University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Public Meeting of the Trust Board of Directors to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page*
1. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda.	Chairman	
3. Minutes from the Previous Meeting To consider the Minutes of a Public Meeting of the Trust Board of Directors dated Monday 30 July 2012 for **approval**.	Chairman	01
4. Chief Executive's Report To receive this report to **note**.	Chief Executive	21
Quality, Performance and Compliance		
5. Quality and Performance Report To receive the standing 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	24
6. Histopathology Action Plan Update To receive this report to **note**.	Chief Executive	109
7. Safeguarding Annual Report To receive this report to **note**.	Chief Nurse	118
Finance and Governance		
8. 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 meetings dated 24 August 2012, and 24 September 2012, including the Report of the Finance Director b. Quality and Outcomes Committee dated 25 September 2012. c. Audit Committee dated 10 September 2012.	Committee Chairs	146
9. Foundation Trust Constitution To receive the revised Foundation Trust Constitution for **approval**.	Chief Executive	166
10. Quality and Outcomes Committee Terms of Reference To receive the revised Quality and Outcomes Committee Terms of	Chairman	180

Item	*Sponsor*	*Page*
Reference for **approval**.		
11. Register of Applications of the Trust Seal To receive this report for **review**.	Chief Executive	181
12. Loan Facility Agreements – Conditions Precedent To receive and consider this report for **approval**.	Finance Director	183
Strategy and Business Planning		
13. Partnership Programme Board Report To receive this report to **note**.	Chief Executive	186
14. Electronic Prescribing – Southern Trusts' Collaborative Business Case To receive the Electronic Prescribing – Southern Trusts' Collaborative Business Case for **approval**.	Finance Director	189
Monitor Reports		
15. Results of Quarter 1 Compliance Framework Monitoring Exercise To receive this report to **note**.	Chief Executive	200
16. Results of Monitor Annual Plan Review To receive this report to **note**.	Chief Executive	202
Information and Other		
17. Any Other Business To consider any other relevant matters not on the Agenda.	Chairman	
18. Date of Next Meeting **Public Trust Board meeting**, Tuesday 30 October 2012 from 10:30 – 13:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	Chairman	

University Hospitals Bristol NHS
NHS Foundation Trust

Minutes of a Joint Public Board and Membership Council Meeting of the Trust Board of Directors held on 30 July 2012 at 10:30 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE

Board Members Present

- John Savage – Chairman
- Emma Woollett – Vice Chair
- Iain Fairbairn – Senior Independent Director
- 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
- 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
- Helen Morgan – Deputy Chief Nurse (deputising for Alison Moon)
- Xanthe Whittaker – Deputy Director of Strategic Development
- Charlie Helps – Trust Secretary
- Victoria Church – Management Assistant to Trust Secretary
- Sarah Pinch – Head of Communications
- Frances Forrest – Head of Hospital Medical Committee
- Elisabeth Kutt – Head of Division, Diagnostics and Therapies
- Anne Ford – Public Governor
- Ken Booth – Public Governor
- Mo Schiller – Public Governor
- Clive Hamilton – Public Governor
- Sue Silvey – Public Governor
- Pauline Beddoes – Public Governor
- Heather England – Public Governor
- John Steeds – Patient Governor, Local and Governor Representative
- Peter Holt – Patient Governor, Local
- Anne Skinner – Patient Governor, Local
- Jacob Butterly – Patient Governor, Local
- Garry Williams – Patient Governor
- Philip Mackie – Patient Governor
- Florene Jordan – Staff Governor
- Louise Newell – Staff Governor
- Jan Dykes – Staff Governor
- Belinda Cox – Staff Governor
- Alex Bunn – Staff Governor
- Jeanette Jones – Partnership Governor, Joint Union Committee
- Jessica Burston – Partnership Governor, Great Western Ambulance Trust
- Jane Britton – Partnership Governor, Avon & Wiltshire Mental Health Partnership NHS Trust
- Maggie Mickshik – Partnership Governor, Voluntary Groups
- Neil Auty – Patient, Tertiary
- Sylvia Townsend – Appointed Governor, Bristol City Council
- Helen Langton – Appointed Governor, University of the West of England
- Gayle Johnson – BT Account Manager, University Hospitals Bristol NHS Foundation Trust
- Sylvie Nooks – Nursing Officer
- Barbara Pond – Public Foundation Member
- Derrick Bookham – Foundation Member
- Vivienne Corbin – Foundation Member
- Bob Skinner – Foundation Member
- Samuel Willetts – Energy and Sustainability Manager *(for Item 14 – 'Big Green Scheme')*

• Lorna Watson – Patient Governor • Wendy Gregory – Patient Governor	• Nathalie Delaney – 'Big Green Scheme' Chair *(Item 14 – 'Big Green Scheme')*

Item	*Action*
1. Chairman's Introduction and Apologies Apologies were noted from Alison Moon and Deborah Lee.	
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 28 June 2012 and **approved** them as an accurate record. It was confirmed that all matters arising were in-hand.	
4. Chief Executive's Report The Board discussed and noted report by the Chief Executive, which included the activities of the Trust Management Executive. Robert Woolley highlighted the following items: • On behalf of a group of chief executives in the West of England, Robert had been leading on work to develop a proposal for the network of Academic Health Science Networks in the area, which included Bristol North, Somerset & South Gloucestershire (BNSSG), Avon, North Wiltshire and Gloucestershire. An expression of interest was submitted on 20 July, and the group expected to hear if it had been accepted by 03 August 2012, prior to completing a full application by September. It was an exciting development, and work was in progress. • Robert said that it was likely that the Board had seen local and national coverage regarding the South West Pay Terms and Conditions Consortium, where twenty trusts in the south west were undertaking an assessment of the challenges facing the NHS and considering how pay terms and conditions can support sustainable health services and employment now and in the future. At a time when the NHS was being asked to save in the order of 5% per annum, and when staff costs actually made up between 60 – 70% of Trust expenditure, there was a responsibility to look at how maximum productivity could be achieved. The twenty organisations in the Consortium had committed to a review of all aspects of staff pay. The review planned to look at control of the pay bill, but no decisions had yet been made regarding what steps to take. National negotiations with the unions, partly regarding Agenda for Change, were still underway, and the Consortium was very clear that it supported the national negotiations and if they came to a satisfactory conclusion, then the Consortium may not need to take further action. The Consortium had expressed concern about the pace with which negotiations had been proceeding and concluded that by working together it	

DRAFT

could identify a limited amount of resource to allow for a review of options.

Each Trust retained its autonomy over decisions about whether it wanted to take action; when the business case is established by autumn 2012, it would be brought back to each trust board for decisions on what action to take.

Robert explained that the Trust was in the Consortium for the right reasons; he had been very candid with staff, both through Newsbeat and staff briefings, about the Trust's position in the group and it was the responsibility of the Board to look at how UH Bristol could control costs going forward.

The Board discussed the Chief Executive's briefing:

- Philip Mackie, a patient governor, asked if the "lobbying" experienced outside the building was related to the South West Pay Terms and Conditions Consortium, which was confirmed.

- Jan Dykes, a staff governor, asked Robert what he thought would be the likely effect on staff morale, when in the document distributed by the lobbyists it said: *"unless voluntary agreement could be secured by either collective bargaining or majority acceptance following direct appeal to staff, it is likely the trust would be obliged to dismiss and re-engage staff to secure such changes".* Jan assumed that Robert was unlikely to be responsible for the wording, but Trust staff would have seen and been upset by it, and by another extract: *"feedback from individual trusts on the temperature of their staff-side engagement would be useful".*

- Robert Woolley responded to Jan's concerns, saying that he realised the issues the paper had created; he clarified that it was a briefing document to the Consortium, and for boards who were considering joining, prior to its establishment. It set-out options that might be looked at, in addition to the "ultimate, worse-case of what would need to be done, or what could be done unilaterally without agreement". Robert said that none of the twenty trusts in the Consortium wanted to end up dismissing staff and re-employing them, and the briefing paper described the worst case, if it could not proceed by agreement. He stressed that it did sound inflammatory when it was described in isolation, but he assured the governors that no decision had yet been taken on this. The Consortium remained entirely supportive of the national negotiations and all its members wanted to work in partnership with the staff-side. This was not about trying to do things unilaterally, or about trying to railroad staff or representatives into agreement.

- Paul May had also received a copy of the leaflet when he arrived at the meeting, and he had spoken to one of the Unison representatives distributing the leaflets. He requested Robert's assurance about Trust industrial relations, saying that "something like this could get a life of its own and damage industrial relations at a local level".

Robert Woolley responded to Paul that there was a difficult tension between national, regional and Trust discussions, but gave his opinion that UH Bristol was on good terms with local union representatives, who were nonetheless unhappy that the Trust had joined the Consortium. The reality was that there was a national and regional position, just as there was a local relationship, and a key reason why the Consortium assembled was due to the perception of slow progress in terms of the national negotiation, and the increased pressure to make savings. He asserted that if responsible decisions to address

DRAFT

economic pressures were ignored, it would not serve the interests of the Trust or its staff.

Kelvin Blake was not in favour of regional pay variations, and cited issues regarding big cities potentially having to pay more. He was uncomfortable about this, given the potential changes that could occur, but he planned to consider what the Consortium brought back to the Board in the future.

Ken Booth, a public governor, endorsed Kelvin's point, and added that there should be built-in incentives for Trust staff, which Robert Woolley confirmed the Consortium would consider.

Louise Newell, a staff governor, said that the document looked explicitly at wages of clinical staff, but asked if it also planned to review the pay of managerial and other non-clinical staff. Robert Woolley responded that it was an open review and all staff groups were included. He continued, saying that while the briefing paper had, unsurprisingly, caused alarm, it only outlined the sorts of areas that could be reviewed, and no recommendations would be received until autumn.

Garry Williams, a patient governor, requested clarification regarding the geographical areas which the Consortium covered, and questioned if there might be difficulties in negotiations between trusts, their employees, and adjacent Trusts. Robert Woolley confirmed that most NHS organisations in the south west were in the Consortium, and it therefore covered the majority of staff in the south west, but some organisations had not joined, for various reasons. Addressing Kelvin's point about regional pay, Robert explained that the Consortium was not set up to try and establish regional pay along the lines of what the Government had described, but it could be one of the recommendations brought back for consideration.

Mo Schiller, a public governor, reminded the Board of the Trust Values in this regard, in particular "respecting everyone", which was acknowledged.

Jeanette Jones, partnership governor for the Joint Union Committee, said that it would require a lot of work from herself and other colleagues on the staff side, as well as input from Trust executives and leads within management teams to restore trust between staff and the leadership of the Trust.

Robert Woolley thanked Jeanette for her commitment and confirmed that he wanted to work with her and her colleagues to ensure a solid basis of trust going forward. He reiterated that Jeanette and her colleagues had been notified that the Trust was in the Consortium some time ago, and that he thought seeing the paper in "black and white" had created the concerns. All members of staff in the group were committed to partnership working with staff, whilst following Trust values, and if national negotiations proceeded then they would be supported. Robert emphasised the importance of staff needing to recognise how pressing the economic challenges were, which the Trust must help them understand. The Board had continuously given commitment over the last couple of years to do all it could to protect jobs, despite the challenging circumstances.

In response to a request for reassurance from Florene Jordan, a staff governor, Robert explained that if it would help boost staff morale, he would be issuing another communication to the Trust about the purposes of the Consortium, to tackle any concerns.

DRAFT

Referring to the communication update that Robert Woolley planned to send to Trust staff, Guy Orpen suggested that it might be of use to mention that it was stimulated directly by the intervention of staff governors, which would highlight active engagement in the quorum with these issues; Robert agreed with this helpful suggestion. • Wendy Gregory, a patient governor, referred to 'Point 2 – Communications', regarding the Lean Programme, which assessed the effectiveness of the communication about drop-off areas to the Bristol Royal Infirmary and Royal Hospital for Children, and also the changes likely to arise from the Oncology initiative. She asked how effective the communication had been, and if it has been evaluated. Sarah Pinch responded that the evaluation was two-fold; via the Patient Involvement Team, 150,000 questionnaires had been distributed to people who had visited both emergency departments over the last six months, and 95% of postcodes were targeted with leaflets. Responses were expected back at the end of August. The second piece of the evaluation planned to look at how many leaflets were delivered, where they were delivered and feedback from them, with plans to take results into the Project Board for Bristol Royal Infirmary Redevelopment in September, and then into Trust Management Executive. Any 'lessons-learnt' from the process would be picked-up for the next period of closure in late 2012. The same evaluation might be considered for the Oncology Centre.	
Quality, Performance and Compliance	
5. Quality and Performance Report The Board noted and discussed this report by members of the Trust Executive. **a. Overview** There had been a marked improvement in the overall 'Health' of the Trust, and most notably in Financial Performance, including the Trust's Finance Risk Rating for Monitor increasing to 3. Further details of the risk rating could be found in Appendix 6 of the Finance Report. Disappointingly, there has been an increase in hospital acquired pressure sores and inpatient falls in the period, further details of which were provided in the Quality Report. There had, however, been improvement in some of the patient experience measures, including the same-sex accommodation standard, for which no breaches were reported in the month. Following a rise last month, there had been a significant reduction in patient complaints, although this indicator currently remained 'Red' rated. Lastly, the Trust had concluded Quarter 1 with an 'Amber-Green' self-assessed Governance Risk Rating against Monitor's Compliance Framework. Although the A&E 4-hour standard was not achieved for the quarter as a whole, it was achieved in June, which provided greater confidence regarding achievement of the 4-hour standard in Quarter 2. **b. Patient Experience** The Deputy Chief Nurse, Helen Morgan, presented the patient experience report, which recounted the issues when a patient of the Extra Care Scheme	

DRAFT

was discharged from one of the medical wards at the Bristol Royal Infirmary. A number of local and organisational learning points were identified and these were documented in the report. Discussion included: • Emma Woollett felt that when a patient was discharged, the wards took the correct action, but stressed the importance of effective communication. • Elective discharge would be discussed later on in the agenda, but Paul requested that a report be brought to the Quality and Outcomes Committee in this regard, to engage in discharge arrangements at a strategic level. Iain Fairbairn endorsed Paul's request to bring a report to the Committee, and Helen Morgan confirmed this action. **c. Quality** The Medical Director, Sean O'Kelly, presented the quality element of the quality and performance report, and referred specifically to the following Exception Reports, which were: 1. **Antibiotic Prescribing Compliance** – Performance remained static at 85% against a target of 90%. Sean reassured the Board that although two divisions had improved, efforts were continuing robustly to ensure divisions who had not yet reached their targets were working towards them. The primary issue appeared to be the non-completion of 'Stop or Review Dates', and those prescribers who were not completing prescriptions correctly were being interviewed by their clinical leads to establish why, and require them to complete these fields in future. Sean O'Kelly met with foundation doctors to impress the importance of this aspect of prescribing and they were scheduled to undergo further training in this regard. 2. **Stroke Care** – The parameters measured for stroke performance were all outside of Trust target ambitions. 42% of patients received brain imaging within one hour, as opposed to the target of 50%. Sean reassured the Board however, that all patients who required thrombolysis had received a scan within an hour of arrival and therefore had not experienced any delay in this treatment. The percentage of patients who spent at least 90%+ of their stay on a stroke unit, had been an area of good performance at various points in 2012, but the Trust was currently struggling to achieve target levels, which was attributed to the pressure on the Clinical Site Team to find beds. There were plans to assess the patients who did not spend most of their time on stroke units, to see if any changes could be made to ensure better availability of stroke beds. 3. **High-Risk TIA (Transient Ischaemic Attacks)** – 57% of patients began treatment within 24-hours, of a target of 60%. They were being managed appropriately, and steps were taken to ensure that patients who wished to be seen within a 24-hour time period were seen during that time. Points of discussion included: • In response to a question by Ken Booth regarding coverage for stroke care at weekends, Sean O'Kelly confirmed that patients were not thrombolysed out-of-hours at UH Bristol, but North Bristol NHS Trust were commissioned to manage these patients. • Sean O'Kelly also responded to a question Emma Woollett had	Quality and Outcomes Committee

DRAFT

regarding stroke care, explaining that if a patient arrived at the Emergency Department undiagnosed as having a stroke, only later to receive confirmation of a stroke out of hours, they would be transferred to North Bristol NHS Trust. There was also a period of overlap, where both trusts could administer thrombolysis well into the evening. In addition, the ambulance service had an increased recognition of stroke, so the majority of patients would be recognised and taken to the correct facility.

- Referring to stroke, Iain Fairbairn received confirmation that the 'Green' threshold of 50% was the statistical percentage of patients requiring imaging within one hour. He asked if it would be possible to re-cast the standard so the Trust imaged 100% of patients who did clinically require it within the hour, without relying on the statistical 'guesstimate' in-place at present.
- Sean O'Kelly replied this would be a more logical approach, with a more meaningful and rigid aim. In principle, the Trust adopted national targets, but in this case there was a degree of variation between activity seen locally and nationally.
- Peter Holt, a patient governor, thought that it would be difficult to administer thrombolysis within one hour until a brain scan was seen.
- Sean O'Kelly assured Peter that NICE guidance was clear about the cohort of patients who required urgent scanning, in terms of their clinical signs, symptoms and history, so that when a patient presented at hospital, they were categorised depending on whether or not they required an urgent scan. If a patient did not need an urgent scan then they would still receive one within 24-hours. The purpose of the scan was to exclude patients who had suffered a haemorrhagic stroke from receiving thrombolysis.
- Elisabeth Kutt added that sometimes paramedics made decisions on a patient's diagnosis and alerted the Emergency Department within minutes, following protocol.
- Paul May emphasised the importance of giving dedicated reviews to people who had suffered strokes.
- Kelvin Blake had spoken to a member of the Health Select Committee, who had informed him that not enough people were being imaged across the country. His main concern was regarding patients spending less time on the stroke care unit, and he asked if patients in beds were mainly outliers or stroke patients.
- In response to Kelvin, Sean O'Kelly said that he did not think this was due to increases in stroke patients, but was more likely due to outliers.
- James Rimmer acknowledged that 'flow' around the hospital could be improved. This month's Patient Experience report gave a good indication that some issues were caused by the Trust, and some were from partnership working and the need for effective communication. Issues from the Patient Experience tied-in with some of the reasons why stroke patients were unable to get beds, but there was an absolute focus on the 'right patient, right bed, right time'.
- Regarding antibiotic compliance, particularly in respect of the elderly, Lisa Gardner asked if medication would just continue being prescribed, and requested assurance of performance management in this regard.

