defined rota basis. Weekend cover will continue to be provided through the city-wide on-call service, as is currently the case.

3 Why change?

There is clinical evidence that centralising specialist services to a smaller number of higher volume providers improves outcomes for patients[1]. In 2006 complex urology cancer surgery was consolidated into Southmead Hospital as part of the process of local health services achieving compliance with the associated NICE Improving Outcomes Guidance. Although the inpatient surgical elements of this complex care are currently delivered at Southmead, patients are still able to receive other aspects of their care such as routine outpatient appointments and some diagnostic services at locations across Bristol, North Somerset and South Gloucestershire (BNSSG).

This proposal, which has been developed in partnership with key stakeholders (see Appendix 1), will create a single centre of excellence for urology services which unifies the clinical teams across Bristol to provide routine and specialist urology services for both the local and wider south west regional population who access their care within Bristol. It is recognised that some of the improvements that patients wish to see in the service can be delivered without major change (e.g. communications), whilst others are dependent on removing the boundaries that exists within the current service (for example, access to the most appropriate clinicians or surgical equipment). As part of the engagement process, attention was focussed on defining, from a patient perspective, those elements of the service that will make a real difference to the patient experience and as a result, the document 'What matters to patients', developed by patient representatives, forms part of the new service specification (available upon request).

4 Opportunity for improvement

There are a number of specific areas where potential for improvements to the current services have been identified, including:

- the current variability in patient experience;

[1] Improving outcomes in urological cancers - Research evidence, NICE, September 2002

- patients access to clinical expertise and equipment is often determined by the organisation to which they were referred rather than clinical need;
- both organisations current use of locum consultants due to difficulties with recruitment;
- inefficient use of consultant time due to supporting a multi-site inpatient and surgical service;
- difficulties in making the best use of clinical resources e.g. junior doctors; specialist nurses;
- duplication of staffing and equipment due to providing some services on two sites; and
- an historic pattern of community clinics which is not based on the requirements and geographic location of the population.

5 Expected Benefits

The benefits that will be realised through these proposed changes to services are expected to be:

- improvements in patient outcomes and patient experience (e.g. improved clinical outcomes, reduced cancellations, improved communications, better access to the right specialist and the right equipment at the time it is needed);
- shared/standardised methods based on best practice across the clinical teams;
- delivery of services which are more productive and efficient through the minimisation of duplication and waste, in particular, to address the inefficient use of consultant time due to supporting a multi-site inpatient and surgical service;
- urology inpatients cared for on a single dedicated urology ward;
- provision of an outpatient unit dedicated to urology care;
- consolidation of research and training on the Southmead Hospital site under the auspices of the Bristol Urological Institute (BUI), to encourage research and innovation in areas such as new surgical techniques and treatment regimes, with the intention of reducing complications and increasing survival rates;
- single waiting list management, providing equity of access; and
- creation of a single centre of excellence for urology in Bristol, enabling the service to better attract national and international clinical staff to work in the specialty.

A full benefits plan detailing the intended benefits and how they will be measured is available on request.

The proposal to locate the new hub for inpatient and daycase surgery at Southmead Hospital and to transfer the management of the centralised service to North Bristol

NHS Trust builds upon the earlier consolidation of urology cancer services and enables the service to maximise the use of equipment, such as the surgical robot at Southmead. NBT is also a leading innovator in the provision of urology services, and has a significant research programme managed within the Bristol Urological Institute (BUI). The development of research will be an important element of the urology service in the future.

6 Impact on patients, carers and families

The number of patients admitted for a surgical procedure, or as an inpatient, is a small percentage of the overall numbers who receive treatment from the urology service. The vast majority of patient appointments are for outpatient consultations or diagnostic services and as part of this proposed change current community diagnostic and outpatient services provided by the Trusts have been reviewed. This has enabled appropriate local services to be offered at the most suitable locations, providing patients with a choice of the location of these services and minimising the need for travel.

Patient representatives and other stakeholders have worked with the Review Team to identify the most appropriate locations for outpatient and diagnostic services, with the locations identified shown graphically in appendix 2.

The relocation of inpatient and day case services from the BRI to Southmead Hospital will have implications for the relatively small number of urology patients and their families who require inpatient or surgical procedures and who previously would have accessed this through the BRI (Appendix 3 contains the volumes of activity by site). However, with the opening of South Bristol Community Hospital, and the commissioning of a weekly urology daycase session and a one-stop clinic at the hospital, additional access is also being provided in the south of the city.

7 Review Panel

A panel[2] independent of the project conducted an event in June 2011, to review the outline proposals from the Project Board and to examine whether they were the right approach for BNSSG. The Panel drew the following conclusions from the process:

> *'The Panel unanimously believe that consolidation of urology services is the right thing to do; and*
>
> *There are opportunities to develop a cohesive, comprehensive multidisciplinary high quality service for patients;'*

The Panel identified that whilst many of the practicalities associated with the proposed change had been identified, further activity was required to work through the details. These comments are addressed in the paper. In particular, the Panel highlighted:

- the importance of clarifying the intended benefits for patients;

[2] Membership of the Panel: Dr Chris Payne, Public Health, NHS South Gloucestershire; Ellen Rule, Commissioner, NHS Bristol; Julia Pollard, Nurse Specialist, Taunton; Kathy Headdon, Non Executive Director, NHS North Somerset; Malcolm Gamlin, Lay Member

- more clearly defining the services that would remain at the BRI to support, inpatient and emergency care; and
- the importance of focusing on the routine as well as the specialist aspects of the service.

8 Service Change Criteria

In May 2010, Sir David Nicholson wrote to all NHS Chief Executives to detail four criteria for service changes. This section documents how the proposal has addressed the requirements set out in his letter.

8.1 Support from GP Commissioners

The role of GP Commissioners has been undergoing a significant change since the start of this project and in light of this the arrangements for GP involvement have also developed. The primary care perspective was built into the process from the start with a local general practitioner, Dr Phil Yates being a member of the Project Board throughout the Project.

The Urology Project is also part of the Healthy Futures Programme and regular progress reports have been provided to the Healthy Futures Programme Board, of which the three local CCG Chairs are members. In addition, the following actions have been taken to ensure GP commissioner engagement and involvement:

- The GP Professional Executive Committees of the three PCTs received an update on the project in summer / autumn 2011;
- The Independent Review Panel received a presentation from Dr Phil Yates reflecting the requirements of primary care; and
- Specific conversations around the way services at South Bristol Community Hospital will operate are taking place between Dr Brian Hanratty (GP) and Mr Tim Whittlestone (Urology Consultant).

The purpose of bringing this paper to the Clinical Commissioning Group is to formalise the support of GP commissioners as part of the process to achieve final approval.

8.2 Patient and Public Engagement

Engagement with patient, carer and public stakeholders throughout this process has ensured the views of the public, patients and carers are taken into consideration in developing the service model and site criteria.

Discussions around these proposed changes commenced in 2010 and have involved patient representatives from Prospect (a support group for prostate cancer patients, their wives, partners and carers) and the Local Involvement Networks (LINk's). There have been a number of meetings and four key stakeholder events (December 2010, March 2011, July 2011 and October 2011) where the proposals were discussed with a wider group of patients, members of the public and clinical staff. These activities have informed the proposals and highlighted those aspects which will offer the greatest benefit to patients and carers.

Four lay representatives have been members of the Urology Project Board throughout the process. The role of these lay representatives was to ensure that users' needs and

opinions were accurately and adequately considered during the project. In addition to their Board contribution, the lay representatives have also met separately in order to progress specific issues and collate their input into the process. Two of the members of this group have been part of the LINks organisations and the others are members of Prospect.

> *"I can honestly say that I have felt fully involved with the development of proposals for urology services and that my views, and those of the other lay members, have not only been listened to but acted on and incorporated. Overall a really good experience"*

Quote from Malcolm Watson, Chair of South Gloucestershire LINK and a Lay representative on the Project Board**.**

8.3 Clinical Evidence Base Underpinning Proposals

In a range of clinical areas, national evidence has been informing the NHS transition towards specialist centres which can offer the best patient outcomes due to:

- the undertaking of sufficient volumes of procedures to support the development of expertise and experience, skill retention and training;
- dedicated inpatient and theatre staff and facilities;
- the development of expert support staff (e.g. radiologists, pathologists, physiotherapists); and
- access to high quality research facilities.

The combination of these factors is recognised as critical to improving the outcomes and experience of patients and has informed national policy in areas such as the Improving Outcomes Guidance and the Darzi report.

Evidence is also being gathered in areas of innovation such as the use of the urology surgical robot and how this improves patient outcomes due to the precision of the surgery that it can deliver.

Work with Lay Members on this review however has also informed us that many of the factors that impact upon the quality of the patient experience involve aspects such as communication and administration. The use of this more anecdotal evidence has greatly informed the design of the service and the attention that is being focussed to getting these supporting elements right.

In response to the evidence for change, clinical teams including urologists, oncologists, radiologists, pathologists, specialist nurses, emergency department staff, physiotherapists, occupational therapists and dieticians have been working to define the method through which clinical services will be delivered at Southmead Hospital, the BRI and the community locations. This has highlighted a number of key areas for consideration including the ongoing support required from urologists to the inpatient and emergency services at the BRI, the vital role that multi disciplinary care teams have in the successful planning and delivery of services and the critical relationship that must exist between urology, the Oncology Centre, the Community Urology Service and continence services.

8.4 Develop and Support Patient Choice

The Darzi report called for services to be 'localised where possible, centralised where necessary'.[3] The proposed model implements this concept by centralising surgery and diagnostics at a hub, as recommended by the Improving Outcomes Guidance, whilst providing routine and follow up appointments more locally at spoke sites.

For inpatient services the choice of location will be reduced from two locations in Bristol, the Bristol Royal Infirmary (BRI) and Southmead Hospital, to one hub at Southmead Hospital. This reflects the trend nationally to move towards specialist centres and is intended to ensure that patients receiving treatment in Bristol experience the best possible outcomes. This approach has received broad support through the engagement process with patient and public representatives, who have recognised the potential benefits to patient care and experience of consolidation of these parts of the service.

This change should be seen in the context of development of patient choice for less complex surgery and treatments, with the introduction of the Emerson's Green Independent Treatment Centre and the work underway to develop Community Urology Services.

The majority of patients accessing the urology service do so through diagnostic and outpatient services and the new model aims to provide services from a range of locations across the city. The opening of the new South Bristol Community Hospital provides an excellent location for accessing diagnostic and outpatient services for patients who live to the South of Bristol. The provision of services in Southmead, BRI, Cossham, Clevedon Portishead and Thornbury offers a good geographic spread, enabling many patients to choose the most convenient location for accessing services (see appendix 4).

9 Are the proposals affordable and deliverable?

North Bristol NHS Trust will provide the newly configured urology service, as specified in the service specification, within national and locally negotiated tariffs. The total value of the service in 2011/2012 was £17.484m (excluding Independent Sector Treatment Centre and Community Urology Service expenditure).

Both provider trusts have undertaken a full financial assessment of the three planned clinical change projects (Breast, Head and Neck, and Urology) and have concluded that the reconfigured services are financially viable.

A financial analysis has also been undertaken by the Cluster contract performance management team to also ensure financial viability from a commissioning perspective. Whilst there are some financial risks created by the reconfiguration, these are not of the level of significance as to cause any grave concern or to recommend ceasing progress of the Project until they are addressed. The two main risks are:

- The potential for increased financial risk in the short to medium term due to increased throughput as a result of improved efficiencies created by new ways of working;
- The need to refine patient pathways when the future commissioning intentions for the provision of community urology has been determined (which will be several months prior to the December 2012 reconfigured urology service start date).

[3] High Quality Care for All: NHS Next Stage Review Final Report. Professor, the Lord Darzi of Denham KBE, 2008.

A copy of the full financial assessment has been sent to the Clinical Commissioning Group Finance Leads for their information, and the BNSSG finance team have an action plan to mitigate and address the identified outstanding issues.

NBT has identified a number of internal efficiency gains associated with reconfiguring services; these include changes to junior doctor provision and the banding of clinical fellows. The Trust also expects to make further efficiencies as the benefits of a consolidated service are realised (e.g. reductions in length of stay due to patients being looked after on a dedicated unit).

Efficiency gains attributable to the commissioners have also been identified. These include a reduction in outpatient follow up's as a result of introducing a one-stop clinic model, and the increased use of follow-up through telephone consultation. These will need to be reflected in the 13/14 NBT contract.

The 12/13 NBT and UH Bristol contracts have been set at 11/12 outturn, with no additional funding mechanism for over performance.

The Urology (specialty 101) forecast expenditure analysis for 11/12 across BNSSG and non-BNSSG commissioners at UHBristol and NBT is as follows:

Table 9a: Total Forecast 2011/12 Urology Expenditure

	UHBristol	NBT	Combined
PbR	£4,979,778	£11,530,328	£16,510,106
Non PbR	£139,373	£834,565	£973,938
Total	**£5,119,151**	**£12,364,893**	**£17,484,044**

The Non PbR expenditure is subject to a review which is currently being undertaken, and will be completed by the end of Q1 12/13.

Table 9b: BNSSG Forecast 2011/12 Urology Expenditure

	UHBristol	NBT	Combined
BNSSG only expenditure	£4.173m	£9.606m	£13.779m

The BNSSG forecast 11/12 urology expenditure represents 78.8% of total expenditure at the two trusts on this specialty.

The following tables show the associated activity for the 10/11 and 11/12 period with the planned activity for 12/13 by location shown in appendix 3.

Tables 9c and 9d: Urology Activity 2010-11(actual) and 2011-12 (year end forecast)

Urology 2010/11 Actual Activity	Elective Inpatients	Day Case	Elective Total	Emergency Inpatients	Outpatients		
					New	FU	OP Proc
UHB	614	2,973	3,587	385	3,265	4,967	66
NBT	1,816	5,773	7,589	863	4,746	12,422	258
Total	2,430	8,746	11,176	1,248	8,011	17,389	324

Source: Trust Contract Monitoring Data

Urology 2011/12 Forecast Activity	Elective Inpatients	Day Case	Elective Total	Emergency Inpatients	Outpatients		
					New	FU	OP Proc
UHB	594	3,378	3,972	451	3,153	5,090	79
NBT	1,625	5,959	7,584	737	4,813	11,675	51
Total	2,219	9,337	11,556	1,188	7,966	16,765	130

Source: Trust Contract Monitoring Data

10 What is the impact on staff of these proposals?

Staff consultation is planned to commence with those directly affected by the service changes in June or July, for a 90 day period, and will run in parallel with the approvals process. Currently the total number of staff posts (medical, nursing and administration) expected to transfer to NBT employment under TUPE regulations, is 9.8 whole time equivalent (wte) and 18 headcount.

11 How will the changes be managed?

A project based approach is being used to manage the process of organisational service change, under a Urology Project Board, chaired by Dr Chris Burton, NBT Medical Director. During the detailed planning phase the Trusts have identified that the delivery of the urology project is interdependent on the head and neck and breast centralisations with respect to operating theatre capacity. This necessitates simultaneous moves to take place in order to minimise any disruption for patients. The decision has therefore been taken to harmonise the implementation of all three projects and to co-ordinate them through a single programme.

12 What does this mean for Bristol, South Gloucestershire and North Somerset Patients?

The impact on Bristol and South Gloucestershire patients is relatively small with the majority continuing to receive their care in the same locations. The most significant impact will be for those patients who previously would have received their inpatient and surgical care at the BRI who will now receive this at Southmead. For some this will mean incurring additional travel; however this should be set in the context of the intended improvements in patient outcomes and experience resulting from the proposed service changes. The majority of North Somerset patients already access their services through Southmead Hospital or Weston General Hospital so the impact on patients within the region will also be relatively small (see Appendix 4). For those patients in North Somerset who routinely access services from the BRI and who require admission to hospital for a urological condition in the future they would instead attend Southmead Hospital.

The improved modelling of community services and their locations (Appendix 3) will help ensure that community based urology services are delivered from the best locations and with the right equipment available.

13 Next steps in the approvals process

The mechanism for gaining approval to proceed to implement the proposed changes to Urology services is as follows:

- Paper seeking approval to proceed, taken through NBT, UH Bristol and BNSSG Cluster Trust Boards in July 2012
- Paper to all three BNSSG Health Overview and Scrutiny Committees seeking approval to proceed in September 2012
- Provided that the proposal receives the necessary approvals, and organisations have concluded their detailed planning, then the service transfer is planned to take place in December 2012

During the approvals process, detailed implementation planning activities are being undertaken to facilitate the service transfer as and when formal approval is provided.

14 Action requested from the Board

The Board is asked to:

1. Approve in principle, subject to resolution of financial impact
2. Support the proposal through authorisation at the three Health Overview and Scrutiny Committees, and then through the process of implementation.

James Rimmer, Chief Operating Officer, University Hospitals Bristol NHS Foundation Trust

Professor David Gillat, Consultant Urologist, North Bristol NHS Trust

Mr Tim Whittlestone, Consultant Urologist, University Hospitals Bristol NHS Foundation Trust

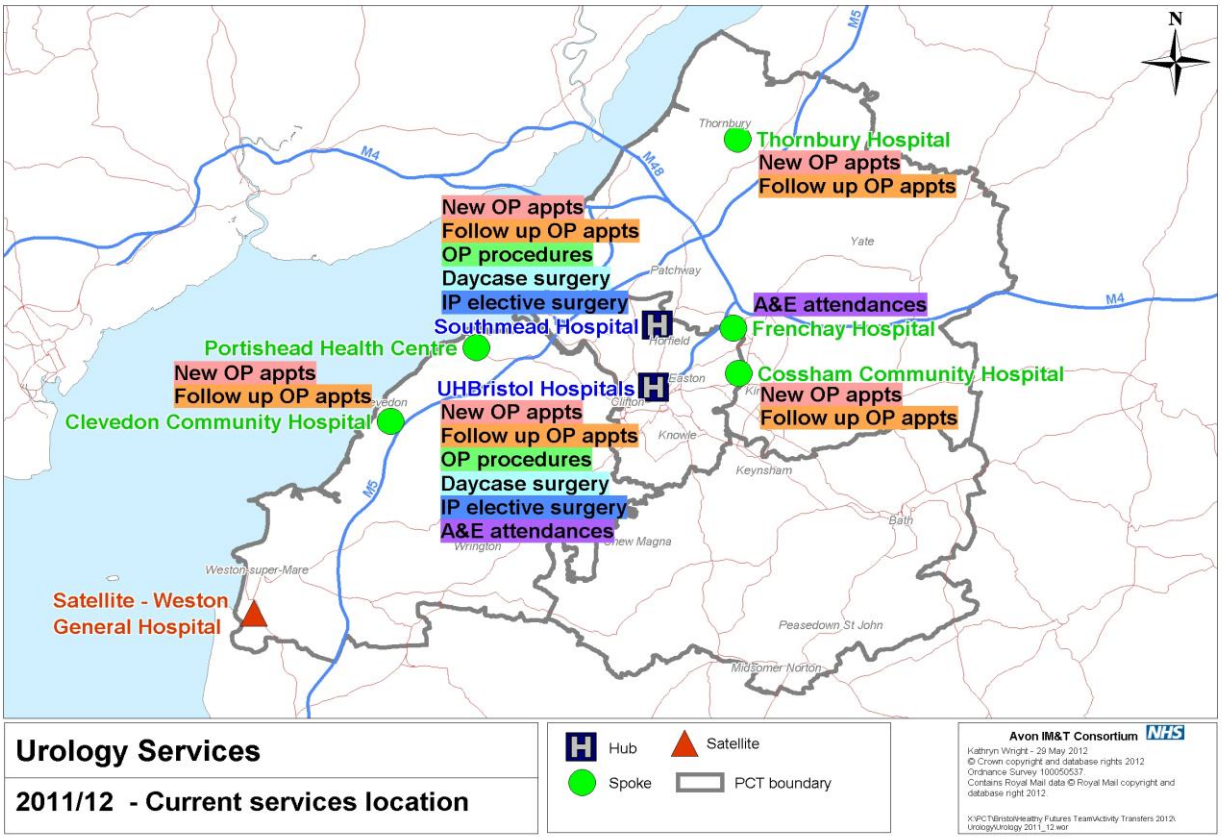
Richard Smale, Healthy Futures Programme Director, NHS Bristol

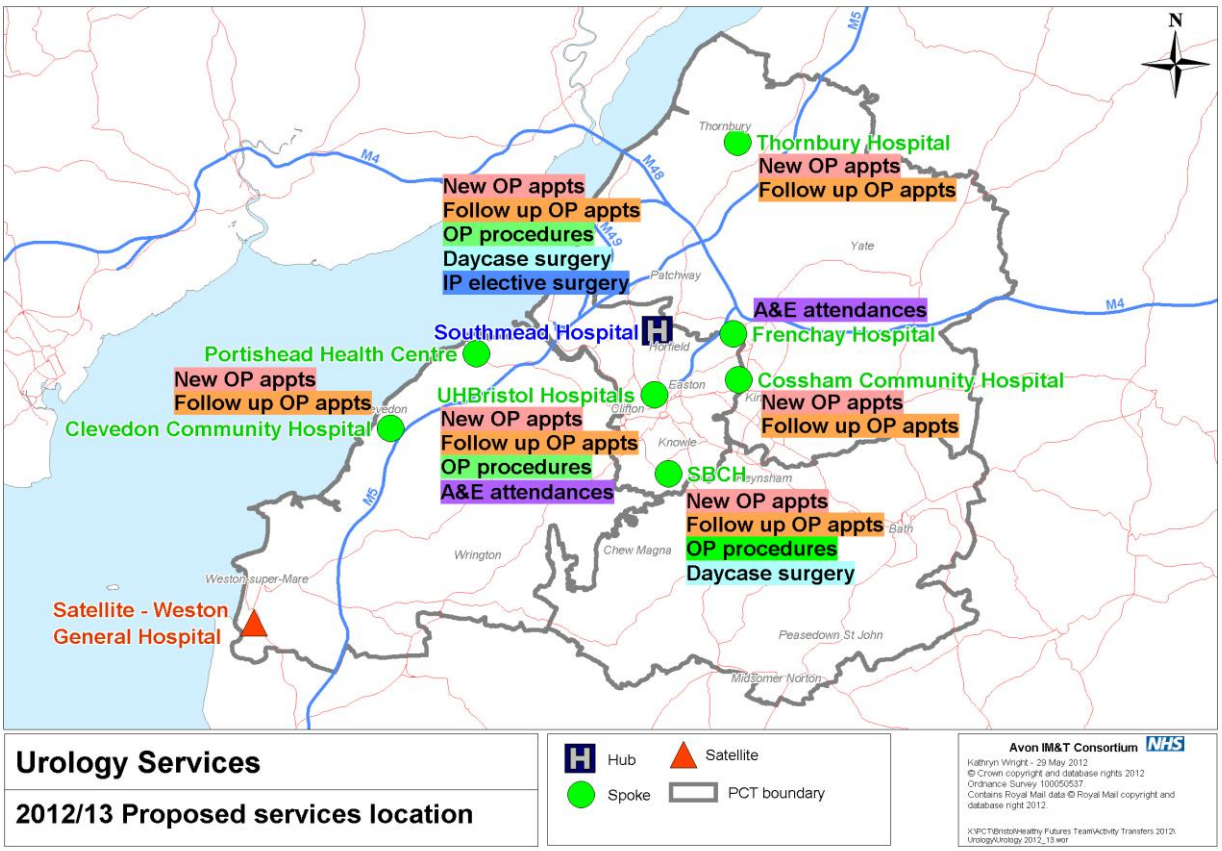
Rob Gittins, Programme Manager

Appendix 1: Chronology

Date	Activity	Outcome
2007	Complex urology cancer operations consolidated into Southmead Hospital	Centralised urology cancer operations
December 2010	Stakeholder event 1 The event included representation from patient groups, Local Involvement Networks, urology clinicians, GPs, commissioners and service managers.	The proposals for consolidation received broad support from the attendees, including a proposal from the audience to bring the management of all urology services under one organisation.
March 2011	Stakeholder event 2	Current plans for a new, improved clinical model for hospital urology services were shared and feedback received.
June 2011	Independent Panel Review event	Supported the consolidation of urology services
July 2011	Stakeholder event 3 (Patient Benefits workshop)	Patient benefits plan developed
July and August 2011	Health Overview and Scrutiny Committee Briefings	Council members were briefed on the proposals and feedback was received to ensure that members' views were considered in the future design of services.
October 2011	Stakeholder event 4	Proposed clinical model and service locations tested
December 2011	BNSSG commissioner service specification signed off by the chair of Urology Project Board	Service specification
January 2012	Clinical teams away day event	Agreement reached on details of revised service scope
April 2012	Further Health Overview and Scrutiny Committee Briefings	Council members were updated on developments with the proposal, and the interdependencies with the Breast and Head and Neck reconfiguration projects.
May 2012	Urology Project Board	NBT Provider Response document approved

Appendix 2: Maps of current and proposed configuration of urology services





Appendix 3: 11/12 actual and 12/13 post transfer proposed volumes by location

Activity	2011-12						
Owner	**NBT**	**UHB**	**UHB**	**NBT**	**NBT**	**NBT**	
Location	**Southmead**	**BRI**	**SBCH**	**Cossham**	**Clevedon/ Portishead**	**Thornbury**	**total**
New OP	4,961	3,105	0	180	175	80	8,501
F/up OP	11,603	5,103		180	175	80	17,141
OP Procedures	71	93	0	0	0	0	164
Daycase	6,135	3,322	0	0	0	0	9,457
Elective IP	1,584	599	0	0	0	0	2,183
Non-elec	749	454	0	0	0	0	1,203

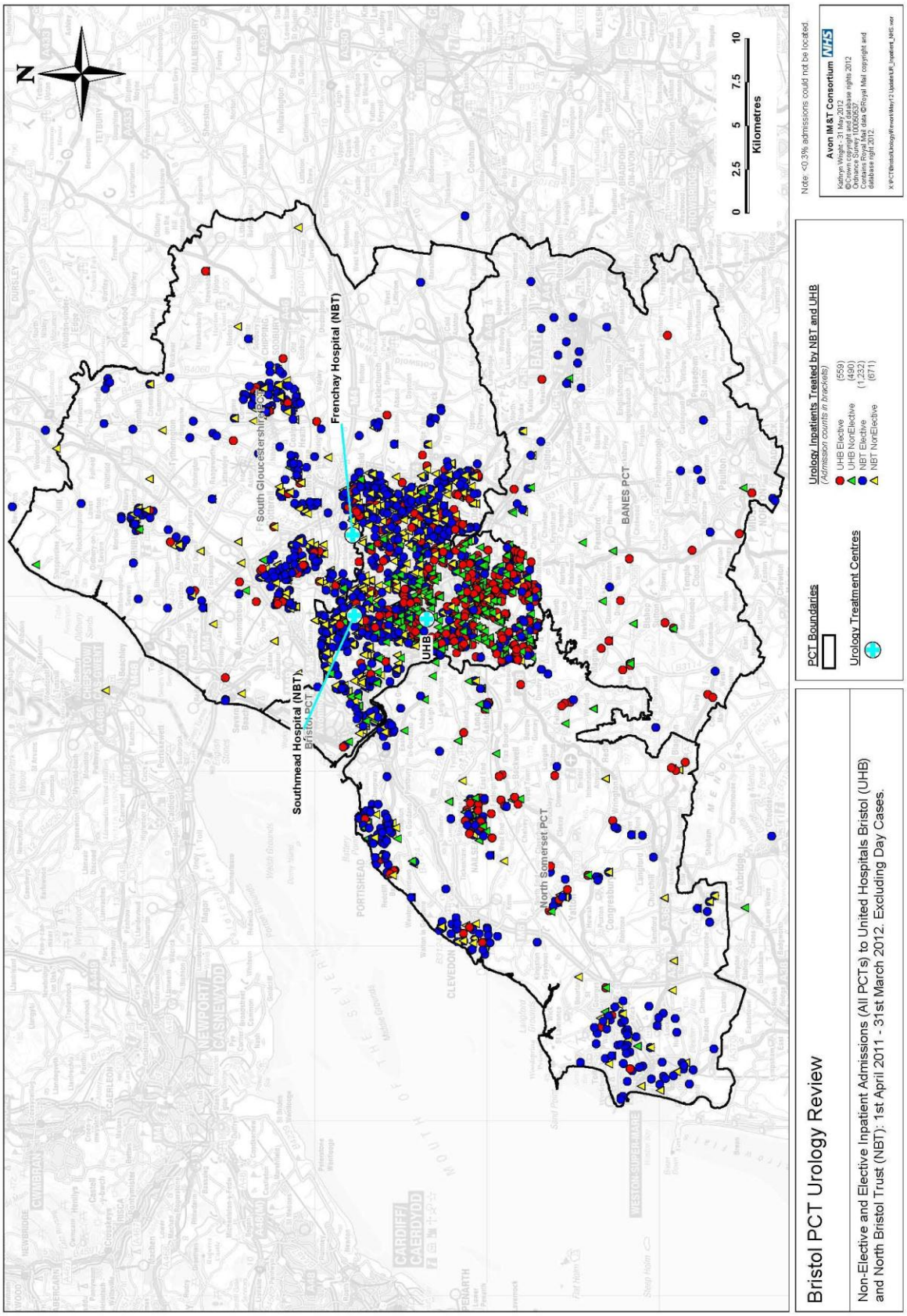
Source: NBT Performance team

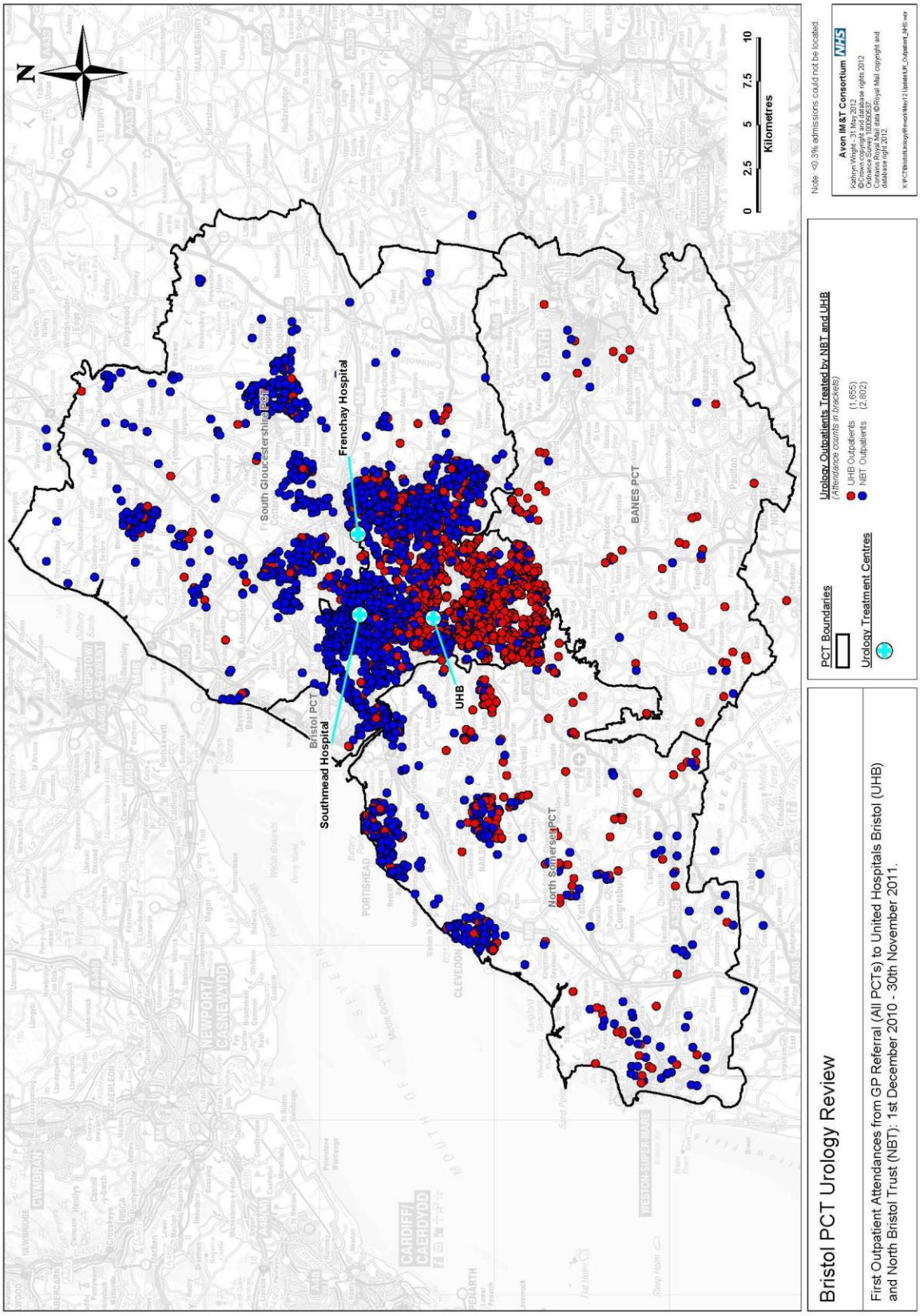
Activity	2012-13 FYE (planned distribution post transfer)						
Owner	**NBT**	**NBT**	**NBT**	**NBT**	**NBT**	**NBT**	
Location	**Southmead**	**BRI**	**SBCH**	**Cossham**	**Clevedon / Portishead**	**Thornbury**	**total**
New OP	5,366	852	1,636	273	136	68	8,331
F/up OP	12,695	1,278	2,454	409	205	102	17,143
OP Procedures	164	0	0	0	0	0	164
Daycase	8,200	900	600	0	0	0	9,700
Elective IP	2,274	0	0	0	0	0	2,274
Non-elec	1,157	0	0	0	0	0	1,157

Source: NBT Performance team

Note 1: Daycase include flexi figures, final distribution and quantum to be determined.

Appendix 4: map of referral locations and where services are accessed.




Bristol PCT Urology Review
First Outpatient Attendances from GP Referral (All PCTs) to United Hospitals Bristol (UHB) and North Bristol Trust (NBT): 1st December 2010 - 30th November 2011.
PCT Boundaries
Urology Treatment Centres
Urology Outpatients Treated by NBT and UHB
(Attendance counts in brackets)
UHB Outpatients (1,655)
NBT Outpatients (2,802)
Note: <0.3% admissions could not be located.
Kilometres
0 2.5 5 7.5 10
N
Frenchay Hospital
Southmead Hospital
UHB
Bristol PCT
South Gloucestershire PCT
BANES PCT
North Somerset PCT
Avon IM&T Consortium NHS

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 13 – Clinical Systems Implementation Programme (CSIP) – 'The Way Forward'

Purpose

The Clinical Systems Strategy, originally approved by the Trust Board in June 2010, has been reviewed and a supplementary document, 'The Way Forward' has been produced to reflect ideas and lessons learnt during the last year, and to clarify the purpose, content and planning of each proposed phase.

Abstract

'The Way Forward' describes the outcome of the recent review of the Trust's Clinical Systems Strategy, which was originally approved by the Trust Board in June 2010. Essentially the original vision contained in the strategy remains valid.

The core components of Phase 1, "Delivering the Foundations", were completed by the end of May 2012 with the implementation of the McKesson Medway PAS/EPR system (including the Clinical Desktop), JAC Pharmacy Stock Control system and the Imprivata 'single sign-on' solution, and the project team is now preparing to deliver the remaining components in August.

Phase 2, 'Consolidating the Patient Record', will run from October 2012 through to late 2013 and will support a step-change in the way we think about and use information technology and clinical information. Phase 2 will include an Electronic Document Management solution to help move away from paper-based clinical records and to improve the clinical workflow.

Phase 3, 'Delivering Clinical Decision Support', will include an Electronic Prescribing and Medicines Administration system to support and promote more efficient, effective and safe clinical practice in this area.

The Trust's current Long Term Financial Plan (LTFM) includes provision for CSIP capital at £4.0m in 2012/13 and £2.0m in 2013/14 for phases 1 & 2. In addition, £2.0m has been provided in respect of diagnostic systems replacement cost.

The costs of Phase 3 have not yet been fully identified. Specifically, the cost of ePrescribing (EPMA) and assumed to be at least in part financed by the South Acute Programme.

It is anticipated that the non-recurring revenue costs of implementing Phase 1b and Phase 2 will be up to £1.0m in 2012/13, 2013/14 and 2014/15. These sums are already identified in the Trust's LTFM.

The savings from harnessing opportunities provided by the new technologies are not included, however. These will be developed as benefits realized through the newly-formed technology transformation workstream through which we anticipate a net revenue benefit throughout the life of the Programme and beyond.