DRAFT

- Sean O'Kelly clarified that if the 'Stop or Review Date' was not completed, it did not necessary indicate that a prescription would not be reviewed by medical staff. To be certain of review however, he would expect to see completion of all 'Stop or Review' boxes, on the prescription chart.
- In response to a question from Clive Hamilton regarding antibiotic prescribing compliance, Sean O'Kelly thought that an extension of the Medway IT system might ease prescription practices. Paul Mapson added that electronic prescribing was expensive, and at least a couple of years away.
- James Rimmer explained to Clive Hamilton that the protocol for the Clinical Site Team and 'Green escalation status' was the Trust's daily bed-reporting system which measured the management of flow through the hospital using a colour-coded system. A 'Green' status indicated that there would always be a bed, which might not be possible in an 'Amber-red' status.
- Ken Booth gave his opinion that in August 2012, birth rates were expected to be exceptionally high. He asked what contingency plans were in-place to manage the situation successfully.
- Robert Woolley assured Ken that the Maternity Service worked continuously to predict demand and instigate contingency plans in anticipation. Belinda Cox, a staff governor, added that the birth rate was increasing in general, and work continuously addressed capacity; she also noted that the Maternity Service risk was high on the Trust Risk Register.

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 standards relating to workforce indicators were being achieved, including:

- Workforce numbers,
- Bank and agency usage; and,
- Appraisal rates – there had been a marked improvement in rates this month, at just over 85%.

The target had not been achieved for sickness absence this month, which was currently running at 4% for June compared to the target of 3.3%. Close work with the divisions was required to establish why rates were still high. Page 75 of the report pack onwards outlined recovery plans which looked at areas reporting high sickness absence and reasons for sickness, which were also charted. All types of stress were noted to be high, along with musculoskeletal conditions, gastrointestinal and colds and flu. All divisions were being supported to get their sickness plans in-place, to ensure a downward trend, and a project was underway in two divisions, to support sick staff back into work. Data was expected in August to see if this was making an impact. Medicine wards had high sickness rates, and Estates and Facilities also tended to have lots of sickness, but they had seen improvements and dropped a percentage coming into July.

Comments:

- John Moore gave congratulations regarding the 85% achievement for appraisals, with a request for a 90% rate in future months. He sought

assurance that managers accepted responsibility to conduct back to work interviews.

- Claire Buchanan confirmed that a 'snapshot' audit had been instigated, which 3 divisions had already responded to. 78% of staff received a return to work interview, but the Trust was working towards 100%.
- In response to a question by Ken Booth, Claire Buchanan confirmed that the 'spikes' seen between July 2011 and February 2012 on the Agency statistics were due to vacancies being held because of changes to the nursing workforce, which created a need for additional agency staff. The figure was beginning to reduce.
- Pauline Beddoes asked if six-monthly appraisal reviews were adhered to and Claire Buchanan responded that the requisite standard was an annual appraisal. All objectives required timescales, and the only way a manager could ensure they were being met was to meet with staff. An audit of staff graded 8a and above had also just commenced, looking at who had received appraisals and if objectives were achieved.
- Iain Fairbairn gave his opinion that effective appraisal was a vital tool in service transformation and in achieving Cash Releasing Efficiency Savings. He encouraged Claire to "keep building on the culture of constant appraisal".

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);**
- **4-hour Accident & Emergency -** Achieved in June, which was a significant step forward from the previous six months, when it struggled to achieve.
- **Last-Minute Cancelled Operations -** Reduced from the previous month but still remained above the ideal target.
- Of positive note, **cancer performance** and **time to treatment performance** had both been maintained, and a new measure had been added regarding incomplete pathways achieving 92%.
- The **4-Hour Accident and Emergency** standard remained on-track to achieve 95% this month, and investigation was on-going into causes of non-achievement. The Trust was working with the Emergency Support Team and implementing an action plan with them, and every bed was currently undergoing an audit. Good working practices were noted with Great Western Ambulance Services and handover times were showing steady improvement.

6. Annual Reports

The Board noted and discussed the following annual reports by Executive Leads.

a) Infection Control Annual Report (2011-12)

Helen Morgan introduced the report, saying that it gave a "positive message to patients and staff". The achievements noted from the report were:

- A reduction in incidents of hospital acquired infections, notably Clostridium Difficile, which reduced from 94 to 54 over the year, and

DRAFT

Methicillin-resistant staphylococcus aureus, which reduced from 5 to 4 cases over the year. The targets set for this year were equally challenging and there was no room for complacency regarding infection control.

Comments:

- Responding to Mo Schiller's question regarding the sterilisation of instrument containers, James Rimmer confirmed that this was continually reviewed in the Service Delivery Group.
- Helen Morgan responded to a concern raised by Clive Hamilton regarding raised numbers of Methicillin-resistant staphylococcus aureus bacteraemia between January and March 2012; she said that the team had been very disappointed to have had two cases to-date, but emphasised that there was a continued focus on the prevention of the bacteraemia and there had been no more since that time.
- Robert Woolley gave thanks to the Infection Control Team and clinical staff who were active on this agenda. Before it was published more widely, the accountability framework on page 113, and the graphic on page 112 required correction, as they did not adequately distinguish between accountability and relationship. It was agreed that the changes would be made and the Report reissued.

b) Health & Safety Annual Report

Claire Buchanan highlighted the three main areas in the report, which were:

1. Stress;
2. Sharps and needlestick injuries;
3. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

- The Health and Safety Executive made six inspection visits to UH Bristol in the period and the Trust responded with action plans, which were accepted.
- Health and Safety training had been developed into the General Essential Training matrix, and work in this area was on-going.
- The Health & Safety Team had spent time in ward and department areas offering support in manual handling of patients and loads, which would be continued as good results had been seen.
- Overall, Health & Safety incidents and near-misses decreased by 6% in the period, and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations reduced by 11%.
- All Health & Safety reporting was now completed on-line, which meant response times were faster and more efficient.

Questions:

- In response to Clive Hamilton, Claire Buchanan said that fire safety training used to be bi-annual, but was now annual.
- Paul May asked if the Trust had a dedicated approach to dealing with stress, and Claire Buchanan confirmed that the Health & Safety team completed stress audits with teams. Depending on the outcomes, they would then work with the team and hand-in-hand with Occupational Health to

DRAFT

provide any counselling or support that was needed. Claire added that this year all HR business partners were being trained to carry out stress audits.

c) Information Governance Annual Report

Sean O'Kelly pointed out that the cover sheet stated that the report highlighted progress against Version 7 of the Information Governance Toolkit, when it should have said Version 9.

The Toolkit changed annually and the report referred to Trust assessment, against the Toolkit, which was that the Trust had improved its position on previous years. The Toolkit identified 6 areas, where 45 parameters were assessed. UH Bristol was achieving a score of 2 or higher on 43 of the 45, with two parameters requiring further work, these were:

1. Pseudonymisation of data;
2. Dataflow mapping.

The Report also referred to staff Information Governance training undertaken in the year, which had improved to 79%.

There had been one reportable Information Governance incident, but no further action was taken against the Trust in this regard.

d) Fire Safety Annual Report

James Rimmer reported good progress, and highlighted four key issues:

1. The need to reduce unwanted fire signals from 3 to 2.5 per week;
2. Fire Safety training had changed from bi-annual to annual;
3. A programme of works was in-place, but was not yet fully funded, which was being prioritised;
4. Departmental risk assessments.

The final three items did not cause worry alone, but together they provided a risk, which was included on the Trust Risk Register.

Questions and comments:

- Clive Hamilton requested clarification of a situation regarding a 13 amp plug top overheating in a kitchen in the Children's Hospital canteen, and James Rimmer replied that although he had no specific detail about the socket, it would have been assessed and made safe.
- Guy Orpen recognised the need to supress unwanted fire signals, but stressed that encouraging contractors to isolate alarms was not without its own risk.
- James Rimmer confirmed that there had been no incidents of contractors covering or isolating fire alarms in the last twelve months at the Trust, but a member of staff had covered an alarm, which had been identified. As a consequence, the staff member was debriefed accordingly.

e) Security Annual Report

James Rimmer hoped that the report gave reassurance of the good security measures across the Trust, before noting no significant rise in security issues. UH Bristol took a 'zero-tolerance' approach to its security measures and this was highlighted in the increased numbers of prosecutions by the Trust.

James thanked the team for their hard work, which John Savage endorsed.

DRAFT

Finance and Governance

7. Committee Chairs' Reports

The Board noted and discussed reports on the activity of board committees by their respective chairs.

a. Finance committee dated 25 July 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 reports a **surplus of £185k for the first quarter** of 2012/13. The results lead to a Financial Risk Rating of 3 (actual 2.90).

Good progress has been made 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. The initial findings indicate that there has been some under performance on out patient service agreement activity in the first quarter.

The Specialised Services Division has moved from Red to Amber / Red rating with **2 Divisions still 'red-rated'** i.e. Surgery, Head & Neck and Women's and Children's services. Executive Directors are working with Divisions to ensure Operating Shortfalls are fully understood and measures identified and progressed to address shortfalls.

The Committee noted the briefing on the current financial position given by the Chief Executive and Finance Director to the Trust Management Executive and for further briefings to be made to ensure that the position is understood by divisional teams and staff generally.

2. A report on **CRES** plans and achievement was received. For 2012/13 the Trust has a CRES Plan of £27.622m. The actual level of savings achieved for the quarter total £5.984m or 86% of the target for the period. The risk assessed forecast outturn is currently £23.7m or 86% of the CRES Plan – although notice was given that this is expected to reduce for the July report. The principal area of concern for the Committee was that for some clinical divisions there remains a significant element of unidentified recurring CRES schemes. The Committee observed that reductions in pay costs are taking longer to achieve than hoped. Looking ahead, work is about to start on assessing the impact of existing CRES plans for 2013/14.

The Finance Committee received the Quarter 1 Summary Financial Performance Report for Monitor. This is an item of business elsewhere on this month's Board agenda. The key issue to be noted is that the Board is advised that the Finance Committee anticipates that the Trust will maintain a financial risk rating of at least 3 over the next 12 months.

3. The quarterly reports on Treasury Management and the Review of Financial Institutions for the Investment of Temporary Cash Surpluses were received. The Committee noted that Monitor provide for three credit rating agencies to be used to assess whether financial institutions meet the **'safe**

harbour' criteria. The current economic uncertainty has resulted in a downgrading by some (but not all three) agencies of two of the banks used by the Trust for the investment of temporary cash surpluses. Monitor is currently deciding what to do regarding the latest round of downgrades.

4. An update was provided on the **Review of Profitability and Efficiency of the Division of Medicine** (a follow up to the April report). It was noted that progress is being made and a further update is to be given to the October meeting. The Committee also received a useful **income and expenditure comparison report** for 2010/11, and 2011/12 with forecasts for 2012/13. This is to be incorporated into the future reporting arrangements to the Committee.

Paul Mapson added that in the first quarter of the year slippages in savings plans were expected, which was what the Trust was seeing. The finances of the divisions were of concern and recovery plans were already being established for a number of them.

The biggest concern was regarding savings plans, as of the £27 million expected save this year, at present only £10 million had been identified, and even this amount was 'slipping'. Paul explained that it was difficult to convert the required savings from national tariff reductions into savings, particularly pay savings.

UH Bristol was consistent with the national picture, but the key for this year would be the scale and extent to which savings plans improved. If they did not pick-up then the Trust would be in a recovery position.

Discussion included:

- In response to a query by Iain Fairbairn, Paul Mapson said that Cash Releasing Efficiency Savings were below shortfall and rising; it was phased on twelfths, and was currently £1 million behind against the phased plan. The same picture had been seen last year, but the Trust had improved.

b. Quality and Outcomes Committee dated 26 July 2012

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

- The Committee reviewed the new Histopathology Action Plan, and noted that the Head of Division for Diagnostics and Therapies, Elisabeth Kutt, now had central control of it. Paul was pleased to note that Rob Pitcher was the clinical lead for Cellular Pathology and for the Severn Pathology delivery.

- James Rimmer continued to apply pressure regarding multidisciplinary teams and job plans, taking into account the need for work to commence. The Committee was reassured that this was being maintained and decided to review it again in six months'.

- The Clinical Quality Group produced a high-level report for the Committee, where they had focussed on the patient safety dimension of the work of the Group, rather than the actual reality of patient safety; they expected to achieve better levels by the end of the year.

- Quality and Performance Report – More information was presented regarding sickness absence, which the Committee discussed in detail.

DRAFT

- Quarter 1 Monitor Declaration and Corporate Risk Register – Two new risks were included on the Register, regarding fire safety and ambulance cases waiting in corridors in Accident & Emergency. Protocols were given regarding how the Trust could intervene with the ambulance service to deal with issues that had previously been ruled out by existing protocols.
- Current pressures on Maternity Service at the Trust were also reviewed.
- A late item was brought regarding South Bristol Community Hospital and some considerable issues relating to food quality and other matters concerning patients and their families at the hospital.

Comments:

- Phil Mackie recounted his experience of visiting South Bristol Community Hospital recently as a patient, saying that he had not been there before and was very pleasantly surprised. He arrived back at home prior to his appointment time, having had the treatment he required.

Board: Strategy and Business Planning

8. Integration of Health Services in Bristol

The Board noted and discussed this briefing by the Chief Executive.

John Savage confirmed that the Board had agreed its recommendation to the Membership Council in a private meeting the previous week, and that this position had been thoroughly discussed, examined and agreed earlier during the Membership Council part of the joint meeting.

Robert Woolley said that he hoped that everyone, including Trust governors, could see that the resolution reflected the principles described earlier in this meeting regarding the Board's approach to the project.

- Clive Hamilton and Robert Woolley discussed the use of the word 'potential' in the first paragraph of the Resolution, as Clive preferred the word 'possible'. Robert Woolley explained that he thought 'potential' was more appropriate, as it said it was both possible, yet conditional.
- Peter Holt gave his opinion that the make-up of the oversight group would be crucial, to avoid repetitive discussions in the future. Robert Woolley explained that the final paragraph stated that UH Bristol needed final agreement with partners in North Bristol NHS Trust and other interested parties, as the Strategic Health Authority would act for the Secretary of State in any possible future transaction. There was a need to finalise the agreement in terms of its organisation, resources and timescales planned. Robert stressed that "the Steering Group was one thing, but actually having the right team supporting them would meet the concerns Clive described".

9. Report from the Transformation Programme Board

The Board noted and discussed this report by the Chief Executive.

Robert Woolley explained that this was the quarterly report to the Board regarding progress with the Transforming Care Programme. He highlighted that it remained a key focus of the Executive, and no opportunity was missed to present it back to staff (including medical staff), with an emphasis on delivering best care and managing the flow of patients in the most

expeditious way through Trust facilities.

Changes had been made regarding project organisation, as Jan Bergman, Interim Programme Director, had left the Trust, and was being replaced. In addition, a new Programme Manager, Dave Evans, had been recruited. The Programme Board sought to embed the work into divisional activity, and it was part of Robert Woolley's routine performance review process with Heads of Division to take forward transforming care initiatives locally.

Robert highlighted the Living the Values scheme, saying that there was an expectation that 1,000 staff would have received training by September 2012. The Staff Recognition Scheme was also being launched, and both schemes were under the building capability 'pillar', which could help the Trust recognise success in delivery of objectives and transformation in particular.

Comments:

- Jeannette Jones explained that although she was a "great believer" in the Transforming Care Programme, she struggled with constant talk of Cash Releasing Efficiency Savings in the plan. She felt that staff might believe that Transforming Care only meant providing savings, and not that it improved patient care and quality and standards of care.
- Robert Woolley responded to Jeanette, saying that the programme should achieve both improvements to patient care and cost savings, and that poor care and poor flow cost money. It was a mixed message, but with an absolute focus on care quality, the Trust should deliver Cash Releasing Efficiency Savings.
- In response to Jan Dykes' question regarding the Centralised Outpatient Booking Centre which opened in July 2012, Paul Mapson explained that it was too early to note any potential progress, but he would provide information when received.

10. Pathology Services Review – Advisory Panel Findings and Recommendations

The Board discussed and noted this report by the Director of Strategic Development.

The Chief Executive, Robert Woolley, reiterated that the Pathology Review in Bristol, North Somerset and South Gloucestershire commenced in 2010. The Board had completed strategy work in development seminars and decided that it was not well-placed to deliver the vision of a single pathology centre of excellence for this area, and did not express an interest in becoming a host for a pathology centre of excellence. The Board did, however, give its support to North Bristol NHS Trust to develop their proposal.

This paper reported on the second visit of an external advisory panel, and their review of what the project had achieved to-date. North Bristol NHS Trust had joined together with the Health Protection Agency to form proposals and develop a model of care for the future of pathology serving Bristol and Weston; the report illustrated that the panel thought the clinical model appropriate, and that it could be more ambitious, particularly in the use of telemedicine and IT, to allow for further centralisation and consolidation of scarce pathology resources. They were disappointed that financial benefits had not been sufficiently articulate and the apparent savings did not reach the

level expected.

Further work was required to complete the business case, and the Board would receive it in autumn 2012.

Discussion:

- John Steeds referred to item 4.4 of page 184 of the meeting pack, and expressed his concern that the plan had not come close to its savings targets.
- Robert Woolley responded to John, saying that a great deal of work had been completed. The benefit of the external review was precisely so this kind of challenge could be made without fear or favour, as they were external parties talking to North Bristol NHS Trust and the Health Protection Agency about their plans. Feedback would be taken seriously and built into further work to prepare the business case.
- Referring to Section 3 on page 180, 'Proposed Service Configuration', Iain Fairbairn asked if a Key Performance Indicator (KPI) was proposed for Central Laboratory Services which was equivalent to the 120 minute turnaround time target for Essential Service Laboratories.
- Robert Woolley thought that there would be KPIs across the whole range of tests and they would probably be variable. Elisabeth Kutt confirmed this, saying that some tests would not run daily as they were too complex. Robert continued, explaining that if a business case was brought back to the Board for approval, laboratory services would be centralised at Southmead and labs on Levels 8 and 9 of the Bristol Royal Infirmary would be vacated, which would leave UH Bristol with a diseconomy. The point being made was that the proposal must work economically for the community, and that it did not just serve the Trust to have a cheaper service elsewhere if a cost pressure was left on-site. This would encourage the commissioners, North Bristol and the Health Protection Agency not to ignore the diseconomy of vacating a clinical space in the Bristol Royal Infirmary. The Trust would consider a range of options regarding alternative facilities for maximising essential lab space, or whatever was most economical.
- Anne Skinner questioned if the Pain Clinic could be relocated to where the current labs were in the Bristol Royal Infirmary, and Robert Woolley replied that the Trust must make the most cost-effective use of the space; if the pain clinic could move and space could be closed behind it to release costs elsewhere, then it might be possible. He was uncertain what the current thinking was regarding the Pain Clinic and how it could be affected by these proposals, but James Rimmer thought that it would not be affected.
- John Savage said that the Pain Clinic suggestion would be noted in the minutes.
- John Steeds asked if a conclusion had been reached regarding the specialist haematology laboratory diagnostic monitoring services, to which Robert Woolley replied that his understanding was that a great deal of discussion had taken place regarding the service, and the external review supported the proposal that most of it could be centralised off-site, which was not the option favoured by Professor Standon.
- Guy Orpen asked if there was consideration to handle Bath & North East Somerset 'business' at Southmead, as he noticed they were not amongst

DRAFT

the groups mentioned. • Robert Woolley confirmed that Bath had chosen not to be involved. He thought there was a case for Severn Pathology to be more ambitious about its catchment and to market more aggressively, not just to Bath & North East Somerset, but also to Gloucestershire.	
11. Quarterly Capital Projects Status Report The Board noted and discussed this report by the Director of Strategic Development. This quarterly update detailed the progress made against the four major capital development projects over the last 3 months. The highlights included: • Planning permission being achieved for the Welcome Centre; • Completion of the second phase of the Bristol Royal Infirmary Emergency Department redevelopment; and, • Approval of the Bristol Haematology & Oncology Centre full business case. In the last week, planning permission had also been granted for the Bristol Haematology & Oncology Centre scheme. Work in the next month would see the completion of the three phases of work at the Bristol Children's Hospital, to support the Centralisation of Specialist Paediatrics. There were no high residual risks to note, or decisions required, and the Board was therefore asked to note the progress made and actions taken to mitigate identified risks.	
12. Urology Services Transfer The board received and considered this report by the Chief Operating Officer for **approval**. James Rimmer reiterated to the Board that three services would be moved from UH Bristol to North Bristol NHS Trust. The report focused on consolidating services, which had been discussed in the Membership Council part of the meeting. The Report specifically looked at Urology, and talked about opportunities regarding the patient pathway and the benefits which were expected, in the form of better pathways and outcomes for patients. The transfer had full clinical support, but requested approval in principle, subject to financial impact, as the finances were not currently included. Once the financial impact had been clarified, there would be a staff consultation, which would happen in early autumn, following agreement of the plan. Comments: • In response to Paul May's questions, James Rimmer confirmed that the links between urology and oncology would be very clear in the final arrangements, and the oncology and urology leads were already involved in the process of service consolidation across Bristol. James continued, explaining that capacity had been created at South Bristol Community Hospital for patients from Clevedon and Portishead, but North Bristol NHS	

DRAFT

Trust had not yet taken capacity, but were considering it as part of the plan. • James Rimmer confirmed that South Bristol Community Hospital held day case surgery and outpatient procedures, as well as outpatient appointments, but at present, these had not been fully agreed or organised. • Iain Fairbairn asked if one of the factors for centralisation at Southmead hospital was the availability of robotic surgery, and if they had investment. • James Rimmer confirmed that Southmead was the specialist centre for radical prostatectomy, rather than UH Bristol, and the figure of between £5–12 million showed the size of the service investment already in-place. *There being no further questions or discussions, the board resolved to **approve** the Urology Services Transfer recommendations in principle, subject to satisfactory resolution of the financial impact.*	
13. Clinical Systems Strategy – The Way Forward The board received and considered this strategy by the Finance Director for **approval**. Paul Mapson informed the Board that a Clinical Systems Strategy was approved in June 2010; the report outlined the various phases on the plan. The report also documented the huge scale of various IT systems in use around the Trust; some interfaced with the main system, but others did not, and a major review of them was being carried out. • In response to Clive Hamilton's question about possible changes to contractual arrangements for IT systems, Paul Mapson confirmed that the Cerner contract would run until 2015, and Medway until 2017, and therefore, IT integration would form a significant part of any future due diligence exercise conducted by University Hospitals Bristol NHS Foundation Trust. *There being no further questions or discussions, the board resolved to **approve** the Clinical Systems Strategy – The Way Forward.*	
14. Big Green Scheme The board received and considered this report by the Chief Operating Officer for **approval**. James Rimmer introduced the report, explaining that the Scheme was set-up three years' ago with the support of the Trust Board. James welcomed the Energy and Sustainability Manager, Sam Willetts, and the Big Green Scheme Chair, Nathalie Delaney, to the meeting. The report outlined progress made on the Sustainable Development Plan in 2011/12 and outlined future plans for 2012/13 and beyond. It also celebrated the successes of the Scheme and described the Trust's progress in becoming an environmentally sustainable organisation. The priorities identified for 2012/13 were: • Increased coverage of sustainability for the Trust through the overarching Sustainable Development Plan; • Ensure robust mechanisms for measuring activities and impact at Trust, site and Divisional level. Board members and Governors were asked to take an active role in	

DRAFT

transforming the Trust into a greener organisation and champion the sustainability agenda by: • Signing up to be part of Green Impact, or encourage teams in their area to be part of the awards scheme next year: www.greenimpact.org.uk/uhb • Consider how they could 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 had considered and addressed sustainability; • Review the environmental impact of their meetings and activities; • Support expenditure on resources required; • Approve the Sustainable Development Plan and reporting arrangements. **Comments** • Paul May stated that in the NHS, 'Green' issues were a major consideration, and the attitude of the Board was to embrace them. He suggested that they looked at the report in more detail on another occasion, which the Chief Executive endorsed. • In response to a question from Clive Hamilton, Sam Willetts explained that the Trust actively worked to achieve correct water temperatures, not only for legionella prevention, but also to avoid wastage. Regarding solar energy, the Trust were working in partnership with Bristol City Council regarding possible community investment in solar panels. • James Rimmer confirmed to Lisa Gardner that the Trust always tried to procure fair trade and ethical products. Nathalie Delaney added that transformation pathway changes would help with procurement. • The Appointed Governor of University of the West of England, Helen Langton, suggested looking at 'joined-up thinking' between the Trust and the University of Bristol regarding 'green' issues; James Rimmer confirmed that the organisations worked in partnership for the Green Impact Awards. • Responding to a question by Guy Orpen, Sam Willetts explained that decisions regarding environmental interventions were almost always focussed economically and technology options were constantly investigated. Regarding voltage optimisation, transformers were located across the site, which could be controlled internally at virtually no cost. • Paul May declared that he was on the Estates' Committee at the University of Bristol. *There being no further questions or discussions, the board resolved to **approve** the Big Green Scheme.*	Trust Secretary
Board: Risk	
15. Board Assurance Framework Report The board received and considered this report by the Director of Strategic Development for **review**. Xanthe Whittaker explained that the report detailed the progress made in the last quarter in achieving the Trust's medium term corporate objectives, and in particular the milestones in 2012/13.	

DRAFT

One objective was currently reported as not being achieved, as indicated by the 'Red' rating. The objective related to on-going compliance with the Care Quality Commission's registration standards, with the Trust being declared non-compliant with outcome 21. The Trust was currently awaiting final confirmation of the Commission's findings following its unannounced visit in June, and potential compliance risk around outcome 13. Of the 55 objectives, 46 were reported as being on track, with a 'Green' status. A further 8 objectives were reported as having an 'Amber' rating. The Board was asked to note this report and the actions being taken to restore delivery of a 'Green' risk rating to the objectives currently not on-track.	
16. Corporate Risk Register The board received and considered this report by the Chief Executive for **review**. Robert Woolley informed the Board that the cover paper highlighted changes to the Register since it was last seen in April 2012. The Board was asked to note the content of the corporate risk register.	
Board: Monitor Reports	
17. Quarter 1 Compliance Framework Monitoring & Declaration Report The board received and considered the recommendation of this report by the Chief Executive for **approval**. Robert Woolley explained that this was the quarterly self-certification regarding compliance with targets which are requirements of the Trust's terms of Authorisation. The self-certification is both retrospective and prospective, and Monitor expects the Trust to have plans in place to support the Board's self-certifications. He recommended to the Board a declaration of 'Amber-Green' due to not meeting the Accident & Emergency 4-hour target, and a financial risk rating of 3. *Having discussed the criteria for these declarations, and there being no further questions or discussions, the Board resolved to **approve** the self-certification of an AMBER-GREEN governance risk rating, and a financial risk rating of 3.*	

DRAFT

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 04 – Chief Executive's Report
Purpose
To report to the Board on matters of topical importance to the Trust, including a report of the activities of the Trust Management Executive.
Abstract
The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Trust Management Executive in the month.
Recommendations
The Trust Board is recommended to note the key issues addressed by the Trust Management Executive in the month and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda.
Report Sponsor
Robert Woolley, Chief Executive
Appendices
• Appendix A – Trust Management Executive Report

APPENDIX A

TRUST MANAGEMENT EXECUTIVE

REPORT TO TRUST BOARD –SEPTEMBER 2012

1. INTRODUCTION

This report summarises the key business issues addressed by the Trust Management Executive in August and September.

2. COMMUNICATIONS

The Trust Management Executive noted the monthly reports on the activities of the Communications Department, particularly, planning for the Recognising Success Staff Recognition in November.

3. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** the Trust's performance against the 4-hour accident and emergency standard. Performance had improved in recent weeks following recovery measures agreed in August and was just above the 95% target for the quarter. Service standards at risk included the cancer treatment times and infection control targets. It was disappointing to note that the target for Clostridium Difficile had been breached for Quarter 2, the second quarter in a row. Assurance was received that all Divisions were focussed on improvement.

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

- The Expression of Interest for the West of England Academic Health Science Network had been approved to proceed to the next stage of application to the Department of Health.
- The Trust's Expression of Interest in becoming an Intestinal Failure and Nutrition Centre had been approved to proceed to the next stage.
- The programme timetable for planned surgical service transfers between UH Bristol and North Bristol Trust had been delayed as a result of financial pressures. A 2012 transfer would not now be achieved and operationally the preferred window for implementing the service transfers was March 2013.
- A report from the external review of pressure ulcer management had been received and a robust action plan for improvement was being developed.
- Work to answer a question posed by the Board about statutory compliance with Parliamentary Acts was in progress. Further information had been requested prior to reporting to the Trust Management Executive.
- An action plan in respect to the National Cancer Patient Experience Survey results would be presented to the Cancer Services Board in September.

4. STRATEGY AND BUSINESS PLANNING

The group **agreed** its support for the strategic ambition to be a Level 1 Centre for Adult Congenital Heart Disease, subject to further detail around the finance and activity model to be worked up.

The group received a report which summarised the work undertaken to refresh the 2009/2010 model of future bed requirements across the Trust and **approved** the proposed development of a Medium Term Operating Plan 2013/2014 to 2015/2016, using the recommended parameters.

The group received an Expression of Interest from the staff of Homoeopathic Services to pursue the right to become a social enterprise. The group **agreed** to support the development of an Integrated Business Plan.

The group received a report following the external review of private patient activity and **approved** the recommendation that an action plan and case for change be worked up for consideration by the Trust Board and Membership Council. Support was also **agreed** for a more corporate and centralised approach.

The Trust Management Executive **approved** continuing membership by the Trust of a Department of Health-led procurement group for an Electronic Prescribing and Medicines Administration System.

The group **approved** a request to host the Local Cancer Research Network and two Research staff in primary care.

5. RISK, FINANCE AND GOVERNANCE

The group **noted** the feedback from Monitor following their review of the Annual Plan 2012/2013, which had confirmed that UH Bristol would proceed on quarterly monitoring, the lowest level of regulatory scrutiny.

The group **approved** the Trust's response to recommendations in the Internal Audit reports concerning the Quality Account 2011/2012 and Private and Overseas Patients. Concern had been expressed by the Audit Committee in respect of the Private Patients and Overseas report and the group **noted** that the Service Delivery Group was monitoring improvement against the action plan.

The group received and **noted** a number of annual reports prior to presentation to the Trust Board (Safeguarding, Infection Control and Complaints).

The group **noted** the updated joint action plan for Histopathology which incorporated recommendations from the revisit of the Inquiry Panel.

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
20 September 2012

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 05 – Quality and Performance Report
Purpose
To brief the Board on the Trust's performance against Quality, Workforce and Access standards.
Abstract
The monthly Quality & Performance Report details the Trust's current performance against national frameworks, and against a range the Quality, Workforce and Access standards. Exception reports are provided, for areas requiring further attention, along with examples of learning and improvement from complaints, incidents and patient stories.
Recommendations
The Board is recommended to **note** the current performance of the Trust and to ratify the actions being taken to improve performance.
Executive Report Sponsor or Other Author
'**Health of the Organisation**' - Deborah Lee (Director of Strategic Development) '**Quality**' - Alison Moon (Chief Nurse) & Sean O'Kelly (Medical Director) '**Workforce**' – 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

September 2012

CONTENTS

PERFORMANCE OVERVIEW

SECTION A – Performance Overview

Summary

Overall, there has been a deterioration in the 'health' of the organisation relative to last month's position, with an increase in RED rated indicators by two, and a decrease in GREEN rated indicators by four. This net change includes the Number of C. diff (*Clostridium difficile*) cases and Contract Penalties Incurred, moving from a GREEN to a RED rating. The latter is due to the inclusion of the penalties for emergency readmissions, following the joint audit carried-out with the Primary Care Trust to assess levels of readmission that were potentially avoidable.

Two of the three measures of Patient Experience have remained GREEN rated, with the GREEN ratings including a third successive month of no Same Sex Accommodation Breaches. The number of Patient Complaints has come down as expected, although the indicator remains RED rated. Disappointingly, both measures of High Quality Care also remain RED rated, with an increase in Inpatient Falls and Hospital Acquired Pressure Ulcers. The Number of Cancer Standards failed in the quarter is showing a provisional AMBER rating. However, the 95% A&E 4-hour national standard has been met for a third consecutive month.

Three of the four measures of financial performance have retained an AMBER rating with EBIDTA (Earnings Before Interest, Taxes, Depreciation and Amortization) showing an improved position on the previous month. There has been a further deterioration in the level of Cash Releasing Efficiency Savings (CRES) achievement in the month due to pressures in some clinical areas and a re-assessment of expected savings. However, the current forecast remains on track for 84% achievement at year-end. The Financial Risk Rating (FRR) declaration of FRR 3 is not at risk.

Based upon performance for the quarter to date, the Trust currently has a potential AMBER-GREEN rating against Monitor's Compliance Framework for Quarter 2. This reflects the achievement of the A&E 4-hour standard, and Referral to Treatment Times (RTT) standards, but the C. diff trajectory now not expected to be met at quarter-end. One of the Cancer Standards remains at high risk of not being achieved for the period.

SECTION B – Organisational Health Barometer

Providing a Good Patient Experience

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
A01	Patient Climate Survey (Overall CQUIN Score)	76	74	N/A	Green: >= 73.9 Red: <71.9	↓	Current month is July 2012.
A02	Number of Patient Complaints	170	158	792	Green: <120 Red: >=135	↓	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	0	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)	3	10	23	Green: 0 Red: > 1	↑	No RAG rating for YTD.
B02	Number of Inpatient Falls Per 1,000 Beddays	6.29	6.33	6.04	Green < 5.6 Red: >= 5.6	↑	

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
C01	Number of Serious Incidents (SIs)	7	11	43		↑	
C02	Number of C.Diff cases	1	6	23	Below Trajectory	↑	

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
D01	18 Weeks Admitted Pathways	91.8%	92.1%	92.2%	Green: >=90% Red: <85%	↑	
D02	Number of Cancer Standards Failed	0	1	0	Green: 0 Red: >=2	↑	Previous and YTD is confirmed Quarter 1 2012/13. Current is provisional Quarter 2 (July and Ausgust only)
D03	A&E 4 Hour Standard	95.26%	95.34%	94.26%	Green: >=97.5% Red: <95%	↑	

PERFORMANCE OVERVIEW

Being Effective

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
E01	Hospital Standardised Mortality Ratio (HSMR)	66.4	74.7		Green: <80 Red: >=90	↑	Previous is May 2012 and Current is June 2012
E02	30 Day Emergency Readmissions	341	362	1340	Below 11/12 Readmission Rate (3.4%)	↑	Previous is June's discharges where there was an emergency Readmission within 30 days. Current is July's discharges.

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
F01	Elective Length of Stay Reduction	4.1	4.1	3.7	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.
F02	Emergency Length of Stay Reduction	4.9	5.1	4.9	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.
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	10.3%	10.3%	12.1%	Green: <=6.0% Red: >=10.7%	↓	Two month's worth of data have been updated since last month's Barometer

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
G01	Appraisal Compliance	86.2%	86.1%	N/A	Green: above target Red: below target	↓	
G02	Staff Sickness	4.4%	4.2%	4.2%	Green: above target Red: below target	↑	

Promoting Research

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
H01	NIHR Income (£000s)	£1,457	£1,524	£1,524	Green:>=5% Increase on 10/11 Red: Reduction from 10/11	↑	Data is a Year To Date measure, starting from April. So Previous is April-July, and Current (and YTD) is April-August.
H02	Number of Patients Recruited Into NIHR Trials	1541	1856	1856	Green: Above 10/11 Red: Below 10/11		Current (and YTD) is rolling YTD position to end of August Previous is to end of July

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
J01	Monitor Governance Risk Rating	1	2	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)	£6.10	£6.20	£6.20	> 50% Green < 50% Red	↑	YTD and Current is Forecast year-end rewards, assuming BNSSG all payable. Previous is month 3 (June), Current is month 4 assessment.
K02	Contract Penalties Incurred - Variance From Plan (£millions)	-£0.07	£0.41	£0.41	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 July, Previous is YTD for June.

Managing Our Finance

ID	Indicator	Previous	Current	YTD	Thresholds	Trend	Notes
L01	Monitor Financial Risk Rating	3	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)	87%	91%	91%	Green: 100% Red: <85%	↑	
L03	CRES Achievement	73%	70%	80%	Green: >=90% Red: <75%	↓	
L04	Liquidity (in Days)	22.1	20.4	20.4	Green: 25+ days Red: <=14 days	↓	

Notes

Unless otherwise stated, Previous is July 2012 and Current is August 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

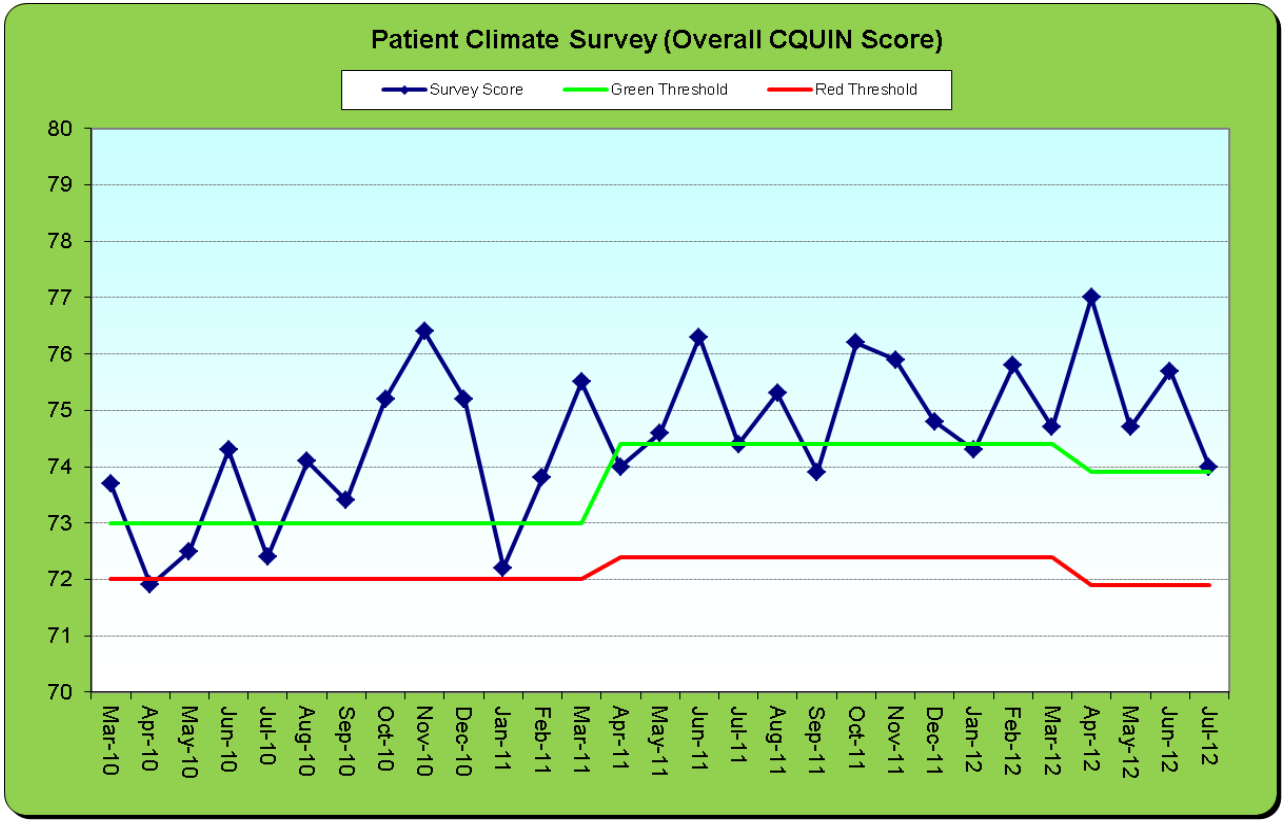
RAG (Red/Amber/Green) rating only applied to YTD where an agreed target number of cases/score exists for the year.