Recommendations

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

Executive Report Sponsor and Other Author

Sponsor – Finance Director, Paul Mapson
Appendices
• Appendix A – Clinical Systems Implementation Programme Strategy

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	30 May 2012				Trust Board Private Seminar – 18 May 2012 Service Development Group – 18 June 2012 IM&T Committee – 06 June 2012 CSIP Board – 20 June 2012

Clinical Systems Implementation Programme

University Hospitals Bristol NHS
NHS Foundation Trust

Clinical Systems Implementation Programme (CSIP)

Clinical Systems Strategy – June 2012

The Way Forward

Draft Version 2.0 - 26 June 2012

Version Control / Amendment History

Issue Status	Version	Date	Author	Input/Amendment Description
Draft	0.1	April 2012	Steve Gray	Version control only
Draft	0.2	May 2012	Steve Gray/David Watteau	Post review comments included
Draft	1.0	June 2012	David Watteau	Final formatting for CSIP Board
Draft	2.0	July 2012	David Watteau	Final formatting for Trust Board

Reviewers:

Name	Title	Date of Issue	Version
Andrew Hooper	Head of IM&T	May 2012	0.1
David Watteau	IM&T Programme Manager	May 2012	0.1
Simon Walrond	Clinical Liaison & IS Training Manager	May 2012	0.1
Paul Mapson	Director of Finance and Executive In-charge of IM&T	May 2012	0.2
CSIP Board	Members of the CSIP Board 20th June 2012 (including Divisional General Managers)	June 2012	1.0

Approval Route:

This document requires the following approvals.

Name of Group	Date of Approval	Version
IM&T Committee	6th June 2012	1.0
Trust Management Executive	May 2012	1.0
Trust Board	July 2012	2.0

Document Location

This is a controlled document.

On receipt of a new version, please destroy all previous versions.

Table of Contents

1 Executive Summary

1.1 Delivering the Strategy

'The Way Forward' describes the next steps in delivering the Clinical Systems Strategy that was approved by the Trust Board in June 2010.

After making this strategic decision to break with the National Programme for IT (NPfIT), UH Bristol has spent the last two years establishing and executing the Clinical Systems Implementation Programme (CSIP) so that, at the end of May 2012, we have delivered the McKesson Medway PAS/EPR, JAC Pharmacy Stock Control and Imprivata 'single sign-on' security solution and are now preparing for delivery of the final components of Phase 1. We are pleased to record that the original Strategy still holds true and our purpose now is to continue with its delivery in the light of our recent experience and on-going developments in the field of healthcare informatics.

Phase 1, 'Establishing the Foundations', has been characterized by a raft of complex activities culminating in a single 'big-bang' go-live of the Medway patient administration system and electronic patient record (PAS/EPR) in April 2012.

Phase 2, 'Consolidating the Patient Record', contains a sequence of equally complex activities building toward a series of go-lives that, while none of them will be as high-impact across the whole organization, will achieve an even bigger step-change in the way we think about and use information technology in the daily business of running the Trust. We see this next Phase taking us from October 2012 through to late 2013.

Looking further ahead to Phase 3, 'Delivering Clinical Decision Support', we can see how work on the previous Phases will have provided our clinical colleagues with a paper-light infrastructure that will promote a more cohesive means for us to collect, view, share and use our patient-based information.

1.2 The primary business cases

Following detailed research we have produced draft business cases for the two most substantial systems on our shopping list. These systems, Electronic Document Management (EDM, scheduled for Phase 2) and Electronic Prescribing and Medicines Administration (EPMA, scheduled for Phase 3), are notable in terms of their relative size, investment and anticipated benefits compared to other systems that we have considered.

For this reason the business cases have been commissioned to demonstrate that there is evidence of affordability. Electronic Document Management, in particular, requires a significant initial investment but, properly managed, will provide savings and tangible efficiencies at an early stage. The case for Electronic Prescribing is compelling but the payback period is less clearly evidenced and, for this reason, we are seeking to supplement our own investment with National funding through the South Acute Programme being conducted by the Department of Health Informatics Directorate.

1.3 Protecting our existing investments

However, whilst these two major systems may provide the functional nucleus of their respective Phases, we need to put equal emphasis on maintaining, developing and, where appropriate, adopting into the CSIP fold the wealth of small departmental and 'stand-alone' information systems that are in wide use around the Trust. These systems represent a huge on-

going investment and have for some time provided the detailed functional applications that have been relied upon by clinical colleagues.

Other major systems currently in use by the Trust are coming to the end of their service life-cycles and will be replaced, mainly during Phase 2. These include our current diagnostic ordering and results system (ICE), and the diagnostic imaging system (PACS). By integrating these functions into our new electronic patient record (EPR) using modern, easy-to-use and consistent systems we will ensure that our clinical and administrative colleagues will gain the direct benefits of a consolidated patient record.

1.4 Accessing, using and sharing our information

We will ensure that, having developed and delivered our new systems, we provide all of our staff with the means to access and use them whenever and wherever they need to using the most appropriate device for the job; whether it is a traditional desktop terminal or a hand-held mobile device, and whether data is collected using keyboard input, voice recognition or proximity reader.

Our focus here is to remove the barriers that often exist that result in data not being collected accurately, in real time, or even at all, and that no patient should be exposed to greater risk simply because we have failed to give our colleagues the means to get at critical information when they need it.

1.5 Making IT Work

Delivering this ambitious Programme requires detailed planning and deployment techniques. Following the successful go-live of Medway, the CSIP and IM&T team has adapted its support and delivery structure to cater for the increased demands of a more clinically-orientated user-base. As our reliance on these systems increases in the coming years, our capability to support and protect them becomes more important and we expect to move towards extended hours cover during Phase 2.

Similarly, our deployment team will engage and relate more closely with clinical colleagues to ensure that what we deliver meets requirements that are practical and properly applied. We will introduce an Informatics Transformation workstream that will be applied to all of our projects to ensure that we align with the Trust's Transformational goals--this will be increasingly important as our systems become more fundamentally involved with the delivery of care.

1.6 Funding and Affordability

We will be unable to make our Strategy work without proving the affordability of our proposals and providing the right levels of funding.

This will be achieved through a combination of direct investment in our informatics infrastructure, benefits-funded business cases, National funding where available, spending to save and, not least, making the best of our relationship with McKesson to secure innovative solutions and good value through our unique position as a Strategic Reference and Development Partner.

2 Introduction

UHBristol's Clinical Systems Strategy was originally approved by the Trust in June 2010 and resulted in the adoption of the Strategy and subsequent planning and delivery of the components identified as Phase1 of the Trust's Clinical Systems Implementation Programme (CSIP).

With the successful deployments of the Pharmacy Stock Control solution in November 2011 and the Medway Patient Administration and Electronic Patient Record (EPR) system in April 2012, the core components of Phase 1 of CSIP are now in place and the Trust is on course to deliver the additional Medway functions identified as Phase 1b during the summer of 2012. This sub-phase will allow us to use Medway to its full potential in terms of improvements to the software and to local processes.

Having successfully delivered Phase 1 of the Programme we have taken stock of the current position, which is now based on solid foundations, considered opportunities offered by new technologies and software engineering, reviewed IM&T in the light of the environment (both in and outside of the NHS) and created this update entitled 'Clinical Systems Strategy – The Way Forward'.

The Strategy is intended to cover a three to five year period from 2012 and is designed specifically to be visionary yet realistic and affordable. We can take considerable confidence from the way Phase 1 has been delivered as we now have the assurance that our original Strategy was fit for purpose and that the Trust has the wherewithal to deliver modern IT systems despite the huge complexity of hospital operations. The April Medway go-live can be considered to be one of the best implementations of its type ever achieved in the NHS.

This document then describes our progress to date and, by looking at the Trust's immediate and on-going requirements for Clinical Systems and associated IM&T facilities, defines and restates the underlying purpose of the successive CSIP Phases and proposes functional business solutions and enabling technologies as appropriate contents for each Phase.

Specifically:

- **Phase 1 – Foundations**

  This Phase has been designed and delivered to provide a firm foundation upon which to build the complex applications and business process changes that will be required to gain the benefits demanded of successive Phases.

  Live across the Trust with all PAS functions, theatres, ED and Maternity, Medway now provides the Trust with a fit-for-purpose, functionally rich and flexible foundation upon which to build additional clinical functionality as part of a comprehensive Electronic Patient Record (EPR) and we are now ready to capitalize upon this. Alongside the JAC pharmacy stock control system and single sign-on infrastructure, Medway completes the major deployments planned for this phase.

- **Phase 2 – Consolidating and Using the Patient Record**

  Giving clinicians appropriate single-view access to an up to date, unified patient record that is available anywhere, at any time, is a critical part of building towards a trust-worthy EPR that clinicians and colleagues can use to support the delivery of high quality patient care and reap the benefits that can be gained from a more cohesive and comprehensive record.

Industrial-strength, Trust-wide systems that have been proposed to meet this purpose include powerful electronic document and casenote management, better data capture technologies including digital dictation and voice recognition, stronger links to GP systems and a secure refreshed medical and general imaging capability. Alongside this we will conduct a systematic review of the information systems used around the Trust and, wherever possible, work with their owners to ensure that they are secure, resilient and provide the right levels of service.

- **Phase 3 – Delivering Clinical Decision Support and Transformation**

  Around the Trust we are already using advanced technology and informatics to provide clinicians with the tools they need to make better, more informed decisions about patient care.

  Our aim in Phase 3 will be to harness this existing demand and capability and to underpin it with investment in fundamental, Trust-wide systems that will deliver advanced clinical benefits across the board and provide an even more effective basis for innovation and transformation.

  For example, electronic prescribing and medicines administration, advanced imaging techniques and the availability of rules-based pathways management can make a fundamental difference to the Trust's clinical effectiveness and are capable of delivering significant financial benefits.

It can be seen that these Phases are defined according to purpose, not to time-scale. Independently, departments and business functions are already making investments in all of these areas. Our responsibility will be to provide a properly constructed framework into which existing solutions and technologies can be integrated with enterprise-wide capabilities delivered by the Programme.

Whilst each Phase will be self-contained in terms of its business case, benefits and change agenda, the sequence of the Phases needs to be retained to take advantage of the building-block approach, but we can see that Phases may well overlap as preparation for some later solutions may commence before earlier components have been fully deployed.

The following sections of this Strategy describe the Trust's current position in more detail; outline the business and benefits proposition for each Phase; present an outline plan for each Phase including the solution content and overall timescales.

Extracts have been provided from the Outline Business Cases that have been worked up for electronic document management (EDM) and electronic prescribing and medicines administration (EPMA) as examples of two of the more significant solutions that have been proposed to fulfil the Trust's Clinical systems Strategy.

The existing CSIP team will need to be re-modelled to present different skill sets for the next phases of the Programme, which will include a high level of clinical change management and a dedicated professional project management function to underpin the proven specialist workstream functions that have been used to deliver Medway. The initial success of the Medway project has reinforced the need for a permanent CSIP Programme Director to lead the team for the next three to five years.

Finally, we expect to capitalize upon the relationship we have established with McKesson, the supplier of our Medway PAS-EPR, by establishing a Strategic Partnership as an effective means to deliver this Programme in the most practical and economically advantageous way.

3 CSIP's Strategic Foundation Principles

The first iteration of the Clinical Systems Strategy communicated the challenges and opportunities of procuring and implementing replacement 'core' systems outside of the National Programme for IT. Reviewing the first version we have noted that the Core Statement and Foundation Principles are as valid today as they were in June 2010 and continue to guide the Trust's Information Management and Technology strategy and plans. They are re-iterated here to set the scene for the rest of the document:

3.1 CSIP's Vision

Our vision for the outcome of the Clinical Systems Implementation Programme is that it should be:

"A systematic programme of activities to deliver a cohesive set of clinically-focused software applications and technologies that will transform and underpin our business processes and provide clinicians and colleagues with the practical means to derive tangible benefits from improving patient care and better use of our assets and resources"

3.2 Foundation Principles

"Information Management and Technology will increasingly underpin service delivery and the Trust's success as a Foundation Trust. It will therefore provide fast, accessible and reliable services to make the capture, processing and display of information as relevant, quick and easy as possible for users. Building on existing strengths, it will be responsive to changing service and user needs, and will promote the delivery of leading-edge technology delivered to a high standard"

"The trust has built its Information Management and Technology strategy on these eight foundation principles:

- Putting in place an appropriate infrastructure and modernising the way the trust stores and communicates information
- Taking a lead on researching new technology to support changing patterns of working, making better use of existing technologies and ways of accessing and presenting information
- Working to national and international quality standards in the storage, use and transmission of patient data and wider information governance principles
- Having a formal methodology for working with local service providers. In particular adhering to the well proven Government recommendations of the Projects in a Controlled Environment (PRINCE) project management methodology supported by appropriate Office for Government Commerce Gateway Reviews
- Ensuring careful preparation by staff at all levels. Recognising that deploying an Information Management and Technology system is not a technology task, but a change management and benefits realisation challenge
- Following a structured management response to risk. Mitigation plans being drawn up in a proactive manner, addressing threats prior to them materialising and not simply being reactive after the event.

- Ensuring any contractor has proved the concept of its approach and that, where appropriate, Connecting for Health has validated that all of the core systems elements are working correctly before making an irrevocable commitment to implement
- Adopting financial prudence. The Trust will deploy a significant in–house Information Management and Technology capability to complete implementations successfully and avoid the need to spend large sums of money on purchasing external resources."

3.3 Other strategic requirements

There are also specific information technology requirements that a Foundation Trust must meet:

- Demonstrate that the information technology systems covering financial reporting and procedures are fit for purpose
- Demonstrate governance of information technology within the Foundation Trust committee structure
- Provide an overview of information technology systems including readiness for national initiatives such as the National Programme for Information Technology, choose and book, etc.
- Provide a summary of key risks for information technology that may impact the trust's plans, assessing likelihood, describing mitigation actions and detailing potential financial and non-financial impact, including describing the worst case scenario.

These principles and requirements have all been followed since the Information Management and Technology strategy was written and will continue to govern the implementation of the new Clinical Systems Strategy.

3.4 Governance of Information Technology in the Trust

To ensure that the Trust's information and technology systems are properly managed an Information Management and Technology Committee chaired by the Director of Finance operates with representative membership from other Executive Directors, General Management, Heads of Division and the IM&T Department. The Committee reports to the Trust Management Executive and undertakes the following core functions:

- To provide overall control, leadership and direction for all aspects of Information Management and Technology within the Trust
- To approve strategies, projects and implementation plans and monitor progress against plans
- To approve business cases within delegated limits or refer to the Trust Board for approval at, as defined in Trust Standing Financial Instructions and Standing Order
- To maintain oversight on projects authorized by the Committee, including achievement of project objectives and deliverables, realisation of identified and agreed benefits and assure adequate funding is available for projects, and to monitor expenditure against budget allocation
- To ensure integration with the Trust's modernisation agenda, change programme and redevelopment programme
- To oversee Risk Management including regular review of the high residual risks relating to IM&T issues

The Trust takes its Information Governance responsibilities very seriously and actively manages this function through the Information Governance Management Group that meets bimonthly. Specifically, purpose of the Information Governance Management Group (IGMG) is to:

- Establish, maintain and performance-manage an Information Governance Action Plan to achieve appropriate levels of compliance with the standards of information governance set out in the Monitor Compliance Framework and the various Care Quality Commission Essential Quality & Safety Outcomes
- Scrutinise and peer review draft Trust-wide procedural documents related to Information Governance and the Caldicott Principles in accordance with the Trust framework for procedural documents
- Provide the Trust Executive Group with advice and guidance on compliance with related Trust-wide standards and policy, and the management of associated risks
- Provide the Senior Information Risk Owner (SIRO) with advice and guidance on information policy,
- Ensure the Trust's Information Governance Management System, including its processes, procedures, protocols, training and awareness programmes, is in compliance with applicable legislation and regulation
- Monitor the implementation of the Trust's Information Governance Management System (IGMS).

The Trust has a structure in place to identify and mitigate information risks, which is headed by the Medical Director in his role as Senior Information Risk Owner (SIRO). The SIRO is supported in this role by Divisional Managers in their role of Information Asset Owners and the System Managers acting as Information Asset Administrators, each of whom are responsible for identifying risks and escalating them as necessary.

Other controls are achieved through staff training at induction and annual refresh; specific IT system controls (e.g. encryption of USB sticks and Laptops) to protect confidentiality and the identification and investigation of specific information governance incidents.

4 The Current Position

Progress on the CSIP Programme has remained true to the original vision and direction for Phase 1 as defined within the Strategy. Procurement and deployment have been successfully completed for Pharmacy Stock Control (PSC) with the JAC System in November 2011, and the Patient Administration System/Electronic Patient Record (PAS-EPR) with System C's Medway System, in April 2012.

The Strategy identified single sign-on as a 'key enabler', given the large number of UH Bristol clinical systems already deployed as well as the capability required for the PAS-EPR Clinical Desktop integration. Single sign-on has been successfully implemented and is now deployed to some 5,400 workstations with on-going benefits in terms of speed and convenience for logging on.

The PAS-EPR contract was awarded to System C Healthcare Ltd (now a McKesson-owned company) in May 2011 following an open and comprehensive procurement exercise. An implementation plan was developed and a go-live date of late-March 2012 was set. After an enhanced level of solution testing and user readiness was deemed necessary a new go live date was set and achieved in late-April 2012. The Medway solution covers all of the functionality defined within the Strategy – Patient Administration System functions, Emergency Department, Operating Theatres and Maternity – within an integrated, affordable offering and also provides the Trust with a toolkit for developing Clinical data capture forms (Medway 'Proformas') and easy-to-use connectivity to our existing systems through Medway's Clinician Desktop, which uses advanced Portal technology that is compatible with our existing single sign-on capability.

In the original strategy a phased approach to the deployment of the PAS-EPR was planned to manage the risks associated with changing core systems in a large Trust. However, the approach was subsequently reviewed with the selected supplier and it was agreed that a 'big bang' approach was in fact less risky and more beneficial for the Trust, and this has been proved to be the case.

A further stage, Phase 1b, is planned for delivery during the summer of 2012. Featuring some new functionality and software fixes identified at go-live, this stage will complete deployment of the core functionality of Medway and provide a base for the next Phases of the Strategy.

4.1 Progress against the Strategy

- Single Sign-on has been rolled-out successfully across the Trust and is now being maintained via 'business as usual' processes.
- Medway has replaced the HP-EDS Swift system – PAS, A&E, Theatres and Maternity went live on April 21 2012. Given the integrated nature of both the Medway and HP-EDS Swift suites, continuing with parts of both in use would have been technically challenging and confusing to users. Single go-live offered economies in terms of training and earlier overall delivery of benefits.
- The HP-EDS Swift legacy system has been set to 'read only', preventing users from making changes and enabling staff to refer back to it during cutover should the need arise. Later in 2012 data will be extracted and migrated into a Historical Data Viewer for any future uses (freedom of information, medico-legal, etc.) and the system will then be decommissioned.

- The Clinician Desktop is an integrated part of the Medway suite rather than a stand-alone solution and hence was incorporated into the April 2012 go-live. We have delivered the first tranche of the Clinician Desktop for existing systems:
- Sunquest ICE Orders and Results;
- Clinical Documents Service (CDS) including Sunquest's e-Discharge Summary;
- Diagnostic Imaging viewer;
- Clinical Coding using 3M-Medicode.

Further systems will be integrated into the Clinician Desktop by the in-house Systems Development team over the coming months including other imaging and ITU solutions.

- Medway's Clinical Support Toolkit (CST) is integrated within the Medway solution and enables UH Bristol to develop simple forms for capturing clinical data in many settings. This has already been used to replace some of the HP-EDS Swift legacy MDI functions but may allow the Trust to retire many of the small, stand-alone systems currently in use and to develop new clinical applications. There is clear benefit in bringing clinical data into the EPR , removing 'information silos' and providing effective information governance across all such data. IM&T will lead work on new developments.
- Pathology and Radiology results are being migrated into Medway to enable clinicians to view them without having to log into the Sunquest ICE orders and results service.
- Pharmacy Stock Control went live in November 2012. It is interfaced with the Pharmacy 'Apostore' robot and also provides information for the Finance department on drug issues and supplier payments.

4.2 Planning for the next Phases

As part of preliminary planning for subsequent Phases, an Outline Business Case is being developed for Electronic Document Management and, subject to approval; a procurement process could be commenced in summer 2012. A summary of the benefits and case for change is included as Appendix A.

Initial evaluation exercise of Electronic Prescribing options commenced in December 2011 with supplier demonstrations of current solutions, to inform our thinking in this area. A summary of the benefits and case for change is included as Appendix B.

As a part of the contract for the supply of the Medway PAS-EPR, the Trust negotiated the optional inclusion of several optional Medway modules including Order Communications and Results Reporting, Clinical Noting and Electronic Prescribing. It is likely that we will take advantage of at least some of these options as we move forward in to the next Phases.

4.3 Strategic Partnerships

Following on from the successful deployment of Medway with McKesson, the Trust recognizes that this supplier has demonstrated a high level of commitment and capability in many of the areas covered by the CSIP Strategy. We have commenced discussions at a senior level within McKesson to establish how we can make the most of our unique position as a Medway reference and development partner, and to ensure that strong technical and business integration is featured in each Phase of our Strategy's development.

5 The CSIP Phases

This section presents further detail on the earlier Phases of the Programme that are introduced in section 3.1, the CSIP Vision. Whilst this section is not intended to constitute a plan, it does list many of the candidate systems that are expected to be deployed within each Phase.

5.1 Phase 1 - Current Status

With the go-live of Medway PAS-EPR we have now moved into the delivery of the second stage of Phase 1 (Phase 1b), where we can concentrate on consolidating and enhancing the Medway solution and aligning the overall IM&T support arrangements with the needs of a more clinically-orientated, real-time solution:

- Consolidation of Medway phase 1 components including bug-fixes and go-live issues such as Casenote management enhancements and the ED attendance deletion
- Additional Medway functions provided under Change Requests such as VTE assessment compliance
- On-going development of Clinical data collection using Medway Proformas
- Continued delivery and support of systems through the IM&T Development Team
- Review and audit of Departmental Systems and Support
- The wider application of smartcard-based quick-logon for use in areas where terminals are shared by several members of staff (already used successfully in the emergency departments)
- The introduction of 'follow-me' desktops that allow staff to take the 'set-up' of their computer desktop wherever they go in the Trust using low-cost Virtual Desktop Integration (VDI) technology.

A project has been initiated to manage the delivery of this stage, which will also include the verification and acceptance of the overall Medway solution as the closure of Phase 1.

5.2 Phase 2 – Consolidating the Patient Record

As indicated previously, the purpose of this Phase will be to give Trust users appropriate single-view access to an up to date, united patient record that is available anywhere, at any time. It is a critical part of building towards a trustworthy EPR that clinicians and colleagues can use to support the delivery of high quality patient care and reap the benefits that can be gained from a more cohesive and comprehensive record.

Some work, e.g. the further development of Medway's Theatre Management module, will be treated as 'business as usual' activity as a part of our partnership with McKesson.

The following paragraphs provide a summary of some of the systems that have been proposed to meet the objectives of this Phase, some of which are replacements for existing solutions and others are new initiatives. Alongside these specific items the Programme will continue to support the selection and delivery of departmental solutions that have been proposed by Divisions and agreed by the IM&T Committee.

5.2.1 Diagnostic Systems Strategy

a) PACS and RIS Replacement

With the closure of the National Programme's contract with Computer Sciences Corporation (CSC) for Diagnostic Imaging (PACS) and Radiology Information Systems (RIS), the Trust is required to formulate and agree an exit plan that gives us full self-sufficiency before June 2013, at which point the Trust would be required to pay punitive costs to CSC.

Following consultation with neighbouring Trusts and other parties, we have initiated a project aimed at defining our requirements, procuring and implementing the various components needed to achieve this objective, which includes not only provision of the technical infrastructure and diagnostic imaging tools, but also the recovery of our diagnostic image data, much of which is currently held off-site at CSC's data centre.

We will work with other Trusts in our region on some elements of the procurement, particularly for those components concerned with sharing images and diagnostic information across organizations.

The delivery of our new Diagnostic Imaging and Radiology Information solutions will be managed as a part of a Trust-wide Medical Imaging Strategy that will take account of the needs of all departments who have an interest in this technology.

b) Pathology Systems Replacement

Depending upon the outcome of the North Bristol Trust 'Severn Pathology' proposal under consideration in autumn 2012 the Trust may need to replace its existing GE Ultra Pathology system, which is nearing the end of its supported life. This uncertainty has prompted us to make an appropriate allowance in the event that the Trust decides to not relinquish its Pathology Services.

5.2.2 Service Ordering and Reporting System Replacement

Recognizing that the Trust's operational requirements have moved on significantly since Diagnostic 'Order Communications' were introduced some years ago, UH Bristol plans to invest in a more broad-based Service Order Entry functionality that will allow clinicians to access all service requests in the same way and start the journey towards pathways-based ordering.

In terms of our current diagnostic ordering service, Sunquest ICE is deployed across the Trust for Pathology and Radiology Requesting and Reporting and has been integrated into Medway via the Clinician Desktop. We are importing laboratory and radiology result data into Medway to facilitate trending of numeric results and avoid delays to users when having to query ICE for large numbers of results, but the continued use of ICE does reduce the benefits available from full integration and involves the management of additional technical interfaces.

As a first step towards full Service Order Entry, it is therefore proposed that the Trust should exercise its contractual option for Medway Order Entry and Results Reporting so that ICE can be replaced and a far more extensive order catalogue can be implemented to include departments and services outside of the current radiology and pathology services.

5.2.3 Electronic Discharge Summary Replacement

Sunquest ICE e-DIS has been deployed across the Trust. It has been reported that it can take15-20 minutes of junior medical staff time to complete each summary. It is proposed that this system should be replaced by using the functionality in Medway and to that end a requirements specification has been drafted so that the supplier can help us to design the necessary configuration to be built into Medway.

5.2.4 Developing the Medway Clinician Desktop

An integral part of Medway, the 'Patient Home Page' is the focal point from which clinicians can gain access not only to information collected in all of Medway's functional modules but also portal access, via single sign-on and in 'patient context', to other systems in an outside the Trust.

We already have links to the Trust's PACS digital imaging solution, diagnostic results and reports and the Clinical Document Store and plan to introduce additional links over the next few months, but during Phase 2 we want to extend the range of systems available through the Patient Home Page beyond the Trust's boundaries to include Social Services, Child Health and Safeguarding, GP direct access, etc. We hope to capitalize on McKesson's commercial ownership of the CarePlus Child Health systems and Liquid Logic Protocol, which is used by Bristol City Council children's services, to promote early integration with these areas.

The use of Medway as a common, single point of access for all of our staff will enable us to maintain a much more cohesive view of the patient record, and supplementing this with patient information from elsewhere will deliver significant benefits in promoting cross-organizational working.

5.2.5 Building on the Medway Theatres Module

During Phase 1 we implemented the first version of the new Medway Theatres module, which is now in use across all theatre suites in the Trust. Phase 1b will introduce some additional features including simple resource conflict checking and theatre whiteboards. In Phase 2 we want to deploy more Medway features as they become available as well as looking at the potential for automated patient tracking and using our single sign-on capability to support fast proximity logons.

5.2.6 Electronic Patient Handover Replacement

The Trust developed an eHandover application but the uptake had been fairly low. It is proposed that the current system be replaced by using Medway functionality, although it is possible that an additional Medway module will need to be procured to achieve this. We are preparing a specification that can be used to determine whether Medway can provide this facility without upgrade once the user requirement has been realistically assessed.

5.2.7 Clinical System for Allied Healthcare Professionals

The Clinical Information System Suite (CISS) system has been used successfully for several AHP developments. Some AHP usage of the old HP-EDS Swift system is also made. The proposed strategy moving forwards is:

- For some new AHP systems, Medway's Proformas offer an integrated solution whereby AHP data can be shared with all clinicians. The IM&T will manage any new developments using Proformas where they provide an appropriate platform.
- Departmental databases that had previously been incorporated into the HP/IHCS PAS have been replaced using the Medway Proforma solution.
- Existing Clinical Information System Suite (CISS) solutions will remain for the time being until UH Bristol prioritizes the migration to Medway Proformas or other solution if this does not prove to be suitable.

5.2.8 Electronic Document Management

An outline business case is being prepared to deploy a comprehensive Electronic Document Management (EDM) and Workflow solution. A summary of the benefits and case for change for Electronic Document Management is included as Appendix A.

One of the high level aims for this project will be to ensure the Trust does not continue to rely on a mixture of electronic and paper-based information to support clinical care. It will also help to reduce the amount of paper that needs to be stored and retrieved by the Trust. Digitising a proportion of our existing paper store over time will release some storage space and reduce the overall cost of records management. The primary challenge will be to design a solution that is affordable within a realistic timescale.

5.2.9 Digital Dictation and Voice Recognition System

A business case has been approved in principle and procurement has commenced to deploy a Trust-wide Digital Dictation and workload management solution with a view to the introduction of Voice Recognition for clinical information capture at a later stage. Integration of the text-based end-product with Medway will be via CDS on the Clinician Desktop.

A key benefit of using this technology will be an improvement in the quality and timeliness if outpatient clinic letters to GPs.

5.2.10 Patient Self-Service Kiosks

Customer self-service capability in other industry sectors such as travel, banking and retail has increased the public's acceptance of properly applied technologies that allow the process of patient arrival and reception, amongst other things, to be automated for many outpatient areas. Alongside improvements in the formatting and content of documentation such as patient letters, the 'kiosks' generally employed for this purpose can often be used for other purposes such as providing patient information and directions. Benefits can include more convenient access and better throughput for some patient groups.

Many self-service solutions rely on technical interfacing with a Trust's patient administration systems, effectively duplicating much of the information that is used. Medway offers us the opportunity to develop and deploy a fully integrated option that could reduce both the overall cost and technical complexity. As a first step, installing a limited number of these devices in selected areas will allow us to prove the concept and develop the most appropriate level of service to meet our needs.

5.2.11 Mobile Technologies

With the introduction of new systems and services, we will commence a series of tests on various mobile platforms. Primary objectives will include the identification of appropriate use cases, proving the security, safety and robustness aspects of the various devices and establishing whether there is value for money in this area, e.g. is a 'bring your own device' (BYOD) policy practical.

This exercise will be undertaken as a part of our on-going IM&T infrastructure development programme, which is discussed in a later section of this strategy.

5.2.12 Ophthalmology Electronic Patient Record and Imaging Systems

Ophthalmology currently has two main systems that it uses alongside the Trust's core systems:

- Medisoft – a specialized Ophthalmology system interfaced with Medway that has now been in use for almost ten years. A procurement process for a replacement system is due to be commenced soon, the outcome of which may be renewal of the existing contract, although a more detailed requirements definition will need to be developed.
- Digital Imaging –a procurement process has been commenced for this requirement, which we need to align with our overall Imaging Strategy and to engage as part of our Digital Imaging (PACS) replacement to ensure that opportunities for cost savings can be identified.

5.2.13 Dental Systems

The Dental Hospital has previously implemented a specialist system known as Salud from Two Ten Healthcare. The use of the system has met with mixed results around the country and uptake at the BDH has been poor. We need to review the position with this system as the current contract is due to expire later this year and BDH has no provision for a replacement.

5.2.14 Assessing and Adopting the Trust's Existing Departmental Systems

The IM&T department is aware of at least 150 departmental systems (and many more that have not been 'discovered') used around the Trust that are being used for a wide variety of purposes and will be contributing operational benefits. We are currently providing interface-based data to feed many of these systems with patient registration and activity data from Medway.

CSIP will embark on an audit of as many of these systems as possible to establish the level of supplier and local support used, compliance with information governance, technical resilience and other factors according to the application involved. We envisage that some of these systems may, with the agreement of their owners, be good candidates for replacement using Medway's clinical data collection facility, Proforma.

Other departments may choose to take advantage of IM&T's capabilities so that the systems can be 'adopted' and managed centrally (subject to resource availability), although it is acknowledged that many will prefer to continue operating and supporting their own solutions once we have completed the audit process and assisted the departments in getting their systems up to the necessary compliance levels.

Appendix D contains a table of existing Trust systems known to the IM&T department.

5.2.15 Telemedicine

The development of robust, cost-effective Telemedicine has long been hampered by mixed results of its use in various health settings. Recent Department of Health initiatives have been inconclusive but it has been noted that they have tended to focus on smaller-scale exercises where benefits will always be difficult to extrapolate.

We propose that a review of Telemedicine-related opportunities around the Trust should be conducted to assess what we have been able to achieve so far and whether a structured investment could deliver more predictable benefits. We may identify some current Telemedicine activities during our audit of the Trust's existing systems and use this information to start the process.

5.2.16 Non-clinical Systems

The Trust operates a wide range of business systems that do not have a direct impact on clinical practice, yet are nonetheless critical to the Trust's business operations. It is suggested that these systems should also be reviewed and support arrangements revised as appropriate.

5.3 Phase 3 - Delivering Clinical Decision Support

Our aim in Phase 3 will be to further harness advanced technology and informatics to provide clinicians with the tools they need to make better, more informed decisions about patient care. To do this it will be necessary to invest in Trust-wide systems that will deliver advanced clinical benefits across the board as well as ensuring that existing investments are protected and incorporated into the overall solution wherever possible.

We are currently evaluating practical candidate solutions and enabling technologies that can contribute to this Phase. For example, the use of Electronic Prescribing and Medicines Administration (EPMA) may help us to reduce the number of Adverse Drug Effects recorded by the Trust, which will improve patient safety and contain our cost of litigation. There is also evidence that the introduction of this facility will, over time, reduce our drug spend and support our clinicians in achieving prescribing best practice.

Again, identifying an affordable solution will be a challenge so the Trust has applied to participate in the South Acute Programme (SAcP) being run by the Department of Health's Informatics Directorate in a group that is collaborating in the specification and procurement of Electronic Prescribing systems and through this hopes to benefit from National funding to assist in the necessary investment. A summary of the benefits and case for change for Electronic Prescribing and Medicines Administration is included as Appendix B.

Our work on proving the value and practicality of mobile access technologies during Phase 2 will also be applied here, where clinical decision support use cases are likely to feature the most appropriate applications for this technology.

The use of decision support systems and mobile technology within this phase will transform the way clinicians work across the Trust, so buy-in from the clinical community is a key factor in its success.

5.4 The Planning Process

Having identified the content of each Phase of the Programme we will need to agree an overall plan, which will need to take into account that each component is likely to require a separate, self-sustaining business case and must mesh in with the rest of the Phase.

In the case of Phase 2, we can see that this will be a complex plan that could potentially contain competing priorities, so an early stage in this process will be to determine the relative priorities of the candidate solutions through their respective business cases and from there derive their inter-dependencies and sequencing. The next stage will be an outline resource plan that will enable us to assess how achievable the combined projects will be, and finally a realistic modelling of the various projects and their stages.

The Medway PAS-EPR project has given CSIP some experience in the level of output and resourcing required to deliver major deployment projects. Whilst none of these projects will be of quite the same scale of the Medway deployment, the sheer variety of the candidate projects and their inter-dependencies are likely to be of a comparable level but with more 'go-lives' over a longer period, so the Programme will need to maintain access to a strong resource pool and good working relationships with the respective suppliers.

5.5 Time-scales

The timescales for delivery of the CSIP Phases are expected to be as follows:

Phase 1b **July to September 2012.**

Planning for this sub-phase is well developed and we expect to provide detailed time-lines in June 2012.

Phase 2 **October 2012 to October 2013**

Whilst we have a good grasp of the overall content of this phase we need to do more work on the sequencing and inter-dependencies before we can develop a firm plan that can be fully resourced, although the overall workload has been estimated and included in the revenue figures.

Phase 3 **November 2013 onwards.**

Electronic Prescribing and Medicines Administration could potentially be brought forward if the South Acute Programme delivers funding at an earlier stage.

6 Bristol Acute Services – Current IM&T Position

6.1 North Bristol

NBT went live on Cerner Millennium PAS delivered through the National programme and BT in December 2011. This implementation is recognized as having been problematic and issues are on-going. Millennium covers all functional areas except Maternity where NBT continues to use the Euroking solution. As yet the Trust has not replaced its Pharmacy Stock Control system.

The Cerner Millennium PAS at NBT is believed to be contracted until June 2015. The continuance and/or exit costs are not known to UHBristol at this stage but some other trusts in London and the South are known to be actively seeking to either replace Cerner or find cheaper alternatives away from the programme to maintain their solutions.

6.2 IT Integration in Bristol

Should a decision be taken to form a single Acute organization in Bristol the integration of the main clinical systems will become a major task and a prerequisite for realizing the benefits from such an organizational integration.

Essentially, a decision would need to be made as to which system would become the primary candidate to be developed and used into the future. This would either be Cerner Millennium (implemented at North Bristol) or Medway (UH Bristol). A full evaluation would be undertaken to reach the necessary conclusion. Due to contractual positions such integration cannot be achieved prior to 2015.

Whatever option is adopted in this eventuality, careful consideration must be given to the ways and means by which historical data can be extracted and loaded into the 'dominant' system so that a true, united patient record can be constituted. In practice this may not be possible for co-terminus periods and it may be necessary to provide an historical data viewer to make available those records that cannot be migrated reliably.

6.3 Information Sharing and Collaboration

In 2010 the Bristol, North Somerset and South Gloucestershire Interoperability Project Board (or 'Connecting Care' Project Board) was formed to examine ways to share data across the numerous care settings involved in the provision of patient care locally.

The Connecting Care Project Board considered that it would be advantageous to test out some form of system integration within three local areas. The three areas that were proposed were:

- **Urgent care**

  This is an important focus area within the NHS 'Quality, Innovation, Productivity and Prevention' (QIPP) challenge. Locally this area involves close interdependencies between GPs, Minor Injuries Units (MIUs) / Out of Hours (OOH), community nursing, and hospital emergency care.

- **Intermediate Care services**

  Locally this area involves close inter-dependencies between health and social care teams, although there are also links in with ambulance services, GPs, community nursing, and hospital emergency care.