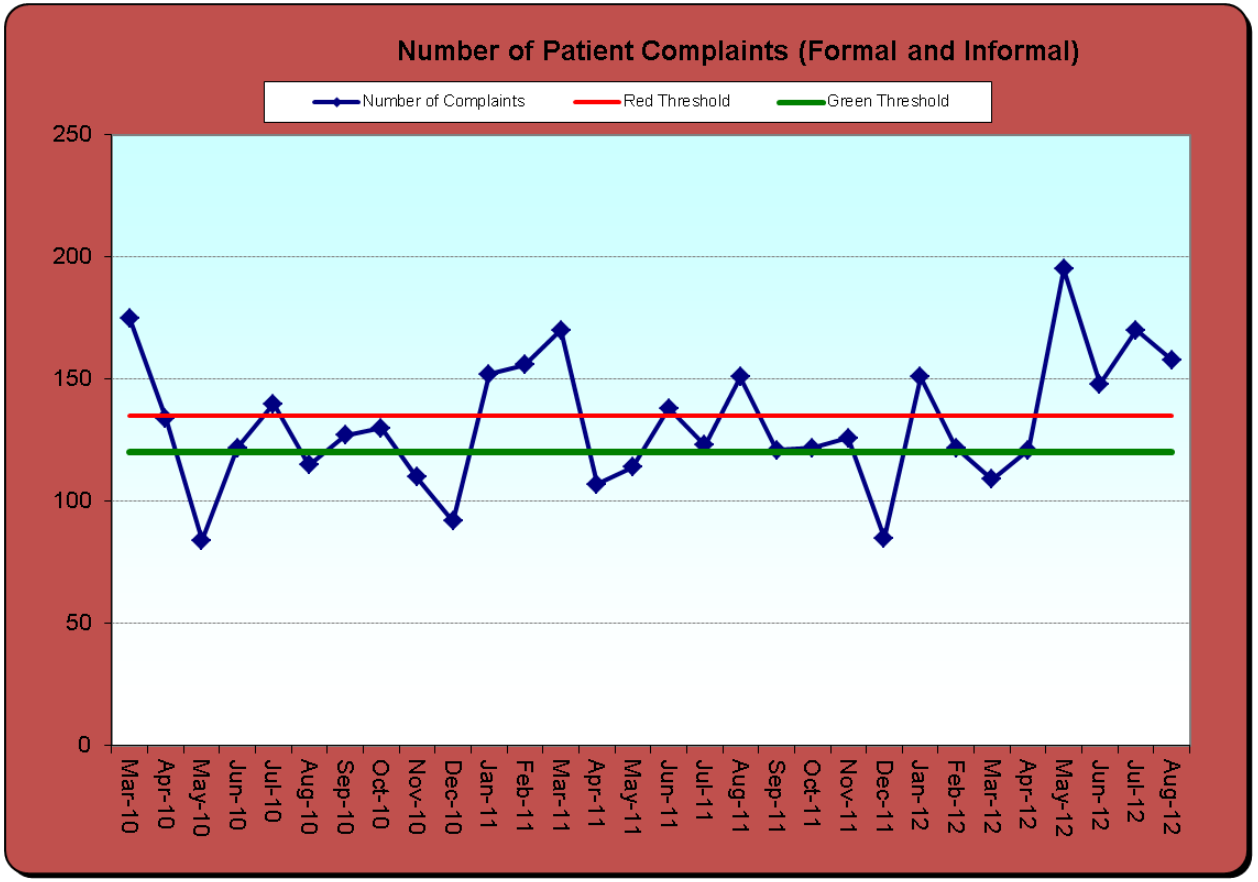
PERFORMANCE OVERVIEW

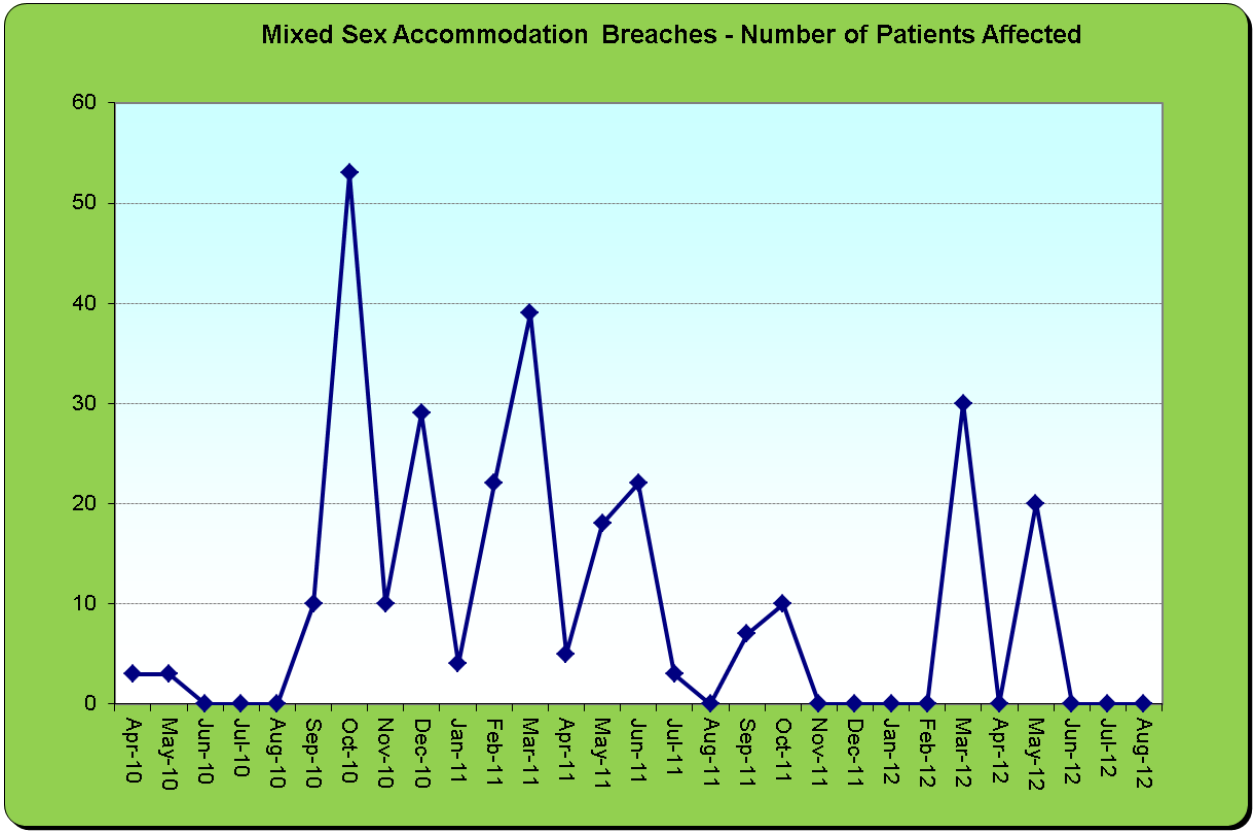
Organisational Health Barometer – exceptions summary table

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	
Number of C. diff cases	In the *Quality* section of this report	
Number of Cancer Standards Failed	In the *Access* section of this report	
Elective Length of Stay	See additional information	Performance in August was 4.07 against a target of 3.64. As in the previous month, there was variation in length of stay across the specialties. But there was no single identifiable reason why elective length of stay had increased, other than possibly due to changes in case mix.
Staff sickness	In the *Workforce* section of this report	
Contract Penalties Incurred	See additional information	The deterioration in estimated contract penalties incurred reflects the impact of Bristol North Somerset South Gloucestershire risk share, in combination with the application of the recently audited levels of avoidable readmission which the Trust will be penalised for under the national Readmission Policy.
Cash Releasing Efficiency Savings (CRES) achievement	In the Finance Report	

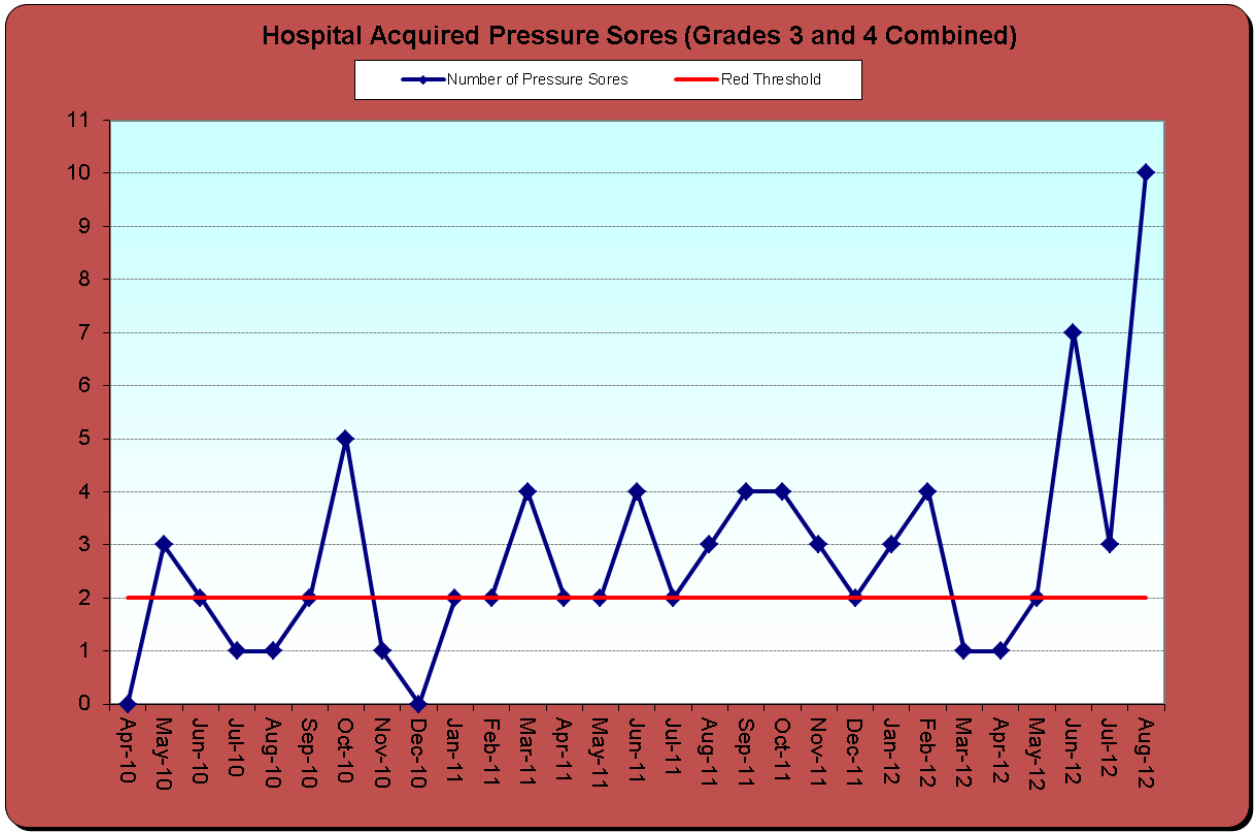
PERFORMANCE OVERVIEW



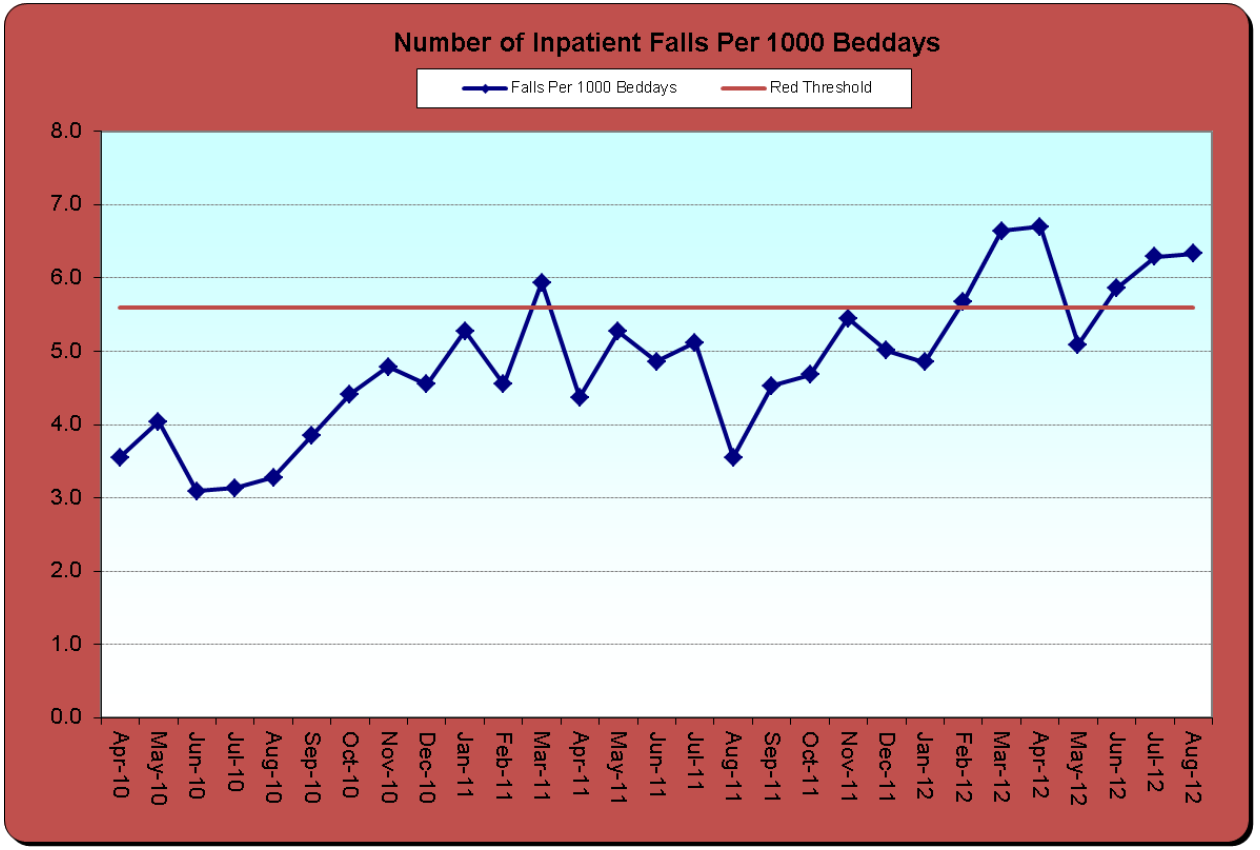

Number of Patient Complaints (Formal and Informal)
Number of Complaints
Red Threshold
Green Threshold
250
200
150
100
50
0
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12

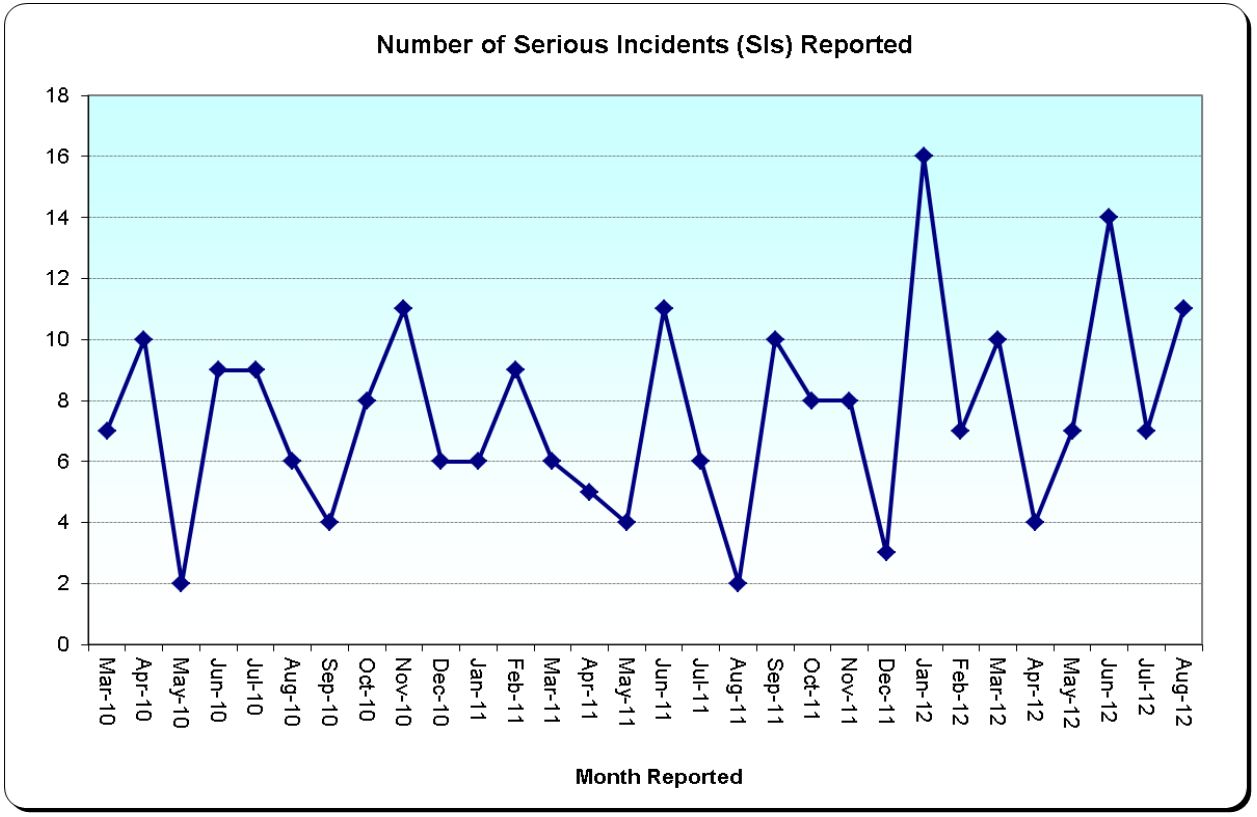

Mixed Sex Accommodation Breaches - Number of Patients Affected
60
50
40
30
20
10
0
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12