- **GP to Child Health**

  Locally this involved a proposal to provide a link between GP systems and the Avon-wide Child Health system.

  A procurement is currently underway to complete a proof of concept that will:

  Deliver a 'quick win', i.e. something tangible within a couple of months

  Test out the technical aspects and prove the technical viability

  To see if the technical solution triggers a genuine interest and involvement from local clinicians and social care staff

  To use any successes in these areas to inform and build up the strategic programme

The Connecting Care Programme board has requested funding from UB Bristol to take part in the pilot project. It was deemed that without a business case to support the procurement we would not at this stage take part in the pilot but keep a watching brief on both the procurement and the subsequent pilot project to understand what benefits if any may accrue to the Trust.

However, it is our clear Strategic intent to support this initiative by working with our partners. An affordable proposal with clear benefits is awaited and a sum has been included for this project in the Business Plan.

7 Strategic Benefits and Transformation

Identifying and delivering cashable savings has traditionally been a major weakness in NHS Clinical IT implementations. It is the norm for anticipated savings to be listed and claimed in Business Cases but rarely delivered in practice, even when a structured benefits realizations plan has been put in place.

The UH Bristol approach is therefore to fully assess the costs of the Strategy and include these explicitly in the Long Term Financial Plan. Divisions are then able to utilize the new and improved systems to generate real savings in support of their CRES and Transformation Programmes.

It is proposed that a Technology Transformation workstream should be established with representation from all Divisions to identify practical and realistic ways to exploit the opportunities available from the new systems and to do so in a co-ordinated manner to avoid double-counting savings from multiple initiatives such as Electronic Document Management and Voice Recognition, both of which can have impacts in the same areas of efficiency and cost.

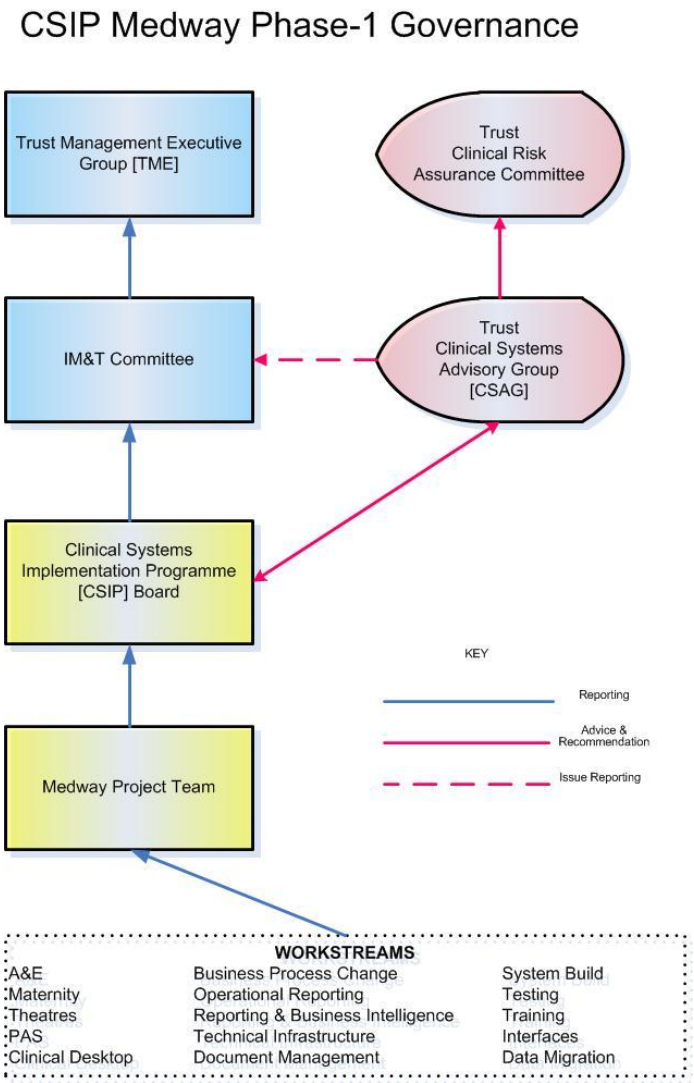
8 Programme Governance and Staffing structure

The Programme Governance and Staffing structure previously established has proved to be fit for purpose and continues to operate effectively. In terms of Programme staffing, the relationship between the IM&T department and staff assigned to CSIP is excellent, with individuals across the organization working together as required by their respective projects—this in itself has been a key factor in the success of the Programme so far.

Some changes have been undertaken, not least of which is the requirement for a more extended support organization since the go-live of Medway. The more extensive nature of the system and its operation has meant that out-of-hours support has been required, i.e. overnight and at weekends. We are adapting the support teams to meet this change in demand but have taken this as an indication that, with the introduction of more clinical systems, this level of support and its associated cost may need to continue.

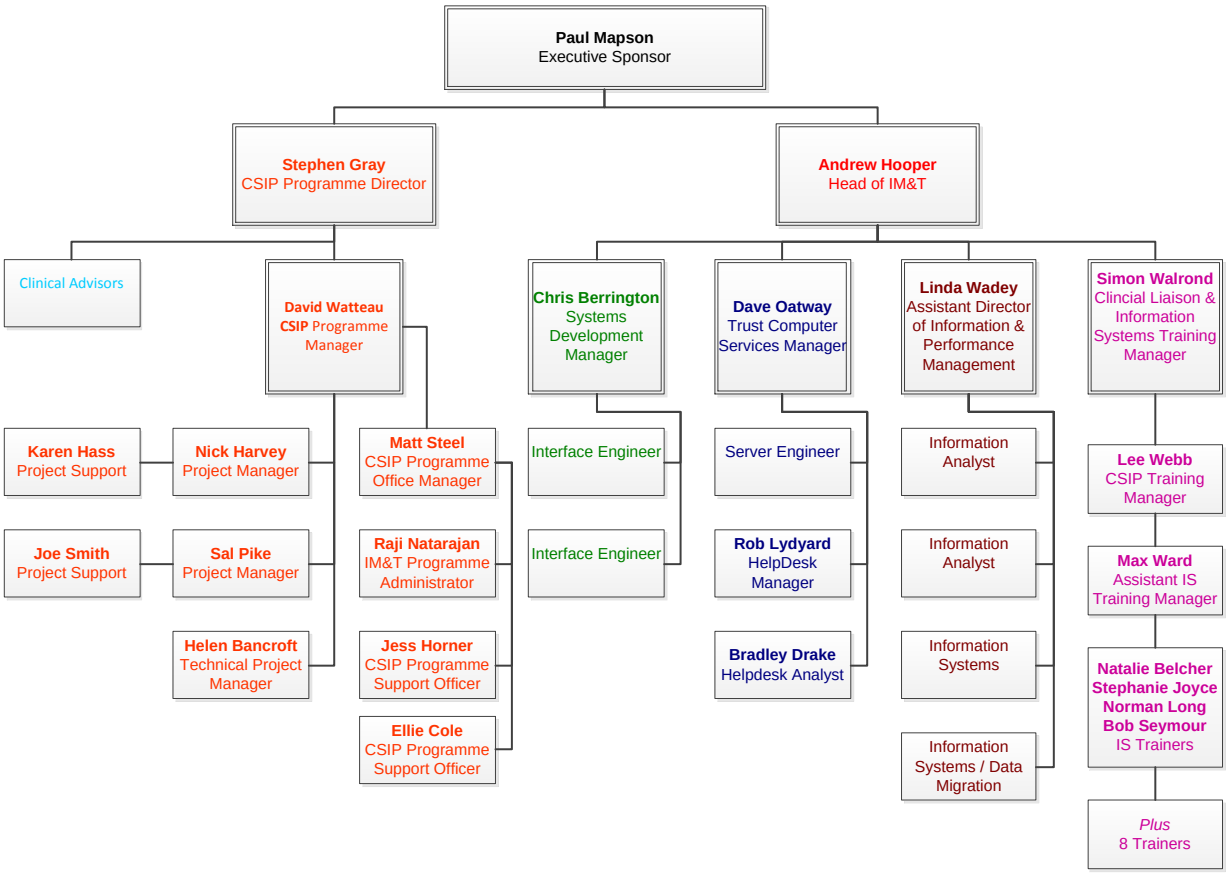
8.1 CSIP Governance

The Overall governance of Phase 1 is illustrated below. It is envisaged that this will continue into subsequent Phases.



8.2 The CSIP Programme Management Structure

CSIP Programme Management Structure



April 2012

8.3 Clinical Engagement

The Transformation Team has created an engagement plan that has been devised to work with clinical teams and clinical champions to improve service and patient pathway design. It is envisaged that CSIP will work within this plan where it provides a good conduit for the delivery of the strategy and its component solutions, although it is acknowledged that some of the CSIP projects may require more detailed engagement.

In addition, it is proposed that the Clinical Systems Advisory Group (CSAG) that was constituted to support Phase 1 by providing clinical advice and a resource to IT projects in the trust should be revised as a voluntary interest rather than remunerated group. In outline, the proposal is that the new CSAG will:

- Contain clinicians, including Nurses and Allied Health Professionals, who will contribute and have a genuine interest in clinical IT
- Be representative of each of the major clinical groupings in the trust.
- Include an IT department representative and one from management.

- Appoint a Chair and Vice Chair.
- Have a membership of 15-20 people.
- Be represented on the IM&T Committee.
- Meet on a monthly basis with a remit to review clinical IT projects with new or currents project presented by an invited speaker for discussion.
- Receive clerical support from the CSIP Programme Office.
- Comment and contribute ideas on specific IT projects, e.g. ePrescribing or the replacement PACS system.
- Contribute members to be involved in specific project groups.
- Make suggestions concerning any aspects of the Trust's IM&T activities and drive development of ideas that can benefit clinical services.

Membership of this committee will be recognized as an allowable activity under 'Managed SPA' in job plans.

8.4 In-house Capabilities

As a result of previous investment and recent experience during Phase 1, UH Bristol now has a strong, diverse team of professionals to form the nucleus of the project teams required to deliver the next CSIP Phases.

The IM&T department has a long-standing capability in the form of the Web Development Team of ten professional staff that has developed and supported a range of clinical and business solutions, many of which are still in use across the Trust. This capability will be maintained and used to provide on-going support for the extensive integration facilities that have been deployed, continued support for in-house solutions, and also to develop new clinical applications, particularly for mobile technologies, based upon Medway's published Web Services interfaces. This will allow us to take the initiative in delivering innovative clinical applications that meet our own requirements.

The development and implementation of in-house solutions will be managed in a more formal way than has previously been the case, to avoid dis-jointed application design with poor uptake and control of usage. The use of Medway as the core EPR around which new in-house modules can be developed will help to ensure that the solutions are more targeted and contribute to a more cohesive data model.

Alongside our core team members, we have made extensive use of specialist contractors, some of whom have contributed directly to the success of Phase 1 through previous experience that would not otherwise have been available within the Trust. The use of contractors allows us to flex the size of our project team to meet the sporadic demands of project work. However, contractors are an expensive resource and we may be advised to recruit into some of the more generic project roles to reduce overall costs and ensure that expertise is retained within the business.

8.5 Partnership with McKesson

McKesson describes itself as "the trusted healthcare technology solutions and services provider dedicated to helping its customers deliver high-quality healthcare by reducing costs, streamlining processes, and improving the quality and safety of patient care".

Following on from the successful deployment of Medway with System C (now a McKesson owned company), the Trust recognizes that this supplier has demonstrated a high level of commitment and capability in many of the areas covered by the CSIP Strategy. We have commenced discussions at a senior level within McKesson to establish how we can make the most of our unique position as a Medway reference and development partner, and to ensure that strong technical and business integration is featured in each Phase of our Strategy's development.

Our Partnership with McKesson will consist of two main activity areas:

- As a Reference Partner for prospective Medway customers to assess McKesson's Medway product and the performance of the company and its staff, and also as an informal point of contact to discuss how UH Bristol worked with McKesson to achieve the Gold Standard deployment and how this could be applied elsewhere.
- As a Development Partner for McKesson products including Medway.

The benefit of this activity, which will require the Trust to invest resource in both areas, will be to retain close links with the Company and, where appropriate, derive significant cost savings on products and services as well as reduced procurement expenses.

9 Hardware and Infrastructure

UH Bristol has invested in state-of-the-art IM&T facilities and staffing that permit us to create and maintain a professional, reliable infrastructure on which to deploy our clinical systems. Looking at the sequence of deployments within the CSIP Phases, it can be seen that incremental increases in storage and processing capability will be required to ensure that the performance and reliability of our systems is maintained as our reliance on electronic systems increases.

Anticipating the Trust's enterprise-wide Imaging Strategy, we have recently invested in a powerful Vendor Neutral Archive (VNA) storage farm, initially to be used to house our PACS images once they have been repatriated from the CSC data centre. Later in Phase 2 this facility will be used to host and share a variety of image sources.

The following section summarizes the additional and enhanced infrastructure that will be deployed to support the Clinical Systems Strategy, providing a high level of performance and resilience. It should be noted that some of the underlying infrastructure used by CSIP applications will be provided under the general IM&T capital budget.

9.1 The Data Centres

Our two main computer rooms already provide a high level of resilience that, over the coming months, will be improved to give us an even more reliable service. For example, we will be implementing:

- 'Data Centre Virtualization', which effectively gives the Trust a 'Private Cloud' that will allow us to manage and protect our systems more flexibly without the user community needing to understand the whereabouts of the systems that they use.
- Additional data storage space by increasing the capacity of our Storage Area Network (SAN), which is our enterprise-wide data storage facility. It is of interest that the volume of data being stored and managed within the IM&T department is doubling every 18 months.
- An industrial-grade back-up and transaction recovery capability to protect our SAN data storage facility. This will not only make the management of our data back-up processes quicker and easier to manage, but it will provide the means to ensure that in the event of a major system failure the Trust's data can be restored and operational as quickly as possible.

9.2 User Access and Devices

As we roll out more complex clinically-orientated systems we will increase the demand of colleagues to be able to use these new facilities and must there make it easy for people to access and use our Clinical Systems. As our Programme delivers, staff will be able to see an increasingly unified view of the patient record, including clinical, administrative and management information, all of which needs to be captured and viewed.

Staff need to be able to use whatever technology is the best for them do tackle the task in hand and over time we plan to make use of the best of proven technologies including wireless networks, laptops, hand-held devices, voice recognition systems, barcodes or conventional desktop computing, etc. Whatever devices we employ must be fast, relevant, flexible and easy to use.

Some of these technologies are mentioned elsewhere in this document, but other products that we are actively working on include:

- 'Virtual Desktop Integration' (VDI), which gives us the ability to use inexpensive and secure desktop devices to support the 'follow-me' desktop, whereby a user can log out of a workstation and then log in again at any other workstation and be returned to the same point in any open applications that they were using previously. Combined with proximity login devices, this will provide big benefits to users who are mobile or work in clinical areas with shared devices. We will be following up a recent 'proof of concept' by rolling out these devices in selected areas including ED.
- Electronic 'Whiteboards' supported by nearby touch-screens that can be used to broadcast and interact with displays of information relevant to their location, e.g. wards, ED, theatres, so that users can find the information they need with the minimum of fuss.
- Mobile technology covers a vast range of options for access and input techniques. We have already trialled a number of tablet devices and smart-phones and our intention now is to establish how to assure and standardize the physical and data security of the devices, controlling the use of 'bring your own device' (BYOD) environments, how to publish only Trust-approved applications, and the design of applications that are most relevant to operation on small screens. This is an exciting and rapidly developing topic that impacts several other areas that we are interested in, including telemedicine and off-site access.
- We expect to roll out more 'semi-mobile' devices across the Trust, for example, computers on wheels (COWs) that make better use of scarce desktop and floor space and can be moved nearer to the place it is needed.
- Proximity cards (RFIDs) offer a wide range of tracking and identification tools that can be used in many applications. We have already deployed smartcards in this context in ED, where they are being used for quick logon/off and user swapping and we hope to roll this out to more departments in the coming months. With appropriate tagging this technology can also be used to track equipment, patients and other assets in real time and we expect to trial some ideas for this during Phase 2. Similarly barcodes, now relatively old technology, offer excellent opportunities to register and track labelled items including patient wristbands, etc.
- Clinical colleagues in many departments are often the first to identify new ways of using new technology and we are keen to work with them to assist in making the best of these opportunities by bringing our knowledge of data and information security and integration to bear where it can be of use.

10 Financials

10.1 External Funding Options

Within the Strategy it was recognised that UH Bristol would have to fund the core systems but that other national initiatives which were only in early conceptual or discussion stages may provide funding. In the event of funding becoming available, UH Bristol would naturally seek to secure any funds available by those routes.

At the time the procurements were being awarded, the future direction and funding of both the National Programme (NPfIT) and the other Department of Health funding options were undecided. From documents released via the Strategic Health Authority, it was considered possible that such funding might be realized and solutions would be made available for Trusts from around the end of 2011. This funding route did not materialize.

A new potential funding route, the South Acute Programme, has been created again led by the DH Informatics Directorate (formerly CfH) on a regional basis. UH Bristol has recently applied to participate in one of the collaboration Groups working on Electronic Prescribing and Meds Administration.

10.2 Internal or External Solution Options

Given the uncertainty over National Programme funding levels the approach of including options for the purchase of additional functional modules within the PAS-EPR contract is sensible and avoids UH Bristol being locked into the national solution or having to run additional procurements for every part of the Trust's IM&T programme.

However, McKesson solutions will not be adopted unless they are proven to be appropriate for the Trust, competitively priced and fit for purpose. Potential solutions that could be selected through this route include Clinical Service Ordering and Results Reporting, Clinical Noting, Electronic Prescribing and Patient Self-Service Kiosks. As a development partner, UH Bristol may also benefit from joint working with McKesson to develop additional Medway modules that could fulfil other requirements.

Where existing procured contracts allow for additional modules to be purchased the Trust will not engage in open procurements where a clear value-for-money benefit can be evidenced. This is, however, only likely to apply to Medway and associated products through the benefits offered by the proposed Strategic Partnership with McKesson.

For most of the candidate solutions within the Strategy (as well as departmental systems requested through the IM&T committee) it is envisaged that open procurements will be used, thereby ensuring that we gain a wide choice of solutions at the initial stage of negotiations.

The IM&T department has a long-standing development capability that has developed and supported a range of clinical and business solutions, many of which are still in use across the Trust. It is envisaged that this capability will be maintained and used to provide on-going support for the extensive integration facilities that have been deployed, continued support for in-house solutions, and also to develop new clinical applications, particularly for mobile technologies, based upon Medway's published web services interfaces.

10.3 Capital Costs

The Trust's current Long Term Financial Plan (LTFM) includes provision for CSIP at £4.0m in 2012/13 and £2.0m in 2013/14. Of this £2.0m is required to fund the costs from Phase 1 leaving the balance of £4.0m to deliver Phases 1b and 2. In addition, £2.0m has been provided in respect of diagnostic systems replacement cost.

The costs of Phase 3 have not yet been fully identified. Specifically, the cost of ePrescribing (EPMA) and assumed to be at least in part financed by the South Acute Programme.

10.4 Revenue Costs

It is anticipated that the non-recurring revenue costs of implementing Phase 1b and Phase 2 will be up to £1.0m in 2012/13, 2013/14 and 2014/15. These sums are already identified in the Trust's LTFM.

The need to keep pace with the growth of data being produced and retained by the Trust (currently doubling every 18 months) will create a net recurring cost pressure of £0.3m per annum.

The savings from harnessing opportunities provided by the new technologies are not included, however. These will be developed as benefits realized through the newly-formed technology transformation workstream through which we anticipate a net revenue benefit throughout the life of the Programme and beyond.

Appendix A: Electronic Document Management (EDM)

Summary of the Case for Change

- the current mixed paper and electronic systems of record-keeping create unacceptably high levels of clinical risk through a lack of cohesion and no 'one place to look' for a patient's history
- the Trust requires an EDRM system that is capable of integrating easily with the Trust's Medway EPR solution;
- the hospital requires a 'paper-light' environment which is not achievable with the current IT and record-keeping systems;
- the current paper-based system does not facilitate the rapid delivery of essential patient information to the point of care, which may be geographically a significant distance away i.e. the South Bristol Community Hospital. It will also support the recentralisation of Oncology and Urology services and any future amalgamation with North Bristol NHS Trust
- staff spend significant time retrieving notes from around the Trust and less time on front line operational work which will affect the availability of notes to clinics and wards;
- business activity and performance is affected by missing case notes
- the main onsite library space (BRI) could be released for direct clinical activity or other purposes and hence assist with alleviating the Trust's need for additional estate;
- physical storage of paper records is expensive, as is filing, retrieving, searching and transporting hard copy records.

Summary of High-Level Anticipated Benefits

Staff Time and Cost Reductions in:

- Clinic preparation of hard copy casenotes
- Filing, retrieval and management of casenotes.
- Transport and portering costs.
- Chasing, managing and reviewing casenotes.
- Transport to and from remote locations such as the South Bristol Community Hospital.
- Stationery costs (folders, binders, dividers).

Space:

- Recovery of space – no more records added to the stores; no new physical space and investment in storage systems.

Availability:

- 24/7 available records permitting record sharing with multiple users and across multiple sites.
- Improved customer and reduction in cancelled clinics, operations, etc.

Clinical and Information Governance:

- Improved privacy protection and confidentiality.
- Permits legal admissibility.
- Permits organisation-wide integration and unification of patient-identifiable records
- Eliminates multiple and duplicate copies of documents.
- An end to loose unfiled documentation.
- Minimises the risk of missing records.

Improved business processes:

- Improved productivity and efficiency
- Time saved storing and retrieving records and filing of paper documents.
- 'Workflow' facility available to manage the progress of common tasks.
- Reduction in costs of complying with Subject Access Requests.

Innovation:

- Platform for e.g. a GP access service; advanced audit tools.
- Support for increased information analysis of data (dependant on level of indexing);
- Improved support for MDT, research and shared clinics.

Appendix B: Electronic Prescribing and Medicines Administration (EPMA)

Summary of the Case for Change

- There is a need to improve the legibility and accuracy of prescriptions and medicines Administration records. Annual prescribing audits frequently identify prescriptions with missing or inaccurate information. Audits of medicines administration records also show incomplete entries, raising doubts whether treatment has been given or not.
- There is an urgent demand to reduce drug prescribing and administration errors which in turn will reduce the large number of costs due to mistakes and litigation.
- Poorly prescribed or inappropriately administered medicines often result in an extended length of stay, serious harm or patient death. The number of Adverse Drug Reactions reported in the Trust during the six month period between 2011 / 2012 was 568. Adverse reactions result in increased length of stay, the prescribing of additional medicines, admission to Intensive Care.
- A considerable amount of staff time is spent retrieving, reviewing or rewriting written prescriptions and medication charts to raise their quality to an acceptable standard, which can give rise to confusion and delays to patient treatment
- The current mixed paper and electronic systems of record-keeping create unacceptably high levels of clinical risk through a lack of cohesion and no "one place to look" for a patient's medication history.
- The hospital requires a 'paper-light' environment in which paper is produced, managed, transported and stored only at an absolute minimum level.
- Each paper chart can only be in one place at a time and even on the ward, the chart may often not be where it is needed, necessitating a search and wasting staff time.
- Most prescribing is performed by the most junior staff, who are less aware of the potential for prescribing errors and their impacts. This, combined with the poor quality of the written prescriptions, poses a very high risk of patient harm and consequent litigation due to prescribing and medicines administration errors.
- There is a requirement to provide access to relevant patient information at the point of prescription and drug administration, including patient allergies, assessments, risk scores, medication and consultation history, and hence a need to integrate the EPMA solution with the Medway EPR.
- There is a requirement to promote or enforce the substitution for generic brand drugs from branded expensive drugs.
- There is a need for reliable and easily accessible audit trails and the ability to access who played a role in each patient's care (i.e. who prescribed medicines and who administered them and when).

Summary of High Level Anticipated Benefits

Operational Benefits

- Prescriptions always available at point of need and at multiple sites
- Facilitates compliance with policies (E.g. antibiotics) and formulary
- Accurate and timely record of all medicines administered;
- Information on medicines availability at the point of prescribing
- Ability to target Clinical Pharmacist activity to patients with greatest need.

Patient Care and Safety Benefits

- No legibility or transcription issues;
- Identifies medicines interactions at the point of prescribing;
- Allergy warnings always available and linked to medicines selection;
- Reduce selection, dose, frequency and duration errors;
- Reduce risk of administration errors;
- Reduced delays in treatment
- Enforce national policies e.g. NPSA Safer Practice Alerts;
- Ability to quickly identify high risk patients;
- Ability to restrict the prescribing of high risk medicines;
- Accurate medication histories able to be transmitted to GPs including changes to therapy.

Financial Benefits

- Ability to accurately cost medicines treatment to the level of what patients have actually received
- Ability to accurately track PbR excluded medicines;
- Reduced cost of dealing with medicines-related adverse events;
- Staff time saving as no more searching for missing medication charts;
- Management and control of medicines expenditure through enforcing Trust formulary policy
- Reduction of medicines waste from poor prescribing;
- Improved Working Practices and Quality
- flexibility to allow better working practices;
- optimised production of clinical correspondence;
- no rewriting of prescriptions needed due to poor handwriting and misspelling.

Improved Support for Patient Care

- clinicians ‘single system’ view of patient information;
- alerts rules for abnormal results/risk re allergies, dose, frequency etc;
- real-time clinical decision support, protocols etc;
- improved safety & security (positive patient I.D.);

- facilitates timely discharge;
- Better Patient experience

Improved Management of Litigation Risks

- reduction in litigation risks;
- ability to carry out for accurate audits in a timely fashion.

Improved Administration (& Reducing Paper)

- reduces administrative time;
- reduced reliance on paper and filing;
- improved data quality to support coding, costing and improved management reporting.

For the Trust

- better data quality and real time information to support audits and reporting;
- more satisfied patients;
- EPMA systems are also able to produce discharge letters, reducing the number of systems clinical staff need to be familiar with;
- IT infrastructure being installed as part of this project, i.e. mobile devices, can be used for other clinical data capture e.g. patient observations at the bedside.

Appendix C: Catalogue of UHB Non-core Systems

The following systems are being actively used across the Trust. IM&T is aware of these systems and in many cases supports their use and provides a hosting service for the central hardware components. We expect to expand this list as new systems are uncovered during our Trust-wide systems audit.

Department	System	Hosting	Interfaced?
Audiology	Auditbase – Paediatric Audiology	Internal	Yes
Audiology	Practice Navigator – Adult Audiology	Internal	Yes
Audiology	EARS – Paediatric Audiology		
Audiology	eSP – Paediatric Audiology		
Audiology	Cochlear Implant – Paediatric Audiology		
Audit	Clinical Audit server	Internal	
Bank	Rosta Pro system	Internal	
Cancer Services	Bristol Cancer Register	Internal	Yes
Cardiac	MUSE (ECG storage)	Internal	Yes
Cardiac	Innovian CIS (chart assist no longer applies)	Internal	Yes
Cardiac	Cardiac Audit PATS (Dendrite)	Internal	Yes
Cardiac	HeartSuite	Internal	Yes
Cardiac	CARDASS	Internal	
Cardiac	Clinical Trials		
Cardiology	EAServer (PACS)	Internal	Yes
Cardiology	Image Vault	Internal	Yes
Child Health	CarePLUS Child health	External	Yes
Clinical Coding	Medicode	Internal	Yes
Clinical Liaison	CISS AHP System	Internal	Yes
Clinical Trials	CRISP, PROMIS, TANDEM, TITRe2, VERDICT		
Colposcopy	Colposcopy	Internal	
Critical Care	RapidComm	Internal	
Critical Care & CICU	ITU Monitoring- Innovian (ChartAssist)	Internal	Yes
CSSD	CSSD	Internal	
Dental	Labtrac (Dental Laboratories)	Internal	Yes
Dental	Dental EPR (Salud)	Internal	Yes
Dental	Community Dental (PDS)	Internal	Yes
Dental	Mediadent (Dental PACS)	Internal	
Dermatology	ADIS	Internal	Yes
Dev Team	Integration Engine	Internal	Yes
Dev Team	Non Clinical Web Applications	Internal	Yes
Dev Team	Clinical Web Apps	Internal	Yes
Dev Team	CONNECT/WORKSPACES	Internal	
Digital Dictation	G2 Speech Recognition Pilot	Internal	
Digital Dictation	Soliton Radiology Speech Recognition Pilot	Internal	
Endocrinology	Endocrine		Yes

Department	System	Hosting	Interfaced?
Endoscopy	Scorpio	Internal	Yes
EROS	Supplies requesting	External	
Estates	Estates Cluster	Internal	
Estates	HelpDesk	Internal	
Estates FM Services	Blick Time management		
Department	System	Hosting	Interfaced?
Finance	All Finance Systems	Internal	
Foetal Medicine	ViewPoint (Foetal Med)	Internal	
Genetics	Shire (Clinical Genetics)	Internal	
HR	ESR	External	
HR	Employee Services	Internal	
Infection Control	ICNet	Internal	Yes
Information	PHD	Internal	Yes
Information	CACI (PAD)	Internal	Yes
Information	CACI (InView)	Internal	Yes
Information	Op		Yes
IT Services	Aventail Remote access server	Internal	
IT Services	Exchange (Email & Fax Server)	Internal	
IT Services	Helpdesk	Internal	
IT Services	Mildred (Personal & Group Shares)	Internal	
IT Services	Phone Mail	Internal	
IT Services	Office Communicator	Internal	
IT Services	NightWatchman		
IUVO	IUVO		Yes
Mattress Loans	eTrace	Internal	
Medical Director Team	NET Consent	Internal	
Medical Illustration	WABA (Medical Illustration Database)	Internal	
Medical Records	Aurora	Internal	Yes
Medical Records	PROSE/DOC1/WinDip	Internal	
Medway	Medway (A&E, PAS, Theatres, Maternity)	Internal	Yes
Medway	Choose & Book	Internal	Yes
MEMO	SEMS, Asset register and call logging system	Internal	
MEMO	SEMS (Equipment Management System)	Internal	
Neonatal	Neonatal DB	Internal	Yes
Neonatology	Badger 3 (CleverMed)	Internal	Yes
Neurophysiology	EEG recording and review	External	
Occupational Health	OPAS	Internal	
Oncology	Adult Chemo Care	Internal	Yes
Oncology	BRCH Chemo Care	Internal	Yes
Oncology	Mosaic	Internal	Yes
Oncology	VARiS	Internal	Yes
Oncology	WinDIP (Scanned Patient Notes)	Internal	
Oncology	VARiS Acuity	Internal	

Department	System	Hosting	Interfaced?
Oncology	BHOC-1 (Personal & Group Shares)	Internal	
Oncology	Visir (OncologyManagement System)	Internal	
Oncology	OMP Treatment Planning	Internal	
Oncology	X-knife	Internal	
Oncology	IRREG	Internal	
Oncology	BrachyVision	Internal	
Oncology	IMSure MU calculator	Internal	
Oncology	CASS Planning workflow manager	Internal	
Oncology	AcQsim CT simulator	Internal	
Oncology	Haemophilia Clinical system		Yes
Ophthalmology	BEH Medisoft	Internal	Yes
Department	System	Hosting	Interfaced?
Ophthalmology	BEH Databases	Internal	Yes
Ophthalmology	BEH EPR	Internal	
Ophthalmology	Diabetic retinopathy	Internal	
Ophthalmology	TopConn Imaging solution	Internal	
Order Comms	ICE Order Communications	Internal	Yes
Out Reach	MedICUs	Internal	Yes
Pain Management	MedICUs	Internal	Yes
Pathology	Ultra Lab Management Syste,	External	Yes
Pathology	Pathology Group Shares		
Pathology	Ward based blood glucose monitoring		
Pharmacy	JAC Stock control	Internal	Yes
Pharmacy	South West Drug Info – MI DataBank	Internal	
Pharmacy	Pharmacy Webtracker	Internal	
Pharmacy	RAID anticoagulation dosing system	Internal	
Pharmacy	Radiopharmacy Unit	Internal	
Pharmacy	ADIOS	Internal	
Pharmacy	PSU (Cytobase)		
Pharmacy	Blood Products (Vigam)		
Pharmacy	Pharmacy Group Shares		
PICU	PICU Badger	Internal	Yes
PICU	MedICUs	Internal	Yes
PODS	PODS		
Radiology	GE PACS Imaging system	External	Yes
Radiology	HSS CRIS	External	Yes
Radiology	BBRad	External	
Radiology	Avon Brest screening (NBSS) ABS/Insignia	Internal	Yes
Radiology	Radwise	Internal	
Radiology	IUVO	Internal	
Radiology	Pukkaj	Internal	
Radiology	Medstamp	Internal	
Radiology	Orthoview	Internal	
Radiology	Terrecon or AquarisNet	Internal	

Department	System	Hosting	Interfaced?
Radiology	Magicweb		
Radiology	Cedera		
Radiology	FTP Service		
Renal	Renal Clinical system	External	
Risk Management	Ulysses	Internal	Yes
Sexual Health	Mill (Telecare)	Internal	
Sleep Service	Sleep unit	Internal	
Thoracics	Thoracics	Internal	
Trackpoint EPR	Trackpoint EPR		Yes
Training	Learning Management system	Internal	
Urology	Mandata	Internal	Yes
Vascular	Vascular Clinical system	Internal	
Vascular Studies	VSU 2000	Internal	

Appendix D: Glossary of Terms and Abbreviations

Several technical terms and abbreviations have been used in this document.

Term	Abbreviation (where relevant)	Meaning
Clinical Systems Implementation Programme	CSIP	The Trust's clinical IT systems programme endorsed by the Trust Board in June 2010. Implementation began in 2011/12 with Imprivata Single Sign-On, the JAC Pharmacy system and the Medway PAS (including ED and Theatres) and Maternity Systems.
Digital Dictation	DD	A system which records voice files and stores them digitally for subsequent retrieval and manual conversion to text for incorporation into the EPR
Electronic Document Management	EDM	Provision of documentation in electronic form, typically sourced from scanning paper originals. The Trust plans to scan patients' clinical casenotes to move away from paper and contribute to the EPR
Electronic Patient Record	EPR	A system, or more typically a suite of integrated systems, which holds the majority of clinical information about individual patients, viewable in one place by those who need to see it. EPRs are usually built incrementally, and the UHBristol CSIP strategy supports this approach.
Electronic Prescribing and Medicines Administration, also known as ePrescribing	EPMA	A computer system which provides intelligent support for prescribing and administration of medicines to individual patients to improve safety, effectiveness and efficiency. The system is linked amongst others to the EPR, an up-to-date drugs database and the Pharmacy stock control system.
Information Management and Technology	IM&T	The Trust department responsible for IT provision and support, including hardware (servers, network, PCs etc), IT systems and interfaces, information and reporting, IT training, clinical coding and medical records management
JAC Computer Services Ltd	JAC	The company that supplies and maintains the Trust's Pharmacy Stock Control system
McKesson		A large US healthcare company with a significant presence in the UK, which acquired System C Healthcare in May 2011.
Medway		The computer system supplied to the Trust by System C/McKesson which records patient information for hospital-based episodes of care, including emergency care, inpatients, theatres and outpatients

Term	Abbreviation (where relevant)	Meaning
Medway Clinician Desktop Also known in Medway as the 'Patient Home Page'.		The function within the Medway system that integrates multiple systems into Medway to enable clinicians to access clinical information about individual patients all in one place. It includes single sign-on and single patient search across all the integrated systems and enhances efficiency and clinical safety.
Medway Maternity		A specialist module designed for recording information about mothers and babies around pregnancy and birth
Picture Archive and Communication System	PACS	A system that manages the storage and routing of digital images such as radiology and cardiology diagnostic examinations.
Patient Administration System	PAS	A computer system which records patient information for hospital-based episodes of care, including emergency care, inpatients, theatres and outpatients
Pharmacy Stock Control	PSC	A system for maintaining stocks and issuing medicines, with links to the EPR, the pharmacy robot, a drugs manufacturing system and the Trust's finance systems
System C Healthcare	SCH	The company that originally produced and owned the Medway and Medway Maternity systems, and which is now owned by McKesson
Virtual Desktop Integration	VDI	The use of inexpensive devices that can be used to provide access to Trust applications together with a 'follow-me' desktop, whereby a user who logs out of a workstation can log in again elsewhere and see their desktop the same as it was in the previous location.
Voice Recognition	VR	A system which records dictated information and automatically converts it to searchable text for incorporation into the EPR

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 14 – Big Green Scheme

Purpose

To update the Board on progress made on the Sustainable Development Plan in 2011/12 and outline future plans for 2012/13 and beyond.

Abstract

The report celebrates the successes of our Big Green Scheme and describes the Trust's progress in becoming a sustainable organisation. The priorities identified for 2012/13 are to:

- Increase coverage of sustainability to all aspects of the Trust through the overarching Sustainable Development Plan;
- Ensure robust mechanisms for measuring activities and impact at a Trust, site and Divisional level.

The Sustainable Development plan details the actions required to take forward the transformation of the Trust to being a sustainable organisation.

Recommendations

The Board is recommended to Note the report.