PERFORMANCE OVERVIEW

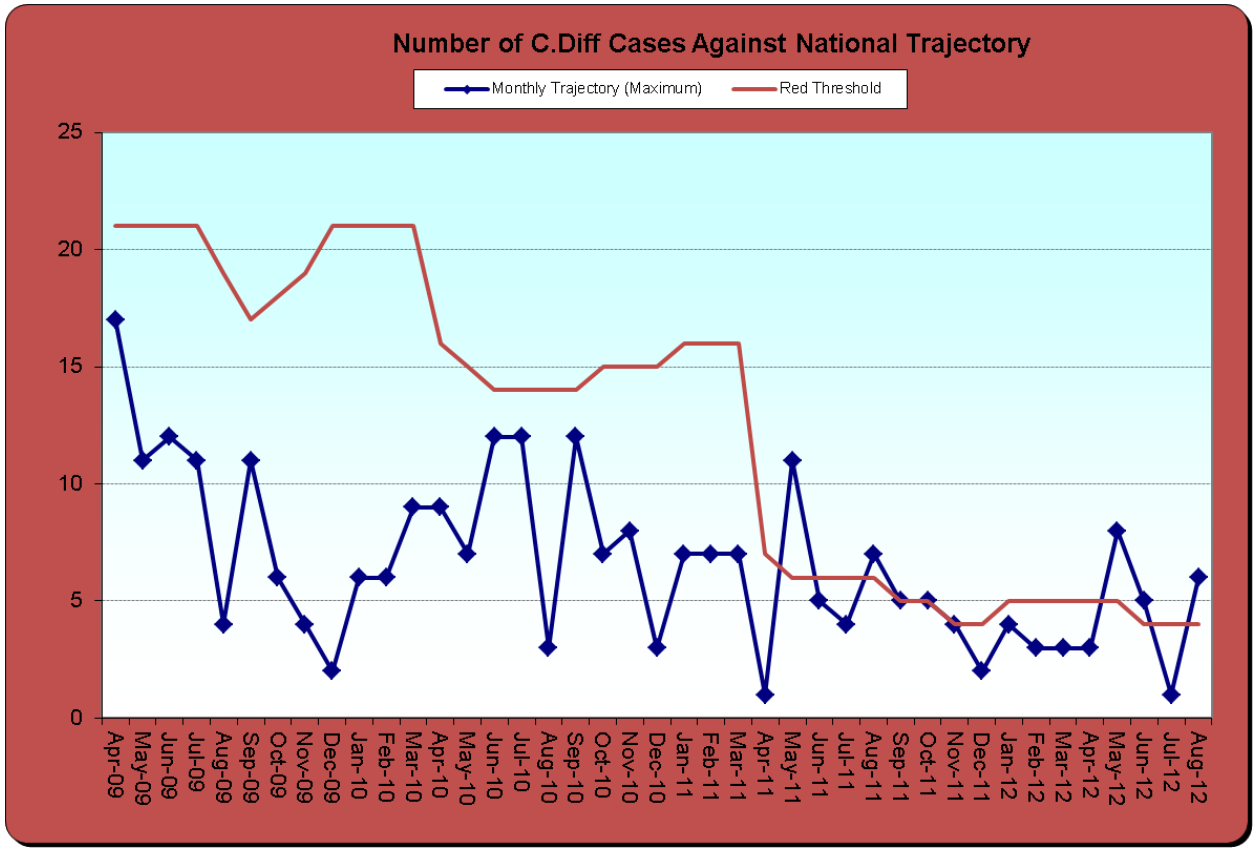


PERFORMANCE OVERVIEW

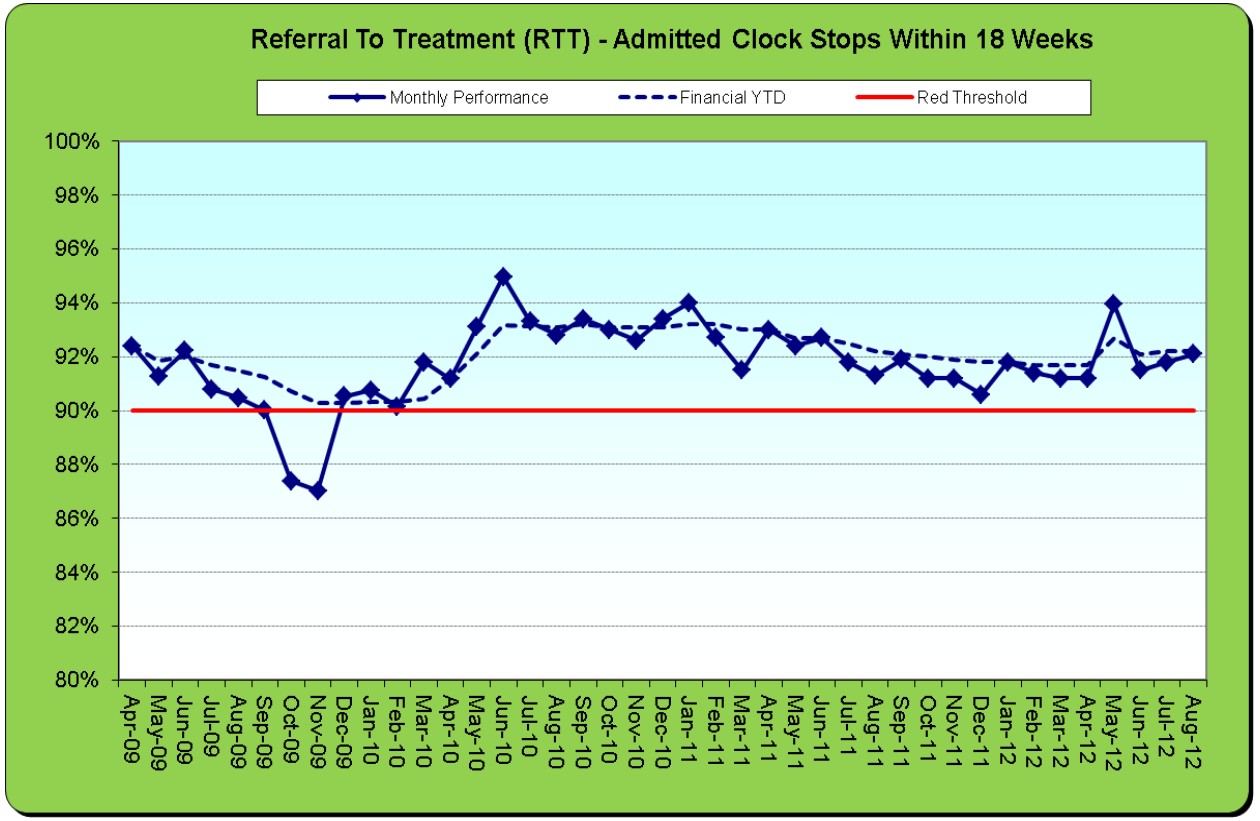



Number of Serious Incidents (SIs) Reported
18
16
14
12
10
8
6
4
2
0
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Month Reported

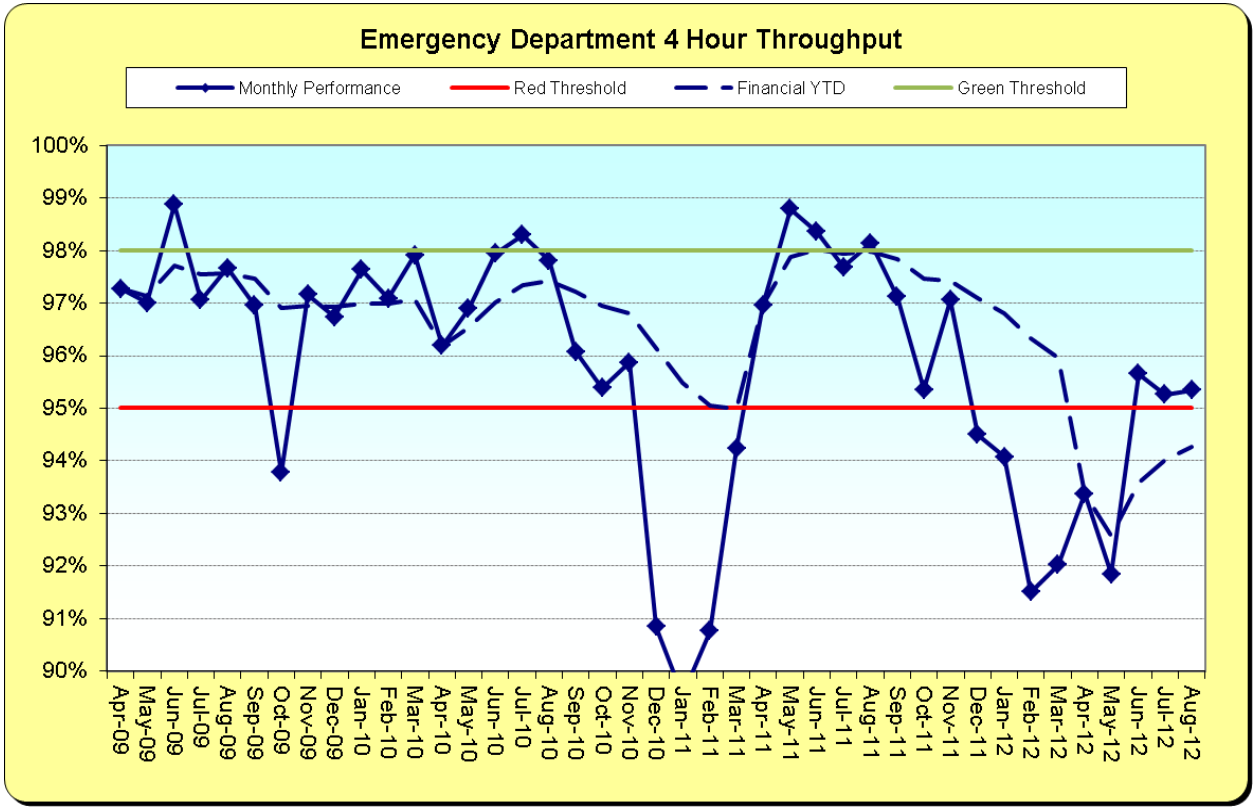
PERFORMANCE OVERVIEW



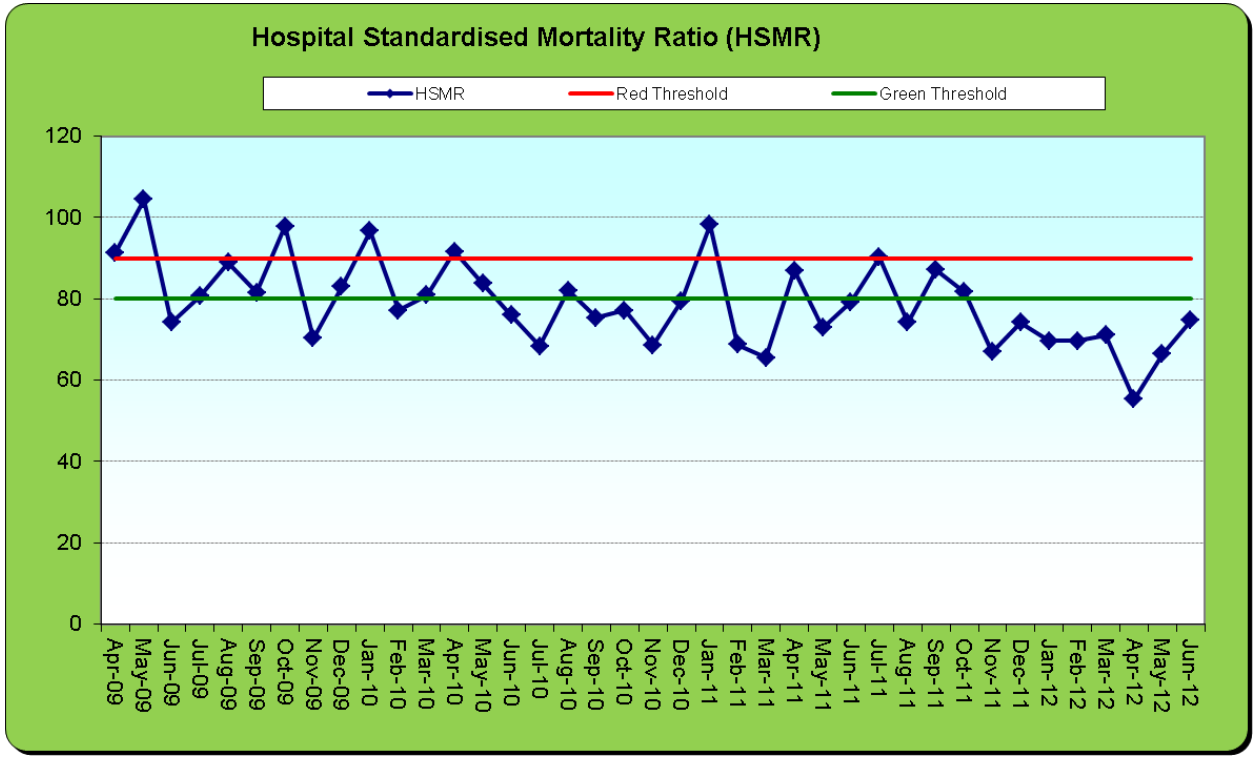
PERFORMANCE OVERVIEW



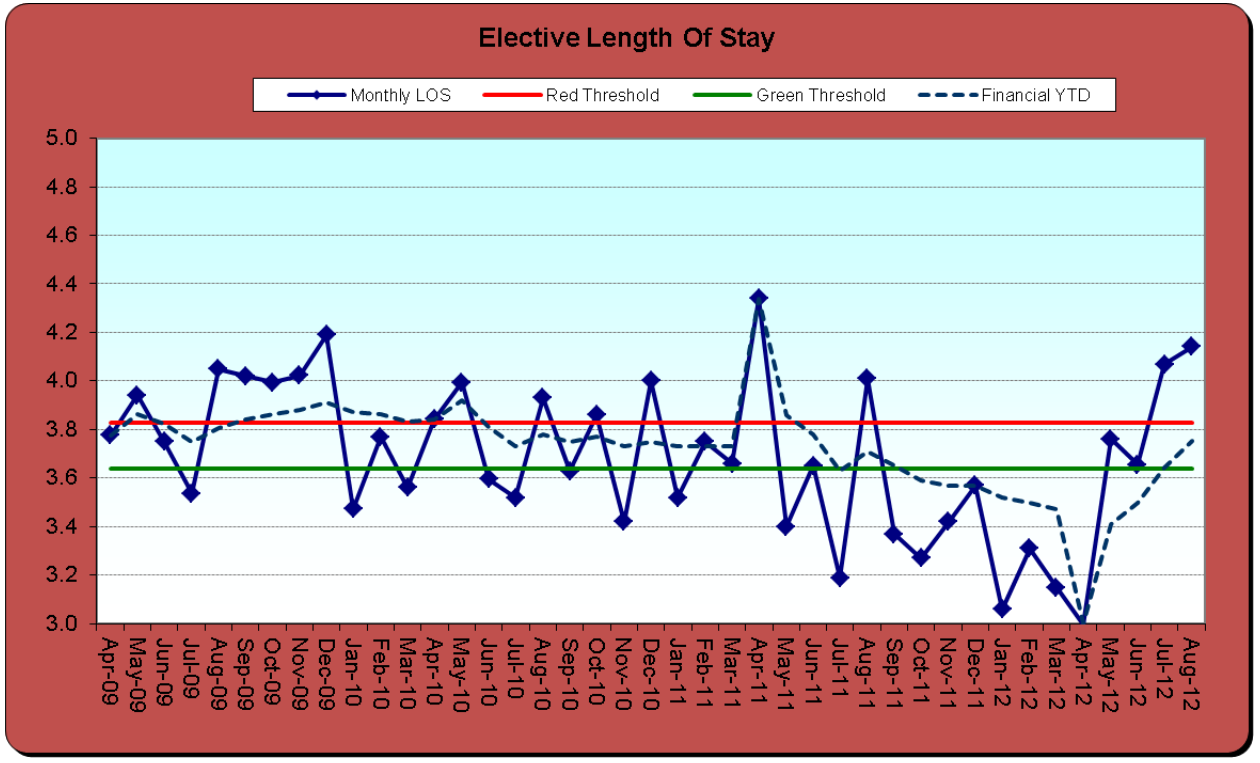
PERFORMANCE OVERVIEW

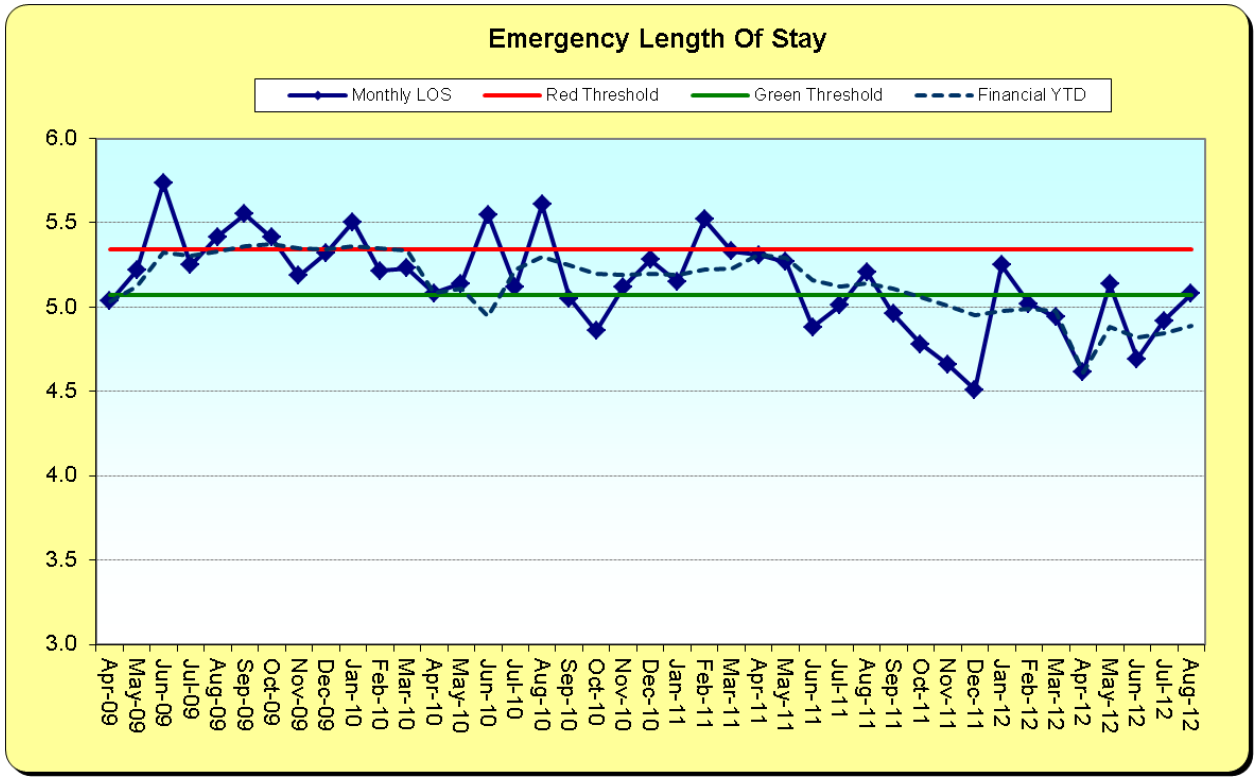


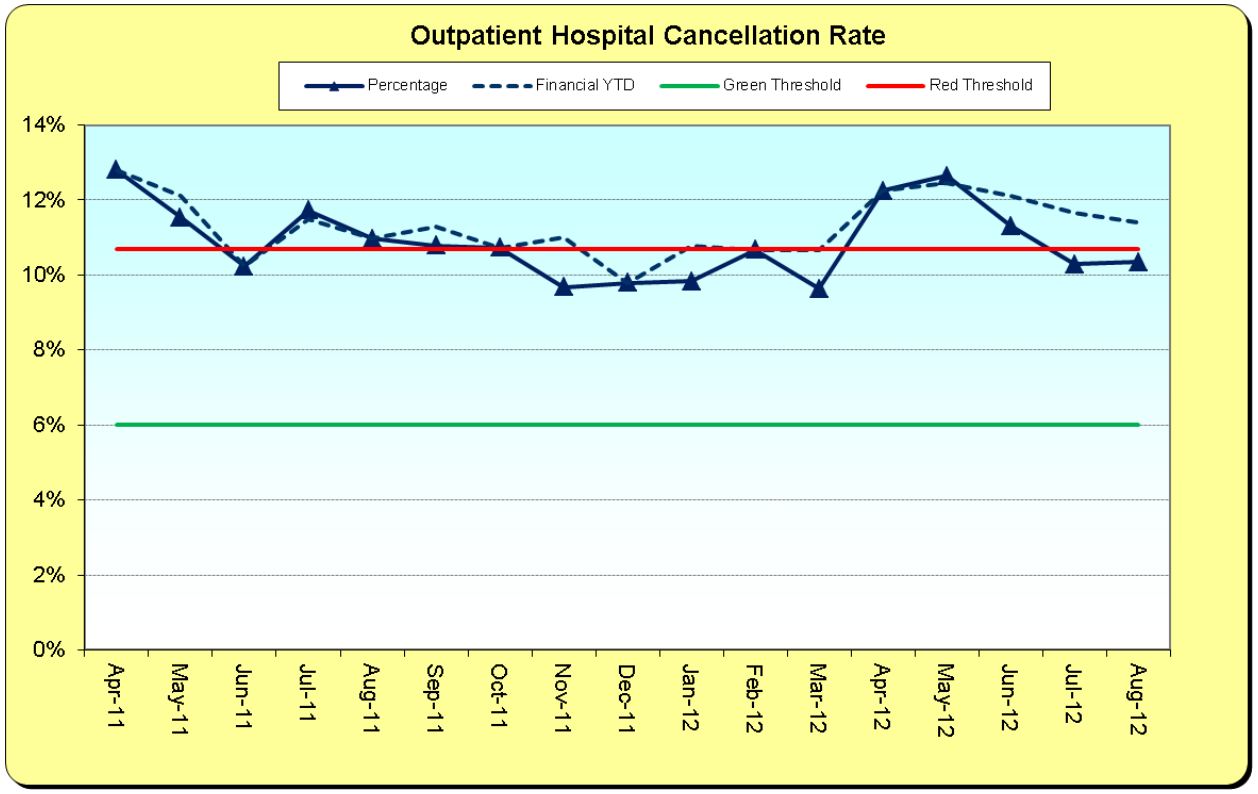
PERFORMANCE OVERVIEW



PERFORMANCE OVERVIEW




Emergency Length Of Stay
Monthly LOS
Red Threshold
Green Threshold
Financial YTD
6.0
5.5
5.0
4.5
4.0
3.5
3.0
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
Jul-10
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
Jul-12
Aug-12


Outpatient Hospital Cancellation Rate
Percentage
Financial YTD
Green Threshold
Red Threshold
14%
12%
10%
8%
6%
4%
2%
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
Jul-12
Aug-12

SECTION C – Monitor's Compliance Framework

At the end of August 2012 the Trust is achieving all of the targets in Monitor's 2012/13 Compliance Framework, with the exception of the 62-day cancer standards and the *Clostridium difficile* trajectory.

The current position against the national cancer standards is based upon the confirmed figures for July and draft performance figures for August. The final August figures will be submitted as part of the national return at the beginning of October. The 62-day referral to treatment standard for GP referred patients is expected to be met for the quarter as a whole. However, there are currently risks to the achievement of the 62-day referral to treatment standard for screening referred patients, based upon performance for the quarter to date. On the basis of the number of cases for the quarter to date, the *Clostridium difficile* trajectory will be exceeded at the end of the quarter. This is now reflected in the scoring against the Compliance Framework.

The following Exception Reports are therefore provided in this report:

- 62-day Referral to Treatment cancer standard for GP and screening referred patients – *Access section*
- *Clostridium difficile – Quality section*

The *Clostridium difficile* target has a weighting of 1.0 in the Compliance Framework. This currently gives the Trust an AMBER-GREEN Governance Risk Rating at this point in quarter 2. 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 2 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	*Q2 12/13 to date	Q2 Forecast*	Notes	Q2 Governance rating forecast
Monitor Compliance Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	23	✓	✓	✓	✖	23	✖	Cumulative trajectory: Q1 14; Q2 27; Q3 41; Q4 54	Not achieved
	2	Infection Control - MRSA Bloodstream Cases Against Trajectory	1.0	< or = trajectory	4	✓	✓	✓	2	4	✖	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%	95.5%	✓	✓	✓	✓	95.0%	✓		
	3c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	99.6%	✓	✓	✓	✓	98.9%	✓		
	4a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	87.4%	✓	✓	✓	✓	84.4%	✓	Currently at risk for the quarter	Achieved
	4b	Cancer 62 Day Referral To Treatment (Screenings)		90%	92.4%	✖	✓	✓	✓	89.6%	✓		
	5	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	92.2%	Achieved each month	Achieved each month	Achieved each month	Achieved each	92.0%	✓		Achieved
	6	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	96.2%	Achieved each month	Achieved each month	Achieved each month	Achieved each	95.6%	✓		Achieved
	7	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	92.2%	Target not in effect			Achieved each	92.3%	✓		Achieved
	8	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	0.5	96%	96.3%	✓	✓	✓	✓	96.6%	✓	Expected to achieve in the quarter	Achieved
	9a	Cancer - Urgent Referrals Seen In Under 2 Weeks	0.5	93%	95.8%	✓	✓	✓	✓	94.4%	✓		Achieved
	9b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	95.9%	✓	✓	✓	✓	96.4%	✓		
	10	A&E Total time in A&E 4 hours (95th percentile)	1.0	95%	94.3%	✓	✓	✖	✖	95.3%	✓		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	Not applicable		Achieved
					rating	AMBER-GREEN	GREEN	AMBER-GREEN	AMBER-RED	AMBER-GREEN	AMBER-GREEN		1.0
													AMBER-GREEN

Please note: If the same 1.0 weighted indicator is failed in three successive quarters, an automatic RED rating is applied. 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. On further advice from Monitor, the quarterly C. diff trajectory has been amended. The target at the end of Q1 was failed. The year-end target remains 54 cases.

***Q2 Cancer figures based upon confirmed figures for July, and draft figures for August. The C diff and MRSA figures are now shown as the cumulative positions against the quarter-end target.**

QUALITY

1.1 PATIENT EXPERIENCE

Ms Y raised a concern via the on-line feedback page of the Trust's website. She described how she gave birth to her baby girl at St Michael's Hospital in March 2012 she commented that, in the delivery suite, the midwife who took care of her was excellent.

However, she goes onto say that she had a really long labour and eventually required the application of a vacuum extractor to deliver her daughter. In her complaint Ms Y writes that her episiotomy stitches were not done properly and that she still suffering because of this and that she had to go to a private hospital to be re-sutured. She also describes how the midwife who saw her baby on the day of discharge did not pick up that her baby was jaundiced and that subsequently she had to rush her back into hospital because of this.

In addition, Mrs Y says that the midwives in the labour ward didn't guide her properly as to how to avoid nappy rash. She was informed not to use any nappy rash cream until her daughter was six weeks old, whereas in Southmead midwives had advised her to use it from day five or six. She says that she is a non-UK born first time mother and things were totally new to her. She states she had some "bad and sad times". In summary, she says on the whole she was not very happy with the way doctors treated her.

Investigation

Ms Y's complaint was fully investigated by the Division and a written response provided to Ms Y with the additional offer of a meeting with the doctor in charge of her care to go through the issues she raised and explain more clearly what happened. The investigation into Ms Y's complaint indicates that one of the key elements which contributed to this complaint was the communication, and staff may not have fully appreciated the difficulties she was experiencing with the birth of her first child in a new country, nor checked the extent of Ms W's understanding of the information she was being given as English was not her first language.

Outcome

- In the response a sincere apology was given to Ms Y for the distress caused by her experience of our services, in particular that the episiotomy repair had not healed well and had caused her suffering. An offer was extended to Ms Y of an urgent review of this by one of our gynaecologists if this was still of concern to her. A full explanation of the issues she raised about her labour was provided.

- Ms Y's notes were checked and it was confirmed that the midwife who conducted the pre-discharge check of her daughter documented that her baby's colour was normal at approximately 40 hours old. The response explains that it is often the case that physiological jaundice does not appear until the baby is 72 hours old. It is normal practice to give all women an information leaflet about jaundice and discuss this with them at this point. The midwife who conducted the pre-discharge check offered a personal apology if this information was not provided.

- The response explains the rationale behind the advice given by midwives in preventing nappy rash. Barrier creams are not routinely advised as they reduce the effectiveness of disposable nappies when this is the mother's choice. Instead advice is given to keep the area clean and dry and

change the nappy regularly. However, should nappy rash occur, advice to treat this is to expose the area to the air when possible and keep it clean and dry, but may also include applying a cream.

Learning

The key learning point from this complaint is to raise awareness among staff that women who speak some English, but it is not their first language, may need additional time and explanation of key points of information about their ongoing care and that of their baby. This should include checking that they have understood key points of information and know who to contact for advice and, if required, accessing the Trusts interpreting service.

Patient information leaflets are available in other languages as required and their existence should be made known to patients who may find it helpful to have such information in their first language, even though they speak sufficient English to communicate on a day-to-day basis and to make their needs known.

1.2 QUALITY TRACKER

		ID	Title	Green Threshold	Year To Date	Monthly Totals												Quarterly Totals			
						Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Q3	Q4	Q1	Q2
Patient Safety	Infection Rates	PS-A1	MRSA Bloodstream Cases Against Trajectory - Monthly Totals	<Traj.	4	0	1	0	0	0	0	2	1	1	0	1	1	1	2	2	2
		PS-A2	C.Diff Infections Against National Trajectory - Monthly Totals	<Traj.	23	5	5	4	2	4	3	3	3	8	5	1	6	11	10	16	7
		PS-A3	MSSA Cases Against Trajectory	<Traj.	14	4	5	2	3	3	3	2	3	4	4	3	0	10	8	11	3
		PS-A4	Number of GRE Bacteraemias	<3 mth	9	1	0	0	2	0	3	0	2	2	1	4		2	3	5	4
		PS-A5	E. Coli Bloodstream Infections		102	28	20	12	16	18	12	20	23	24	16	21	18	48	50	63	39
	Infection Control	PS-A6	MRSA Pre-Op Elective Screenings	95%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.6%	100.0%				
		PS-A7	MRSA Emergency Screenings	95%	93.2%	93.2%	93.4%	94.1%	93.8%	94.1%	94.4%	92.0%	92.2%	93.8%	92.3%	93.9%	93.5%				
		PS-A8	Hand Hygiene Audit Compliance	95%	97.4%	97.3%	97.2%	96.2%	98.5%	98.3%	98.2%	98.3%	98.0%	98.2%	97.1%	97.8%	95.7%				
		PS-A9	Antibiotic Compliance	90%	84.0%	76.7%	81.5%	83.3%	82.9%	86.8%	84.2%	83.7%	80.6%	84.7%	84.2%	85.1%	85.9%	82.7%	84.9%	83.0%	85.5%
		PS-A10	Matron's Checklist	95%	94.0%	94.5%	95.2%	94.9%	95.2%	95.5%	96.4%	98.8%	97.3%	95.6%	93.4%	91.5%	94.0%	95.1%	96.3%	94.9%	93.6%
	Cleanliness	PS-A11	Cleanliness Monitoring - Overall Score	95%		96%	95%	96%	94%	96%	95%	96%	96%	95%	95%	94%	94%				
		PS-A12	Cleanliness Monitoring - Very High Risk Areas	95%		97%	97%	96%	95%	96%	96%	96%	96%	97%	96%	96%	97%				
		PS-A13	Cleanliness Monitoring - High Risk Areas	95%		97%	96%	97%	96%	95%	96%	96%	96%	95%	95%	95%	96%				
	Incidents	PS-B1	Number of Serious Incidents (SIs) Reported		43	10	8	8	3	16	7	10	4	7	14	7	11	19	33	25	18
		PS-B2	Number of Serious Incidents (SIs) as a Proportion of Activity																		
		PS-B3	Serious Incidents Reported Within 48 Hours	80% (Q3)	88%	50%	62%	75%	33%	69%	86%	80%	75%	86%	93%	100%	82%	63%	76%	88%	89%
		PS-B4	Percentage of Serious Incident (SI) Investigations Completed Within Timescale	80% (Q3)	88%	100%	100%	100%	57%	71%	86%	92%	88%	100%	100%	88%	77%	79%	85%	95%	81%
		PS-B5	Total Never Events	0	1	0	0	0	0	0	0	1	0	0	0	0	1	0	1	0	1
		PS-B6	Total Number of Patient Safety Incidents Reported		4836	688	839	782	778	755	807	892	803	850	955	1141	1087	2399	2454	2608	2228
		PS-B7	Patient Safety Incidents Reported per 100 Admissions		9.2	6.6	8.0	7.5	7.8	7.0	7.8	8.0	8.2	7.9	9.3	10.3	10.4	7.8	7.6	8.4	10.4
	Falls	PS-C1	Number of Inpatient Falls Per 1,000 Beddays	<5.6	6.04	4.54	4.68	5.45	5.01	4.84	5.68	6.64	6.70	5.09	5.86	6.29	6.33	5.04	5.72	5.86	6.31
		PS-C2	Repeat Inpatient Falls		23.9%	13.4%	28.6%	17.7%	27.9%	23.3%	13.4%	19.6%	12.9%	28.7%	30.9%	18.4%	26.9%	24.7%	18.6%	24.7%	23.1%
		PS-C3	Number of Inpatient Falls - Patients Aged 65 And Over		578	78	87	96	92	98	94	125	116	101	103	123	135	275	317	320	258
		PS-C4	Number of Inpatient Falls - Patients With Cognitive Impairment		323	44	48	47	51	60	43	61	62	57	63	66	75	146	164	182	141
	Pressure Ulcers Developed in the Trust	PS-D1	Total Pressure Ulcer Incidence per 1,000 Bed Days	<0.651	1.46	1.40	2.12	1.52	1.41	1.64	1.57	1.58	1.37	1.30	1.61	1.34	1.71	1.69	1.60	1.42	1.52
		PS-D3	Number of Hospital Acquired Grade 2 Pressure Ulcers	<83 yr	161	29	49	33	32	33	33	39	32	32	33	31	33	114	105	97	64
		PS-D4	Number of Hospital Acquired Grade 3 Pressure Ulcers	<1	21	4	4	3	1	2	3	1	1	1	7	3	9	8	6	9	12
		PS-D5	Number of Hospital Acquired Grade 4 Pressure Ulcers	<1	2	0	0	0	1	1	1	0	0	1	0	0	1	1	2	1	1
	Pressure Ulcers Present On Admission	PS-D6	Number of Grade 2 Pressure Ulcers Present On Admission		290					47	45	44	41	52	61	70	66		136	154	136
		PS-D7	Number of Grade 3 Pressure Ulcers Present On Admission		73					7	9	8	6	6	16	19	26		24	28	45
		PS-D8	Number of Grade 4 Pressure Ulcers Present On Admission		25					7	0	4	4	3	6	6	6		11	13	12
	Venous Thrombo-embolism (VTE)	PS-E1	Adult Inpatients who Received a VTE Risk Assessment	90%	97.4%	97.6%	97.5%	98.0%	98.4%	98.2%	98.4%	98.9%	98.7%	93.3%	95.3%	96.5%	95.1%	98.0%	98.5%	97.8%	95.7%
		PS-E2	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	90%	98.4%	89.6%	97.5%	89.7%	97.5%	96.0%	92.5%	97.4%		97.8%	98.4%	98.9%	98.4%	94.4%	95.3%	98.1%	98.6%
	Nutrition	PS-F1	Fully Completed Nutritional Screening Within 24 Hours	90%	86.5%	92.0%			83.5%			85.9%			86.5%			83.5%	85.9%	86.5%	
		PS-F4	Protected Mealtimes Observed (Adult Inpatients)	95%	90.0%										90.0%					90.0%	
		PS-F2	Malnutrition Risk Identified in Adults	90%	78.9%										78.9%					78.9%	
		PS-F3	Malnutrition Risk Identified in Children	90%	85.8%										85.8%					85.8%	
	Safety	PS-G1	WHO Surgical Checklist Compliance	98%	98.0%	97.7%	97.0%	97.3%	97.5%	98.7%	98.4%	99.0%	95.4%	98.7%	99.4%	98.4%	98.1%	97.3%	98.7%	97.8%	98.2%
	Medicines Reconcilliation	PS-H1	Medication Reconciliation Performed Within 1 Day of Admission.																		
		PS-H2	Non-Purposeful Omitted Doses of the Listed Critical Medication																		
	NHS Safety Thermometer	PS-J1	NHS Safety Thermometer - Coverage		100%									99%	100%	100%	100%			100%	100%
		PS-J2	NHS Safety Thermometer - Harm Free Care		91.4%									90.3%	91.4%	92.6%	91.5%			90.9%	92.1%
		PS-J3	NHS Safety Thermometer - No New Harms		95.9%									94.2%	95.8%	96.8%	96.9%			95.0%	96.9%