Board members and Governors are asked to take an active role in transforming the Trust into a greener organisation and champion the sustainability agenda by:

- signing up to be part of Green Impact, or encourage a teams in their area to be part of the awards scheme next year www.greenimpact.org.uk/uhb
- consider how they can bring sustainable thinking and actions into their day-to-day role and work of teams reporting to them, including asking challenging questions about how Trust activities have considered and addressed sustainability;
- review the environmental impact of their meetings and activities;
- support the expenditure of resources required;
- approve the Sustainable Development Plan with reporting arrangements.

Executive Report Sponsor and Other Author

Sponsor – Chief Operating Officer, James Rimmer

Author – Nathalie Delaney, Big Green Scheme Chair, Sam Willitts, Energy and Sustainability Manager.

Appendices

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

- Appendix A – Review of Progress
- Appendix B – Sustainable Development Plan

More information on the Trust's environmental work can be found at:

Connect: http://connect/green

Workspace: http://workspaces/sites/Teams/BigGreenScheme/

Contact: thebiggreenscheme@uhbristol.nhs.uk to subscribe to the regular newsletter

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	15 February 2012				

Sustainable Development Plan – The Big Green Scheme: Review

1. What Has Been Achieved So Far

1.1 The Trust has had an environmental strategy since 2003, which has evolved over the years. The original strategy identified five target areas: **energy**, **waste**, **water**, **transport** and **procurement,** and these were reflected in the Trust's Environmental Policy Statement at the time. The strategy set up an Environmental Management Group (EMG) chaired by the General Manager of Estates, with Divisional representatives.

1.2 In 2008, UH Bristol undertook a review and analysis programme with the Carbon Trust, resulting in the following year in the production of a Trust **Carbon Management Plan**. This set out a programme of Carbon Footprint reduction for the five years through to April 2014 and the following low carbon vision for the Trust:

> *As a leading employer within Bristol and as a regional player in the healthcare community, this Trust wishes to place itself at the forefront of tackling the effect that the activities of delivering healthcare services have on Climate Change.*
>
> *By means of a major commitment, over the next five years, to identify unnecessary or excessive sources of carbon emissions in the activities which we undertake and by developing a programme of improvement, running over the next five years, we plan to reduce emissions and make our contribution and set an example to the communities we work within.*

1.3 At the same time similar programmes were run in the University of Bristol and Bristol City Council, resulting in Bristol achieving designation as a **Low Carbon City**.

1.3 The Trust plan identified the following five strategic themes: **behavioural change**, **engineering improvement** (energy), **waste minimisation**, **procurement**, and **travel** (transport). This refreshed the original function of the EMG and reported via TOG (now Service Delivery Group) with an annual report to TEG (now Trust Management Executive).

1.4 As part of the Carbon Management Plan, the Trust officially launched the Big Green Scheme environmental awareness campaign on 6 July 2009. This aimed to recruit a network of Green Champions, to take initiatives and make an impact at a local level. The Chief Operating Officer was appointed as project sponsor, and signed up to the environmental pledge:

University Hospitals Bristol NHS Foundation Trust commits itself to saving energy and reducing CO^2 emissions through The Big Green Scheme. This commitment will be shown through:

- *The continuing implementation of the Trust's Carbon Management Plan.*
- *The recruitment, training and support of Green Champions.*
- *Recognising the achievement of Green Champions through the Green Impact environmental awards scheme.*
- *The appointment of the Chief Operating Officer, as Campaign Director.*
- *The Campaign's progress being a Board agenda item for the next three years.*
- *The implementation to achieve the Sustainable Development plan to achieve sustainability into existing policy and related initiatives.*
- *The full support of the Campaign Team in their work.*

1.5 The Trust has now trained in excess of **200 Green Champions** and over 800 people are involved through Green Impact.

1.6 In 2011, the Carbon Management Plan evolved into the **Sustainable Development Plan.** This broadened the scope of the plan and laid out the actions required to allow the Trust to move towards being an environmentally responsible organisation, as well as contributing to the protection of natural resources and the development and support of sustainable local and global communities.

1.7 A gap was identified in terms of the measurement of impact, and so in September 2011, we launched the awards scheme Green Impact to specifically tackle these areas. This was a pilot programme following the successful development of the model in student unions, universities and colleges. UH Bristol were the first NHS Trust in the country to participate.

2. Vision

2.1 Our vision is for **good environmental practice to be part of everyone's day-to-day job**; in the same way that infection control is an integral part of everything we do. Embedding carbon reduction and sustainability in our activities will enable us to seize the cross cutting opportunities a low carbon future offers in improving health, sustainable financial savings and leadership in our community. The following will be included in standard Trust job description:

> *"University Hospitals Bristol NHS Foundation Trust recognises the impact our activities have on climate change and the effects that climate change will have on people's health. The Trust is committed to reducing its impact on the environment, in line with the NHS Carbon Reduction Strategy. All staff have a responsibility in achieving this goal by using resources efficiently and disposing of waste responsibly."*

2.2 The Trust is expected to use its considerable influence and resources in ways that will benefit the local community and the country as a whole. The substantial capacity of the Trust means it has the potential to damage the social, economic and environmental conditions in which people live. How the Trust chooses to influence and run its businesses practices can and does have a significant effect on resources such as transport, waste, energy, and consumable products such as food and paper. As an employer the Trust has considerable effect on the lives of its 8,000 employees and their associated families. As a commissioner of significant quantities of building work in the Terrell Street development, Centralisation of Specialist Paediatrics and BHOC redevelopment, the Trust affects the lives of the people living around its sites in terms of environmental disturbance and as a corporate neighbour.

2.3 In terms of the impact on the environment:

- Our water consumption 208,368 m^3 is the equivalent of almost 1,900 houses
- Our gas consumption 56,297,986 kWh is over 3,400 houses
- Our electricity consumption 27,848,740 kWh is over 8,400 houses

3. Successes and challenges

3.1 Progress against each of the themes is included in **Appendix 1**, setting out the successes, challenges, next steps and measures being used for each area.

3.2 Overall, this series of workstreams, initially confined very much to the estates arena, has had significant recognitions:

- March 2008: Business in the Community Awards - Carbon Positive Footprint Award,
- December 2011: Health Business Awards - Environmental Practice Award.

3.3 More information about the Trust's environmental work is on connect at http://connect/green or the Big Green Scheme workspace.

3.4 In summer 2011, a staff survey was carried out into the environmental work of the Trust. Staff responses were used to inform the work of the 2011/12 plan and fed back to Green Champions in the Green Impact Newsletter: *You said, we did*

> *"'The majority of suggestions revolved around the buildings we have, and the lighting and heating we use in these. Other people had things to say about our recycling scheme, which received such positive feedback more people wanted to get involved. We've been sending out further recycling bins to people who request them and have now increased our recycling rates. You also asked for more clarity in our communications around recycling which we've provided through Green Impact, our monthly newsletter, bin labels and including recycling in staff inductions. When asked what we could do to better enable good environmental practice across the Trust a number of ideas came up, some good prizes and incentives for getting involved (such as the Green Impact awards), working on the heating levels in buildings (a building management system engineer has now been appointed to the Trust) and for more cake (all our events now come with baked goods). We aim to keep improving our performance across all areas of sustainability—energy, waste, water, travel and procurement so, as always, if you have any ideas please do get in touch via thebiggreenscheme@uhbristol.nhs.uk"*

3.5 The awards scheme for staff involved in the awards was held in June 2012, just after Bristol's Big Green Week, in partnership with the university. 22 teams took part, covering 805 staff. 257 greening actions were put in place at the hospital as a direct result of the programme (and rising). There were great results for the first year, with 7 bronze awards, 4 silver, and 1 gold. There were also three special awards. Feedback from teams involved in the Green Impact awards were very positive:

> *"Being involved in Green Impact has given a new aspect to my role – I'm learning things and developing professionally. I'm definitely classing this as CPD."*
>
> *"It's given me some legitimacy – people don't just think of me as the office nag any more, they can see a reason why I'm doing it."*
>
> *"It's great to see the Trust supporting this centrally. It's not just about the few enthusiastic people now"*
>
> *"Green Impact has given some structure to the Green Champion role. Instead of just receiving a newsletter and having a green lanyard, now I have a clear role and can see the role I'm having."*
>
> *"There is definitively momentum building with the green agenda in the Trust."*

3.6 The challenge is to bridge the gap between enthusiastic green champions and the Trustwide strategy at a Divisional level. It is therefore important that all Divisions have a green objective in their 2013/14 operating plans.

3.7 In addition, although some sites have been excellent (notably at the Dental Hospital and Education Centre), many of the main hospital buildings lack coordination around environmental efforts. Therefore the aim will be for every hospital site to have a Green Impact team in the 2012/13, including clinical areas, and for a Green Impact team at SBCH. This means that the message about green issues has not yet reached all areas, as shown by this recent feedback:

> *"I am surprised, if not a bit shocked, at how 'behind' the hospital is in terms of waste and "green" issues. … I've been giving patients Fortisip and build-up which come in plastic recycling containers and I've been diligently washing them out when finished. "Where do these go for recycling?" I ask the kitchen staff, who look at me a bit weirdly and answer 'chuck 'em out.' In the bin where I dump them there's already a huge pile of milk and orange juice cartons." (June 2012)*

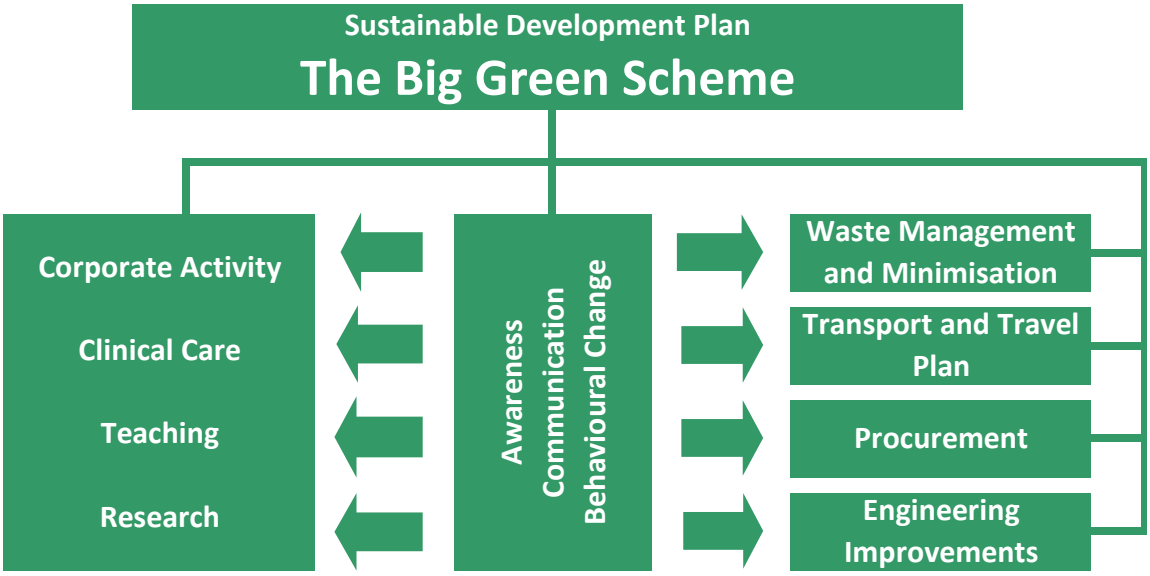
3.8 This shows the need to ensure that the message is reaching all areas of the Trust, beyond the current 10% coverage.

3.9 Therefore the priorities for 2012/13 are:

1. *Increase coverage of sustainability to all aspects of the Trust through the overarching Sustainable Development Plan;*
2. *Ensure robust mechanisms for measuring activities and impact at a Trust, site and Divisional level.*

4. Next steps

4.1 The scope of the project has now widened to encompass the entire activity of the Trust. TME has already agreed that no area is exempt from contributing to the Sustainable Development Plan. All of the action plans relating to each workstream, are now being brought together into one overarching **Sustainable Development Plan (SDP)** which is now being taken forward under the Big Green Scheme brand.



4.2 Green Impact has already built stronger links with the University and other neighbours. We are now looking at shared heating systems through work with the Council, and NUS are in discussions with them about establishing Green Impact at the Council. If they sign up, Bristol will be the first city with a university, NHS Trust and Council all running Green Impact. In terms of the criteria we will be raising the bar slightly by adding a few extra criteria to each award standard to encourage continual improvement.

4.3 The annual Big Green Scheme event this year will be held in October 2012 in the Education Centre. As part of the format we hope to introduce workshops from Green Impact teams to share their learning and encourage others to sign up. It will also provide information and motivation for Divisional management teams to develop their green objectives for 2013/14.

4.4 Two new themes are proposed to join the existing workstreams: **Food** and **Staff Wellbeing**.

5 Governance

5.1 Responsibility for monitoring the SDP sits with the Environmental Management Group, which will also now be called The Big Green Scheme, who will review progress on a quarterly basis. The terms of reference will be reviewed and revised to reflect this. The group will report every six months to TME, with an annual report to Trust Board. This will be a version of the annual, mandatory, sustainability report that is included in the public Annual Report.

5.2 The Group will also be responsible for revisiting and reviewing the Good Corporate Citizenship model annually and included in the reporting process.

6. Resources required

Item	Time commitment	Provided By	New/ Existing
Chief Operating Officer Time	TME + Annual Report preparation meetings (2 hours), Chair quarterly BGS review meetings per year (4 hours), Green Impact launch event and awards ceremony (3 hours)	Trust Services	Increase on current
Energy Manager time	1 day per week	Estates	Existing

Big Green Scheme chair	1 day per month	Division of Specialised Services	Existing
Divisional Leads	3 hours per month (1 hour BGS meeting, 30 mins preparation and follow-up actions, 1 hour supporting Green Champions)	Divisions	Existing
HR lead	4 hour per month	HR	To be identified
Transformation Team lead	4 hours per month	Transformation Team	To be identified
Comms team lead	Increase time commitment to 1 day per month	Communications Team	Increase on current
Green Champions/ Green Impact teams	2 hours per month	All areas	Existing
Ward sisters	1 hour per year for waste walkabout	All wards	New
Financial commitment			
Green Impact Scheme Year 2 Option - Sustainable Behaviour Assistant support service	£5200 (30% discount received) £22000 Full time (potential shared resource/cost with partner organisation University or Council) Enhanced Green Impact delivery through intensive support of Divisions	NUS	New
Big Green Scheme support fund	£1500 room hire, catering, photography, posters, awards (all beyond provided by Green Impact)	BGS	New
Sponsorship	Seek sponsorship of special awards	Biffa waste, EDF, Corona, British Gas Business	New

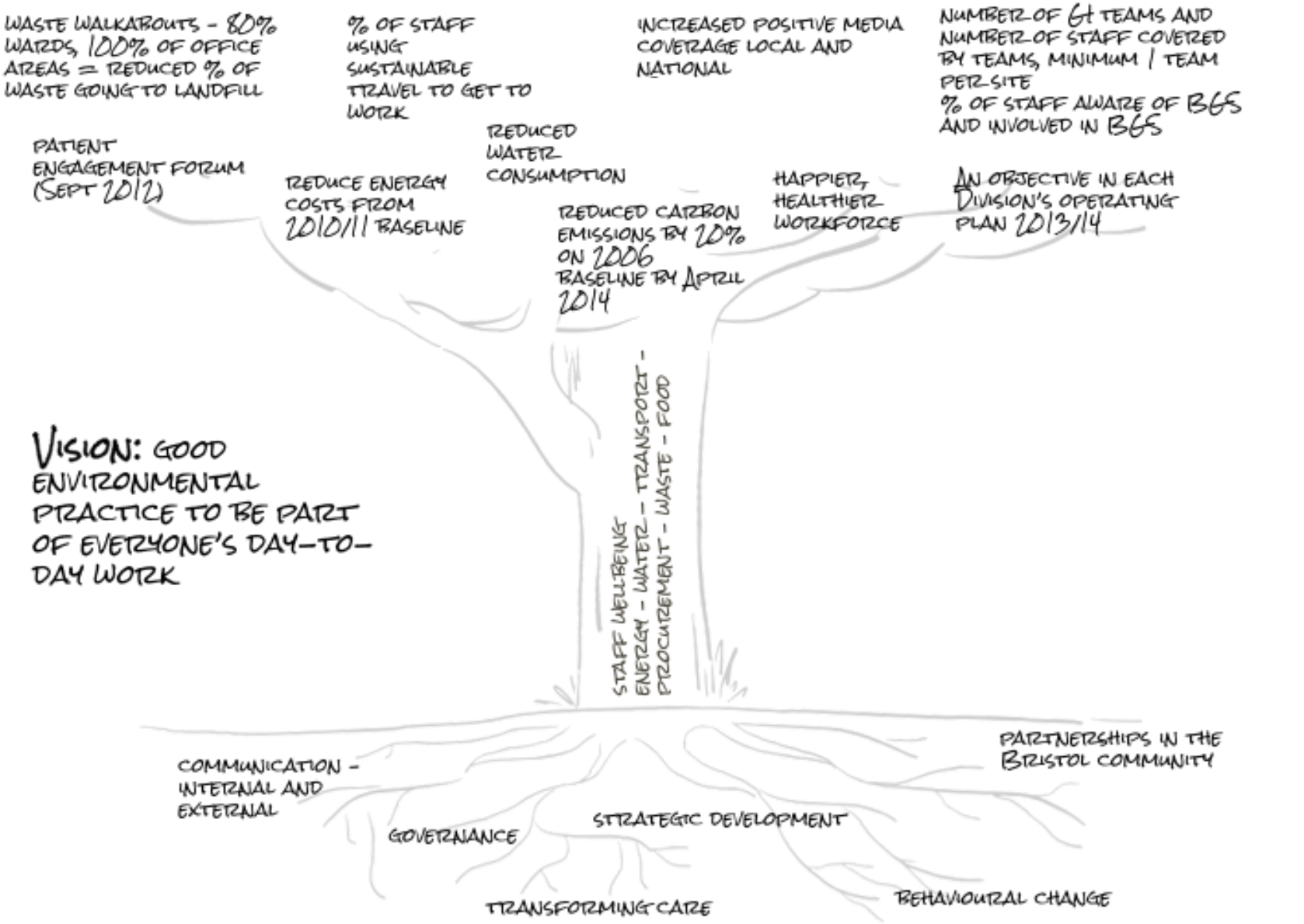
7. Call to Action

Board members and Governors are asked to take an active role in transforming the Trust into a greener organisation and champion the sustainability agenda by:

- signing up to be part of Green Impact, or encourage a teams in their area to be part of the awards scheme next year www.greenimpact.org.uk/uhb
- consider how they can bring sustainable thinking and actions into their day-to-day role and work of teams reporting to them, including asking challenging questions about how Trust activities have considered and addressed sustainability;
- review the environmental impact of their meetings and activities;
- approve the resources required;
- approve the draft Sustainable Development Plan with reporting arrangements as described above.

Nathalie Delaney
Big Green Scheme Chair, thebiggreenscheme@uhbristol.nhs.uk

Sam Willitts
Energy and Sustainability Manager



UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST, JUNE 2012

Appendix 1. Review of progress

	Lead	Successes	Challenges	Next steps	KPIs
Big Green Scheme awareness campaign	Nathalie Delaney, Performance & Operations Manager, BHOC	The Big Green Scheme has recruited and trained over 200 green champions; Two successful annual events have been held in the BHI atrium (2010 and 2011); Staff survey with 524 responses in 2010 and repeated in 2011 with 364 responses demonstrated that staff awareness was good but staff felt that more needs to be done with regard to education and awareness of environmental issues in the Trust. Strong brand image and regular communications through newsletters, Newsbeat and Voices. Green Impact awards scheme launched in September 2011; Big Green Scheme communications plan for 2011/2012 activities;	On-going support for green champions both through the Scheme and in Divisions; Environmental walkabouts, although some have been carried out we have no data on when and where, and what actions arose. Measurement of impact of green champions.	Target to embed Big Green Scheme into induction programme for new staff at Trust by Quarter 4 2012.	Number of teams signed up to Green Impact scheme, **target 30 for first year**; Output measures from Green Impact workbooks; Number of environmental walkabouts carried out in each hospital site, **target 2 per site per year.**
Energy & Carbon	Sam Willitts, Energy and Sustainability Manager	We reduced our energy costs by 13% in 2010/11, saving £562,459. 24% of our electricity is generated by our CHP on site, and 25% of the electricity we purchase is generated from renewable sources. Lighting controls have been fitted with presence detection in areas that are intermittently used such as corridors. Those implemented so far will save £12,700 and 168 tonnes of CO2 each year so we will be rolling out controls to all suitable areas. Nightwatchman activated on all Trust PCs: this helps shut down PCs overnight.	Energy costs continue to rise. Payback periods for investment in energy saving projects will become longer	We are fitting meters so we can monitor and manage where energy is being used. We are insulating our pipework to reduce heat losses We are improving heating and cooling controls to reduce the energy consumption. Develop further projects for investment in energy reduction	The overall impact of plans to reduce carbon emissions aims to save £1,355,000 over the next 5 years. Our target in our Carbon Management Plan is a 20% reduction on 2006 baseline levels (22614 tonnes CO2) by April 2014 (18091 tonnes CO2) to achieve this we will need to reduce our 2010 emissions by 8.4% per annum (2034 tonnes CO2 per annum). For each tonne of carbon dioxide we avoid emitting we save an average of £165 in our energy costs.
Waste	Colin Waldron,	Dry mix recycling bins implemented	DMR bins in patient areas	Focus on availability of DMR	Total waste (in tonnes) split between domestic

	Lead	Successes	Challenges	Next steps	KPIs
	General Manager, Facilities	across the Trust; Contamination is rare, ie staff are using bins correctly; In April - September 2011 we recycled 97 tonnes of DMR and 41 tonnes of confidential waste, out of a total of 535 tonnes waste. Each tonne of recycled waste saves around £80 compared to sending it to landfill.	have been requested, but contamination is high.	bins into patient areas by having bins behind reception desks with posters by bins asking patients to give recyclable rubbish to desks. Encourage further update of DMR bins across the Trust.	waste to landfill and recycled waste (DMR and recycled confidential waste); Total number of DMR bins across the Trust.
Water		Green champions have been active in identifying areas of wastage – dripping taps etc and ensuring they are repaired.	Our water consumption has increased by 147 cubic meters in 2010/11. There was a large increase in 2008/09 due to the opening of the BHI.	Investing in metering to identify leaks and high use areas to target reductions	Water consumption in cubic meters
Travel & Transport	Stewart Cundy, Transport Manager and Paul Wood, Head of Security and Transport	Sustainable Transport Plan in place promoting use of alternative travel including bikes and public transport. HUBS and Cabot Circus bus continue.	Establishing the carbon footprint of all staff and patient travel.	Recording staff and patient travel to enable future planning. Refreshing Green Travel plan.	Increased use of lower carbon impact travel Reduced mileage
Procurement	Carine Verstraete	All tenders include evaluation criteria around fair and equitable trade, sustainability & environmentally friendly sourcing. Procurement staff have personal objectives around sustainability and carbon reduction. Working with our distributors to reduce the carbon footprint through rationalisation of suppliers, standardisation of products, demand management through the implementation of a Managed Inventory system and Kan Ban principles. Streamlining delivery locations has reduced our fuel emissions by an	Monitoring and measuring. Ensuring sustainability and carbon reduction is considered by everyone who makes purchasing decisions not just procurement staff		

	Lead	Successes	Challenges	Next steps	KPIs
		equivalent of two cars off the road for one whole year. Investigating the possibility of collaboration between Bristol NHS trusts, Bristol council to set up an off site consolidation store for all deliveries. Exploring out of hour deliveries to reduce emissions. Using recycled tote boxes and roll cages for deliveries. Working with suppliers to achieve optimum fleet utilization, tele- and video conferencing.			

Appendix 2. Draft Sustainability Development Plan

Attached

Theme	Outcome	Action	Who by	By when	Status	Measure	Target	Comments
SUPPORTING THEMES								
Communication (external/ internal)	**Increase awareness of Big Green Scheme activities within the Trust**	Continue monthly Big Green Scheme newsletter	BGS chair	Monthly		Number of subscribers to BGS newsletter	Baseline 200; Target 450 by October 2013	Switch to mailing list that allows tracking of metrics to include reading and click-through
		Continue to promote BGS activities on Newsbeat and front page of Connect	BGS chair/ Comms	Monthly				
		Include BGS article in every edition of Voices	BGS chair/ Comms	Every two months				July - Green Impact awards ceremony; September - Big Green Scheme annual event
		Hold BGS annual event	BGS chair/ Energy and Sustainability Manager	Oct-12		Number of attendees at event		To include workshops to share learning from GI, stalls from local suppliers/ sponsors
		Ask Green Champions for stories/ quotes to include in BGS communications	BGS chair/ Comms	Oct-12				
		Update Connect site	BGS chair/ Energy and Sustainability Manager	Jan-13				Use "green hooks" - "are you a commuter… do you want to know more about healthy eating…" to provide more targeted information based on FAQ to BGS address
		Visit Divisional meetings for all Divisions to seek feedback from them on input into BGS/ SDP	BGS chair/ Energy and Sustainability Manager	Oct-12				D&T 31 July, SHN done, SPS awaiting date ? July, need dates for Medicine and Women's & Children's
		Repeat staff survey in March 2013 to gather feedback on scheme and measure awareness	BGS chair/ Energy and Sustainability Manager	Mar-13		% of staff aware of BGS		
		Identify governor for sustainability	BGS chair		DONE			

Theme	Outcome	Action	Who by	By when	Status	Measure	Target	Comments
Communication (external/ internal)	**Increase awareness of Big green Scheme activities external to the Trust**	Agree guidelines for use of Twitter account and acceptable tweets	BGS chair/ Comms	Oct-12				
		Set up Twitter account for external comms	BGS chair/ Comms	Oct-12		Number of subscribers to Twitter account	Target: 449 followers by October 2013	
		Write 4 x BGS press releases p.a. to promote activities and good news stories (where possible in partnership)	BGS chair/ Comms	On-going		Number of positive news stories generated about environmental activities of UH Bristol	Increased positive media coverage (local and national)	
		Submit Trust for relevant national awards	BGS chair/ Energy and Sustainability Manager	On-going		Number (and level) of awards	Baseline and Target: 1 award p.a.	Green Apple awards submission (July 2012)
		Update Trust website with information on sustainability activities at Trust	BGS chair/ Energy and Sustainability Manager/ Comms	Nov-12				
		Include in Trust Annual Report	BGS chair/ Energy and Sustainability Manager/ Comms	May-13				
		Hold public lecture relating to sustainability and health during Big Green Week June 2013	BGS chair/ Energy and Sustainability Manager/ Comms	Jun-13		Number of attendees to lecture		Opportunity for educating staff and community on environmental factors that contribute to the burden of disease, as well as the relationship between public environmental health and disease prevention
		Hold patient engagement forum to identify patient views on the work of the Trust. Set up patient engagement sustainable redesign of clinical pathways	Energy and Sustainability Manager/ Patient Involvement Manager	Sep-12		Event held and number of actions resulting from event incorporated into SDP. Pilot project set up for patient engagement in sustainable redesign of clinical pathway.		Members views to be reflected in Sustainable Development Plan. Patient involvement in sustainable redesign of clinical pathways.
		Identify site for Green Open Doors March 2013	Energy and Sustainability Manager/ Comms	Jun-13				

Theme	Outcome	Action	Who by	By when	Status	Measure	Target	Comments
Behavioural change	**Embed Big Green Scheme into HR processes**	Identify HR sustainability champion	BGS chair	Sep-12				
		Update BGS induction guide for inclusion in induction programme	BGS chair/ HR lead	Oct-12				
		Finalise "Greener ways to get to work" guide to go out with offer letters and on Trust website	BGS chair/ Green Travel administrator	Oct-12				To be available on website and NHS jobs to encourage new staff to start green
		Develop leadership competencies to deliver carbon reduction	Energy and Sustainability Manager/ Head of Teaching and Learning	TBC				
		Provide sample green objectives for staff and managers to use in appraisal	Energy and Sustainability Manager/ HR lead	TBC				Link to Divisional objectives and actions in SDP
		Ensure that job description template has been updated with green paragraph	Energy and Sustainability Manager/ HR lead	TBC				
	Extend coverage of Green Impact awards to all areas of the Trust	Submit proposal for resource of Green Impact Year 2	Energy and Sustainability Manager	Jul-12		Number of Green Impact Teams; Number of staff covered by teams as a % of total staff	Baseline: 22 teams covering 805 staff; Target: 30 teams covering 1,200 staff	
		Review workbook to include learning from Year 1	BGS chair/ Energy and Sustainability Manager/ NUS	Aug-12				
		Sign-off workbook	BGS group	Sep-12				
		Launch Green Impact year 2	BGS chair/ Energy and Sustainability Manager/ NUS	Oct-12		Number of returning teams, number of new teams	Target: minimum of 1 team per hospital site including SBCH	
	All staff to have the opportunity to access support to embrace sustainability in changing working practice	Support GI teams by 3 events throughout the year to ensure they have opportunity to meet and share learning	BGS chair/ Energy and Sustainability Manager/ NUS	Oct 2012 - April 2013		Level of awards received, Number of green actions put into place as a result of scheme	Baseline: 257 actions in 2012, 7 bronze, 4 silver, 1 gold	Provide ways to make it easier for green champions to share good ideas and best practice by setting up forum under BGS connect workspace
		Contact new facilities and estate manager at SBCH to explore how Green Impact team can work there	BGS chair/ Energy and Sustainability Manager	Oct-12				

Theme	Outcome	Action	Who by	By when	Status	Measure	Target	Comments
Governance	**Establish effective governance structures**	Chief Operating Officer to continue as Executive Sponsor for BGS	Chief Operating Officer		DONE			
		Review and sign-off terms of reference for EMG	Energy and Sustainability Manager	Sep-12				
		Agree reporting arrangements for EMG	Energy and Sustainability Manager		DONE			
		Set up comprehensive action plan to ensure that actions identified in environmental walkabouts are reported to BGS meeting and progress monitored	Divisional leads	Oct-13		Number of environmental walkabouts per site per year; Actions identified and outcomes	1 environmental walkabout per site per year	
		Set up robust reporting mechanisms at Trust, site and Divisional level on measures in SDP	BGS chair/ Energy and Sustainability Manager	Jan-13				
		Review and sign-off revised Environmental Policy	Energy and Sustainability Manager	Jan-13				
	Embed sustainability in Divisional activities	Identify Divisional lead for all Divisions to attend BGS/ EMG meetings	Divisional Managers		DONE			
		Review and sign-off Divisional lead responsibilities	BGS group	Sep-12				To include reporting at Divisional Boards and department meetings, and supporting the work of Green Champions in their Division
		Divisions to identify an objective in operating plans 2013/ 14	Divisional Managers	Dec-12		Objectives per Division plus associated measures		Encourage Divisions to think about sustainability and link to actions and projects in place, including transformational projects
		Divisions to report on performance against sustainability actions and measures at Quarterly Performance & Operations Reviews	Divisional Managers/ Chief Operating Officer	Apr-13				
	Embed sustainability in Trust governance activities	Produce guidance on how to review meetings to ensure that they are greener	BGS chair/ Trust Secretary	Jan-13				
		Ensure that TME, SDG, Board meetings are reviewed and actions taken to improve sustainability	Chair of TME, SDG, Board	Mar-13		Baseline to be measured	Reduction in costs including paper, printing and travel	
Transforming Care	**Embed sustainability in Transformation Team activities**	Identify Transformation team sustainability champion	BGS chair	Oct-12				
		Transformation Team to review activities to ensure that they are sustainable	Transformation Team Lead	Mar-13		Baseline to be measured	Reduction in costs including paper, printing and travel	
		Transformation Team to ensure that sustainability is considered as part of transformational activities	Transformation Team Lead	Mar-13				

Theme	Outcome	Action	Who by	By when	Status	Measure	Target	Comments
Strategic development	**Reduce Trust environmental footprint, and make our hospitals healthier places to work and visit**	Support green and healthy hospital design and construction.	Strategic Programme Director, Director of Facilities and Estates	On-going			Major new buildings BREAAM excellent; Major refurbishment projects BREAAM "very good"	
		Incorporate green building principles and practices into design and construction of health facilities.	Strategic Programme Director, Director of Facilities and Estates	On-going				
		Life Cycle costs to be included in all new development and works replacement projects.	General Manager Estates	Mar-13		Add to standard project brief and audit completion from April 2013		To be included in all future briefing documents. Sustainability options identified with costs/ benefits
		Develop Adaptation plan	Director of Facilities and Estates/ Emergency Planning/ Energy and Sustainability Manager	Mar-13				http:/ / www.sdu.nhs.uk/ documents/ Adaptation_to_Climate_Change_in_NHS_Organisations.pdf
		Develop Biodiversity Strategy identifying health benefits from greenspace	Director of Estates and Facilities/ Energy and Sustainability Manager	Mar-13				NHS organisations should take every opportunity to protect and enhance the natural environment surrounding NHS buildings. This can improve the quality of life for patients, staff and visitors, as well as the long term quality of the environment. Develop partnerships with Natural England, the Forestry Commission and the Woodland Trust as well as Wildlife Trust to help develop the natural environment around and near to healthcare facilities systematically. Resources - http:/ / www.d4b.org.uk/ resources/ index.asp
		Create "green map" of UH Bristol Estate identifying green travel facilities (bike racks, showers, pedestrian routes), green spaces, and other areas of interest (eg recycling points, Edible Arts project, etc.)	BGS chair/ Energy and Sustainability Manager	Mar-13				Example at: http:/ / www.kwmc.org.uk/ greenmap/ greenmap.html
Partnerships in the local community	**Link with partner organisations on sustainability especially travel networks and food procurement**	Identify opportunities for joint working with NBT on sustainable initiatives under the Partnership Agreement	Director of Estates and Facilities/ Energy and Sustainability Manager	Mar-13				
		Trust leads to be actively involved in local dialogue, debate and initiatives related to sustainability in the City	Identified leads	On-going				Promotion of health benefits of natural greenspace

Theme	Outcome	Action	Who by	By when	Status	Measure	Target	Comments
			WORKSTREAMS					
Travel	**Minimise the environmental impact of the Trust on the city and on our neighbours**	Review and sign-off revised Travel Plan	Director of Estates	TBC				
		Optimise the energy efficiency and hospital fleet vehicles	Transport Manager	TBC				
	Enable good access to the services delivered by the Trust for patients, visitors and staff	Continue to provide HUBS and Cabot Circus free bus services for patients and staff	Transport Manager	On-going		Number of people using HUBS bus and Cabot Circus bus services.		Baseline 1250 (HUBS) per week and 1300 (Cabot Circus)
		Establish mechanism to record carbon emissions of patients traveling via hospital transport	Patient Transport Manager	Mar-13		Carbon emissions/ mileage connected with patient travel		
	Reduce unnecessary demand for on-site parking	Ensure information on sustainable travel options for patients continues to be included in all new outpatient letters	Patient Transport Manager	On-going				
		Discuss with Bristol City Council the extension of evening opening hours on the Park & Ride site	Green Travel administrator/ Head of Security and Transport	TBC				
		Ensure that service changes that increase use of telemedicine, communication by email and other alternatives to face-to-face communication, or deliver services closer to community locations are assessed for their environmental impact and included in annual report	BGS chair/ Commissioning Team	On-going				
	Promote a healthier and more productive workforce	Include information on sustainable travel in offer letters for staff and induction guidance	BGS chair/ HR lead	Oct-12				http:/ / www.livingstreets.org.uk/ - http:/ / www.sustrans.org.uk/ - Bristol Better by Bike http:/ / www.betterbybike.info/
		Promote "Walk to Work week" 2013	BGS chair/ Green Travel administrator	May-13		Walk to Work week measures		
		Promote "Jambusting Commuter Challenge"	BGS chair/ Green Travel administrator	Mar-13				
		Re-launch Bicycle User Group (BUGS)	Green Travel administrator	Mar-13				To include cycle training and maintenance support/ discounts
		Set up “Bike Buddy” scheme (where staff who live near each other arrange to cycle in together)	Green Travel administrator	Mar-13				
	Reduce unnecessary expenditure on staff travel in connection with work	All Divisions to update staff study leave and travel expenses policies to ensure it encourages sustainable travel	Divisional HR BPs	Jan-13				
		Establish mechanism to record carbon emissions of staff travel via expenses claims	Director of Finance	Mar-13		Carbon emissions/ mileage connected with staff travel		Data required for planning costs/ benefits of future models of care.
		Set up and promote travel clinic/ bike doctor to have 1:1s and group sessions with staff on how they can get to work in more sustainable ways	Green Travel administrator	Mar-13				
		Carry out staff survey to assess staff travel to work against 2010 baseline	Green Travel administrator	Mar-13				
		Keep abreast of the introduction of new car club vehicles near the Trust and promote their use through BGS newsletter, Connect and Newsbeat	Green Travel administrator/ Head of Security and Transport	On-going				

Theme	Outcome	Action	Who by	By when	Status	Measure	Target	Comments
Energy	**Reduce carbon emissions and expenditure on energy over the next 5 years**	For existing buildings, review energy conservation and efficiency programme, develop business cases and implement. For new buildings, ensure design to achieve building energy performance targets	Energy and Sustainability Manager	On-going			Climate change act 80% reduction in carbon emissions by 2050	Our target in our Carbon Management Plan is a 20% reduction on 2006 baseline levels (22614 tonnes CO2) by April 2014 (18091 tonnes CO2) to achieve this we will need to reduce our 2010 emissions by 8.4% per annum (2034 tonnes CO2 per annum). For each tonne of carbon dioxide we avoid emitting we save an average of £165 in our energy costs.
		Implement energy monitoring and targeting alongside regular energy audits and use the results to inform awareness and retrofit programs.	Energy and Sustainability Manager	Mar-13				
		Once efficiency measures are implemented, investigate sources of clean, renewable energy and include its generation in all new building plans. Explore onsite and offsite (district generation/ heating/ cooling) opportunities	Energy and Sustainability Manager	TBC				
		Integrate occupant education and awareness programs to reduce energy consumption related to occupancy	Energy and Sustainability Manager	TBC				
	Reduce carbon emissions and paper usage in relation to IM&T systems	Report on impact of implementation of Nightwatchman	IT Support Services Manager	Oct-12				
		Continue to develop digital solutions to replace paper-based systems in line with strategic CSIP projects	IT Support Services Manager	On-going				
		Reduce expenditure on printing across the Trust and improve the quality of printed paperwork.	Print Manager	On-going				Guidance for staff on changing to duplex printing: http:/ / connect/ aboutus/ Communications/ Pages/ printanddesigncontacts.aspx

Theme	Outcome	Action	Who by	By when	Status	Measure	Target	Comments
Waste minimisation	**Reduce % of total waste going to landfill with associated reduction in expenditure**	Encourage further update of DMR bins across the Trust	General Manager, Facilities	On-going		Baseline In April - September 2011 we recycled 97 tonnes of DMR and 41 tonnes of confidential waste, out of a total of 535 tonnes waste.		Each tonne of recycled waste saves around £80 compared to sending it to landfill.
		Focus on availability of DMR bins into patient areas by having bins behind reception desks with posters by bins asking patients to give recyclable rubbish to desks.	General Manager, Facilities/ Comms team	On-going		Total number of DMR bins across the Trust.		
		Roll out "offensive waste" stream across the Trust wards	General Manager, Facilities	TBC				
		Provide guidance on items that can be recycled in DMR on wards as article in newsbeat and poster for clinical areas	General Manager, Facilities	Dec-12				
		Carry out "waste walkabouts" with sisters in ward areas to identify types of waste being generated, appropriate waste streams and ensure waste is being collected and removed in an economical, safe and environmentally sustainable manner.	General Manager, Facilities/ Ward Sisters	Mar-13		Waste walkabouts in 80% of wards and 100% of office areas -- locations identified via Ulysses H&S locations		
		Implement environmentally preferable purchasing procedures and avoid toxic materials such as mercury, PVC and unnecessary disposable products.	Director of Purchasing and Supply/ Head of Supply Chain Management/ General Manager Facilities	Mar-13				
		Implement a comprehensive waste reduction program, including avoiding, where feasible, injectable medicines where oral treatments are as effective.	Divisional Leads to consider as part of service redesign	On-going				
		Implement a comprehensive waste management training program, including injection safety and safe handling of sharps and other waste categories.	General Manager, Facilities	Mar-13				
Water	**Reduce water consumption from main supply by capturing and reusing grey water**	Identify locations for water butts for use by Cornish (gardening contractors)	General Manager, Estates/ Energy and Sustainability Manager	Jan-13				
		Identify clinical leads in high water usage areas (renal and endoscopy)	Energy and Sustainability Manager/ Service leads	Jan-13				
		Develop action plans to reduce water wastage and increase water reuse (where appropriate) in high water usage areas	Service leads	Mar-13				
		Regularly analyse water quality	General Manager, Estates	On-going				
		Ensure that no areas have bottled water sources where high-quality potable water can be available	General Manager, Estates	Mar-13				
		Identify and prioritise repairing water leaks including routinely checking plumbing and pipes	General Manager, Estates	On-going				

Theme	Outcome	Action	Who by	By when	Status	Measure	Target	Comments
Procurement	**Embed carbon reduction in procurement policy, processes and practice of all staff**	Review facility procurement practices, and patronize local vendors who carry third party certified sustainable products and follow sustainable and ethical practices whenever possible.	Director of Purchasing and Supply/ Head of Supply Chain Management	TBC				
		Implement a sustainable purchasing agenda that considers the environmental and human rights impact of all aspects of purchasing, from production to packaging to ultimate disposal - life cycle assessment.	Director of Purchasing and Supply/ Head of Supply Chain Management	TBC				
		Develop coordination between hospitals to increase buying power for environmentally preferable purchasing.	Director of Purchasing and Supply/ Head of Supply Chain Management	TBC				
		Utilize a sustainable and certified computer purchasing program for computer and electronic needs.	Director of Purchasing and Supply/ Head of Supply Chain Management/ Head of IM&T	TBC				
		Require suppliers to disclose chemical ingredients and safety testing data for product purchases and give preference to suppliers and products meeting these specifications. Limit hospital/ health system purchases to products meeting these specifications.	Director of Purchasing and Supply/ Head of Supply Chain Management	TBC				
		Utilize purchasing power to obtain environmentally responsible and ethically produced products at cost competitive prices and work with manufacturers and suppliers to innovate and expand the availability of these products.	Director of Purchasing and Supply/ Head of Supply Chain Management	TBC				
		Make sure all contracts meet socially-responsible business principles: Follow the guidelines on ethical procurement for health from the Ethical Trading Initiative and the British Medical Association.	Director of Purchasing and Supply/ Head of Supply Chain Management	TBC				
		Advocate for Extended Producer Responsibility, and for products to be designed so they generate less waste, last longer, are less disposable, use less hazardous raw materials and include less packaging	Director of Purchasing and Supply/ Head of Supply Chain Management	TBC				
		Use P4CR flexible framework to benchmark and set targets for achieving progress for each strand - Rollout to all Trust staff that make procurement decisions	Director of Purchasing and Supply/ Head of Supply Chain Management	TBC				P4CR flexible framework guidance
		Substitute harmful chemicals with safer alternatives.	Director of Purchasing and Supply/ Head of Supply Chain Management	TBC				
		Improve the health and safety of patients, staff, communities and the environment by using safer chemicals, materials, products and processes, going beyond the requirements of environmental compliance.	Director of Purchasing and Supply/ Head of Supply Chain Management	TBC				How far have we made the switch from film-based imaging which uses large quantities of water and non-renewable resources to digital imaging; NB oral chemotherapy (as a replacement for IV chemo) is a "greener" choice, need to capture this and other replacements like this

Theme	Outcome	Action	Who by	By when	Status	Measure	Target	Comments
Food	**Reduce hospitals' environmental footprint while fostering healthy eating habits in patients and staff.**	Purchase and serve sustainably grown, healthy food by encouraging good practice from existing suppliers and switching to alternatives if necessary	General Manager, Facilities/ Director of Purchasing and Supply/ Head of Supply Chain Management	Mar-13				
		Support access to locally and sustainably sourced food in the community - Farmers' market either on site or promoted in BGS communications	Energy and Sustainability Manager	Mar-13				
		Develop partnerships Bristol City Council - Good Food procurement, NBT, Soil Association - Food for Life	Energy and Sustainability Manager	Mar-13				Be part of the Council Public Sector good local food procurement club, Opportunities for partnership with NBT – praised for their food and hold Soil Association Food for Life Bronze catering mark, local ice-cream from Bath, seasonal menus
		Sign up to Bristol Good Food charter and review actions required	Director of Estates and Facilities	Jan-13				See Bristol Good Food charter http:/ / bristolgoodfood.org/ wp-content/ uploads/ 2012/ 03/ The-Bristol-good-food-charter.pdf
Staff wellbeing	**Promote a healthier and more productive workforce**	Regular articles in Voices and BGS newsletter on green activities and promotion of low carbon healthy lifestyles	BGS chair/ Energy and Sustainability Manager/ Comms	On-going			Support Divisional reductions in sickness absence and increased staff retention	
		Develop Intranet page to collate wellbeing information	HR/ Comms	Mar-13			Support Divisional reductions in sickness absence and increased staff retention	Signpost staff towards walking clubs (http:/ / www.bristol.gov.uk/ node/ 3089), discounts on sports and leisure (eg yoga, local sports centres and societies), garden centres
		Improve working environment (temperature/ ventilation)	Energy and Sustainability Manager	On-going				
		Establish Members' allotment on precinct	BGS Chair/ Energy and Sustainability Manager	Mar-13				
		Develop staff wellbeing objectives and measures for 2013/14	HR lead	Mar-13				Sample objectives: encourage and assist people to become more physically active in the workplace, for example by promoting workplace champions for sport and physical activity, highlighting the benefits of physical activity; encouraging employees to take stairs insteads of lifts; ensuring access to healthy food and drinks in all available channels to employees, provision of responsibly sized food portions within food outlets, provision and promotion of consumption of fruit and vegetables through availability and price promotion, water is visible and freely available. [Some of these already in place, but could include on resources like 51 green map]

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 15 – 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 1 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 2012/13 milestones which were derived as part of the 2012/13 Annual Planning process. Importantly, the framework also describes any risks to delivery that have been identified to date and describes the actions being taken to control risks identified 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 and Trust Management Executive Group.

Quarter 1 Position

There is one objective where the inherent risk to delivery is considered High (RED) relating to the Trust's non-compliance with Outcome 21 during Q1. This remains a prospective residual risk of RED pending receipt of the CQC findings following their planned, unannounced visit of the 21 June 2012 which reviewed compliance with outcomes 1, 4, 5, 7, 13, 14 and 16 in four service locations.

Finally, there are 46 objectives with a residual rating of GREEN and 8 AMBER rated objectives all of which have active management plans in place, with the aim of restoring delivery to GREEN status.

Recommendations

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

Executive Report Sponsor or Other Author

- Executive Sponsor – Chief Executive, Robert Woolley
- Author – 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
	11 July 2012				Risk Management Group – 3 July 2012

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2012-2013	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 implemented in line with plan. 5% increase in satisfaction with Teaching and Learning provision against 2011 Benchmark	25% to 50%	Currently managing progress against 12 Teaching & Learning strategic objectives at varying stages of progress 2012 Customer Survey being completed over month of June	Lack of progress with 12 strategic objectives identified.	Green	Building capability work stream days occur monthly.	Teaching and Learning Group	Green		Dir W&OD	Teaching and Learning Group
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	Developmental research groups established and productive.	Clear, agreed priorities for each Divisional Unit to be agreed. All researchers to be linked to Divisional Research Units Increase grant income by 5%	25% to 50%	All Divisions now have, or are in the process of planning, dedicated Research Units. These Units will be the delivery vehicle for our research. Each Unit reports to TRG and on to TME and the Board.	Grant income is not increased	Green	Continued support of R&I unit for identified research priority areas to apply for grants		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.	The First HITs led from UH Bristol will need support to agree clear, deliverable objectives. Baseline measures to be agreed against which to monitor impact of the HITs	25% to 50%	The first Health Integration Teams (HITs) are currently undergoing assessment for accreditation by Bristol Health Partners. Two HITs from UH Bristol are through to full application stage. Four more will re-apply in the Autumn	Unable to fund research time for staff	Green	Robust job and capacity planning		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	Systems to be established to support reporting to DH on time taken from receipt of valid application for research trials to recruiting the first patient for the trial (new BRU contracts place contractual obligation on Trust to achieve first patient first visit within 70 days of receipt of application for trial). Systems to be established to support researchers in delivering research to agreed timelines and target recruitment levels	25% to 50%	Recruitment to trials is on track to meet our targets this year, following a disappointing decrease in recruitment last year. However, we need to continue our focus on recruiting patients in to trials to increase our funding from the WCLRN for the delivery of research	Recruitment targets of patients onto clinical trials in not achieved	Green			Green		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 status for Paediatric Cardiac Surgery, Paediatric Major Trauma, Paediatric Epilepsy Surgery (in partnership with NBT), Achieve Designation for Adult Intestinal Failure (IF) and Adult Congenital Heart Disease (CHD). Play leading role in Specialised Commissioning Repatriation Project. Develop marketing and implementation plans for repatriation of target services (Bone Marrow Transplant and Cardiac Surgery)	25% to 50%	Paediatric Epilepsy Surgery designation secured. Paediatric Cardiac Surgery Designation decision 4th July. Adult CHD, launched 12th June and baseline assessment submitted. IF designation underway and Expression of Interest submitted 19th June. Bristol Heart Institute (BHI) Strategic Review underway and due to conclude end of September.	Designation status is not secured through national process.	Green	Strong leadership and support to Divisions for designation processes.	Clinical Strategy Group retains corporate oversight of all designation activity.	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 and agree further priorities for service change Achieve successful transfer of UHB services to SBCH Transfer head & neck, breast and urology services Continue active involvement in Avon Wide Pathology Review with aim of consolidating pathology services under leadership of NBT (subject to successful Business Case) Deliver all BRI and CSP annual milestones to support service transfer in May 2014	25% to 50%	Internal strategy work undertaken and concluded, now being considered in context of City wide work on acute service integration. SBCH transfer successfully achieved. Tri-service move delayed but anticipated for December 2012. Pathology Review progresses on original plan, second Advisory Panel 9th July. No major risks to CSP / BRI programmes. BHOC planning permission remains a risk, planning	Failure to reach agreement with NBT and commissioners on future acute service strategy. Tri-service move is further delayed due to inability to resolve financial gap. Pathology Advisory Panel does not support, or requires further work from, Severn Pathology Proposal. Failure to secure BHOC planning permission.	Amber	Acute Services Project established to address question of future service model and organisational form. Robust programme management of all strategic capital programmes in place. Tri-service programme arrangements strengthened including appointment of Senior Programme Manager	All strategic programmes managed through respective Programme Board arrangements including independent chair for Acute Services Project Board. Gateway Review process adopted for Tri-service move. BRI/CSP both subjected to external Gateway	Amber	1660	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 developing private patient provision.	25% to 50%	External partner secured and final report due mid-July. Preliminary report identifies three options.	None Identified	Green			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	Subject to approval of Welcome Centre Comprehensive procure partner to develop Centre and commence construction. Evaluate and decide upon Trust model for commercial development Identify further opportunities for commercial developments / partnerships	25% to 50%	External partner secured and final report due mid-July. Preliminary report identifies three options.	No further commercial opportunities identified.	Green	Consideration of creation of Commercial Director Role.	Regular reporting to BRI Redevelopment Board.	Green		Dir SD	BRI Redevelopment Board
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.	Training and guidance on setting behavioural objectives focuses in writing values related objectives. Staff Survey remains in top 20% of Trusts - Improvements in the annual staff survey and Multi Professional Education and Training (MPET), especially relating to bullying and harassment. Staff sickness below 3.75% for the year outcomes	0% to 25%	Rolling out values training to all staff. Values now incorporated into objectives and value based questions being developed for recruitment interviews. Have remained in top 20% of Trusts for Engagement. Overall reduction in staff sickness rate aimed for	Sickness not reducing as per trajectory	Green	Continued supporting of managers to manage and reduce absence.	Trust Board and HR Board	Green		Dir W&OD	Trust Management Executive

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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.	Develop Partnership Agreement with Bristol Community Health (BCH) as a means of developing opportunities for improved integration of UH Bristol service offer with community services. Confirm future service model and organisational hosting arrangements for Bristol Homeopathic Hospital Services. Scope and identify further opportunities for community service partnerships. Identify test and learn opportunities with community provider partners such as GP Care and others	25% to 50%	Partnership agreement with BCH agreed and approved by both Boards. Regular meetings between Executives in place. Estates strategy for Homeopathic Service agreed, staff consultation commences July 2012. Paper to consider organisational form developed and being considered by Executive team in July. Test and Learn Pilot agreed with GP Care, contract signed with service commencement expected September 2012.	Limited capacity in UH Bristol and BCH Executive Teams to develop joint proposals impacts on pace and scale of achievement.	Green	Clarity regarding priorities for Executive time and appropriate prioritisation of initiatives with greatest potential for positive impact	Executive team oversight	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.	Clarity regarding organisational model for acute services in Bristol. UH Bristol position in relation to SBCH and Weston formulated and agreed by Board.	Continue to work in close partnership with NBT to consider and evaluate options for organisational integration. Actively engage in the "Weston Futures " project to maximise UH Bristol opportunity to work in partnership with WHAT for mutual benefit. Successfully embed Lead provider role for SBCH	25% to 50%	Acute Services Project established and underway. Key decision point end of July. Good engagement from UH Bristol Executives and lead clinicians in Weston Futures work and developing engagement between respective clinical teams notably in relation to gynaecology and maternity services. Agreement reached with NBT regarding respective roles in supporting Weston. Meeting established between Medicine Division and South Bristol CCG Locality Board to explore vision and early priorities for further development of SBCH.	Failure to reach agreement with NBT and commissioners on future acute service strategy. Current Weston model of an Integrated Care Organisation operating as an NHS Foundation Trust cannot be stacked up financially and role of / impact upon UH Bristol becomes uncertain again.	Green	Weston Futures Transition Board established with UH Bristol as active player to ensure UH Bristol has maximum opportunity to both support and influence.	Acute Services Project Board established with independent chair in place. Clinical Strategy Group retains corporate oversight of all Weston Futures work.	Green		Dir SD	Clinical Strategy Group
2	R&I	2.3	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	Academic Health Sciences Collaborations operating across health partners with demonstrable increase in research and teaching activity as a result.	Establish successful HITs programme of work and support. Engage with Formal AHSC application process.	50% to 75%	Bristol Health Partners (BHP) formally established in May 2012. Director (Professor Peter Mathieson) appointed. Positioned and ready to apply for formal AHSC accreditation as and when next call from DH released.	Lack of engagement at divisional level	Green	Performance management of HIT delivery	BHP Executive Group and BHP Board	Green		Dir Med	Bristol Research and Innovation Group for Health
3	T&L	3.1	Learning and Development Centre of Excellence - We will create an Academy recognised both within and outside the Trust, that delivers high	The trust will have a Training Academy that delivers quality assured solutions to its staff and the wider community	Academy framework document developed and academy established. Full implementation plan to deliver consistent solutions that are quality assured and appropriately evaluated put in place	25% to 50%	New Teaching & Learning infrastructure implementation to be completed by Q2 (2012) Mapping of cross-divisional training	Discussions with Divisions on structure if take longer than planned. May limit completion.	Green	Tight project management controls	Teaching & Learning Group	Green		Dir W&OD	Teaching and Learning Group
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.	KSF career pathways completed Career planning workshops and support introduced KSFs fully used in performance management	25% to 50%	All 8a and above staff should now have objectives based on divisional operating requirements.	Not all staff have yet had their appraisal to set the objectives and outcomes	Green	Appraisal returns	HR Board	Green		Dir W&OD	Teaching and Learning Group
3	CSS	3.3	To be recognised by our patients and their families for the consistently high quality of the care they receive whilst in our care	For each of the next three years, we will seek year on year improvements in patient-reported experience of care as measured by our own robust patient surveys and national patient surveys. We will carry out robust patient surveys during 2012/13 to measure progress on these goals. Baseline data will be derived from previous surveys and the targets will be based, as a minimum, on the best Trust score nationally (as determined by the national outpatient survey). We will also seek to improve our scores for 50% of indicators in each successive National Patient Survey.	1. We will reduce patient-reported noise at night. 2. We will ensure that patients are treated with kindness and understanding. 3. We will improve communication with patients: in particular about waiting times in clinic and making sure patients know who to speak to if they have worries or concerns. 4. We want to see fewer complaints being made, but where things go wrong and people have cause to complain about quality of care, we will provide a full response as quickly as possible within agreed timeframes. We will also focus on the quality of responses to complaints and on wider organisational learning from complaints. 98% of complaint responses will be provided within the timescale agreed with the complainant. We will aim for zero dissatisfied complainants due to the quality of response provided.	0% to 25%	Actions 1-3: measurable targets have been agreed with Divisions. Measurement via core surveys. Q1 data will be available in early August. Action 4: training has been given to managers in Divisions on improving quality of complaints responses; average numbers of complaints received in April, but May showed an unprecedented increase in complaints - mostly about appointments and admissions.	Risk of complaints reduction not being achieved, based on current trajectory.	Amber	Measures in place to address the sources of recent increases in complaints: Staffing issues in Ophthalmology and Trauma & Orthopaedics Outpatient Departments are currently being addressed through normal management processes. We are working to ensure that these gaps are filled and currently we have temporary staff in place. In Ophthalmology we have recruited to all vacancies and plan to have these filled by the end of July. An intensive support team, comprising Medway staff and transformation staff working on the Productive Outpatients project, is in place and is working with local teams to review outpatient processes and the Medway interface to put in place process improvements and clear any backlog. The team have prioritised their review in the following outpatient departments: Women's & Children's (complete), Ophthalmology, Dental, Trauma and Orthopaedics. A system is now in place in Ear, Nose & Throat Outpatients whereby people can now contact someone who is able to help them resolve their queries relating to their appointments.	Service Delivery Group	Amber		Chief Nurse	Patient Experience Group, reporting to the Clinical Quality Group

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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.	To reduce adverse events by 30% and mortality by 15% from the 2009 baseline by the end of 2014.	1. Recover lost ground and achieve a score of 3.5 in the NHS South West Quality and Patient Safety Improvement Programme. This means achieving spread of all key changes in one to three (breadth) work streams with at least 50% penetration (depth) into other applicable patient populations and areas. 2. Implement the NHS Safety Thermometer achieving 50% coverage in Q2, 75% in Q3 and 100% in Q4. 3. Completion of planned histopathology clinical audits in the 2012/13 Clinical Audit Plan. 4. Continue to embed high quality nutritional care across the Trust as part of the follow up to Care Quality Commission inspections in 2011.	0% to 25%	1. 15% reduction in mortality since October 2009 achieved. Adverse event rate reduction showing variation. Three of the five work streams on or exceeding target scores. New work stream leads identified for the General Ward work stream and review of priorities to progress this work stream is currently being conducted. Medicines Management is making some progress and focussing on key measures. 2. NHS Safety Thermometer has been piloted in May and June and achieved 100% coverage in June. CQUIN measurement begins in Q2. 3. Histopathology clinical audit details for 2012/13 being finalised. 4. Q4 2011/12 nutritional audits s demonstrate sustained performance between 82-88% (average 86%), just below target of 90%.	There is a risk that the improvement programme may not progress at a rate sufficient to achieve the target score of 3.5 by the end of 2012/13.	Amber	NHS South West Quality and Patient Safety Improvement Programme: Each work stream has an identified executive lead. Work stream operational leads to produce action plans to demonstrate how they will sustain or on trajectory to achieve the required level of improvement.	Quarterly reports being monitored by the Patient Safety Group	Green		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.	For each of the next three years, we will seek to maintain our 'lower than expected' headline mortality ratings (HSMR and SHMI). We are also committed to developing the use of service-specific standardised mortality ratios to monitor clinical outcomes wherever this data is available to us.	1. We will ensure that at least 90% of patients are treated for at least 90% of the time on a dedicated stroke ward. 2. We will continue to focus on outcomes of care for the frail elderly, including implementation of our extensive Dementia action plan. 3. We will ensure that patients with identified needs (such as a Learning Disability) have a risk assessment and patient-centred care plan in place. 4. We will develop the use of enhanced recovery for all surgical areas. 5. Our aim is to see year on year improvements in one and five year cancer survival, echoing a key priority of the NHS Outcomes Framework. We will work with the South West Public Health Observatory to develop our understanding and practical application of this data. 6. We will re-focus on ensuring compliance with published National Institute for Health and Clinical Excellence (NICE) guidance including targeted use of clinical audit.	0% to 25%	Further work is required to make objectives SMART - to be completed by 31st July 2012. 82% of stroke patients are spending 90% of time on a stroke ward (reported to Board June 2012); implementation of the Dementia action plan continues to be overseen by the Dementia Strategy Steering Group; implementation of NICE guidance and audit continues to be overseen by Clinical Effectiveness Group; Trust-wide steering group established to oversee development of enhanced recovery.	1. Stroke - the key delivery risk is the operational challenge of protecting dedicated stroke beds at time of high demand for beds. 2. Frail elderly - the key delivery risks are the challenge of enabling all appropriate staff to receive dementia training, and ensuring that the implementation of the standards happens across the whole Trust and is not confined just to Care of the Elderly wards. 3. LDs - the risk is that our targets will not be achieved. 4. Enhanced recovery - the risk of non-delivery is failure to reduce length of stay leading to patients having to spend longer in hospital than required, reducing capacity for other patients. 5. Cancer survival - the risk to achieving our stated goal is that the measures of performance are dependent on the performance of other providers as well as ourselves. 6. NICE - there is a risk that every aspect of a piece of NICE guidance will not be implemented because of local service considerations and	Amber	1. Contingency plans are in place to mitigate risk. 2. Risk is mitigated by the operational leadership of the Dementia Implementation Group. 3. Progress against is actively monitored on a monthly basis and reported at Divisional and Trust Board level. 4. Risk is mitigated by operational leadership from the Bed Optimisation work stream (Improving Patient Flow element of Transformation programme).	Lead operational and assurance groups for each planned area of action.	Amber		Dir Med	Variously: Quality Intelligence Group, Clinical Effectiveness Group, Clinical Quality Group
3	R&I	3.6	We will achieve compliance as far as is reasonably practicable with all Health & Safety regulations	We will achieve 5 - 10% improvement year on year with audit compliance across the Trust	Each Division/ area drafts and completes resultant action plan to achieve 5% increase in compliance year on year Health & Safety will feature in the Divisional Operating plans as an objective	50% to 75%	We have set compliance against the revised audit process taking place in 2012 this provides Trust compliance of 66%.	1 Division does not comply fully with the standards and requires substantial improvement whereas the remainder do not fully comply with the standards / guidelines and require minor alterations / improvements.	Amber	Health and Safety has become part of the Divisional operating plans.	Operating Plans, subject to monitoring and review in Divisions, and via Divisional and Health and Safety Forums.	Green		Dir W&OD	Risk Management Group
4	CSS / CES	4.1	We will play a greater role in shaping the health system in Bristol and the Southwest through our early and constructive engagement with future influencers. We will improve our reputation with our commissioners by understanding their needs better and rapidly responding to the issues they raise.	Established and productive relationships with PCT Clusters, GP Consortia and National Commissioning Board with evidence of UH Bristol leading, not reacting to, change. GPs will report improved levels of satisfaction with UH Bristol's response to their commissioning intentions and ad hoc issues (evidenced through formal market surveying)	Develop and fully participate in the Healthy Futures Programme and associated sub-groups e.g. BNSSG Clinical Leaders Forum Establish effective working with successor SCG and regional outpost of National Commissioning Board Establish a means of mapping and tracking our reputation with key stakeholders Undertake survey of GP communication needs and satisfaction with services offer	25% to 50%	BNSSG Clinical Leaders Forum now established and meeting monthly with good engagement from UH Bristol clinical leaders and senior management. Continued positive working with new SCG arrangements, national arrangements confirmed in mid June and topic of discussion at TME Strategy session in late June to ensure UH Bristol are well placed to respond. GP Survey concluded in May and results fed back to TME and GP Practices; action plan in response to survey findings developed with oversight for delivery via Service Delivery Group (SDG). 360 Survey of partners planned for Q3 to gain greater insights into how UH Bristol is perceived by its key partners.	No significant risks identified.	Green			Green		Dir SD	Clinical Strategy Group

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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.	Implement all milestones in GP Engagement Action Plan. Undertake review of purpose and content of GP Newsletter "Stethoscope" in close liaison with GP community and wider Trust. Develop and implement SBCH Marketing Strategy with view to maintaining or increasing market share from SBCH practices.	25% to 50%	GP Engagement planned review by TME at May meeting and good progress against all milestones - on track for delivery. GP Newsletter re-branded and re-launched in April 2012 with positive early feedback from primary care. Opportunities for market share growth being actively pursued in relation to planned care market through review and possible expansion to case mix delivered at SBCH.	Successful marketing by competitors undermines UH Bristol efforts to grow share	Green	Ensuring quality of SBCH offer, understanding priorities of SB GPs and their patients and responding promptly to opportunities for growth.	TME maintains active oversight of GP Engagement and Marketing activities	Green		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.	Track delivery of fund raising activities and make changes to strategy / approach as required. Actively engage in A&B Appeal Board	25% to 50%	A&B Appeal Board established, strategy developed. The Grand Appeal making very good progress with strategy and good working relationships developing at both corporate and divisional level.	Financial austerity makes fundraising targets challenging and difficult to achieve. Multiple on-going appeals confuses potential donors with adverse impact on appeal objectives.	Green	Effective appeal strategies and governance arrangements.	All strategic programmes Boards have oversight of fundraising activities of key charitable partners.	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	Competencies linked to all leadership development activity and integrated into performance management Programmes fully rolled out to target populations based on the Talent Pool	50% to 75%	Leadership Framework agreed. Appraisal process updated. Talent Management Matrix being developed for Bands 7 and above, Bands 5 & 6 and Bands 1 to 4	Lack of divisional engagement Resourcing implications for external/internal programmes	Green	Tight project management controls Centralisation of devolved Teaching & earning L budgets	HR Board and Teaching & Learning Group	Green		Dir W&OD	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	Continuation of improvements, with UH Bristol becoming a commentator as well as a 'reported' story. The Trust seeks to target and maximise exposure through those media accessed by patients and staff.	25% to 50%	The Trust continues to secure more positive than negative coverage. Positive to Negative ratio April – June 2011 7:1 July – Sept 2011 6:1 Oct – Dec 2011 5:1 Jan – March 2012 7:1 April – 25 May 2012 7:1 However more meaningful and sophisticated measurement is being developed for media monitoring and evaluation.	None Identified	Green			Green		CE	Trust Management Executive
4	CES	4.6	The Trust embraces all appropriate methods of communication, with staff, patients, members and the wider public to involve them in the strategic developments of the Trust.	Staff survey shows improvements in staff perception of communication with respect to capital developments All KPIs being achieved to required standards. Minimal patient complaints about negative impact of construction works	Communications Steering Group is well developed and all communications for the media, patients, staff, members and Governors and stakeholders is consistent, coordinated and cohesive. The emphasis on proactively managing communications enables mitigation of any potential issues The mid project evaluation demonstrates a positive outcome for all affected audiences. The Trust works closely with its key charitable partners to ensure cohesion of messages.	25% to 50%	All projects are supported by a communications strategy and plan; evaluation is under way for the communications activities around key changes to the BRI drop off and pick up. In addition the BHOC development is coming on stream and a coordinated approach is being implemented across all the fundraising partners, incl. Above & Beyond, the Grand Appeal, the Friends of the BHOC, TCT, Help Appeal	Failure to identify relevant stakeholders and implement appropriate communications	Green	Continue to enforce discipline of proactive communications and engagement plans in all change projects and programmes.	Monitoring of media coverage and patient and stakeholder feedback.	Green		CE	Capital Programme Steering Group
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	Review plans for the implementation of Phase 4 and align these with the 3 year rolling capital programme. Review year 2 of the 3-year rolling capital programme to reflect progress made and changing operational requirements	0% to 25%	SESG approved scope of works. TME received range of issues requiring inclusion.	Debate around Trust merger.	Green	The actions in progress column.	Monitored by 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. Annual Willis Risk Assessment undertaken, reviewed against preceding action plan and updated. Close liaison with Divisions to identify issues. The capital programme to be prioritised and addressed through slippage in 12/13 capital plan; to be reviewed in 13/14 prioritisations. Maintain back up generator testing prior to installation of new HV generators in Autumn 2012.	0% to 25%	Centralised generator project proceeding. Regular review / update of Risks in Risk Register. Progressing capital.	Pause in Fire Safety Improvement Programme due to capital non-availability.	Green	The actions in progress column.	Monitored by Service Delivery Group	Green		COO	Service Delivery Group

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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	Implement arrangements and clarify responsibilities for business continuity re-assessing the balance of corporate and divisional responsibility Review of suitability of existing Business Continuity Plans	0% to 25%	Review and feedback / lessons learned with regard to incidents reviewed by SDG.	History shows departmental Business Continuity Plans are often wanting when tested in anger.	Green	The actions in progress column.	Monitored by Civil Contingencies Committee; Internal audit planned.	Green		COO	Civil Contingencies Committee
5	ES	5.4	Improvement trust wide satisfaction with the services provided by the Estates Function Development of KPIs and systems of feedback from Divisions to ensure improvements in responsiveness	User surveys indicate an 80% level of compliance with Service Level Agreement Key Performance Indicators User surveys show 80% return being good or excellent	Set standards for estates and facilities services, including response times. Develop a set of KPIs to monitor achievement of standards and report at divisional level Agree key performance requirements with Divisions annually and introduce an annual Division to Division review of estates performance	0% to 25%	Estates Transformation Project proceeding to programme. Customer survey about to be undertaken. Person appointed to develop an Estates Service Level Agreement.	On programme.	Green	The actions in progress column.	External review; actions being monitored by Audit Committee	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 all aspects of infection risk including Legionella Compliance Implement ward upgrade improvements	0% to 25%	PPM Programme reviewed and updated. Implementation of Estates Transformation Project to programme.	Actions on programme.	Green	The actions in progress column. No plans to increase single rooms before 2014/15.	Monitored by Infection Control Group	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. Relaunch Big Green Scheme to include Green impact award. Implement annual milestones of three year energy strategy and Big Screen Scheme.	25% to 50%	Big Green Scheme reporting to Trust Board July. Green Impact Scheme Awards ceremony. Capital programme / Spend to Save projects being implemented and new projects developed / evaluated.	Actions on programme.	Green	The actions in progress column.	Reported through Big Green Scheme	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 process fully implemented. quality baselines for performance management implementation established Compliance levels at 85%	25% to 50%	Appraisal rates currently at 83% with divisional plans in place to increase to 85%.	Not reaching and maintaining 85%	Amber	Monthly monitoring at corporate and divisional level		Amber		Dir W&OD	Teaching and Learning Group
6	LTFP	6.2	Develop and embed a Trust wide transformation programme to ensure that the Trust maintains and wherever possible improves the quality of its services whilst reducing the cost base of those services in line with funding requirements.	The Trust achieves a balanced plan for the next three years	Embed the programme for Transforming Care across the Trust Ensure appropriate management structures are in place to deliver Transforming Care including Transformation Board, Programme Steering Group and Programme Management office. Ensure Transforming Care Programme is aligned at Executive level and maximizes available resource.	50% to 75%	A transformation programme has been developed with objectives agreed at the transformation board meeting in April. Twelve work streams have been established running across the organisation and supporting Divisional CRES Schemes which has helped achieve a balanced plan. There is clear accountability for delivery for each of the work streams and Divisional CRES schemes. A project management office has already been established to support process, ensure rigour and support clear accountability.	Change in Programme Director could delay progress.	Green	Regular one to ones between Programme Director and Chief Operating Officer.	Review by Monthly Transformation Programme Steering Group.	Green		COO	Programme Steering Group
6	CSS	6.3	Delivery of significant improvement in outpatients by 2014.	The Outpatients function is transformed and is upper quartile nationally on a range of indicators including new to follow-up appointments, Do Not Attends and Cancelled appointments. Clinical Administration is streamlined by using technology, the new Patient Administration System is used to best effect and saved Consultant PAs have been redistributed/eliminated.	Implement the plan for analytical bookings agreed in 2011/12 and review planning of new and follow up appointments. Continue to 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. Identify further appointments arising from Medway implementations.	0% to 25%	There is a specific work stream for outpatients and is well established under the leadership of the finance director. There is a focus in reducing cancelled appointments. A new information management system has recently been introduced.	Focus on Medway could delay operational benefits	Green	Operational team and Medway working together	Review by Monthly Transformation Programme Steering Group.	Green		COO	Transformation Programme Board