QUALITY

		ID	Title	Green Threshold	Year To Date	Monthly Totals												Quarterly Totals			
						Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Q3	Q4	Q1	Q2
Patient Safety	Infection Rates	PS-A1	MRSA Bloodstream Cases Against Trajectory - Monthly Totals	<Traj.	4	0	1	0	0	0	0	2	1	1	0	1	1	1	2	2	2
		PS-A2	C.Diff Infections Against National Trajectory - Monthly Totals	<Traj.	23	5	5	4	2	4	3	3	3	8	5	1	6	11	10	16	7
		PS-A3	MSSA Cases Against Trajectory	<Traj.	14	4	5	2	3	3	3	2	3	4	4	3	0	10	8	11	3
		PS-A4	Number of GRE Bacteraemias	<3 mth	9	1	0	0	2	0	3	0	2	2	1	4		2	3	5	4
		PS-A5	E. Coli Bloodstream Infections		102	28	20	12	16	18	12	20	23	24	16	21	18	48	50	63	39
	Infection Control	PS-A6	MRSA Pre-Op Elective Screenings	95%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.6%	100.0%				
		PS-A7	MRSA Emergency Screenings	95%	93.2%	93.2%	93.4%	94.1%	93.8%	94.1%	94.4%	92.0%	92.2%	93.8%	92.3%	93.9%	93.5%				
		PS-A8	Hand Hygiene Audit Compliance	95%	97.4%	97.3%	97.2%	96.2%	98.5%	98.3%	98.2%	98.3%	98.0%	98.2%	97.1%	97.8%	95.7%				
		PS-A9	Antibiotic Compliance	90%	84.0%	76.7%	81.5%	83.3%	82.9%	86.8%	84.2%	83.7%	80.6%	84.7%	84.2%	85.1%	85.9%	82.7%	84.9%	83.0%	85.5%
		PS-A10	Matron's Checklist	95%	94.0%	94.5%	95.2%	94.9%	95.2%	95.5%	96.4%	98.8%	97.3%	95.6%	93.4%	91.5%	94.0%	95.1%	96.3%	94.9%	93.6%
	Cleanliness	PS-A11	Cleanliness Monitoring - Overall Score	95%		96%	95%	96%	94%	96%	95%	96%	96%	95%	95%	94%	94%				
		PS-A12	Cleanliness Monitoring - Very High Risk Areas	95%		97%	97%	96%	95%	96%	96%	96%	96%	97%	96%	96%	97%				
		PS-A13	Cleanliness Monitoring - High Risk Areas	95%		97%	96%	97%	96%	95%	96%	96%	96%	95%	95%	95%	96%				
	Incidents	PS-B1	Number of Serious Incidents (SIs) Reported		43	10	8	8	3	16	7	10	4	7	14	7	11	19	33	25	18
		PS-B2	Number of Serious Incidents (SIs) as a Proportion of Activity																		
Clinical Effectiveness	Mortality	CE-A1	Hospital Standardised Mortality Ratio (HSMR)	<=80		87.1	81.7	67	74.2	69.6	69.7	71.1	55.3	66.4	74.7						
		CE-A2	Summary Hospital Mortality Indicator (SHMI)	<=80	66.5	75.1	69.2	63.5	67.9	71.8	68.9	64.2	59.2	69.4	70.6			66.9	68.2	66.5	
	Learning Disability	CE-D1	Risk Assessment of Patients with Known Learning Disability within 48 Hours	85%	80.5%	87.5%	85.7%	81.8%	83.3%	100.0%	100.0%	88.9%	92.9%	63.6%	68.4%	90.5%	82.4%	83.3%	95.5%	75.0%	86.8%
		CE-D2	Risk Assessment of Paediatric Patients with Learning Disability within 48 Hours	85%																	
	Readmissions	CE-E1	Emergency Readmissions Within 30 Days	<3.36%	3.1%	3.5%	3.7%	3.4%	3.5%	3.2%	2.9%	2.9%	2.7%	3.2%	3.2%	3.1%		3.5%	3.0%	3.0%	3.1%
	Maternity	CE-G1	Percentage of Spontaneous Deliveries Compared to All Births	64.3%	64.4%	57.8%	63.8%	62.0%	62.5%	65.8%	62.6%	66.7%	67.8%	61.3%	62.3%	66.7%	63.5%	62.8%	65.1%	63.9%	65.2%
	Fracture Neck of Femur	CE-H1	Fracture Neck of Femur Patients Treated Within 36 Hours	95%	67.0%	53.8%	44.8%	57.7%	54.5%	56.2%	58.8%	92.3%	80.0%	61.3%	62.5%			52.3%	70.5%	67.0%	
		CE-H2	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72hours	95%	81.8%	84.6%	86.2%	61.5%	87.9%	84.4%	76.5%	79.5%	80.0%	93.5%	71.9%			79.5%	80.0%	81.8%	
		CE-H3	Fracture Neck of Femur Patients Achieving Best Practice Tariff	90%	51.1%	46.2%	41.4%	38.5%	51.5%	56.2%	44.1%	53.8%	64.0%	54.8%	37.5%			44.3%	51.4%	51.1%	
	Stroke Care	CE-J1	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	50%	49.5%	37.9%	28.6%	24.3%	25.7%	33.3%	46.4%	50.0%	41.2%	42.1%	59.1%	56.2%		26.0%	44.1%	46.8%	56.2%
		CE-J2	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	80%	69.4%	97.1%	85.7%	87.8%	81.4%	65.8%	68.3%	64.3%	82.1%	55.1%	71.9%	73.0%		84.9%	66.1%	68.3%	73.0%
		CE-J3	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	58.67%	77.78%	75.00%	64.29%	72.22%	52.63%	59.09%	71.43%	83.33%	57.14%	53.85%	52.38%	53.33%	70.45%	60.00%	64.10%	52.78%

Patient Experience	Single Sex Accom.	PE-A1	Same Sex Accommodation Breaches - Number of Patients	0	20	7	10	0	0	0	0	30	0	20	0	0	0	10	30	20	0
	Patient Survey Responses	PE-B1	Patient Survey - Overall CQUIN Score	73.9		74	76	76	75	74	76	75	77	75	76	74		76	75	75	74
		PE-B2	Monthly Patient Survey - Noise At Night	84-86		80	83	82	82	80	81	79	83	81	82	82		82	80	82	82
		PE-B3	Monthly Patient Survey - Explaining Medication Side Effects	61-64		59	59	59	56	59	61	60	59	61	64	58		58	60	61	58
		PE-B4	Monthly Patient Survey - Maternity Services	85		82			80			86			85	85		80	86	85	85
		PE-B5	Monthly Patient Survey - Patients Who Would Recommend The Trust	92%		96%	95%	97%	96%	96%	97%	96%	96%	95%	96%	95%		96%	96%	96%	95%
	Patient Complaints	PE-C2	Patient Complaints as a Proportion of all Activity	<0.25%	0.4%	0.2%	0.3%	0.2%	0.2%	0.3%	0.2%	0.2%	0.3%	0.4%	0.4%	0.4%	0.4%	0.2%	0.3%	0.4%	0.4%
		PE-C3	Percentage of Complaints Resolved Within Timeframe (Formal Complaints)	98%	94.9%	92.6%	90.2%	90.9%	84.2%	81.4%	95.2%	94.3%	96.7%	94.5%	94.7%	94.2%	94.8%	88.7%	91.2%	95.2%	94.5%
		PE-C6	Complainants Disatisfied with Response (Not Responded In Full)		12		6	1	0	0	0	2	2	3	4	0	3	7	2	9	3

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

<u>Please note:</u> The final details of the measures for PS-H1 and PS-H2 are still under discussion with commissioners and should be available for the end of Q2.

QUALITY

1.3 SUMMARY

The Quality dashboard has been reviewed and updated as planned. A number of new metrics have been added to reflect priorities for 2012/13. These have been selected through the CQUIN framework in commissioning contracts, and some of which are about developing improvements in-year to reach the required target by Q3 or Q4. In addition, the revised dashboard contains internally identified areas for quality improvement largely about working towards best practice standards. Some previous measures have been removed and some have been refined whilst others remain unchanged. There will be further developments to the dashboard in year.

Achieving set threshold (19)	**Thresholds not met or no change on previous month (7)**
- MSSA (Meticillin Sensitive *Staphylococcus aureus*) cases against trajectory - MRSA (Meticillin Resistant *Staphylococcus aureus*) screening – elective - MRSA (Meticillin Resistant *Staphylococcus aureus*) screening – emergency - Hand Hygiene Audit - Cleanliness monitoring very high risk areas - Cleanliness monitoring high risk areas - Serious Incidents reported with 48 hours - 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 - NHS Safety Thermometer-coverage - Hospital Standardised Mortality Ratio (HSMR) - Summary Hospital Mortality Indicator (SHMI) - Stroke care: percentage receiving brain imaging within 1 hour - 30 day emergency re-admissions - Number of breaches of the same sex accommodation standard - Patient experience overall CQUIN score - Monthly patient survey: patients who would recommend the Trust - Number of complainants dissatisfied with the response (not responded in full)	- Antibiotic prescribing compliance - Matrons checklist (*C. difficile* dashboard) - Cleanliness monitoring overall Trust score - Number of hospital acquired grade 4 pressure ulcers - Monthly patient survey: noise at night - Monthly patient survey: explain medication side effects - Percentage of complaints resolved within formal timescale

QUALITY

Quality metrics not achieved or requiring attention (17)	Quality metrics not rated (19)
- MRSA (Meticillin Resistant *Staphylococcus aureus*) bloodstream cases against trajectory - *Clostridium difficile* cases against national trajectory - GRE (Glycopeptide Resistant *Enterococci*) Bacteraemias - Serious incident investigations completed within required timescales - Never Events - In-patient falls incidence per 1,000 bed days - Total pressure ulcer incidence per 1,000 bed days - Number of hospital acquired grade 2 pressure ulcers - Number of hospital acquired grade 3 pressure ulcers - Risk assessment of patients with known learning disability within 48 hours - Percentage of spontaneous deliveries compared to all births - 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 - Stroke care: percentage spending 90% + time on a stroke unit - High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours - Patient complaints as a proportion of all activity	**Quarterly metrics due to report at end of Q2** - Fully completed nutritional screening within 24 hours - Protected mealtimes observed (adult inpatients) - Malnutrition risk identified in adults - Malnutrition risk identified in children **Data not available** - Medicines reconciliation performed within one day of admission - Non-purposeful omitted doses of listed critical medication - Risk assessment of paediatric patients with learning disability within 48 hours **Thresholds not yet applicable** - E coli *(Escherichia coli*) blood stream infections - NHS Safety thermometer-harm free care - NHS Safety thermometer-no new harms - 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 - Number of Grade 2 pressure ulcers present on admission - Number of Grade 3 pressure ulcers present on admission - Number of Grade 4 pressure ulcers present on admission

QUALITY

Summary of Performance against Commissioning for Quality and Innovation (CQUIN) Quality Dashboard Metrics

The Board is asked to note that CQUINs 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 July was 74 against a target of 73.9.
- Patient Experience: reducing noise at night. Score for July was 82 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 July was 58 against a target of 64 to be achieved by Q3.
- Patient Experience: patients who would recommend the Trust. This is a new CQUIN for 2012/13. Score for July 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:

- *Clostridium difficile* cases against national trajectory up ↑ from one in July to 6 in August.
- Number of Glycopeptide Resistant *Enterococci* up ↑ from 1 in June to 4 in July
- Number of grade 3 pressure ulcers up ↑ from 3 in July to 9 in August

1.5 EXCEPTION REPORTS

Exception reports are provided for 17 RED rated indicators and two further indicators* which is amber rated, 19 indicators in total.

1. MRSA (Meticillin Resistant *Staphylococcus aureus*) bloodstream cases against trajectory
2. GRE (Glycopeptide resistant *enterococci*) bacteraemias
3. Antibiotic prescribing compliance*
4. *Clostridium difficile* cases against national trajectory
5. Serious incident investigations completed within required timescales
6. Never Events
7. In-patient falls incidence per 1,000 bed days
8. Total pressure ulcer incidence per 1,000 bed days
9. Number of hospital acquired grade 2 pressure ulcers
10. Number of hospital acquired grade 3 pressure ulcers
11. Risk assessment of patients with known learning disability within 48 hours
12. Percentage of spontaneous deliveries compared to all births
13. Fractured neck of femur patients treated with 36 hours
14. Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours
15. Fractured neck of femur patients achieving best practice tariff
16. Stroke care: percentage spending 90% + time on a stroke unit
17. High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours
18. Patient complaints as a proportion of all activity
19. Number of complainants dissatisfied with the response (not responded in full)*

QUALITY

Q1. EXCEPTION REPORT: Meticillin Resistant Staphylococcus Aureus (MRSA) cases against trajectory Q2. EXCEPTION REPORT: GRE (Glycopeptide resistant enterococci) bacteraemias	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Q1: The number of patients in hospital for more than two days who acquire MRSA bacteraemia. The target for 2012/13 is two. This target has no financial penalties but does contribute to the Monitor Compliance Framework.

Q2: The number of cases of GRE (Glycopeptide resistant enterococci) bacteraemias

Performance in the period, including reasons for the exception:

There was one Trust apportioned case of MRSA in August 2012 at South Bristol Community Hospital. The actual number of cases in 2012/13 to the end of August is four, two over the annual target.

There were four cases of GRE bacteraemia in August against and internally set target of no more than two cases per month. These are usually antibiotic related.

Recovery plan, including expected date performance will be restored.

Widespread screening for MRSA is undertaken in the Trust. All post-48 hour cases are investigated by the clinical team. A Root Cause Analysis is completed. Learning is shared at the Infection Control Operational meeting chaired by the Deputy Chief Nurse and the multi-disciplinary teams within the ward area. 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.
- Discussions are being held with the Microbiologist and laboratory to increase screening further.
- The Drug Liaison Nurse is informed when a patient who is an intravenous drug user has been admitted to the Trust and is MRSA positive. They will follow up the patient to encourage them to sustain topical treatment as prescribed and act on preventative advice and information provided.
- 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.

QUALITY

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

For GRE bacteraemias, in addition to the management of intravenous lines described above a review of antibiotics prescribed will take place for each patient.

QUALITY

Q3. EXCEPTION REPORT: *Clostridium difficile* cases against trajectory	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The number of *Clostridium difficile* cases for patients in hospital for more than 3 days. The national reduction objective set centrally is 54 cases in year (including a potential 20% increase due to new diagnostic methods). Financial penalties are not linked to the national target but occur if a ceiling of 64 cases is breached in 2012/13.

Monitor measurement period: Quarterly; the cumulative target for Quarter 2 = 27 (targets for each quarter: Q1 = 14; Q2 = 13); a total of 7 cases reported at the end of August for the quarter to date.

Performance in the period, including reasons for the exception:

There were six Trust apportioned cases of *Clostridium difficile* in August 2012.

Division	Target	Number of target cases
Medicine	2	1
Surgery, Head and Neck	1	2
Women's and Children	0	1
Specialised Services	1	2

The Divisions of Surgery Head & Neck, Specialised Services and Women's & Children's exceeded their monthly target in August. The six cases in August follows a month of good performance with *Clostridium difficile* with one case reported in July 2012. The cumulative cases from July to August 2012 is 7, taking the total to 23 cases reported by the end of August for the year to date.

All cases of *Clostridium difficile* infection are investigated by the Infection Control team using a modified root cause analysis process.

Recovery plan, including expected date performance will be restored:

The Infection Control Operational meeting is held monthly chaired by the Deputy Chief Nurse. New and existing cases are reviewed and implementation of prevention measures monitored.

QUALITY

- Positive patients are admitted to the cohort ward.
- Specimens are being sent when staff have contacted the of the Infection Control Team/Microbiologist and Matrons for advice.
- The Trust risk assessment and stool chart has been re-sent to Heads of Nursing and Matrons for redistribution to all areas.
- Specimen sending guidelines have been re-sent to Heads of Nursing and Matron for redistributing to all areas.
- Trust-wide email sent to remind staff of the five elements of the Trust's **FLUSH** *Clostridium difficile* prevention bundle: As stated below.
    - **F**ollow antibiotic guidelines
    - **L**ocation of patients with *Clostridium difficile* and diarrhoea in isolation.
    - **Us**e and remove protective clothing correctly
    - **S**potlessly clean environment and equipment.
    - **H**and washing with soap and water

These actions will be monitored through the monthly Infection Control operational meeting and through the exception reporting to the Service Delivery Group fortnightly.

QUALITY

Q4. 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 rose by 0.8% from 85.1% in July to 85.9% in August. This is the first August we have not seen a dip in compliance with the change-over of doctors.

Compliance improved this month in:

- Women's & Children's - 90.9%, an increase from 81.1% in July; this is the first time Women's & Children's have achieved above the target of 90%
- Specialised Services - 90.6%, a rise from 88.9% in July
- Surgery, Head & neck - 82.5%, a rise from 81.2% in July

Compliance fell this month in:

- Medicine - 84%, a fall from 87.6% in July

Reasons for the exception:

- 64 of 647 prescriptions audited in August did not include a valid stop or review date. This continues to be the main cause of failure to reach the 90% target.

Recovery plan, including expected date performance will be restored:

- Continue with joint microbiology/ pharmacy review rounds.

QUALITY

- A revised adult version of the drug chart is now available and has been rolled-out through the Trust. 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. The paediatric drug chart is being reviewed.
- Continue to monitor through Divisional Boards.
- A list of all doctors within the trust has been obtained; this will aid the feedback of compliance to prescribers.

QUALITY

Q5. EXCEPTION REPORT: Serious Incident investigations completed within timescale Q6. EXCEPTION REPORT: Never Event	RESPONSIBLE DIRECTOR: Medical Director/Chief Nurse

Description of how the standard is measured:

Q5. Serious incidents are required to be investigated and a report provided to NHS Bristol within timeframes set out in the National Framework for Reporting and Learning from Serious Incidents (SIs) Requiring Investigation: 45 days for a Grade 1 SI and 60 days for a Grade 2 SI.

Q6. Never events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. There are currently 25 listed by the Department of Health for 2012/13. The Never Event which occurred was "Unintended retention of a foreign object in a patient after a surgical intervention including interventional radiology, cardiology and vaginal birth".

Performance in the period, including reasons for the exception:

Q5. Thirteen serious incident investigations were completed in August, and of these three breached their timescale = 77%. Of these three breaches, two were related to delays in finalising and signing off the reports for complex investigations. The third one was due to a delay in starting the investigation of the deterioration of a grade 2 pressure ulcer to a grade 3, because the patient had moved wards across Divisions during their stay and there was lack of clarity as to which Division was leading the investigation.

Q6. One Never Event occurred in August which involved a swab being left in situ following a forceps delivery which required an episiotomy and subsequent suturing of the perineum. A full investigation is underway, and the initial review suggested that the correct Standard Operating Procedure to prevent retained swabs was not fully complied with.