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2012-2013	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
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 and deliver re-bookings within 28 days. Maintain the short notice protocol for DNA patients (Eye Hospital) and staggered admissions on the day is introduced.	0% to 25%	There is an established work stream for theatre improvement led by the Divisional Manager for Surgery, Head and Neck. Productive theatre processes have been introduced and well established.	Programme is in its third year and risk that interest could be waning.	Green	work with Transformation teams to refresh programme.	Review by Monthly Transformation Programme Steering Group.	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 and sustain 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.	0% to 25%	A work stream to improve bed optimisation is well established led by the Divisional Manager for Medicine. Significant focus is being placed on reducing patients with a length of stay of more that 14 days, including escalation processes.	Risk that referrals and emergency admissions do not standardise / decline as planned so benefits of reduced Length of Stay cannot be realised.	Amber	Activity reviewed with commissioners.	Review by Monthly Transformation Programme Steering Group.	Green		COO	Transformation Programme Board
7	CSS	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.	Fully engaged workforce evidenced by their participation in and awareness of transformation programme, reflected in staff survey results	Transforming Care fully launched as the vehicle for engagement of staff across the Trust. Full engagement plan in place for each pillar within transforming care, designed to reach all stakeholder groups.	0% to 25%	Transforming Care Programme Workshops in February/March. Workshops being rolled out within divisions. Monthly programme steering group reporting on all themes.	Lack of full engagement with staff.	Green	Senior and clinical management engagement at divisional level	Programme Steering Group and Trust Board	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	Increased number of staff participating in research activities with associated increase in number of approved research Pas, patients in trials and grant income.	Research staff within the Divisions will receive input from R&I staff to develop individual development plans to be agreed at appraisal. The development plans will support delivery of new national metrics around the time taken to recruit patients into trials. Return on Investment to research methodology units will be monitored against successful grant applications and income. Commercial income will be monitored against contract value.	25% to 50%	Research Matron appointed to support performance management, training and development of staff. The matron will commence employment in September, funded for first year from WCLRN FSF funding.	None Identified	Green			Green		Dir Med	Research Group
7	CSS	7.3	Ensure continuing GMC licensing of all Medical Staff, and compliance with Responsible Officer legislation, through the development and operation of an effective and efficient Revalidation process	An effective and efficient system of Revalidation supporting the continued licencing of Medical Staff by the GMC	Ensure the development of Trust's Revalidation system and the identification of continuous support to operate Revalidation. Identify a system for remediation.	0% to 25%	Appointment of Associated Medical Director for Revalidation achieved.	Ensuring appropriate levels of Appraisals amongst consultant staff to meet GMC revalidation time line	Green	Increased communication to consultants re appraisal expectations and increased training provided for Trust appraisers.		Green		Dir Med	Trust Management Executive
7	T&L	7.4	We become an acknowledged regional leader in equality and diversity outcomes both for our patients and staff	All Trust staff (new and existing) undertake basic E&D training dealing with communication and behaviours Selected Trust staff undertake specialist training and updates Patient satisfaction levels are broadly similar across all protected characteristics Patient complaints centred on E&D issues are minimised Staff satisfaction levels are broadly similar for all protected characteristics	Year on year increase in % accessing training. Target 80% by 2014 Year on year development of trained and supported staff, competent in new legislation, new clinical issues such as dementia care etc. Rising patient satisfaction levels and low differentials Reduction by 15% Rising staff satisfaction levels and low differentials	25% to 50%	Values training centering on communications and behaviours being rolled out to all Trust Staff.	Lack of engagement at divisional level	Green	Provision of training to Trust staff	Regular reporting of numbers attending	Green		Dir W&OD	Equality and Diversity Steering Group ; Patient Experience Group
7	T&L	7.5	We become a national exemplar for the NHS Equality Delivery System	Implementation of the NHS Equality Delivery System	Implementation enables the Trust to make year on year improvements in reported health outcomes for those in protected groups	25% to 50%	Results of inpatient and staff attitude survey measure progress towards achievement	Lack of engagement at divisional level	Green	Monitoring of attendance	Regular reporting of numbers attending	Green		Dir W&OD	Equality and Diversity Steering Group Trust Board
8	IT	8.1	Implement modern clinical information systems in the Trust	Modern clinical information systems are in use in the Trust	Phase 1 Go-Live of replacement core systems and Clinical Desktop Integration. Phase 2 and Phase 3 work commences	0% to 25%	Implemented April 2012	Continuing monitoring of system operation.	Green	Regular monitoring group in place.	IM&T Committee and CSIP Committee	Green		DoF	Information Management and Technology Board
8	IT	8.2	Review and deliver fit for purpose clinical admin support processes	Fit for purpose clinical admin process in place	Agree and implement action plan arising from review. Convert into transformation work streams.	75% to 100%	Now converted into other work streams	None Identified	Green			Green		DoF	Transformation 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	Train operational and corporate teams in the use of the QlikView Business Intelligence System. Implement InfoFlow for publishing QlikView reports to a wider audience. Develop and implement the Workforce and 2012/13 Service Level Agreement report modules. Develop relevant Trust & Divisional Board, Committee and Group performance reports which can be automatically updated via QlikView.	25% to 50%	Financial and Performance leads for QlikView Business Intelligence System have received training on the use of InfoFlow. A plan will now be developed and implemented, to use InfoFlow to manage the publication and distribution of all types of reports to staff across the Trust (both QlikView and Excel based reports). An initial scoping exercise has been undertaken on Workforce data, with plans in place to make this available to Divisional and Corporate teams via QlikView by September.	None	Green	Not applicable	Not applicable	Green	Not applicable	Dir SD	Trust Management Executive

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2012-2013	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
8	LTFP	8.4	Develop better understanding of service profitability using Service Line Reporting	Better resource allocation in the Trust	SLR development.	0% to 25%	2011/12 Quarter 3 results published April 2012. Quarter 4 publication planned for August 2012 after completion of the National Reference Cost exercise.	None Identified	Green		Results published and discussed with Divisions.	Green		DoF	Finance Committee
					Inclusion in Medicine Review.		Report to April 2012 meeting of the Finance Committee. Study to be extended in Quarter 2 to the Surgery, Head and Neck Division.	None Identified	Green		Report to Finance Committee	Green			
							Trust involved in the development of a Patient Cost benchmarking tool with c40 other NHS organisations.	None Identified	Green		Results published and discussed with Divisions.	Green			
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	Roll out in line with plans Formal establishments and maintenance targets agreed for completed areas.	25% to 50%	A number of departments are using spans & layers methodology	Currently only being used by areas that request supporting methodology. Full Trust review as currently offered as optional consultancy tool	Green	Ensuring spans & layers is included in all service reviews in line with operating plans	HR Board and monthly building capability theme meetings	Green		Dir W&OD	Trust Management Executive
10	LTFP	10.1	Deliver minimum normalised surplus	Deliver minimum normalised surplus	Achieve positive contract settlement with BNSSG and SCG commissioners	75% to 100%	Service Agreement contracts for BNSSG on 30th April. South West, South Central and West Midlands Specialist Commissioning Groups contracts signed on 4th May. Non Bass contract signed also signed in May.	None Identified	Green		Signed Service Agreements. SLA performance fines and PCT income challenges risks mitigated in contracts.	Green	962	DoF	Finance Committee
10	LTFP	10.2	Deliver minimum cash balance	Deliver minimum cash balance	Maintain ratio of at least 15 days and cash balance of no less than £15m.	0% to 25%	Trust liquidity at 21.2 days and cash balance of £34.16m at 31st May. Trust remains on target to meet objective this year.	None Identified	Green	Monthly cash flow projections and liquidity performance reported monthly to Finance Committee.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.	Green	962	DoF	Finance Committee
10	LTFP	10.3	Deliver the annual Cash Releasing Efficiency Savings (CRES) programme in line with the LTFP requirements	Cost reductions commensurate with CRES target achieved	Ensure robust in year oversight of Divisional CRES plans through monthly Finance & Operations Reviews Develop recurrent CRES plans to ensure all non-recurrent CRES is secured recurrently by Q3 2012. Review approach to 2013/14 CRES identification to mitigate risks associated with future CRES requirements	75% to 100%	The Trust is forecasting 85% (£23.720m) delivery of its CRES target of £27.622m. Of this £5.887m is currently identified as non recurring. The performance to date as at month 02 is delivery of £3.924m against a target of £4.718m.	Key risks are that currently £3.902m of CRES remains unidentified. Also whilst all effort is made to ensure current plans are robust, there remains a risk of some CRES schemes slipping due to for example inability to close wards due to operational demands	Amber	Risks are reviewed each month at finance and operational reviews chaired by the COO. Plans are also reviewed each month at Divisional CRES reviews. Divisions are required to deliver their operational plans and so any shortfall on CRES will be picked up and dealt with within each Divisions recovery plan required as part of the Trusts escalation process.	Reports to Finance Committee from each Division on a monthly basis	Amber	741	COO	Finance Committee
11	LTFP	11.1	Maintain Monitor Financial Risk Rating of 3 or above	Maintain Monitor Financial Risk Rating of 3 or above	Achieve EBITDA, Net Return after Financing, Net Surplus Margin and Liquidity ratio in line with plan	0% to 25%	Financial Risk Rating of 2.35 is behind plan projection of 3 as at 31st May.	Delivery of CRES plan. Increase in volume of clinical activity to secure income from activities income in line with SLA and Trust Plan.	Green		Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.	Green		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	Remain compliant in audit	25% to 50%	There were 57 rotas that were monitored in the Trust wide exercise that commenced on the 20th February 12. 28 of the rotas did not produce a 75% return rate and are being re-monitored. Of the remaining 29 rotas 17 produced a valid return of which 4 were non-compliant. Subsequently 2 are being re-written and the others are scheduled to re-monitor. There are 10 rotas that have yet to be monitored due to low staffing levels. The remaining 2 rotas are being chased for returns as the exercises have recently ended.	Work continuing to ensure all rota's are compliant. Cardiology and Trauma and Orthopaedics remain risk areas where 80% banding is being paid.	Amber	Maintain communication with job holders concerning hours worked.	Monitoring of Junior Doctors hours.	Amber		Dir W&OD	Trust Management Executive
11	CSS	11.3	Maintain registration with CQC including compliance with essential standards of quality and safety	Continued compliance with all relevant CQC standards	Ensure on-going compliance with all CQC registration Outcomes	0% to 25%	1. CQC Abortion Act inspection found Moderate Concerns in relation to Outcome 21 at Central Health Clinic. 2. CQC Histopathology final report - compliant with all relevant Outcomes of care. 3. CQC Scheduled Inspection 21 June 2012 - draft report received and being reviewed for factual accuracy.	The objective of maintaining continued compliance has, by definition, not been achieved in Q1. The specific issue which led to Outcome 21 non-compliance has been addressed - our action plan demonstrating compliance has now been sent to CQC. The planned unannounced inspection visit flagged areas of compliance risk (outcome 13) and remedial action plans are being prepared where they are not already in existence.	Red	Compliance with CQC standards is actively monitored by the Regulatory Compliance Group.	Regulatory Compliance Group.	Red	402	Chief Nurse	Risk Management Group
11	CSS	11.4	Maintain a "Green" Monitor Governance Risk Rating and meet all mandated and contractual performance targets.	Continued compliance with all relevant performance standards set as part of Monitor's performance framework (and contractual negotiations), with special reference to those three priorities set out below,	Ensure 4 hour standard is delivered consistently through the year. Maintain grip and focus on cancer standards. Ensure delivery of new RTT standard of 92% of patients on incomplete pathways waiting less than 18 weeks. Highly active management of HCAI agenda in light of revised targets and notably VERY low MRSA target	0% to 25%	4 hour standard and C Diff will miss Q1 leading to Amber-Red rating. Cancer and RTT remain on track.	Risk to 4 hour delivery is rigour against escalation processes. External issues addressed by Urgent Care Programme.	Amber	Mitigates through additional controls and escalation. External risk mitigated through Urgent Care Programme.	Emergency Care Intensive Support Team.	Amber	743	COO	Trust Management Executive

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 16 – Corporate Risk Register

Purpose

To brief the Board on the content of the Corporate Risk Register.

Abstract

The corporate risk register contains current risks in division risk registers with an inherent risk rating of 15. 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. In addition, the corporate risk register presented to the Board will not show a divisional risk which is already reflected in an existing corporate risk.

Three divisions (Surgery Head & Neck, Medicine and Specialised Services) have risks in their risk registers scoring 15 or more which are not shown in the corporate risk register as they are already reflected in corporate risk 741.

Risks escalated to the corporate risk register since last presentation to the Board in April are:

- Risk 1603 - Compliance with Fire Safety
- Risk 1829 - Ambulance queuing in the Emergency Department

Risks de-escalated since April are:

- Risk 885 - Risk of non-compliance with NHSLA Risk Management Standards

The current corporate risk register is provided at Appendix A.

Recommendations

The Board is recommended to **note** the 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

Appendices

- Appendix A – Corporate Risk Register

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
					Risk Management Group - 03 July 2012

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	Control Details	Effectiveness of controls	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	29/05/2012	27/08/2012	Alison Moon	4 Likely	5 Catastrophic	20	4. Extreme	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 stafffing 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.	07/02/2012	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.	Submission deadline 16th December 2011.	31/03/2012	31/03/2012	
													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. Escalation plans in place for when units are full across Bristol and Weston.	31/10/2012	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 for triage area and midwifery led unit and extra 11.4 WTE midwives and plans to transform the model of care under discussion.	Plans being developed. Expression of Interest submitted December 2011 but was unsucessful. For further discussion at the Trust Management Executive April 2012. Team 9 in place and extra 5.6 WTE midwves recruited. Funded midwife to birth ratio 1:38.	31/07/2012	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. 23rd April 2012 A bid has just been sunmitted for more resuscitarires, beds and CTG's. This bid has been successful.	31/07/2012	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							

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	Control Details	Effectiveness of controls	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. This risk is also reflectd as risks scoring 15+ in the risk registers of three divisions (risks 1912, 1420 and 1021) .	Annual Planning Process	Financial	11.3 Maintain Financial Risk Rating	25/06/2012	25/06/2012	23/09/2012	James Rimmer	4 Likely	4 Major	16	3. 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	Moderate	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.	Divisional Operating Plans have identified 85% of CRES;plan to close gap by the end of Q2.	30/09/2012	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							
766	Delays in discharge or transfer due to community services or delays in accessing community services.	Performance Monitoring	Strategic	2.1 Strategic Intentions Community Service Provision	22/06/2012	22/06/2012	20/09/2012	James Rimmer	4 Likely	4 Major	16	3. High	Performance Management	Weekly Trust performance meeting to discuss 'red list'	Medium	Moderate	Hospital DischargeTeam Restructure		31/03/2013	Not yet due	Divisional Board Medicine
													Audit -Trust Origin	Hospital discharge team (HDT) monitor progress. Social workers to move to 7/7 cover Metrics for 'back door' performance management			Social workers to move to 7/7 cover		31/03/2013	Not yet due	
													Local Policy In Force	Weekly MDT on all wards.			Metrics for 'back door' performance management		31/03/2013	Not yet due	
													Service Redesign	Restructuring of HDT to incorporate external funtions (e.g. liaison posts, healthcare@home)							
955	Running of two obstetric theatres out of hours with inadequate theatre personnel. Recruitment of some additional staff, ensuring there are now 3 members of staff available at night, this means that it is possible to open two theatres out of hours and provides some mitigation of this risk. However, there are risks associated with the level of staffing when this occurs and the increased frequency of having to open two theatres, means that this risk remains high. The service is only funded for one theatre and is likely to become increasing problem with increasing maternity workload. This is a shared risk with the Division of Women's and Children (1898).	Incidents Or Near Misses	Governance	3.4 Harm Reduction And Safety	20/04/2012	20/04/2012	19/07/2012	James Rimmer	5 Almost Certain	3 Moderate	15	3. High	Designated Accountability	Out-of hours surgery is co-ordinated by the anaesthetic 'folder holder'. This is the consultant on call. His/her decisions are dependent on accurate information about a patient's condition from the surgeons. The 'folder holder' will prioritise the order of the patients within the Trust.	Medium	Moderate	Review of staffing model, given frequency of use of second theatre to be undertaken by Jane Palmer/Kate Liddington and recommendations to be made regading increased staffing required. Agreement then to be reached with Division of W&C regarding allocation of resource and recruitment to be undertaken accordingly.	Additional recruitment to StMH theatre team has happened	01/04/2012	01/04/2012	Divisional Board Surgery, Head & Neck
													Local Policy In Force	Current 'good will' of the 'day' Anaesthetist to cover after 5pm to undertake emergency surgery or late finishing of elective lists if the on-call Anaesthetist is not able to attend immediately.			Further review of demand for theatre and staffing levels to take place Q1 2012/13		01/07/2012		
													Governance - All Types	Current practice of recovering patient in theatre to ensure adequate anaesthetic and nursing cover prior to commencing surgery on next patient.							
1316	Lack of sufficient reporting time in radiology for x-ray plain films. Delays in reporting may lead to delay in acting upon abnormal findings resulting in avoidable patient harm.	Incidents Or Near Misses	Governance	3.4 Harm Reduction And Safety	29/05/2012	29/05/2012	27/08/2012	Sean O'Kelly	3 Possible	5 Catastrophic	15	3. High	Workforce Management	Radiographers currently are vigilant in alerting radiologist to abnormal scans for reporting.	Medium	Moderate	Review of unreported film and predictions in November 2011. Development of an action plan to report backlog. Needs approval at Divisional Board and Risk Management group. Action plan agreed at board November 2011.	Radiology department continuing to work through the backlog. 2011 x-rays still to be reviewed. Paul Davison will report progress to Patient Safety Group in May 2012. No abnormal findings from the backlog reported to date.	07/08/2012	Not yet due	Divisional Board Diagnostics And Therapies
													Planning	Business case for additional radiologists being urgently pursued at TEG							
													Planning	Some less complex work is being outsourced while recruitment process is ongoing.							
													Documentation - Trust Paperwork	Policy for unexpected findings in place but will be reviewed in light of increasing backlog.Update to Patient safety group on progress with reducing backlog.							

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	Control Details	Effectiveness of controls	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
1422	Failure to meet the 5 core ED clinical indicators results in non-compliance with Monitor and this will incur significant financial penalty to the Trust. 1. 95% percentile achievement of 4 hour arrival to disposal standard 2. Initial assessment to be completed within 15 minutes of arrival foe ambulance patients 3. Time to treatment - 60 minute median for al ED patients arrival to start of treatment (start of treatment defined as point of assessment by discharge capable clinician) 4. Number of patients who 'did not wait' to be seen 5. Number of patients who return to ED for the same complaint within 7 days of previous ED attendance	Regulatory Compliance	Governance	11.4.1 Compliance With Emergency Access Targets	22/06/2012	22/06/2012	20/09/2012	Christopher Davies	4 Likely	4 Major	16	3. High	Local Policy In Force	Clinical Site Management Team ED electronic tracking board located in ED, MAU, CSM team offices, STAU and on Connect. ED staffing structure to support compliance with the standard, validation processes for all 4 hour breaches, additional portering staff to assist with transfers and admissions, 3 daily patient flow meetings, data analysis and bank holiday planning.	High	Moderate	- Winter planning event for Trust organised for 05/07/2011 to prepare for seasonal winter pressures. - Review of site team remit, structure and responsibilities. - Review of Band 7 non clinical time on wards - KPI for wards. - New internal transfer process	Pilot phase for transfer process out of ED and MAU has finished but will not be continued. New administrative role in Majors is now in the pilot phase and is likely to continue. The staff consultation phase is about to commence. This will assist with flow and administrative duties to release clinical time. Divisional escalation plan has been written led by the DDM of Medicine Ward Sister Supervisory role is in place this will focus on patient flow. New CMS system is in place that will now facilitate automatic hospital diverts. Emergency Access Steering Group is currently being held weekly to monitor the ED clinical indicators	31/03/2013	Not yet due	Divisional Board Medicine
													Performance Management	Daily validation process and review of performance			The whole ED team need to consider how this can be achieved and maintained with current resources	Unable to validate all 15 minute ambulance arrival times until staffing levels increase. Agreement from DDM Medicine to use short term bank band 2 to complete this work. Regular meetings to take place with GWAS and Bristol PCT to review and monitor performance and to look at more efficient ways of working	31/03/2013	Not yet due	
													Governance - All Types	Feedback to clinical staff each time a breach occurs				Time stamps purchased. 2 extra consultants in place An advert for an additional 4 ENP's is currently advertised. Closing date 29/07/12	31/03/2013	Not yet due	
													Monitoring Board/Commitee	Review of performance on a weekly basis. There was a short term dip in performance due to validation issues in response to the new IT Medway system. This has now been rectified.							
													Equipment	Review of resources and equipment in order to achieve this indicator (medical and nursing). There was a short term dip in performance due to validation issues in response to the new IT Medway system. This has now been rectified.							
1603	Compliance with the Regulatory Reform Order 2005 Act and Firecode Health Technical Memorandom 05-02. The risk stems from the fact that a £4m programme. of works, approved by Capital Prioritisation Group, has not yet been completed.As part of the programme, all hospitals have now been brought up to the L1 fire detection and alarm rated standard (The highest rating for health care premises). This has materially improved the overall risk profile.A programme for other remedial works has still to be completed covering BHOC, BRI Queens and the KEB buildings.Capital funding is awaited to continue the programme.Non compliance, could lead to a further Notice being served upon the Trust and / or prosecution by Avon Fire & Rescue.	Regulatory Compliance	Operational	5.2 On-Going Compliance With Fire and Safety Audits	09/08/2010	05/07/2012	04/10/2012	Robert Pepper	4 Likely	4 Major	16	3. High	Partnership Working	Programme of remedial works to take all hospitals to complete compliance is designed. Schedule of next priority (Queens Building) works will go to Capital Programme Steering Group in August to consider phased release of funding to allow phased implementation of works on a floor by floor basis, risk assessed. Implementation of the new Fire Safety Policy by monitoring Divisional compliance with Departmental Risk Assessments being in place - managed by Service Delivery Group Fire Training - frequency of training has been increased to meet statutory requirements to annual. Compliance being monitored through Servive Delivery Group Ad hoc inspections, visits and specialist training for Risk Assessors continuing on an ongoing basis. Departmental Risk Assessment for has been simplified to encourage its completion	Low	High	In addition to other actions, ad hoc visits, inspections and audits undertaken by the fire safety team across the Trust.	Currently running at 57% compliance with Departmental Risk Assessments.	31/03/2013	Not yet due	Service Delivery Group
													Workforce Management	Competent advice Consultants + recruitment			Capital Programme Steering Group have oversight of the issue and whilst the risk is above the surveillance level it is reviewed by Risk Management Group and Service Delivery Group.				
																	New fire policy agreed - implementation of Departmental Risk Assessments by the Divisions is being monitored by Service Delivery Group.				
																	Fire Training - availability of training courses increased - although take-up is suboptimal.	Progress by divisions towards compliance is slower than required profile	31/03/2013	Not yet due	

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	Control Details	Effectiveness of controls	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. Update 20.06.2012 Plan to stabilise this through staffing changes, subject to consultation that commences in July 2012 with the IAU & Clinical Strategy Group.	Service Wide Risk Reviews	Governance	3.3 High Quality Care	30/04/2010	19/04/2012	18/07/2012	Sean O'Kelly	4 Likely	4 Major	16	3. 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	Moderate	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 June 2012 update: Procurement process now completed and final decision to be ratified prior to end June 2012; Welcome Centre Pharmacy implementation reliant upon Welcome Centre timeline; now scheduled to be open by October 2013; implementation planning commencing.	01/10/2013	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.		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 (carreid out at BRI and BHI wards)		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) valid 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) April 2012 update - Ongoing June 2012 update - Staffing skillmix developments have been actioned alongside clarification of budgets and service changes (eg SBCH); progress made but not complete.	01/10/2012	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 June 2012 update - the Pharmacy guidance was produced in May 2011 but has has negligible impact; Carmen Chadwick Cox (ADM from D&T) has been asked to chair a project group reviewing patient flow / medicines discharge, and these are commencing in July. The ToR have been drafted and will address implementation of these standards.	01/10/2012	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 June 2012 update Pharmacy has been asked for a nominee for a 'Clinical Planning Group' for the new build IAU and Kevin Gibbs will represent Pharmacy; we are awaiting the Tor and first meeting of this group to confirm that the detailed action will be within the remit	01/10/2012	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	June 2012 update: Liaison with HR undertaken; consultation drafted and will be addressed alongside on-call consultation in July	01/10/2012	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		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		09/01/2012	

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	Control Details	Effectiveness of controls	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 Emergengcy Access Targets	10/01/2012	21/06/2012	19/09/2012	James Rimmer	4 Likely	5 Catastrophic	20	4. Extreme	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.	Medium	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 18-06-2012 Patient Safety Advisor meeting with Margaret Barnaby relating RCA action plan and which ones have been achieved. Minutes of meeting to disseminated to Carole, Claire, Emma and Mark for Divisional meeting with Margaret in the future.	31/07/2012	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.			Div of medicine to buy x3 ED trollies to transfer queue patients onto. These are wider and more comfortable and the mattress is of high quality specification in relation to pressure relief. Action HON/Chris Davis to agree funding. 1 month		31/03/2013	Not yet due	
													Equipment	Supplementary oxygen from portable cylinders Portable suction from ambulances or from ED resuscitation room			ED require 24 hr band3 patient flow co-ordinators to facilitate clinical and admin flow of patients (assist the patient journey)this will support the management of the 4hr target.	Pilot in place for June 2012	31/03/2013	Not yet due	
													Environment	If possible keep cubicle space free in Ed to use as rolling cubicle for toileting, undressing of patients etc.							
													Governance - All Types	Ambulance crews to monitor patients vital sign and pain control as per own protocol or if needed on a more regular basis as guided by the ED shift coordinator. All vital signs need to be reported to the ED shift coordinator Prioritise patients and off load when ED capacity available 20-06-2012 GWAS and UH Bristol expect advice from EUST to allow shared care of any queuing patients with a 'rapid assessment and treatment' approach. Joint GWAS - acute trust meeting to discuss and agree approach 12/07/2012.							
													Governance - All Types	Pressure area care by ambulance crews, if this is part of their remit. Can advise patients to change position in some instances							
													Local Policy In Force	ED notes of these patients kept with the ED shift coordinator. Patients in corridor identified in this way on the tracking system. Put queuing patient id no on shift coordinators sheet. Ensure the CSMs are aware of patients queuing							
													Governance - All Types	When capacity becomes available it will be used for the patient of highest priority							
													Local Policy In Force	New RCA process in discussion with James Rimmer 1.All 4 hour Ambulance waits will be designated a SI, reported within 48hours and a full RCA carried out as per usual. It has been argued that such an event may not specifically adhere to the NPSA SI criteria. This point was acknowledged, but in the light of several serious related events occurring recently and the fact that such a delay indicates that the system as a whole is under severe strain, it was felt that using the SI approach was appropriate. 2.All 2 hour waits would continue to be reported to the SHA by Chris 3.Multiple 2 hour waits was the issue that was required further discussion with the Clinical team, with regards to what this term actually meant (relating to circumstances such as static queues or moving queues) and how / if it should be responded to with an SI. This will be discussed at the Emergency Access Steering Group and the conclusions reported via the Patient Safety Group							

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	Control Details	Effectiveness of controls	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
1705	Risk of harm to patients from falling. The total number of reported falls in 2011/12 was 1429 compared to 1345 in 2010/11. In 2011/12, 15 falls were recorded as Serious Incidents resulting in fractures, the same number as in 2010/11.	Incidents Or Near Misses	Governance	3.4 Harm Reduction And Safety	03/05/2012	03/05/2012	01/08/2012	Alison Moon	4 Likely	4 Major	16	3. High	Documentation - Trust Paperwork	Patient Falls are now reported as Patient Safety Incidents. Questionnaire now appears on the online reporting system for alll falls incidents reported. Improved accuracy of report completion and merging process.	Medium	Moderate	Work specifically within the Medicine Division on reducing the number of in patient falls. Specific project identified for Medicine.	Matron allocated to lead Being the Best programme in Medicine. Being the Best programme preparation phase complete Being the Best programme implementation phase complete	31/10/2012	Not yet due	Clinical Quality Group
													Documentation - Trust Paperwork	Combined risk assessment incorperating Falls screening tool launched January 2011. All Adult inpatients are assessed for falls risk within 6 hours of admission. Falls prevention care plan assessment of the patients risk of falling and the use of bedrails - launched January 2011			Work on the care plan to further develop good practice for these patients.	Care plan was updated and relaunched Jan 2011	31/03/2012	31/03/2012	
													Benchmarked Best Practice	Increased supervision and intentional rounding implemented on some wards and being tested on other wards. Cardiac Units with side rooms carrying out 1-1 care with patients at risk of falling. Patient Safety briefings, productive ward crosses and Board Rounds now requesting details on the previous evenings falls. Ensuring MDT communication re: falls prevention and risk assessment Template for intentional rounding introduced Trust wide January 2011			Purchase of further ultra low beds via 2011/12 capital bid.	Delay in tender process for beds - purchase will now occur in 2012/13	31/03/2012	03/05/2012	
													Training	'1 hour to prevent a fall' sessions commenced June 2011 Trust wide. Falls discussed during Corporate Patient Safety induction and updates.			National Falls Awareness week June 2012: stand will be in place outside the Trauma and Orthopaedic Clinic and in the Bristol Heart Institute atrium	Plans in place including communication to staff about the event.	30/06/2012		
													Designated Accountability	Patient Safety Advisor in post in Division of Medicine ensuring falls is standing item for Clinical Governance meetings. This has now been extended to all divisions							
													Monitoring Board/Commitee	Trust Falls Steering Group reviews data on falls and ensures themes and recommendations are communicated to divisions for action. New Chair of Falls group to review Terms of Reference in May 2012. Matrons to meet in between Falls Steering Group to review falls ocurring in divisions identifying key themes and any subsequent actions that need to be taken.							
													Equipment	Rental agreement in place for ultra low beds when required							
													Service Redesign	Being the Best rapid spread improvement progarmme being implemented.Falling star symbol above beds of patients at risk of falling.							
													Documentation - Trust Paperwork	Falls Management Policy in place.							

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	Control Details	Effectiveness of controls	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
1755	Risk of harm to patients due to acquisition of pressure ulcers. Trust pressure ulcer incidence twice that expected in comparison to a nationally populated database in 2010.	External Audit Reports	Governance	3.3 High Quality Care	03/05/2012	03/05/2012	01/08/2012	Alison Moon	5 Almost Certain	3 Moderate	15	3. High	Local Policy In Force	Policy for the prevention and management of pressure ulcers	High	Moderate	Implement a rapid spread programme to embed best practice in preventing pressure ulcers	Project group meeting weekly Launch scheduled for 13th September 2011 Being the best programme in place with next review date of 9th November 2011 Being the best programme has now moved into the embedding phase and will be further reviewed in January 2012 Plan to extend Being the Best into the Care Campaign	31/05/2012		Clinical Quality Group
													Audit - External To Trust	Audit of pressure ulcers carried out bi-annually by Huntleigh Arjo			Programme of external prevalence audits and internal prevalence audit between external audit	Prevalence audit repeated Feb 2011. Result reported to Board May 2011. Repeat internal audit in August 2011. Internal prevalence completed in July 2011. Prevalence lower than in previous survey. External prevalence survey scheduled for October 2011 Prevalence repeated October 2011 Prevalence survey completed in October. Next survey to be undertaken in Sepetmber 2012.	31/10/2012	Not yet due	
													Equipment	Availabilty of electric profiling beds to prevent pressure ulcers. At present this represents only 50% of bed stock			NHS Patient Safety Thermometer to be introduced into the Trust starting with a pilot in May 2012. Aiming for 50% coverage in Q2 2012/13, 75% in Q3 and 100% in Q4.	Heads of Nursing engaged. Pilot on track to commence in May 2012.	31/03/2013	Not yet due	
													Equipment	Availability of pressure relieving mattresses							
													Local Policy In Force	Pressure ulcer prevention protocols. These protocols include on admission assessment of each patient and ongoing assessment weekly or when patient condition changes. This assessment then guides the appropriate individual patient management to reduce risk of pressure ulcers. In addition there is a comprehensive care plan in place.							
													Audit -Trust Origin	Root cause analysis process in place for grade 2 and above pressure ulcers. Chief Nurse and Lead Tissue Viability Nurse meet with the relevant ward sister for Grade 3 and above to ensure suitable actions are in place. Pressure Ulcer prevalence is discussed at each Divisional Quarterly review with the Trust Board.							
													Benchmarked Best Practice	Re launch of trustwide Being the Best project planned in May, Multi professional intentional rounding on all patients to be implemented.							
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	20/06/2012	19/07/2012	James Rimmer	4 Likely	4 Major	16	3. High	Workforce Management	Appointed to CNS post, in post from 5th December 2011	Low	High	Letter sent from D Lee to A Jarvis in September 2011 noting the risks relating to the current provision of this service. Recruitment process underway for CNS and Dietetic posts. Job plan for Consultant post prepared and waiting approval	UHB proposal for increased resources has been funded for the 2012/13 financial year. Steps are now being taken by W&Cs to recruit the necessary personnel required to mitigate the high risk associated with the current IMD provision. Recommended that the risk remains on the risk register until the relevant specialist individuals are in post. Funding approved, but continue to keep risk on the register	30/08/2012	Not yet due	Divisional Board Women's and Children's
																	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. Discussions held with Birmingham to establish network to support out of hours service			Potential for working with Guy's and St Thomas' in London regarding adult outreach service indentified but we are waiting for further clarity from the on-going discussions about the paediatric network before pursuing this.	New action	31/12/2012	Not yet due	

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	Control Details	Effectiveness of controls	Residual Risk	Action Details	Progress	Target Date	Completed Date	Monitoring Group
1898	Lack of decicated emergency Theatre sessions, resulting in delays in accessing Theatre and the risk of cancellation of planned cases at St Michael's Hospital. The issue regarding lack of 'in hours' operating list is an on going concern which is on the Risk Register for Surgery Head and Head risk number 955. St.Michael's theatres 1-5 continue to serve gynaecology, ENT and breast surgery patients. The proposed transfer to ENT surgery to the BRI in 2012 will have little impact on the need for an in hours emergency gynaecology list.	National Confidential Enquirie	Governance	3.4 Harm Reduction And Safety	04/02/2012	25/06/2012	23/09/2012	Sean O'Kelly	5 Almost Certain	3 Moderate	15	3. High	Governance - All Types	Priority given to emergency cases when clinically indicated on an individual basis.	Low	High	With the transfer of one list to South Bristol From April 2012 the plan was to close a list here at St Michael's. The Division is re-visiting this with the Division of SH&N with the intention of retaining this Friday morning list for some planned and emergency work. March '12 Limited progress made. Senior level discussions between the two Divisions	Meeting with take place in February March '12 Further meetings to take place	01/05/2012		Divisional Board Women's And Children's
													Planning	Weekly review of Theatre capacity to ensure all available sessions ultilised (Annual leave etc). Discussion with Division of Surgery Head & Neck and multiple other services.			Reviewing allocation of emergency 'slots' within each planned list, with a view of having identified emergency time at the end of several lists per week. March '12 Discussions on-going. Reviewed at Women's Executive meeting and at Women's Governance meeting.	Commenced Febraury - will review with team from SH&N for potential for additional emergency 'slots'. March '12 Limited progress made - further discussion with SH&N. Heads of Division/Divisional Managers involved	01/05/2012		
1901	Unsustainability of current model of service delivery. Children with highly dependent needs (including long term ventilation) are currently managed across the whole hospital, with the nursing staff supported by outreach team. Whilst this model is functional for a small number, when the ratio of highly dependant patients increases nursing resources are pulled from other areas in order to manage the clinical needs of individual patients on a daily basis. This results in a adhoc system of delivering care to a cohort of patients who have high dependency requirements and who require a high level of monitoring, intervention and nursing ratio. This results in frequent reduction in total bed base, reliance on temporary staffing and an inherent risk of compromised care.	Strategic Decision Making	Governance	3.3 High Quality Care	09/02/2012	25/06/2012	23/09/2012	James Rimmer	5 Almost Certain	3 Moderate	15	3. High	Workforce Management	Utilisation of temporary staffing in response to clinical need	Medium	Moderate	Submission of formal bid through commissioning and planning process to provide a defined High dependent Unit.	Bid submitted, awaiting outcomes	31/03/2012	Not yet due	Divisional Board Women's And Children's
													Planning	Frequent and formal processes for managing reources (beds and staff) across the hospital as a whole. Significant team working. Reliance on flexibility in deployment of resources.			Data collection. Senior staff visiting other centres. Close working with North Bristol Trust		31/03/2012	Not yet due	
													Workforce Management	Daily deployment of practitioners within Outreach team with advanced clinical skills. Team limited to one person per 24/7 to cover hospital as a whole.					20/06/2012	Not yet due	

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 17 – Quarter 1 Compliance Framework Monitoring & Declaration (including Quarterly Financials)

Purpose

To consider the quarterly governance and finance self-certification to Monitor for Quarter 1 of 2012/13.

Abstract

The Trust Board of Directors is required to make quarterly statements with respect to governance and finance risk ratings, in accordance with the monitor compliance framework.

The Director of Strategic Development had provided an analysis of performance in support of the Governance Statement, as set out at Appendix A.

Director of Finance has provided a comment on financial performance for Quarter 1, as set out at Appendix B.

Recommendations

The Trust Board of Directors' is recommended to:

- Approve a **governance risk rating** of AMBER-GREEN, and
- Approve a **financial risk rating** statement of 3, and that the Board expects to maintain a rating of 3 for the forthcoming 12 months.

Report Sponsor

Chief Executive, Robert Woolley

Appendices

- Appendix A – Monitor Quarter 1 Declaration of Governance Compliance 2012/13
- Appendix B – Quarter 1 Financial Performance Commentary for Monitor Return.

Previous Meetings

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

University Hospitals Bristol NHS
NHS Foundation Trust

Monitor Quarter 1 Declaration of Governance Compliance 2012/13

1. Context

The Trust is required to make its Quarter 1 declaration of compliance with the 2012/13 Monitor Compliance Framework by 31 July 2012.

The scoring against the Compliance Framework remains the same as last year:

Score less than 1 = GREEN
Score 1 or 1.5 = AMBER-GREEN
Score 2 to 3.5 = AMBER-RED
Score 4 or more = RED

Each quarterly declaration to Monitor must take account of both performance in the quarter, and expected performance risks in the coming quarter.

The context for the declaration is a Monitor Annual Plan Governance Declaration of an AMBER-GREEN rating reflecting inconsistency in performance against the 4-hour achievement. The Trust considered *Clostridium difficile* (*C. diff*) and Referral to Treatment Time (RTT) Incompletes standards to be at medium rather than high risk.

2. Performance in the period

The attached matrix (Table 1) shows the Quarter 1 position against each of the standards in Monitor's Compliance Framework. The A&E 4-hour standard was not achieved for the quarter, but was achieved in June. With all the other standards expected to be confirmed as achieved (on final reporting) this gives the Trust a provisional AMBER-GREEN rating. The matrix also details the known risks as they are currently perceived in relation to Q2 2012/13, which could require us to over-ride this rating.

The Trust had two Care Quality Commission (CQC) reviews in the period. There were no material impacts on the scoring of the Governance Risk Rating as a result of these reviews.

3. Q2 risk assessment

The risk assessment detailed in Table 1 sets out the performance against each standard in Monitor's Compliance 2012/13 Framework, along with the key risks to target achievement for the coming quarter. The mitigating actions that are being taken are also provided, along with the residual risk.

Three standards have been assessed as having a medium residual risk. These are: the A&E 4-hour, *C. diff* and RTT Incompletes standards. No standards have been assessed as having a high residual risk. It should be noted that a declared risk of failure to achieve the A&E 4-hour standard for this third quarter (i.e. quarter 2 2012/13) would constitute a RED rating over-ride.

4. Recommendation

It is recommended that the Board declares an AMBER-GREEN Governance Risk Rating for quarter 1 2012/13, reflecting performance in the quarter against the A&E 4-hour standard, but with no significant risks to achievement of standards in quarter 2. The draft declaration for Quarter 1 is shown in Appendix 1.

Table 1. Performance in Q1 against the 2012/13 Compliance Framework, and risks to achievement of these targets in Q2 2012/13

Measure	Threshold for 2012/13	Performance in Q1	Risks for Q2	Risk	Mitigation of risks	Residual risk
Clostridium difficile *(C. diff)*	54 cases per annum (measured as the cumulative number of cases at each quarter-end) Q1 – 17 cases Q2 – 16 cases Q3 – 11 cases Q4 – 10 cases Please note, the above quarterly trajectory has been revised to reflect the pattern of cases seen in 2011/12 (when out-turn was also 54 cases). The revision to the trajectory has been agreed with the Primary Care Trust and Monitor.	16 cases against a target of 17 for the quarter. 5 of the 16 reported cases in Q1 were found incidentally, following inappropriate sampling.	Incremental improvements in performance were reported in each quarter of 2011/12, with 10 cases being reported against a target of 15 for Q4. The Trust would have reported 11 cases in Q1 had the sampling protocol been followed (i.e. patients not inappropriately tested). A new national testing protocol will come into effect in quarter 2, which may *increase C. diff* detection rates by upto 20% based on published guidance. Although the Trust year-to-date has had 30% of its annual target of C. diff cases, as of the 17th July, there have been no *C. diff* cases in Q2.	High	A number of actions are being taken, including a mandatory protocol established on the Order Comms system to prevent inappropriate sampling, reminders of the sampling protocol on screen savers, refresher training for staff and the replacement of some ward equipment to further improve hygiene standards.	Medium

Measure	Threshold for 2012/13	Performance in Q1	Risks for Q2	Risk	Mitigation of risks	Residual risk
MRSA	2 cases per annum (measured as the cumulative number of cases at each quarter-end) Q1 – 1 case Q2 – 0 cases Q3 – 1 case Q4 – 0 cases	2 cases against a target of 1 in Q1 2012/13.	Although the trajectory was not achieved in the first quarter, there were no new cases in June. A *de minimis limit* of six cases applies to 2012/13[1]. This means the Trust will not be scored against this standard unless it reports more than six cases in the year. This is in place to take account of the expected natural variation in cases, when the overall incidence is very low.	Medium	Zero tolerance to MRSA bacteraemia cases to continue to be adopted. Continued focus on good clinical practice.	Low
Cancer: 31-day wait for subsequent treatment	Surgery – 94% Drug therapy – 98% Radiotherapy – 94%	Achieved in Q1, and in every quarter in 2010/11 and 2011/12	Key risks are around cancellations of surgery on the day due to a lack of an adult Intensive Therapy Unit (ITU) bed, and also peaks in demand for Upper GI hepatobiliary surgical demand.	Medium	Prospective planning of subsequent treatments continues, along with tight management of cancer pathways. The impact of last-minute cancellations can be more effectively mitigated by the booking of dates for surgery at least a week prior to the breach date. This is possible with prospective planning of	Low

[1] Monitor will score NHS foundation trusts for breaches of the MRSA objectives as follows:

- Where the number of cases is less than or equal to the *de minimis* limit (i.e. six cases), no formal regulatory action (including scoring in the governance risk rating) will be taken;
- If a trust exceeds the *de minimis* limit (i.e. six cases), but remains within the in-year trajectory for the national objective, no score will be applied;
- If a trust exceeds both the *de minimis* limit (i.e. six cases) and the in-year trajectory for the national objective, a score will apply; and
- If a trust exceeds its national objective above the *de minimis* limit, Monitor will apply a red rating and consider the trust for escalation

Measure	Threshold for 2012/13	Performance in Q1	Risks for Q2	Risk	Mitigation of risks	Residual risk
					subsequent treatments.	
Cancer: 62-day wait for first treatment	GP referred – 85%	GP referred standard achieved in Q1 and in every quarter in 2011/12 and 2010/11.	Significant proportion of breaches wholly attributable to late receipt from another provider; this risk is more difficult to mitigate. Internal risks have significantly diminished due to tight management of pathways. But a few avoidable breaches still arise each quarter for a diverse range of reasons. At the end of quarter 1 the Trust is carrying forward a higher number of patients that are expected to breach when treated in quarter 2, than in previous quarters. However, the volume of breaches is within the usual tolerance for the quarter, and felt to be manageable.	Medium	Action plan refreshed each quarter, following a review of the reasons for breaches. Given consistent achievement of both standards in the last three quarters, the action plan is now reported to the Service Delivery Group (SDG) by exception. 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. An audit has been carried-out by each Trust, to determine the reasons for late referral to other providers.	Low
	Screening referred - 90%	Screening referred standard achieved in Q1, Q3 and Q4, but not Q2 2011/12. Achieved in all quarters of 2010/11 except Q4.	The number of breast screening breaches increased significantly in Q2 due to changes to the clinical pathway and a shortfall of capacity. The screening standard would have been achieved without the increase in breast breaches. The nationally prescribed bowel screening pathway is difficult to complete within 62 days. Any delays can result in a breach and	Medium	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. But tight management of pathways has	Low

Measure	Threshold for 2012/13	Performance in Q1	Risks for Q2	Risk	Mitigation of risks	Residual risk
			these delays are often outside of the control of the Trust (e.g. patient choice; late tertiary referrals)		limited the impact.	
18-week Referral to Treatment Time – admitted patients	90% (Trust aggregated level)	Achieved in every month in Q1 and the last two years.	Backlog of over 18 week waiters remains high. Tight management of booking of breached patient remains critical to maximise the number of breach patients we are treating within the constraints of achievement of the 90% standard. 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 – non-admitted patients	95% (Trust aggregated level)	Achieved in every month in Q1 and the last two years.	Minimal risks, relating to the delayed outcoming of outpatient clinics on Medway.	Low	Daily monitoring of clinic outcomes to continue until levels of data completeness return to normal.	Low
18-week Referral to Treatment Time – incomplete pathways	92% (Trust aggregated level)	Achieved 92.2% in April and May (and June subject to final validation).	The number of > 18 week incomplete pathways is primarily affected by the following factors: 1) Outpatient waiting times 2) Clinic outcomes not being captured in real-time 3) Size of the elective > 18 week backlogs The Medway implementation is having an impact on clinic outcomes due to staff taking time to understand the new outpatient process.	High	Outpatient waiting times are falling. With focus on achievement of a maximum 11 week wait in 2012/13 (within the constraints of the contract), this should shorten pathways. There is activity within the 2012/13 contract to focus on reducing elective RTT backlogs. Continued focus on treating patients in the 14-18 week wait category is required, in addition to treating the long-waiters, to	Medium

Measure	Threshold for 2012/13	Performance in Q1	Risks for Q2	Risk	Mitigation of risks	Residual risk
			Performance at present is only just above the required standard, following significant efforts to validate each month.		help reduce the backlogs quickly. The current low rates of outcoming of clinics following the Medway implementation represents the greatest risk to achievement of this standard and requires continued focus in the immediate term until normal levels of clinic outcoming are restored. Further mitigation could be provided by manual validation of clinic outcomes and pathways.	
Cancer: 31-day wait for first treatment	96%	Achieved in Q1 and in all quarters in 2011/12 and 2010/11.	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 and breast symptomatic achieved in Q1 and in all quarters in 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
A&E maximum wait of 4 hours	95%	Not achieved in Q1 as a whole (93.6%), but achieved for June (95.7%).	The deterioration in performance in Q4 and Q1 was attributed to a number of key factors. These include, discharges happening later in the day, increasing over 14 days stays and an increase in the number of elderly patients needing to be admitted. The age group of patients being admitted is a good indicator of patient acuity/complexity, and therefore	High	The actions plan developed at the end of June delivered the agreed recovery trajectory. The actions included target numbers of discharges before 10:00, target reductions in over 14 days stays, robust escalation of delayed discharges and the closure of flex bed capacity which it was felt was diluting clinical input to medical wards.	Medium

Measure	Threshold for 2012/13	Performance in Q1	Risks for Q2	Risk	Mitigation of risks	Residual risk
			expected medical input and length of stay. This, along with delayed discharges (i.e. discharges dependent on an external agency), are factors outside of the full control of the Trust. Q2 has historically been a high performing quarter, with the 95% standard consistently achieved. However, this year, performance has not matched historical trends. Recent performance at the Children's Hospital has dipped below the target 98%, due to high levels of illnesses usually only seen in winter. This is felt to be associated with the unseasonal weather. However, the 95% standard is still expected to be routinely achieved.		Additional actions are planned for Q2, to realise further improvements in performance. The focus will continue to be achievement of the 95% standard as a minimum, in each Emergency Department.	
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 1 – Draft Monitor declaration for Q1 2012/13

eclaration of risks against healthcare targets and indicators for 2012-13 by University Hospitals Bristol

se targets and indicators are set out in the **Compliance Framework**

nitions can be found in Appendix B of the **Compliance Framework 12/13**

TE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key: must complete

may need to complete

Target or Indicator (per Compliance Framework 12/13)	Threshold or target YTD	Scoring	Risk declared at Annual Plan	Score	Quarter 1 Actual Performance	Achieved /Not Met	Any comments or explanations
Clostridium Difficile -meeting the C.Diff objective	14	1.0	No	0	16	Achieved	*Following agreement with our PCT quarterly targets have been revised. Q1 target is 17.*
MRSA - meeting the MRSA objective	1	1.0	No	0	2	Not relevant	*De minimis reporting level not reached.*
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	No		94.5%	Achieved	*Figures subject to final reporting*
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments	98%	1.0	No		100.0%	Achieved	*Figures subject to final reporting*
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	No	0	99.4%	Achieved	*Figures subject to final reporting*
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer)	85%	1.0	No		89.0%	Achieved	*Figures subject to final reporting*
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	90%	1.0	No	0	95.7%	Achieved	*Figures subject to final reporting*
Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients	90%	1.0	No		92.7%	Achieved	*Subject to final reporting - standards met each month*
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	95%	1.0	No		97.4%	Achieved	*Subject to final reporting - standards met each month*
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	92%	1.0	No	0	92.2%	Achieved	*Subject to final reporting - standards met each month*
Cancer 31 day wait from diagnosis to first treatment	96%	0.5	No	0	96.6%	Achieved	*Figures subject to final reporting*
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected)	93%	0.5	No		95.3%	Achieved	*Figures subject to final reporting*
Cancer 2 week wait from referral to date first seen, sympomatic breast patients (cancer not initailly suspected)	93%	0.5	No	0	96.5%	Achieved	*Figures subject to final reporting*
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	1.0	Yes	1	93.6%	Not met	*95% standard achieved in June.*
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	0.5	No	0		Yes	
Risk of, or actual, failure to deliver mandatory services	N/A	4.0	No	0		No	
CQC compliance action outstanding (as at 30 Jun 2012)	N/A	special	No			No	
CQC enforcement action within last 12 months (up to 30 Jun 2012)	N/A	special	No			No	
CQC enforcement notice currently in effect (as at 30 Jun 2012)	N/A	4.0	No			No	
Minor CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Jun 2012)	N/A	special				No	
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Jun 2012)	N/A	special	No			No	
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Jun 2012)	N/A	2.0	No	0		No	
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	N/A	2.0	No	0		No	
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A	special	No			No	
Has the Trust has been inspected by CQC (in the quarter ending 30 Jun 2012)	N/A	special			no of standards	Yes	*Outcome of the review still pending.*
If so, did the CQC inspection find non compliance with 1 or more essential standards	N/A	special			0	No	*Outcome of the review still pending.*
		Results left to complete	0			0	
		Total Score	1			1	
		Overide Rating (if any)					Enter the reason for any non-scoring related rating override here
		Indicative Governance risk rating	AMBER-GREEN			AMBER-GREEN	

University Hospitals Bristol NHS
NHS Foundation Trust

For consideration and approval by

Finance Committee	25th July 2012 – Agenda Item 7
Joint Trust Board and Membership Council meeting	30th July 2012 – Agenda Item 17

QUARTER 1 FINANCIAL PERFORMANCE COMMENTARY FOR MONITOR RETURN

Director of Finance
July 2012

1. EXECUTIVE SUMMARY

This commentary covers the results for the quarter ending 30th June 2012.

The Trust reports an EBITDA[1] surplus for the quarter of £7.199m. This is £1.048m lower than the Annual Plan projection to date of £8.247m. EBITDA is at 87% of Plan. The summary income and expenditure statement shows a surplus for the quarter of £0.185m (EBITDA and financing costs). The financial risk rating of 3 is in line with the Annual Plan forecast of 3.

	Weighting	30th June 2012	5	4	3	2	1
EBITDA							
Margin %	25	5.5%	11	9	**5**	1	<1
Achievement of Plan	10	87%	100	**85**	70	50	<50
Net Return after Financing	20	0.23%	6	5	**3**	-2	<-2
I&E surplus margin	20	0.14%	3	2	1	**-2**	<-2
Liquid ratio (days)	25	20.1 days	60	25	**15**	10	<-10
Overall rating				**3 (actual weighted score = 2.90)**			

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

Prudential Borrowing Limit Performance	**Monitor Ratio Tier 1**	**30th June 2012**	**Projection – March 2013**
Minimum Dividend Cover	>1x	3.4x	3.6x
Minimum Interest Cover	>3x	80x	25x
Minimum Debt Service Cover	>2x	55x	22x
Maximum Debt Service to Revenue	<2.5%	0.1%	0.3%

The financial plan for the year is a £5.7m income and expenditure surplus.

[1] Earnings Before Interest Taxation Depreciation and Amortisation

2. CLINICAL INCOME

Clinical income is £1.331m higher than the Monitor Annual Plan, standing at £101.699m for the quarter. Clinical income includes income from NHS commissioners, territorial bodies, and non-NHS clinical income.

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

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

	£m
Monitor Plan	100.368
Other Changes To The Plan	0.954
Current Plan	101.322
Over Performance (See Table 2 Below)	0.377
Quarter To Date Income	101.699

Activity and Income by Worktype

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

i. Elective Inpatients

Overall Elective Inpatients are £0.149m behind plan. The under-performance is across a number of specialties particularly Cardiac Surgery, Paediatric Cardiac Surgery, and Urology.

ii. Non-Elective / Emergency Inpatients

Non-Elective Inpatients are £0.180m behind plan for the quarter. The key areas of over-performance are Paediatrics, Accident and Emergency and Trauma and Orthopaedics. This position excludes the impact of contract penalties which are included in Other NHS activity below.

iii. Day Cases

Day Cases are £0.048m ahead of plan for the quarter. The key areas of over-performance are Clinical Haematology, Dermatology and Cardiology.

iv. Outpatients

Outpatient activity has over-performed by £0.010m; the key area of over-performance is Genitourinary Medicine.

v. Accident and Emergency

A&E has under-performed by £0.098m against plan.

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 has under-performed by £0.391m for the quarter.

viii. Other Clinical Revenue

Other Clinical Revenue is over-performing by £0.016m.

Table 2 – Clinical Income by Worktype

Worktype	Plan £m	Actual £m	Variance £m
Elective Inpatient	11.493	11.344	(0.149)
Non-Elective Inpatient	25.296	25.116	(0.180)
Day Case	7.327	7.375	0.048
Outpatient	16.850	16.860	0.010
Accident & Emergency	2.948	2.850	(0.098)
Other NHS	36.442	37.636	1.194
Private Patient Revenue	0.669	0.278	(0.391)
Other Non Mandatory	0.299	0.241	(0.058)
Grand Total	101.322	101.700	0.378

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	0.600	1%
NHS North Somerset	(0.080)	(1%)
NHS South Gloucestershire	0.253	3%
NHS Wiltshire	0.055	3%
South West Specialised Commissioning	(0.006)	-
NHS Somerset	(0.040)	(1%)
NHS Gloucestershire	(0.040)	(2%)
Prior Year Income	1.071	N/A
Variable Estimates	(0.663)	N/A
Other (including Exceptional Funding)	(0.773)	N/A
Total	0.377	-

3. OTHER OPERATING INCOME

Overall other income is £0.066m lower than planned for the quarter. The main reasons are:

- Lower than planned Skills for Health income £0.547m.
- Higher than planned other income £0.483m

4. EXPENDITURE

Overall operating costs of £123.175m for the quarter are £2.661m higher than plan. Trust pay costs are £0.47m lower than plan and non pay costs are £2.708m higher than plan.

4.1 Pay Costs

Pay costs at £76.817m for the quarter were £0.047m, lower than plan.

4.2 Drugs

Drug costs of £11.884m are £1.530m higher than plan for the quarter. This is related to activity

4.3 Clinical supplies and services

Clinical supplies and services costs at £11.588m for the quarter were £1.066m lower than plan

4.4 Miscellaneous Other Operating Expenses

Other costs were £1.863m higher than plan. This is due mainly lower than planned CRES delivery and a higher than planned spend on premises and fixed plant.

4.5 Depreciation

Depreciation charges at £4.577m were lower than the Annual Plan projection of £4.864m for the quarter. Depreciation charges are expected to increase later in the year as expenditure on the capital programme increases.

4.6 Non Operating Expenses

There are no significant variances within this section.

5. CAPITAL

There have been a number of approved changes to the Trust's Capital Programme since the submission of the Annual Plan in May. At that stage expenditure for the year was projected to be £81.514m with expenditure for the first quarter of £16.857m. Actual expenditure at £12.899m equates to 77% of the Annual Plan projection. The forecast outturn is £75.4m – this equates to 92% of the Annual Plan projection of £81.514m.

The table provided below shows a comparison of the Trust's current plan with actual expenditure to date. The variance on Strategic schemes is a combination of forecast underspendings (£0.25m) and slippage (£0.45m) into 2013/14.

	Quarter ending 30th June 2012		
	Plan for Period £'000	Actual for Period £'000	Variance £'000
Sources of Funding			
Donations	238	-	(238)
Retained Depreciation	4,287	4,287	-
Asset Disposals	-	-	-
Prudential Borrowing	-	-	-
Cash balances	9,834	8,612	(1,222)
Total Funding	**14,359**	**12,899**	**(1,460)**
Expenditure			
Strategic Schemes	(9,644)	(8,940)	704
Medical Equipment	(936)	(681)	255
Information Technology	(2,430)	(2,044)	386
Roll Over Schemes	(147)	(169)	(22)
Refurbishments	(270)	(335)	(65)
Operational / Other	(932)	(730)	202
Total Expenditure	**(14,359)**	**(12,899)**	**1,460**

6. STATEMENT OF FINANCIAL POSITION (Balance Sheet)

The significant balance movements and variances are explained below.

6.1 Non Current Assets

The balance of £318.406m at the end of June is £4.818m lower than plan. This mainly reflects lower than planned expenditure for the first quarter.

6.2 Inventories (formerly referred to as Stock)

At the end of June the value of inventories held totalled £6.907m. This is broadly in line with the Annual Plan projection of £7.086m.

6.3 Current Tax Receivables

The balance of £1.875m at the end of June mainly represents a claim made to the HMRC for additional VAT that is recoverable under legislation. These moneys will be received in July and is higher than the usual monthly claim.

6.4 Trade and Other Receivables (Including Other Financial Assets)

The balance at the end of June at £8.388m is £7.397m less than plan. However a stricter classification of monies owed to the Trust, but not yet invoiced being shown as Accrued Income. This is currently £11.036m which is £9.455m higher than the plan figure. The Trust continues seeking to reduce the amount of money owed to the Trust. The invoiced debtor balance at 30th June equates to 9.4 debtor days.

6.5 Prepayment

The prepayment balance at the end of June is £2.007m. This is mainly due to payments for maintenance contracts for servicing of equipment. This is lower than the plan of £3.002m.

6.6 Non Current Assets held for Sale

This item relates to the 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 3 months.

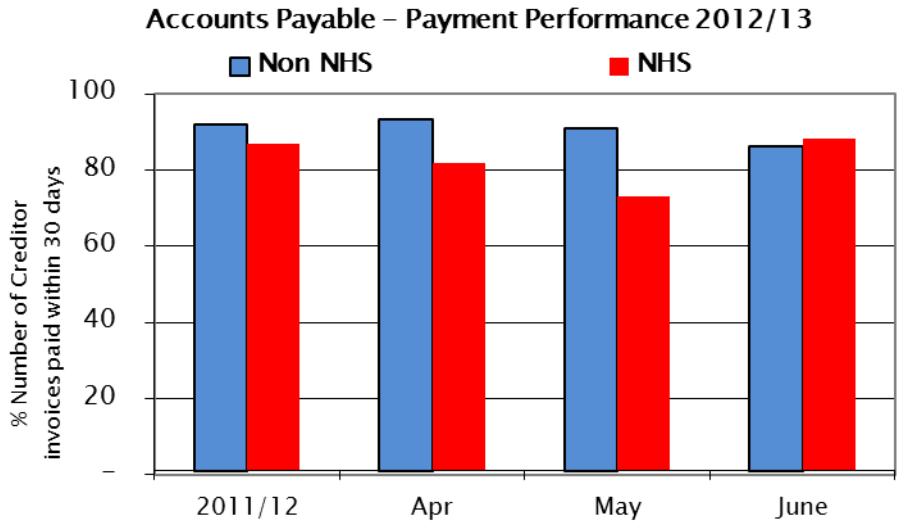
6.7 Deferred Income

Deferred income of £5.444m is £1.483m lower than the plan of £6.927m. The principal balances relate to Skills for Health services and research and development moneys.

6.8 Trade Creditors / Other Creditors / Capital Creditors

Trade, 'Other' and Capital Creditors total £15.215m at the end of June. This is £4.295m less than the Plan projection of £19.510m.

The Trust aims to pay at least 90% of undisputed invoices within 30 days. For Quarter 1 of 2012/13 the Trust achieved 81% and 90% compliance against the Better Payment Practice Code for NHS and Non NHS creditors.



6.9 Other Financial Liabilities

The closing balance for Accruals at £27.960m is higher than the Plan projection of £13.878m reflecting the Trust's current estimate of amounts owing for which invoices had not been received at the quarter end.

6.10 Summary Statement of Financial Position

A summary statement is given below showing the balances as at 30th June together with comparative information taken from the Trust's Annual Plan.

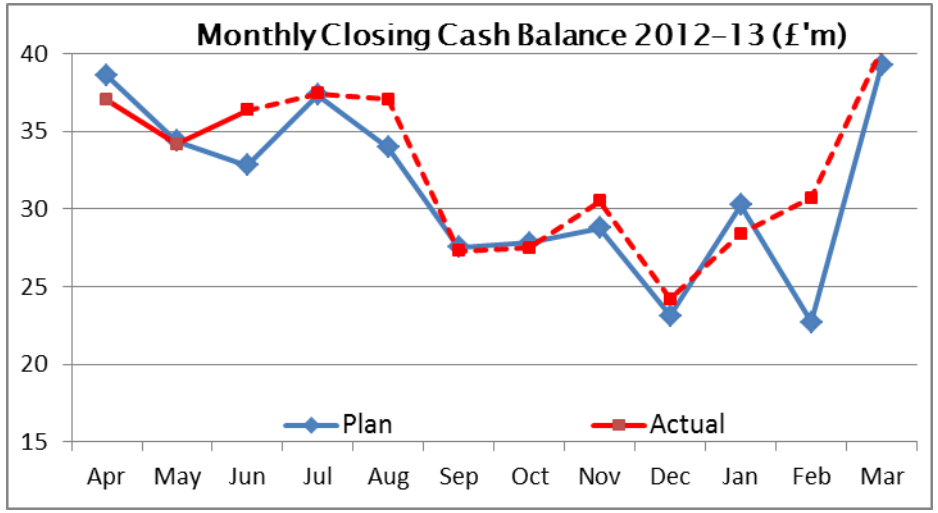
Summary Statement of Financial Position (Balance Sheet)

	Position as at 30th June 2012		
	Plan	Actual	Variance Fav/ (Adv)
	£'000	£'000	£'000
Non Current Assets			
Intangible	4,724	5,870	1,146
Property, Plant and Equipment	323,224	318,406	(4,818)
	327,948	**324,276**	**(3,672)**
Current Assets			
Inventories	7,086	6,907	(179)
Current Tax Receivables	399	1,875	1,476
Trade and Other Receivables	15,785	8,388	(7,397)
Other Financial Assets	1,793	11,248	9,455
Prepayments	3,002	2,007	(995)
Cash & Cash Equivalents	32,822	36,448	3,626
Non Current Assets held for sale	7,482	7,482	-
Assets Current Totals	**68,369**	**74,355**	**5,986**
ASSETS TOTALS	**396,317**	**398,631**	**2,314**
Current Liabilities			
Deferred Income	(7,244)	(5,716)	1,528
Provisions	(6,664)	(6,736)	(72)
Current Tax Payables	(6,675)	(6,362)	313
Trade and Other Payables	(19,510)	(15,215)	4,295
Other Financial Liabilities	(16,464)	(30,536)	(14,072)
Other Liabilities	(5,428)	(5,428)	-
Liabilities Current Totals	**(61,985)**	**(69,993)**	**(8,008)**
NET CURRENT ASSETS/(LIABILITIES)	**6,384**	**4,362**	**(2,022)**

	Position as at 30th June 2012		
	Plan	Actual	Variance Fav/ (Adv)
	£'000	£'000	£'000
Liabilities Non Current			
Loans	(4,950)	-	4,950
Provisions	(231)	(236)	(5)
Finance Leases	(5,906)	(5,906)	-
Liabilities Non Current Totals	**(11,087)**	**(6,142)**	**4,945**
TOTAL ASSETS EMPLOYED	**323,245**	**322,496**	**(749)**
Taxpayers' and Others' Equity			
Public Dividend Capital	191,011	191,011	-
Retained Earnings	62,376	61,627	(749)
Revaluation Reserve	69,773	69,773	-
Other Reserves	85	85	-
TAXPAYERS' EQUITY TOTALS	**323,245**	**322,496**	**(749)**

7. Cash and Cash Flow

The Trust held cash balances at the end of June of £36.448m. This is £3.626m more than the Annual Plan projection of £32.822m. The improvement over the quarter reflects slippage on the capital programme and lower than expected payments to traders. The graph shown below provides a comparison of actual and projected month-end cash balances for 2012/13.



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. The Finance Committee has recently agreed that the first of 2 one-year options to extend this arrangement should take effect from September 2012.

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 margin of 5.5% is slightly behind the Plan for the quarter of 6.4%. The Trust expects to results for the second quarter to be in line with Plan for the year to date.

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 = 18% (£1.567m) of the Trust's total debtor balances exceed 90 days. This amount (net of a bad debt provision of £0.231m) 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.

NHS South of England has recently launched an initiative which asks all NHS organisations to clear all debtor balances over 90 days. The expectation is that parties will work to clear all '90 day aged debts' in the October - December quarter and maintain that position going forward. UH Bristol will actively participate in this piece of work.

Information on aged debtors is presented to and considered by the Trust's Finance Committee on behalf of the Trust Board each month. The Trust does have and will continue to pursue other aged debts (other than the £1.567m mentioned above). As at 30th June this balance of £4.2m was fully covered by a bad debt provision.

The Trust is aware that this metric has been triggered for the ninth 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 quarter to date.

UH Bristol = Not applicable. The Trust's capital expenditure for the quarter of £12.9m is equivalent to 77% of the Annual Plan forecast for the period. The forecast outturn capital expenditure is now projected to be £75.4m for the year – equivalent to 93% of that shown in the Annual Plan. The reduction is expenditure reflects the revised delivery date of a linear accelerator (£2.455m moving to April 2013) and the re-profiling of strategic capital expenditure (BRI Redevelopment and Centralisation of Specialist Paediatrics) of £1.05m into 2013/14 expenditure with no change to the project completion date.

9. Other Information

9.1 External Audit Services

The Trust has completed a tender and evaluation process for the appointment of the Trust's external auditor. The report of the Tender Panel, comprising governors and non-executive directors, was presented to the May meeting of the Membership Council for consideration and approval. It has been agreed that PricewaterhouseCoopers should be appointed as the Trust's External Auditor.

9.2 Annual Accounts and Foundation Trust Consolidation (FTC) schedules.

The Trust has completed its 2011/12 Annual Accounts and FTC schedules and these have been submitted in line with the national timetable.

9.3 Private Patient Income Cap

Private patient income for the quarter is £0.398m or 0.39% 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

Minutes of Membership Council Meeting, held on 29 May 2012 at 13:00 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 20

Membership Council Members Present	
• John Savage – Chairman • Anne Ford – Public Governor, North Somerset • Clive Hamilton – Public Governor, North Somerset • Mo Schiller – Public Governor, Bristol • Pauline Beddoes – Public Governor, South Gloucestershire • Sue Silvey – Public Governor, Bristol • Heather England – Public Governor • Jade Scott-Blagrove - Public Governor, Bristol • John Steeds – Patient Governor, Local • Neil Auty – Patient Governor, Tertiary and Governor Representative	• Lorna Watson – Patient Governor, carers of patients under 16 years • Wendy Gregory – Patient Governor, carers patients of 16 years and over • Jan Dykes – Staff Governor, Non-Clinical Healthcare Professionals • Alex Bunn – Staff Governor, Non-Clinical Healthcare Professionals • Sylvia Townsend – Appointed Governor, Bristol City Council • Jeanette Jones– Partnership Governor, Joint Union Committee • David Tappin – Bristol Primary Care Trust
Others Present or In Attendance	
• Robert Woolley – Chief Executive • Paul May – Non-executive Director • Deborah Lee – Director of Strategic Development • Alison Moon - Chief Nurse • Paul Tanner – Head of Finance	• Sean O'Kelly – Medical Director • Charlie Helps – Trust Secretary • Maria Fox – Membership Manager • Debbie Marks – Membership Administrator (minute taker) • 2 Foundation Trust Members

Item	*Action*
1. Chairman's Welcome and Apologies The Chairman, John Savage, welcomed everyone to the meeting. He noted apologies from: Ken Booth, Mary Hodges, Anne Skinner, Peter Holt, Jacob Butterly, Philip Mackie, Belinda Cox, Florene Jordan, Phil Quirk, Jessica Burston, Helen Langton, Tim Peters, Ken Cockrell, Louise Newell, Joan Bayliss, and Maggie Mickshik, *It was confirmed that those present constituted a **quorum** of the Membership Council.*	
2. Declarations of Interest In accordance with Foundation Trust Constitution, all members present are required to declare any conflicts of interest with items on the Membership Council Meeting agenda.	

Item	*Action*
No declarations of interest were made.	
3. Minutes and Matters Arising The Membership Council considered the minutes of the previous meeting held on 2 May 2012 and **approved** them as an accurate record of matters transacted subject to the following amendments: **Item 7 Monitor Declarations** Clive questioned the recurring problem of failure to meet targets in the fourth quarter of each year and asked whether this was due to staff taking accrued leave and/or managers tightening their budgets to improve end of financial year cost position. **Item 18 Board Assurance Framework Report** Clive noted that under serial 1.7 of the Board Assurance Framework report, the trust was looking into the feasibility or increasing private patient income and requested that the governors be kept informed and consulted on any changes proposed. Deborah Lee replied (on 29th May) that any changes would be brought to the governors Strategy Working Group for consideration. **Item 19.3 Governor involvement in strategic decision making** The governors expressed their desire to be informed as soon as possible of any potential strategic decisions such as possible mergers and acquisitions. Robert Woolley briefed the governors in depth about the possible merger with North Bristol Trust (NBT). As highlighted at the Membership Council meeting on 2 May, the trusts are at an exploratory stage and a working party has been set up and is chaired by Professor Steve West (vice chancellor for University of the West of England). The group includes members from UH Bristol Trust, NBT, Primary Care Trust (PCT) and a local commission lead from South Gloucestershire. Robert distributed a brief last week stating that the working party have agreed a framework. The timetable is: • June 2012: A recommendation will be written on whether to take forward the process for a merger or acquisition. A factor to be noted is whether NBT are able to achieve foundation trust status independently. • July 2012: The report on the recommendation will be available. • 30th July 2012: The report will then be presented to the Trust Board of Directors • July 2012: The report will be presented at an extra-ordinary Membership Council. Robert continued that if a merger were agreed, the trusts would need to follow the formal approval route as stated by our regulators, Monitor. John Savage assured the governors that in additional to the above, that there will be opportunity for discussion at the governors monthly meeting with John.	

Item	*Action*
Questions from governors: **Q1:** John Steeds asked if this is a merger or acquisition? Robert Woolley explained that there are pros and cons including acceptability to both Trust Board of Directors, and if NBT are able to achieve foundation trust status. The recommendation for which route to take will take place at the end of July. **Q2:** John Steeds asked what is the timescale for governors to approve any decision made? Robert replied that the timescale for governors and the trust to approve the recommendation would be short but assured all governors there will be enough information available to enable governors to make their decision. **Q3:** Mo Schiller asked when would NBT achieve foundation trust (ft) status? Robert explained that NBT have started to recruit members and governors. However, they are presently a shadow council ie they have no statutory responsibilities. NBT have submitted a plan to the Department of Health who are yet to make a decision. **Q4:** Neil Auty thanked Robert for the options of holding extra-ordinary Membership Council meetings to discuss the recommendation in July and thereafter. Neil and Wendy Gregory highlighted that the governors felt cautious about making a decision given on what information is presently available. **Q5:** Pauline Beddoes pointed out that both trusts have different pay scales and asked how that issue would be resolved? Robert explained that they are aware of this matter. Both trusts agreed that they would need to harmonise pay scales. **Q6:** John Steeds mentioned he has recently attended a Foundation Trust Governors Association event in Bristol and one of the presentations was from someone who has overseen a merger between Winchester hospital and Basingstoke. John is being forwarded this information and will share with the governors. The Chairman reminded the group that Neil Auty finishes his role as governor representative at the end of June 2012 and thanked him for his hard work and commitment. *The Membership Council **considered** the schedule of matters arising and confirmed the status of actions arising from previous meetings.*	
4. Membership Council Self-Assessment and Annual Plan The Membership Council received and considered a report by Charlie Helps. The objective of this report was to consider the outcomes from the Membership Council self-assessment held in February 2012 and the new Health and Social Care Act 2012 responsibilities for governors. Outcomes from two workshops were included. The workshops were held for governors to consider the implications of the Act. Monitor have now published information on this Act on their website and information can be found on: www.monitor-nhsft.gov.uk/information-nhs-foundation-trusts/information-governors	

Item	*Action*
To take forward the outcomes, a 'short-life task-and-finish group' will be set up within the next few weeks. The terms of reference was outlined in the report. The group will report to the membership working group and to the membership council. *The governors agreed:* *a) A short life task and finish group to be set up to take into account of the feedback when considering revisions to governor meetings and activities.* b) *The terms of reference as outlined in the report.*	
5. Trust's Annual Plan for 2012/13 to 2014/15 Deb Lee presented the trust's Annual Plan for 2012/13 to 2014/15 to the Membership Council to gather views on any matters the Council wishes the Board to have regard for when it approves the plan at its meeting on 31st May 2012. Deb thanked the governors Strategy Working Group for their help and input into the annual plan and to John Steeds who took personal time to review the plan and provide valuable feedback. In addition, Deb made an in depth presentation on the key elements of the plan. A copy of the presentation can be obtained from the Membership Office. Questions from governors: **Q1: Page 20 - Maternity services risk:** Neil Auty wished to comment that changes to maternity services was a huge step forward and will make a difference to the service. **Q2: Page 8 – Quality Goal, Patient Safety:** Neil Auty asked for clarification on the key actions for the goal. Robert Woolley explained there are five work streams and each one is measured. Sean O'Kelly elaborated on the five work streams: • Leadership • General ward i.e. communication • Medicines • Intensive care • Peri-operative Sean continued to explain that two out of the five work streams are proceeding very well. Two work streams are struggling somewhat (general ward and medicines) and intensive care have an issue around data collection. He continued to explain that, as intensive care is now a paperless department and use an electronic system, there is a problem when collecting some Workstream-specific data. However, the electronic system is currently being streamlined and the Workstream expect to have more complete data collection as a result of this. Sean also clarified that each work stream has an executive lead. Garry Williams asked about the quality goal for nutrition at the Bristol Royal Children's Hospital. Alison Moon confirmed that nutrition regimes, and the	

Item	*Action*
problem with parents bringing in food, have been investigated. A positive outcome was the children in the hospital had created posters, which are now displayed around the children's hospital. **Q3:** Patient Experience: In response to a question from Sylvia Townsend regarding noise at night, Alison highlighted that complaints from patients about noise at night is staff noise e.g. the 'flip lid' bins making a loud noise when used at night. She has personally conducted night visits and as a result of a recent night visit to the children's hospital, dimmer light switches are being installed in the children's hospital and the Bristol Heart Institute. Dimmer switches will also be built into the new children's development. **Q5:** Delivery of Care: Wendy asked which South West trust came first in the delivery of stroke services at the recent Stroke Network event, given that UH Bristol was awarded second prize. Deb Lee clarified that Salisbury Trust was first. Sean O'Kelly said UH Bristol was not far behind and learning from other trusts that carry out good practice is encouraged through the Stroke Services Network. **Q6:** Page 30 Medicines procurement and usage, number 4: Anne Ford asked if retain pharmacy is part of the offer. Deb Lee confirmed it is part of the offer and there will be a VAT benefit to the trust. Anne Ford thanked Deb Lee for taking the governors through the annual plan so clearly. *There being no further questions or discussions, the Membership Council resolved to **endorse** the annual plan 2012/13 to 2014/15.*	
6. Any Other Business No other business to note.	
7. Foundation Trust Members' Questions **Q1.** A member commented that South Bristol Community Hospital has provided excellent care to them personally and the staff went out of their way to deal with a problem. After the meeting closed, the governors met with Catherine Campbell (Compliance Inspector) and Sue Burn (Compliance Manager) from the care and quality commission for an annual update.	
8. Date of Next Meeting **Joint Trust Board and Membership Council** on Monday 30 July 2012 from **10:30 – 15:30** in Lecture Theatre 1 of the Education Centre, Upper Maudlin Street, Bristol, BS2 8AE.	

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 21 – Governor Representative Report
Purpose
To brief the Membership Council on governor activity.
Abstract
A brief summary of governor meetings covering governor's statutory requirements.
Recommendations
The Membership Council is recommended to Note the report.
Report Sponsor
John Steeds, Governor Representative

It has been a particularly busy period for the governors since our last formal meeting. In addition to holding monthly governor meetings coupled with meetings with the Chair, John Savage, and the meeting to set the agenda for today's meeting there have been several other meetings.

Two of these were informal meetings with the Trust Secretary prior to the last Membership Council meeting, to review the existing activities of the governors so that can be refined and made appropriate for the new responsibilities that are envisaged in the recent Health and Social Care Act 2012. In particular, a plan will be put forward for appropriate induction and training of governors. The outcome of these meetings, as announced at the May Membership Council meeting, was the decision to set up a small working group, named the Task and Finish group, to bring proposals to the Membership Council for approval. The conclusions of these meetings are included in the report on the agenda.

In addition, the governors have given attention to the on-going discussions between the Trust and the North Bristol NHS Trust about a possible integration of acute health services in Bristol. We also attended an extraordinary meeting of the Membership Council to inform us about the current state of negotiations with the North Bristol NHS Trust. The Chairman and Chief Executive of the Trust Board have informed us that if the Board is minded to go to the next step of evaluation of plans for integration, this step will be subject to the approval of governors.

As part of North Bristol NHS Trust's foundation trust process, they held events for their members to find out about the role of governors. Representatives of University Hospitals Bristol NHS Foundation Trust governors attended two meetings at Southmead to share their experience as governors.

Neil Auty resigned as Governor Representative at the end of May and I was elected to succeed him. We now have a formally elected Deputy Governor Representative, Mo Schiller, although she has acted very effectively in that capacity, informally, for the past twelve months. We would like to express our gratitude to Neil for his hard work and effective leadership of the Membership Council in this role.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 22 – Governors Quality Working Group Report

Purpose

To report to the Membership Council on the observations and conclusions of the Governors Quality Working Group meetings held on the 15 May 2012 and 17 July 2012.

Abstract

This report briefly highlights the activity of the group, which ranges from the National Patient Surveys to a 'question and answer' session with the Chief Nurse.

Recommendations

a. The Membership Council is recommended to note the report of the Governors Quality Working Group.

b. The Membership Council is asked to approve a request for assurances that action plans are in place to remedy the deficiencies in performance outlined in the quality and access standards in May 2012 indicated above and as part of the report presented to the Board on 28 June 2012 and to give an update on progress so far.

c. The Membership Council is asked to approve a request for assurances that action plans are in place to progressively improve the scores recorded in the NHS National Outpatient Survey for 2011/12 by an average margin of 10% by 2014 and, in particular, those relating to appointment administration and telephone response to receive the priority action.

d. The Membership Council is asked to approve a request for assurances that action plans are in place to improve the scores recorded in the NHS National Inpatient Survey for 2011/12 to show an overall improvement average of 5% at the time of the 2012/13 survey.

e. The Membership Council is asked to approve a request for further work to be done to investigate staff sickness absences related to manual handling involving upper limb injury with particular reference to training and provision of equipment aids.

Report Sponsor

Clive Hamilton, Chair of Governors Quality Working Group

1. The group **appointed its chair and deputy** for the coming year.
2. The **governor's log of communications** was discussed including entries relating to staff smoking in or near to the patient smoking shelters, difficulties relating to patient communications with the trust and to review the process for the governor's log.
3. Paul Lewis gave the governors a briefing on section 242(1b) of the NHS Act 2006 – **the Duty to Involve the Public** when service changes are proposed.
4. The group received its regular update from the governor representative on the **Patient Experience Group.**

5. The results of the **National Outpatient Survey** were assessed and in common with many other trusts, University Hospitals Bristol did not score well on waiting times and communications. An outpatient transformation programme has been set up to address the issues where scores were low.
6. **The National Inpatient Survey** results were examined and it was noted that our trust scores were much the same as other trusts but better than average on 3 measures; however, it was pointed out that we were not best in any of the measures. We anticipate that the improvement action plan approved by the Board in June will lead to better scores and in some cases the best scores.
7. The Quality Group regularly reviews the effectiveness of **staff engagement** in the process of improving care so it was particularly interested in the results from the **2011 NHS National Staff Survey.** In general our trust scores were on a par with other trusts but were above average on Staff Engagement. Scores were not so good on Health and Safety and incidence of Violence and Aggression. The acting Director of Workforce and Organisational Development gave a briefing on staff engagement at the meeting on the 17 May with particular emphasis on the reasons for **staff sickness absence** and progress with improving the rate of **staff appraisals.** The trust target for staff sickness is below 3.5% and after a higher than normal level in May, the June rate had dropped to 4% so there is still some way to go. Stress and manual handling were the factors given as causing the highest levels of staff sickness. There is now steady improvement in staff appraisal rates with the target of 85% being achieved in June. This rate does not include doctors who have their own competence appraisal system. Governors on the quality group have frequently raised concerns about information flow and managers not giving sufficient feedback to their staff. The Acting Director of Workforce and Organisational Development agreed that 2 way communication was essential and that the current values training sessions were addressing this.
8. The governors on the quality working group had been engaged in reviewing the Trust's **Quality Report** for the year 2011/12 and in writing a commentary as part of the Annexe to the report. The final Draft of the Membership Council annexe was approved by the group at the end of May prior to Board approval and final submission to the Secretary of State. At its meeting on 17 July, the governors received a briefing from the **independent auditor** who gave assurance that the report complied with standards laid down by Monitor. The complete Quality Report has now been published and can be viewed on line under NHS Choices - University Hospitals Bristol.
9. The Trust's **Learning Disability Nurse** gave a comprehensive presentation on her work to the governors at the meeting on 17 July.
10. Governors on the group now receive regular updates on the Trust's **quality and access target performance.** They noted a downward trend in performance through April to May with 9 indicators overall showing red rating or worsening performance. The failure to meet the Emergency Department target of 95% of patients treated within 4hrs had remained below the threshold at 92.6% meaning that it would be red rated for the 1st quarter of 2012/13. Also of particular concern to governors was the incidence Clostridium Difficile cases above target, the incidence of Pressure Ulcers, the Number of Patient Complaints, breaches of Same Sex Accommodation coupled with worsening Staff Sickness Absences and a deteriorating financial risk rating. There was good news in that the upward trend in Inpatient falls had been reversed and was now below the red threshold. **The data examined at the 17 July meeting was nearly 2 months old and will not be representative of the current position. In future, all meetings of the**

Governors Quality Working Group will be scheduled to take place during the week after the Board meeting for the current month.

11. At the meeting on 17 July, the governors were given a 20 minute presentation on Trust board Quality and Access metrics by the Head of Performance Assurance and Business Intelligence and the Head of Quality – patient safety. There were a number of questions of clarification and a suggestion that it would be useful for governors to have a seminar on the subject after various changes to the Quality and Access dashboards had been agreed.
12. The **Chief Nurse or her Deputy** attend all of the Governors Quality Working Group meetings and all governors can record specific questions for her to answer at this session. There were specific questions about tissue viability when outpatients were sitting on hard chairs waiting for transport, the system for ensuring that diabetic patients had access to food and drink and snack availability when the W.R.V.S. canteen is closed.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 23 – Governors' Nominations and Appointments Committee Report
Purpose
To brief the Membership Council on the committee's activity.
Abstract
The committee met in June and discharged its duties in accordance within its terms of reference. A summary of the activity is listed below.
Recommendations
The Membership Council is recommended to **note** the report.
Report Sponsor
Jeannette Jones, Partnership Governor.

1. Membership of the Committee

The committee noted that there was a vacancy for a public or patient governor on the committee, and, commenting that the committee was both interesting and efficient, members undertook to encourage a public or patient governor to step forward to fill the vacancy.

2. Nominations and Appointments Committee Self-Assessment

It was agreed that the analysis of the committee's activity indicated that it had discharged its duties in accordance with its terms of reference. There were no concerns as to the suitability of the committee terms of reference and it was concluded that the committee did not require any further development.

3. Six Monthly Review of Non-executive Director Activity

The Non-executive Directors submitted their activity sheets for the period January to May 2012. Members of the committee discussed these, sough clarification form the Chairman where necessary, and agreed that the Non-executive Directors reports indicated significant levels of activity.

4. Trust Board Self-Assessment 2011/12

The committee received a briefing on the process and outcome of the self-assessment conducted for the Trust Board of Directors. It was noted that there may be wider interest in the process adopted, and the action plan. The Trust Secretary will include this in a briefing as part of the Membership Council development plan.

5. Terms of Office for Non-executive Directors

It was noted that terms of office for Non-executive Directors are to be calculated from the first day of the Trust's authorisation as a foundation trust, or their appointment date, whichever was the earlier. This had recently been made clear on the Monitor website. The committee noted that this affected the end-dates for some of the Non-executive Director's terms of office.

The committee discussed this in some depth and agreed that in the interest of succession planning, suggestions as to how best to stagger "churn" would be sought from the Chairman and Trust Secretary.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 24 – Resignation of the Auditor
Purpose
To note the resignation of the Auditor.
Abstract
The Audit Commission is to be wound up and services tendered to alternate providers. The Trust noted the intention of the Auditor to resign as a result, and has appointed a new auditor through a process of competitive tender.
Recommendations
The Membership Council is recommended to **note** the Auditor's 'side letter' attached.
Report Sponsor or Other Author
Trust Secretary

13 December 2011

The Governors
University Hospitals Bristol NHS Foundation Trust
Marlborough Street
Bristol
BS1 3NU

Direct Line 0844 798 1208
Mobile 07881 832360
Email w-rickard@audit-commission.gov.uk

To the Governors of University Hospitals Bristol NHS Foundation Trust

Audit of University Hospitals Bristol NHS Foundation Trust

1. This letter should be read with my letter of 18 April 2011 the terms of which you agreed on 27 May 2011 (signatures not dated, but received by me on that date).

2. I anticipate that I will resign as your auditor no later than 27 September 2012 i.e. the proposed date of the annual general meeting.

3. Between now and resigning as your auditor I will undertake my responsibilities in respect of the year ending 31 March 2013 as detailed in sections [14], [19] (in so far as it relates to immediate reporting in the public interest) and [20] of my letter dated 18 April 2011.

4. My fees for any work that I undertake in connection with my responsibilities as detailed in paragraph 3 above shall be determined in accordance with paragraph [24.2] of my letter dated 18 April 2011.

Yours sincerely

Wayne Rickard
Officer of the Audit Commission

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 25 – Governors' Membership Working Group Report
Purpose
To brief the Membership Council on the group's activity.
Abstract
The group meets bi-monthly and the draft minutes from the last meeting is below.
Recommendations
The Membership Council is recommended to **Note** the report.
Report Sponsor or Other Author
Sue Silvey, Public Governor

DRAFT Minutes of a Governors Membership Working Group Meeting held on 03 July 2012 at 10:00 in Tutorial Room 1, Education Centre

Governors Membership Working Group Members Present

- Sue Silvey – Chair and Public Governor (Bristol)
- Mo Schiller – Public Governor (Bristol)
- Jade Scott-Blagrove - Public Governor (Bristol)
- Peter Holt – Patient Governor
- Florene Jordan – Staff Governor (Nursing and Midwifery)
- Clive Hamilton – Public Governor (North Somerset)
- Anne Skinner – Patient Governor

In Attendance

- Ken Booth – Public Governor (Bristol)
- Charlie Helps – Trust Secretary
- Cathy Gane – Young Person's Involvement Worker
- Fiona Reid – Head of External Relations
- Michelle Doubtfire – Carers Strategy Lead
- Maria Fox – Membership Manager
- Debbie Marks – Membership Administrator (minute taker)

Item	Action By
1. Welcome and Apologies The Chair welcomed the group. Apologies for absence were noted from the following: Anne Ford, Mary Hodges, Jacob Butterly, Heather England, Wendy Gregory, Sarah Pinch and Claire Buchanan. *It was confirmed that those present made up a quorum of the Membership Working Group.*	
2. Minutes and Matters Arising The Membership Working Group considered the minutes of the previous meeting. The group resolved to **approve** them as an accurate record of matters transacted. The Membership Working Group considered the Schedule of Matters Arising. *The group **noted** there were no actions for the Membership Working Group.*	
3. Governors Log of Communications Items for the Membership Working group have been resolved. *The group **noted** there were no actions for the Membership Working Group.*	
4. Membership Working Group Forward Planner The Trust Secretary presented the Membership Working Group forward planner. He explained that the document is a standard format used by the Trust Board of Directors, their committees, Trust Management Executive and their management groups. Therefore, this document will be familiar to directors and senior staff. The forward planner lists the scheduled reports for the financial year 2012 – 2013. Charlie explained the planner is useful for setting agendas and for producing the annual report. The planner also shows which areas the group have focused on and explains the purpose of the reports. Questions from governors: • Sue queried the necessity of reports from governor working groups. Charlie clarified that verbal updates are sufficient if relevant to the Membership Working	

Group. *The Membership Working Group agreed to **note** the Membership Working Group forward planner.*	
5. Recommendations to the Membership Council The group had no comments. *The group **noted** there were no items to approve for the Membership Council Meeting.*	
6. Foundation Trust Constitution The Trust Secretary confirmed the process for annual review of the foundation trust constitution. The constitution will be agreed by the Membership Working Group before being presented at Membership Council. Charlie recommended postponing the review of the constitution to see whether there are any developments regarding the Health and Social Act; as well as what transpires in July with respect to the possible integration of acute health services in Bristol. Monitor has issued a new revised model core constitution for trusts to look at but not to be adopted at this point. If UH Bristol's revised constitution were to comply with the new model core constitution then we would be compliant with the new act. Governors should decide what they want to add to it. Charlie pointed out that once the Health and Social Care Act of 2012 commencement orders applied, constitutional changes won't need to be approved by Monitor - governors and the Trust Board of Directors will approve changes jointly and would therefore become "self-governing" in this regard. Queries from governors: • Mo raised a concern with North Bristol Trust (NBT) only having public governors and stressed the importance of having a broad spectrum of governors. • Cathy pointed out that the proposed membership age at NBT is 18 years of age and stated she will be pleading for younger members. NBT have talked about having a youth council and Cathy expressed how proud she is of UH Bristol's youth council and young membership. • Ken asked how the trust addressed the risk elements of mergers. He also pointed out that the integration with NBT will make this trust the largest in the country and queried how the trust is approaching this risk. Charlie declared there is a technical process for the trust to follow and explained the REID guidance (Risk Evaluation in Investment Decisions) which sets out the process that the trust follows in assessing the risks. **Action** – Maria to e-mail the REID guidance link to all governors. Charlie drew attention to the terminology 'merger' and clarified that the correct wording should be 'integration by acquisition'.	M. Fox
7. Health and Social Act Timetable Charlie gave a verbal update on the Health and Social Act. Governors are aware of the changes in the legislation and also know that no changes have any effect until the commencement orders are issued by the Secretary of State. Charlie advised that, until the commencement orders are issued, governors discuss how they want to work under the new act so when it does commence, they are ready to do so. He also commented that the task and finish group had a very productive	

meeting last week with more attendees than the core which was very encouraging. The task and finish group will take their recommendation to the Membership Council Meeting in July.	
8. Engagement and Communication **8.1 Update on Trusts Events** Fiona pointed out that trust events are advertised through Newsbeat and asked for clarification on the type of information the Membership Working Group required. Sue explained that the group previously received regular updates on future events and open days. Fiona offered to provide the group with copies of a weekly planning tool; this includes all events over a six week period. **Action** – Fiona will e-mail the Membership Working Group the planning tool. In response to a query from Mo, Fiona explained that Stephanie Phillips is dealing with all 'open door' events. Cathy confirmed that the BHI open doors session is being held on 08 September 2012. **8.2 Medicine for Members' Events** Maria presented her report to the group - Evaluation for Nutrition for Members' event. This report contains evaluation data from the medicine for members' event that took place on 16 May – 'How good nutrition aids recovery'. The next medicine for members' topic is Accident & Emergency (A&E) and is being held on 10 October 2012. Maria asked for ideas for the A&E topic: • Sue suggested waiting times, why patients have to wait so long in the department. • Anne Skinner pointed out a problem with vending machines at the Children's hospital. The vending machines are in view of children who may be unable to eat due to a scheduled operation and she suggested that the machines be better situated. Maria explained that the topics for these events are chosen from members special interests and asked the Membership Working Group for topic ideas for next years' events. Any suggestions to be e-mailed to Maria please. Charlie recommended an internet poll to allow anyone in Bristol to comment on topics for these events. Sue reminded the group that the 'medicine for members' title was due to be changed. Clive suggested 'Medicine at the BRI' and Mo suggested 'Health Matters at UH Bristol Trust'. Fiona agreed to discuss this change of title at the next Communications team meeting and will feedback suggestions at the next Membership Working Group meeting in September. Sue offered help and support in obtaining speakers for future events. Maria agreed that an invitation from a governor would be appropriate. **Action** – Maria will summarise the events that have taken place so far and will bring to the next meeting. **Annual Members Meeting** Charlie confirmed that the annual members meeting will be held on 20 September when the annual report will be presented. One of the changes in the Health and Social Act, regarding how governors go about revising the constitution, will be that any provisions around the operating of membership council (council of governors) in	F. Reid ALL C. Helps F. Reid M. Fox

the future will be subject to the approval of members. This would take place at Membership Council Meetings. Maria asked if a report on governors' activity would be included. Sue suggested that the governor representative undertake this report. Ken commented that reports from the Quality Working Group and Strategy Working Group would be useful. **Action** – Sue agreed to speak to John Steeds (governor representative) regarding the activity report for the annual members meeting. **8.3 Members Newsletter Update** Sue informed the group that the editorial committee have now integrated with the Membership Working Group and confirmed that 'members newsletter' will be a standing agenda item. Fiona explained the process of the newsletters. The editorial committee discuss what articles and information need to go into the letter and how to populate the pages - ensuring there is an interesting mix. Fiona looks at which articles will work in the space available and then forwards it to the printers. She explained there are lots of deadlines along the route and suggested that governors be given this information. **Action** – Maria will draw up the newsletters timeline and distribute to the Membership Working Group. Maria pointed out that the members newsletter is issued three times per year and key items include elections and annual members meeting. The timings of distribution are flexible. The second issue will be distributed next week and the third issue will be due September/October time. The timing of the third issue will be flexible due to the inclusion of the annual report and will also be aligned with the staff magazine 'voices'. The group agreed to discuss the content for the third issue at the next Membership Working Group on 06 September. Governors' suggestions for newsletter articles: • Anne informed the group that she recently attended a south west group meeting and has passed on copies of their newsletters to Maria. She commented that these newsletters don't compare to those of UH Bristol Trust. • Ken suggested that reports from Chairs of the Quality Working Group and Strategy Working Group be included in the newsletters. • Ken questioned how many public members are interested in the newsletter items. Maria confirmed that the committee commissioned a survey of members last year which resulted in 200 responses. A summary of these responses was included in a newsletter and Maria will bring this summary to the next meeting. • Mo suggested that a member be asked to write an article about being a foundation trust member. • Clive proposed information about changes of service delivery. • Sue recommended information about governors' activity. Maria pointed out that the members newsletter is a one way form of communication and suggested that events be created to enable governors to communicate with members.	M. Fox
9. Youth Council Report for the Membership Council Cathy updated the group on community projects which the youth council have been	

involved with:

- Knowle west media centre is a local charity that works with vulnerable groups including young people. A joint project has been completed which designed signage for teen zones that are being put around the trust.
- A new website for the transition of children services going to adults. The website has been designed around cardiac and will be a template for other specialties.
- A youth council meeting took place on Saturday 30th June and was attended by 11 young people. They were given a development update which involved a tour of the building site. Young members are being involved with an arts workshop which will involve looking at new public arts for the new build, especially relating to children's area.
- Mystery shopping update – Cathy attended training about young inspectors. Local authorities have taken this idea on board and it will be a step further beyond mystery shopping (young people will train to go and inspect services). The youth council will look into this idea further in November.

Anne Skinner suggested that youth council updates be included in the members' newsletter.

10. Report from the Patient Experience Group

Sue Silvey explained that the Patient Experience Group report is produced quarterly by Chris Swonnell, Head of Quality (patient experience and clinical effectiveness).

There were no comments from the group.

*The Membership Working Group agreed to **note** the Patient Experience Group report quarterly.*

11. Report from the Quality Working Group

Clive informed the group that the next Quality Working Group meeting will be held on 17 July. There were no items relevant to the Membership Working Group.

The group continued to discuss Quality Working Group issues and these have been noted under item 14, any other business.

12. Report from the Strategy Working Group

No update was available.

13. Carers Strategy

Michelle Doubtfire updated the Membership Working Group on the carers' strategy. She explained that her role is 17.5 hours per week and she is employed to help implement the carers' strategy. The main points discussed were:

- The national carers' strategy, set up by Gordon Brown in 2008, is due to run until 2018. The basic premise is to provide carers with more support within health, recognise carers in the health sphere, supporting carers to stay mentally active and making sure carers have a life and don't give up their education/life.
- There is a local strategy group for Bristol and UH Bristol Trust are currently developing their own strategy.
- Carers are now identified on UH Bristol Trust admission forms and are included in the discharge process.

- A carers' emergency card is available for carers to carry on them – this will highlight to staff, should a carer be admitted to hospital, that there may be a vulnerable person at home.
- There is now a carers' page on the front of the trust's webpage.
- The carers' strategy group has been running for 2 years and is made up of; social work team, carer governors, human resources, patient advice and liaison service, Alison moon (organisational lead) and a head of nursing. There is also a carers' reference group which runs alongside the carers' strategy group.
- A booklet for carers is currently being developed.
- Provide support for staff carers.
- A questionnaire is being developed to gain feedback from carers.

Questions from governors:

- In response to a question from Mo, Michelle explained that carers don't need any proof of identification.
- Ken asked if governors can help with gaining feedback from carers. Michelle thanked the governors and suggested the possibility of joining the Bristol Carers Voice group – she will think about which group would mostly benefit from governors input.
- Maria stated that the Membership Working Group looks at membership for carers and commented that recruiting carer members is difficult. She suggested the Membership Working Group look at how to recruit carer members and how governors can help carers.

Governors can contact Michelle on the trust e-mail system, michelle.doubtfire@UHBristol.nhs.uk

14. Any Other Business

14.1 Quality Working Group

Queries from the Membership Working Group regarding Quality issues were:

- Anne Skinner said she has experienced problems when telephoning different departments within the trust and commented that departments seem to use the new Medway system as an excuse for any problems.
- Ken requested an update on progress and milestones with the productive outpatient's project. An update from Cat McElvaney (Improvement Lead) and Paul Mapson (Director of Finance/Executive Sponsor) is on hold until after discussion by the task and finish group regarding speakers.
- Charlie suggested that the agenda for the Quality Working Group be structured around the three key elements which Monitor defines as quality; patient safety, clinical outcomes and patient experience. Charlie offered his help with re-structuring the agenda. He also mentioned using the concept of triangulation (comparing databases of your report with information from other places). Clive agreed that quality metrics could be separated into the three concepts and will do this for the next meeting. Clive also requested that Charlie include the above information in the terms of reference for the Quality Working Group. Ken commented that the three concepts are helpful and pointed out that the Quality Working Group should be adding value by what they do.

C. Hamilton
C. Helps

Governors Membership Working Group Members Present	
14.2 Staff Membership Florene raised concerns with staff membership and issues with being able to reach staff members. Florene has attended several departmental meetings to speak to staff about the governor role. Two main issues that Florene has encountered are a) staff doesn't seem to understand the governor role and b) Trust information is not filtering through to all staff. There will be a staff governors' communication meeting taking place on 26th July with Chris Swonnell (Head of Quality – patient experience and clinical effectiveness). Florene is hoping that Chris will be able to help staff governors with these communication issues.	
15. Date of Next Meeting ***Change of date:*** Thursday 06 September, 10:00 – 12:00 in the Conference Room, THQ.	
16. Trust Workforce Questions and Answers There were two trust workforce questions: • Governors understand the ratio of midwives to patients is below the recognised requirement. In view there is a national shortage of midwives what is the trust doing to ensure that adequate direct entry midwifery students are trained at UWE. What support is given to midwifery assistants at St Michaels to do a foundation course who are deemed capable at appraisal to then apply to UWE for the training? The trusts in Bristol including UHB and the south west have recognised the need for more midwives and through the Strategic Health Authority commissioned more midwife education places at universities including UWE both last year and this has been sustained for this year. Therefore there will be more midwives entering the workforce. However the direct entry course is a three year course so it will be another two years before this impacts the workforce. A return to midwifery practice course exists to enable those midwives not currently practising to come back to work. There is also a short programme for qualified nurses to become midwives, this is not always commissioned to run but exists if needed/asked for. • What forward planning is being undertaken to ensure that adequate paediatric nurses will be available when paediatrics transfer to BCH from Frenchay, both for ward and theatre work, in case Frenchay staff do not wish to relocate. Claire Buchanan was unable to attend today's meeting, therefore Charlie has taken the two questions on board and will enter them onto the governors' log of communications. **Action** – To enter the two trust workforce questions onto the log of communications.	Secretariat

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 26 – Membership Council Task and Finish Report
Purpose
To report to the Membership Council on the activity and recommendations of the short-life 'task-and-finish group'.
Abstract
The Membership Council established a short-life 'task-and-finish group' to consider revisions to governor induction, training, development and activities with a view to enabling governors to prepare for meeting the responsibilities set out in the Health and Social Care Act 2012 (once these apply through the release of 'commencement orders').
Recommendations
The Membership Council is advised to **approve** the recommendations set out in this report.
Sponsor
Sponsor – John Steeds, Governor Representative.

1. Background

On 29 May 2012 the Membership Council considered reports on the Membership Council self-assessment survey held in 01 February 2012 and related implications for the Membership Council governance structure, induction, development and activity. The Council establish a short-life group to progress the work required in this regard.

2. Process and Outcomes

The task-and-finish group met on 28 June 2012 and 17 July 2012 to consider this agenda. Governors addressed each element both in within these meetings and in pairs outside of the meetings.

Having assessed and discussed each element in turn, the group reached the following conclusions:

2.1 Membership Council corporate governance structure and principles

a) The group endorses the corporate governance structure set out at Appendix A.
b) The group endorses associated meetings set out at Appendix B.
c) Each group and meeting shall have terms of reference.
d) Governor working groups do not require a deputy chair.

e) Governors should reconsider their attendance at meetings of the Trust's operational groups and non-Membership Council committees. It was suggested that continued attendance should be subject to a strong case being made by each governor on a case-by-case basis. In any event, governors who attend operational group meetings do so in the role of volunteer or lay person, not officially as a governor.
f) Outpatient experience surveys shall be discontinued at the end of December 2012.

2.2 Governors induction, training and development

The group has established processes to:

a) Revise the governors' handbook.
b) Revise the governors' statutory and mandatory induction and development process.
c) Write a governors' role description.
d) Plan trust staff speakers at governors group and meetings as part of governors' development.

3. Recommendations

The Membership Council is recommended to approve:

a) The formal Membership Council corporate governance structure set out at Appendix A;
b) The associated meetings set out at appendix B; and,

The Membership Council is recommended to note the following next actions and outputs:

c) Revised governors' induction and handbook;
d) Training needs analysis and revised development plan;
e) Standard operating procedures for the conduct of membership council business;
f) Governors' role description;
g) Revision of involvement in operational groups.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Joint Public Board and Membership Council Meeting, to be held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Item 27 – Governors' Strategy Working Group Report
Purpose
To brief the Membership Council on the groups activity.
Abstract
The group meets bi-monthly and the minutes from the last meeting is below.
Recommendations
The Membership Council is recommended to **Note** the report.
Report Sponsor
Anne Ford, Public Governor.

Minutes of a Governors Strategy Working Group Meeting held on 19 June 2012 at 11:00 in Lecture Theatre 3, Education Centre

Governors Strategy Working Group Members Present	
• John Steeds – Patient Governor (Local) & acting chair • Jan Dykes – Staff Governor – non clinical healthcare • Wendy Gregory – Patient Governor – Carers of 16 years and over	• Joan Bayliss – Partnership Governor – Community Group • Clive Hamilton – Public Governor (North Somerset)
In Attendance	
• Paul May – Non-executive Director • Deborah Lee – Director of Strategic Development • Paul Tanner – Head of Finance • Claire Buchanan – Deputy Director of Workforce and Organisational Development	• Fiona Reid – Head of External Relations • Mary Perkins - Deputy Director of Research and Innovation • Debbie Marks – Membership Administrator (minute taker)

Item	*Action By*
1. Chair's Welcome and Apologies The Chair welcomed the members. Apologies for absence were noted from the following: Anne Ford, Neil Auty, Anne Skinner, Ken Cockrell and Sarah Pinch. *It was confirmed that those present made up a quorum of the Strategy Working Group.*	
2. Minutes and Matters Arising The Strategy Working Group considered the minutes of the previous meeting. The group resolved to **approve** them as an accurate record of matters transacted. The Strategy Working Group considered the Schedule of Matters Arising. The status of each item for action arising from previous meetings was confirmed. *The group **resolved** to update the Strategy Working Group Meeting schedule of matters arising accordingly.*	
3. Appointment of Chair and Deputy The election for a chair and deputy was conducted with the members of the group. There was one nominee for chair. Anne Ford will be reappointed as Chair for the Strategy Working Group for another year. The group discussed the need for a deputy and, as this will be reviewed by the start and finish group, it was decided to await development. *The group **noted** the appointment of Anne Ford.*	
4. Governors Log of Communications The log of communications was presented to the group for discussion.	

Item	*Action By*
*The group **noted** there were no items for the Strategy Working Group.*	
5. Trust Clinical Strategy Group Deborah Lee presented her 'Management Group Report to Trust Management Executive Group'. Deborah explained that she produces bi-monthly reports on the Clinical Strategy Group for the Trust Management Executive (TME). This report provides a summary on progress against work plan, key milestones, key risks and next steps. She asked the group if these reports would be useful information to help the governors in carrying out their statutory duties. The group welcomed these reports and agreed these reports will be a standing item at future meetings. Questions from governors: a) In response to a question from John, Deborah confirmed that breast and urology specialties will be transferred to North Bristol Trust and UH Bristol Trust will gain head and neck specialty. The impact on beds and theatres has been carefully assessed and through flexible use of the main BRI site, St Michael's and South Bristol Community Hospital, these changes can be managed. *The governors agreed to **receive** the trusts clinical strategy group management report to help inform them in their role.*	
6. Acute Services Integration Deborah Lee presented the paper 'Bristol Acute Services Project Board – meeting on 25 May, 2012'. Deborah explained that although the timetable for considering integration with North Bristol Trust (NBT) may seem accelerated, preparatory work has been on-going for some time. The end of July is the current timeline for the next step regarding foundation trust status for NBT. Deborah responded to a question about the likelihood of delays to NBT's application and said that Monitor have delayed several foundation trust applications by three months but could not confirm whether NBT is one of these. Governors raised several concerns regarding NBT gaining foundation trust status. Deborah pointed out that NBT remain confident that they are likely to achieve foundation trust status, having paid off a large proportion of their debt and having established an integrated business plan which they believe meets Monitor's requirements authorisation. She also explained that UH Bristol Trust Board of Directors was working closely with the project team and that the Board of University Hospitals Bristol would not proceed with any integration activity that might be detrimental to the performance of the Trust. Deborah expressed that the next important decision to be made will be the one that governors and the Trust Board of Directors make at the end of July. Questions from governors: a) John raised a query about the information staff had received regarding the possible merger. Deborah reported that an open meeting took place on 18th June involving clinical leaders from both organisations. A second meeting is planned for next week. b) John also mentioned a recent merger that has taken place between Basingstoke and Winchester hospital trusts. Deborah saw this as relevant and noted that one of the key players in this merger was providing useful insights to the project team. c) Clive raised a query regarding section 2, page 2, of the paper which states 'the	

Item	Action By
significant five benefits for the people of Bristol which can be delivered from the integration of UHB FT and NBT'. Deborah explained that work is currently being carried out across the city to identify the clinical benefits that might be achieved through the integration of health services in Bristol.	
7. Research and Innovation Strategy Mary Perkins presented her paper 'Research and Innovation Strategy Update to Governors, 19 June 2012' to the group. Mary explained that the Research and Innovation Strategy is a partnership between UH Bristol Trust and Bristol's two universities which are looking at academic, education and clinical outcomes. The Health Integration Team (HIT) has been set up to look into how we can transform the way we provide care, their agenda involves research, health and care. There were 23 expressions of interest, which was very encouraging, 9 of which are able to start delivering something now – others have been asked to come back when they have developed further (this includes cardio-vascular specialty who have been asked to re-apply in the autumn). Mary pointed out that this strategy was refreshed in 2010 and is due to run until 2015 but it may be looked at sooner given that the Bristol Health Partners Agenda is now up and going. Mary emphasised the advantages for patients taking part in trials which include not only being closely looked after and monitored, but also the advantage of having access to the medical team and treatments. She explained that they have a two prong approach: 1) they do their own research and 2) they recruit into other peoples trials. Mary also pointed out the graph on page 2 of the paper which indicates recruitment levels for 2010, 2011 and 2012. She stated that UH Bristol Trust are aiming for 2010 levels and are presently exceeding those levels. Questions from governors: a) In response to a question from Wendy, Mary explained that other areas/countries set up trials but may not necessarily have the patient numbers required therefore other areas can recruit into their trials. She expressed that all trails have strict criteria and ensure that all trials are ethically set up. b) John enquired about research nurse posts. Mary said that they are currently looking at a new piece of work which will look at the skill mix of staff i.e. are staff currently in post in the right area/division. There are approximately 80 – 100 research nurses across the trust. c) John asked about the effect on research should UH Bristol Trust and North Bristol Trust merge. Mary said the merger would catapult UH Bristol Trust in the research field. She explained that both trusts currently sit well within the national profile but if put together with NBT we would be in a different league. d) Paul May asked how the risk to a patient is assessed. Mary explained that any possible risk to a patient would be from any clinical intervention, research doesn't add any risk. e) Clive asked about the risks with pharmaceutical trials. Pharmaceutical trials are firstly carried out on animal models, then healthy volunteers and then trialled on patients with the relevant illness – these patients are very closely monitored and independent regulators keep checks on all trials. If an alert is raised then the trial is stopped immediately. Mary also explained that a lot of drug trials consist of existing drugs that have been modified therefore the risks are already known. f) Paul May pointed out that the robust decision making in trials is not made clear to	

Item	*Action By*
patients and Mary agreed to look into this. g) Wendy raised an issue with patients who are given a placebo drug. Mary said that nowadays a placebo trial can only take place if there is currently no treatment available for that particular illness. Deborah Lee informed the group that Charlie Helps will be arranging seminars in the future. One of the seminars will be about UH Bristol Trust relationship with the universities and this could include Bristol Health Partners. John commented that the research that has happened so far is very encouraging. All governors thanked Mary for her update. **Post meeting –** There is a typing error on page 3 of the paper. The first sentence should read 'Last year (11/12) our turnover from commercial clinical trials was **£1,300,000** – up from **£910,000** the previous year'.	
8. Any Other Business **8.1 Trust's Annual Plan** John Steeds requested that the meeting of the Strategy Working Group to discuss the draft annual plan should be deferred until the members of the group have had the opportunity to read it in future. This will enable governors to make more informed comments on the content.	
9. Date of Next Meeting Wednesday 15 August, 13:00 – 14:30 in the Board Room, THQ.	