Recovery plan, including expected date performance will be restored:

Administrative support for serious incident review panels has been reviewed and a tracking system implemented.

Staff have been reminded of need for clear communication as to who is leading incident investigations in situations where the initially identified lead is not thought to be the best placed individual to conduct the investigation.

The occurrence of the Never Event and importance of complying with the correct Standard Operating Procedure to prevent retained swabs has immediately been communicated to staff in maternity services, pending the outcome of the investigation and further learning identified from this.

QUALITY

Q7. 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 6.33 falls per 1,000 bed days against the national benchmark of 5.6. There were 159 inpatient falls in August. Of these, 135 occurred in patients aged 65 and over, with 47% of patients having a cognitive impairment.

The degree of harm, based on NPSA guidance, arising from the falls in August were:

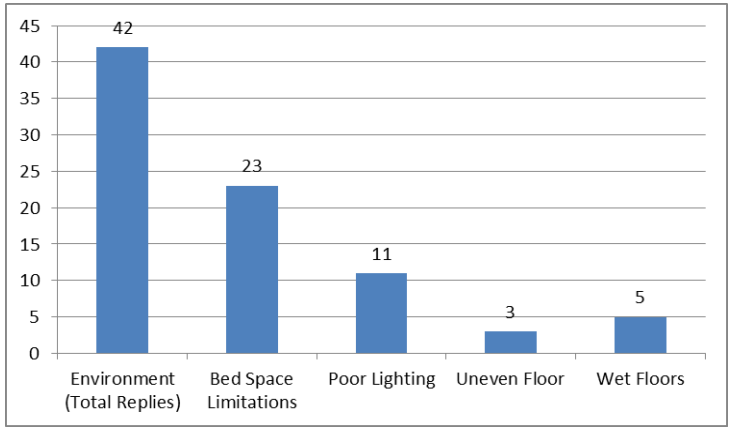
Degree of Harm	April	May	June	July	August
Near Miss	3	8	6	5	0
Negligible	141	92	93	91	73
Minor	17	32	47	61	85
Moderate	1	2	0	0	1
Major	1	1	2	3	0

There were no falls that led to bone fractures in August 2012.

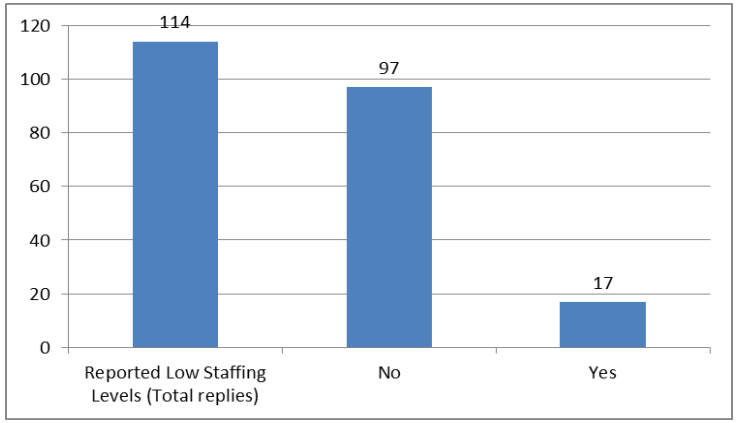
The Moderate Actual Harm fall involved a patient with a cerebral bleed who fell because of the bleed rather than the fall causing the bleed. It is highly unlikely that this fall could have been prevented.

The graph below indicates some of the most common evironmental factors which contributed to patient falls. A number of practical approaches are being taken to ensure, bed spaces are kept as free from clutter as possible and that wet floor signs are clearly visable to patients and staff.

QUALITY



The next graph indicates that low staffing levels did not contribute to the number of falls in the majority of cases.



Breakdown of Falls by Division

Division	April	May	June	July	August
Diagnostics & Therapies	2	1	1	1	1
Medicine	98	78	97	104	102
Specialised Services	29	26	20	21	25
Surgery Head & Neck	30	21	27	32	28
Women's & Children's	4	8	3	2	3

QUALITY

Recovery plan, including expected date performance will be restored:

1. A pack published by the Royal College of Physicians in July 2012, FallSafe, Care Bundles and Resources to Reduce Inpatient Fall, is an excellent practical resource and supports areas the Trust is focussing on, including lighting, equipment, footwear and understanding patients night-time toilet habits. It has also indicated other areas to explore, including medication reviews and a reduction in night sedation. A CD e-learning course is also available.
2. A presentation of this work was given at the September Falls Group. Focussing on 1 high risk areas in Medicine, Surgery Head and Neck and Specialised Services, the clinical falls leads will be working closely with 3 ward Sisters/Charge Nurses to implement and undertake a full evaluation of the FallSafe Care Bundle. Following implementation guidance in the pack, this will take place over the next 3 months with a full report available in January 13.

QUALITY

Q8-Q10 EXCEPTION REPORT: Pressure ulcer incidence per 1,000 bed days Number of hospital acquired grade 3 pressure ulcers Number of hospital acquired grade 4 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 1.71 per 1,000 bed days in August 2012, an increase from July's figure. The reporting of pressure ulcers has now changed from numbers per 10, 000 bed days to 1,000 bed days. This change was one of the recommendations from the recent external Pressure Ulcer review and was approved at Clinical Quality Group. The majority of Trusts report in this way and will allow for better benchmarking.

Division	August 2012	July 2012	June 2012	May 2012	April 2012
Medicine	1.50	1.98	2.05	1.95	1.24
Specialised Services	1.45	0.71	2.37	0.64	1.65
Surgery Head & Neck	3.79	2.18	2.06	2.08	3.00
Women's & Children's	0.60	0.29	0.15	0.29	0.30
Trust	**1.71**	**1.34**	**1.61**	**1.30**	**1.37**

There were nine grade 3 pressure ulcers and one grade 4 pressure ulcer which developed in hospital in August 2012 – details outlined below.

Division	Ward/Unit	Site	Information
Specialised Services	Cardiac Intensive Care	Back of lower leg	Complex issues following cardiac surgery. Root Cause Analysis (RCA) underway.
Surgery Head &	**Intensive Care**	Anal region	1) Admitted to Intensive Care. RCA underway

QUALITY

Neck	**(ITU) x 2** **Ward 9** **Ward 14 x 3**	Bridge of nose Buttocks Right heel Right heel Sacrum & buttocks	2) Admitted to Intensive Care with community acquired pneumonia, renal failure and sepsis. Possible preventive actions were not taken, which has been fed back to staff. RCA underway. Admitted for repair of aneurysm, presented with multiple co-morbidities. 1) Admitted with a fractured left hip. Known diabetic. RCA underway 2) Admitted with a fractured neck of femur. A small blister deteriorated. RCA underway 3) Admitted with a fractured left wrist and shoulder. Shearing and friction ulcers on both buttocks. RCA underway
Women & Children's	**Neonatal Intensive Care**	Occiput Septum	1) RCA underway 2) RCA complete. Recommendations from the RCA are: A care plan and Standard Operating Procedure for babies requiring oxygen masks is being developed.
Medicine	**Ward 11**	Sacrum	**Grade 4 pressure ulcer.** RCA completed. Recommendations from the RCA are: Sister to ensure bedside handovers are completed properly at every handover to ensure all documentation is reviewed, accurate and completed in a timely manner. Complete Trust teaching plan on Pressure Ulcer Prevention "Everyone's Responsibility" for all nurses Nurse in Charge to ensure a safety briefing is completed at the beginning of each shift Continue with proactive recruitment programme.

Recovery plan, including expected date performance will be restored:

- Following an external review in August 2012, a formal report has been received and circulated to key Trust staff. A detailed action plan has been developed and will be presented to Clinical Quality Group on Oct 4th 2012. The Deputy Chief Nurse, Tissue Viability Lead Nurse and Heads of Nursing will monitor progress of the plan on a weekly basis to ensure progress is being made.
- A planned programme to test all mattresses in the general ITU (Intensive Therapy Unit) is underway and will be completed by Oct 8th
- A detailed briefing report has been prepared by the Neonatal Intensive Care team. Benchmarking with other units has shown that no other Neonatal Intensive Care Units report skin damage or pressure ulcers as a clinical incident. Other units are now keen to learn from UH Bristol's approach. Given the highly specialised nature of the unit's work, manufacturers are also keen to work with the Unit to develop more effective pressure relieving equipment.
- A Trust-wide programme of teaching is in place. All nurses and healthcare assistants are on target to receive training in pressure ulcer

prevention by the end of September 2012.

- A trial of a prophylactic silicone-based dressing for patients with fractured neck of femur has been completed. The results will be presented at the next Tissue Viability Steering Group and appropriate actions taken.
- All Divisions are required to complete and submit detailed recovery plans to the current Trust Board 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.
- 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

Q11. EXCEPTION REPORT: Risk assessment of patients with known Learning Disability within 48 hours	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Patients with a known learning disability will receive an assessment within 48 hours of admission to an inpatient bed. The CQUIN target set last year was at 85% to be achieved by Q4 2011/12. A CQUIN has not been set for 2012/2013 however we are aiming to sustain last year's achievement.

Performance in the period, including reasons for the exception:

There was a slight drop in performance in August 2012 to 82.4% following significant improvement in July. This equates to 14 out of 17 patients with a known learning disability being assessed within 48 hours.

Recovery plan, including expected date performance will be restored:

- The Learning Difficulties Nurses (LD nurses) have implemented the role of the Learning Difficulty Champion and have currently recruited 26 nurses across the Trust. The LD Nurse has drafted guidance around the role of the champion and monthly meetings have been agreed.
- The champions will be supported to ensure that staff in their area are able to complete the risk assessments, so that this does not rely purely on the LD nurses alone. In addition to this the LD web site is maintained and accessible for patient information relevant documentation for appropriate patient care.
- The LD nurses have reviewed the current risk assessment (first draft) which ensures it captures all key information in a succinct way and is intuitive to use. This includes reasonable adjustments.
- The LD Nurse have secured training at Trust Induction, which incorporates the high level of importance the LD risk assessment has for inpatients with LD, and includes information about the Autism Strategy. LD nurse continues to provide training to ward/staff as required or as requested. The implementation of the Autism Strategy is supplemented by the National Autistic Society delivering training to staff teams. This training consists of two full days and a further two days will be agreed for the end of the year.
- The development of a training matrix and programme will be a key priority for the LD nurses and LD Steering group.
- With the significant improvement made to achieve the CQUIN for last year, it is anticipated that we will maintain standards.
- Raising awareness of the staff in the confident use of the alert system on Medway.

QUALITY

- Reach agreement where the LD risk assessment and relevant documentation should be stored within the patient's medical notes.

Q12. EXCEPTION REPORT: Number of Spontaneous Vaginal Deliveries as a percentage of all births	**RESPONSIBLE MANAGER: Chief Nurse**

Description of how the target is measured:

Number of Spontaneous Vaginal Deliveries as a percentage of the number of all births including caesarean sections. The target for 2012/13 is 64.3% which is a 1% increase on 2011/12 outturn of 63.3%.

Performance during the period, including reasons for exception:

In August percentage of spontaneous vaginal births was 63.5% of all births. There has been an increase in operative vaginal births.

Recovery plan, including expected date performance will be restored:

- Continuing with work via the Normal Birth Working Party to achieve the CQUIN for 2012/13.
- Continue to promote VBAC (Vaginal Birth After Caesarean section) antenatally.
- CQUIN funding secured to purchase sonnicaids and telemetry tocographs, which will allow women to be more mobile in labour and increase the chance of a normal birth.
- Normal birth study day has been held.
- The community midwives from Granby team are starting back in hospital at the beginning of October, who are experienced in home birth and will be able to share expertise.
- Recruiting to more experienced Band 6 midwives and Band 7.

QUALITY

Q13-Q15. EXCEPTION REPORT: Fractured neck of femur to be treated within 36 hours Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours Fractured neck of femur patients achieving best practice tariff	RESPONSIBLE DIRECTOR: Medical Director

Description of how the standard is measured:

Best Practice Tariff (BPT) for hip fractures requires all of the following to be achieved:

1. Surgery within 36 hours from admission to hospital
2. Orthogeriatric review within 72 hours of admission to hospital
3. Joint care of patients under a Trauma & Orthopaedic Consultant & Ortho-geriatrician Consultant
4. Completion of a Joint Assessment Proforma
5. MDT (Multi Disciplinary Team) rehabilitation led by an Ortho-geriatrician
6. Falls Assessment
7. Bone Health Assessment
8. Abbreviated Mental Test done on admission & pre-discharge

Performance in the period, including reasons for the exception:

	Apr 12	May 12	Jun 12	Q1	July 12	Aug 12
Total eligible patients	25	31	32	**357**	21	25
BPT achievement	64%	55%	38%	**46%**	36%	6%
Surgery within 36 hours	80%	61%	63%	**60%**	76%	32%
Ortho-geriatrician review within 72hours	84%	92%	72%	**76%**	43%	32%

There remain two main constraints in improving BPT performance, access to theatre within 36 hours of admission, and Ortho-geriatric review within 72 hours. Plans are currently being discussed with the Trust Executive to support increased investment to improve performance against these metrics.

<u>Ortho-geriatrician Review</u>

Performance has improved for patients being reviewed by Ortho-geriatricians within 72 hours over the last 12 months. This improvement resulted in an average achievement of 63% in 2011/12. This was achieved through a small increase in Consultant sessions (1 PA), and the introduction of a Hip

QUALITY

Fracture Nurse Specialist, which enabled improvement in consultant efficiency.
A short-term pilot in Quarter 1 2012/13 of a Clinical Fellow role increased Ortho-geriatrician input to 92% against the BPT indicator. This additional input has now ended and performance has dropped since June 2012 due to limited Consultant sessions and a lack of cross-cover during holiday periods. A business case is currently being considered by the Trust Executive to increase consultation sessions by a further 25 hours and to make the Clinical Fellow post substantive to bring resources in line with national standards.

Surgery within 36 hours

Access to theatres within 36 hours remains the largest constraint in improving BPT performance at UH Bristol. In 2011/12, 57% of fractured neck of femur patients had surgery within 36 hours (194 of 338 patients). Monthly performance varies widely depending on total trauma demand as there is no daily dedicated trauma theatre.

There are currently 34 hours of dedicated trauma operating time per week. A business case to increase operating capacity for trauma patients by a further 10 hours per week is in the final stages of approval by the Trust Executives and plans are in progress to open these additional theatre sessions within 2012/13.

Other BPT Indicators

We are now 100% compliant in Falls (85% to 100%) and Bone Health Assessment (45% to 100%); this work is primarily carried out by the hip fracture specialist nurse appointed in September 2011. A new clerking proforma has been agreed for multi-disciplinary use. Education and training with junior doctors is on-going to ensure this documentation is completed fully.

Recovery plan, including expected date performance will be restored:

A business case for investment in further Ortho-geriatrician input and theatre sessions has been included in the Divisional Recovery Plan and is currently being considered by the Trust Executive. Performance against Best Practice Standards for theatre access and Ortho-geriatric review will remain static until further investment is agreed.

QUALITY

Q16-Q17. EXCEPTION REPORT: Stroke care	RESPONSIBLE DIRECTOR: Medical Director
• **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 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:

Please note: the report below on 90% stay on a stroke unit is the same as provided last month. The April to August stroke data is currently under review, following the final submission of the fully coded hospital spells data. The original submission of spells data was later than the usual submission due to the data checks required following implementation of the Medway Patient Administration System (PAS).

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

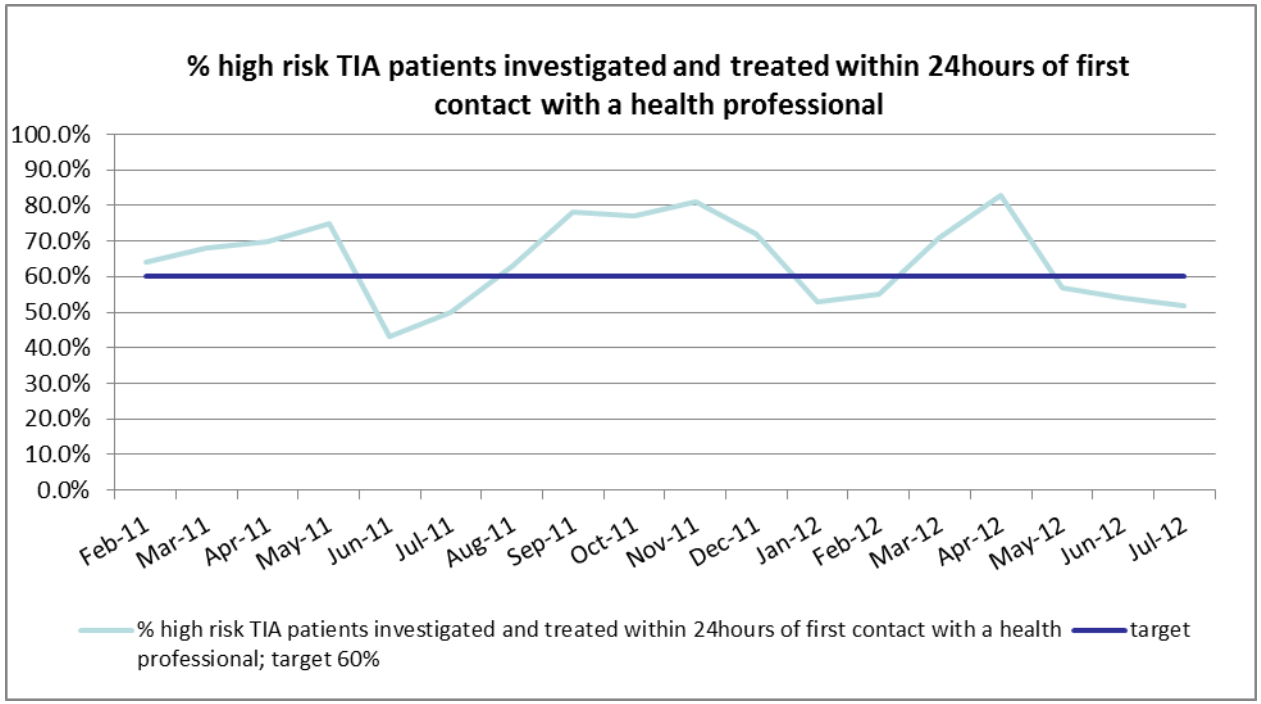
The 80% national standard was achieved in April (82.1%). Performance between May and July has been below the 80% standard, although performance has improved month on month. July's performance was 73.0%. Patients suspected as suffering from a stroke patients should be directly admitted to the Stroke Unit 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. The key reason for breaches of this standard has been inability to access stroke beds due to the presence of non-stroke patients on the Acute Stroke Unit.

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

Performance in August was 53.3%, and below the 60% standard. Overall performance against this standard is just below the 60% national target year-to-date (58.7% against the 60% standard). Performance against the TIA standard often falls at this time of the year, for reasons not well understood (see graph below). The main reasons why patients are not treated within 24 hours include:

QUALITY

- 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 (now end September)
- There are now weekly reviews of all cases where stroke patients did not spend at least 90% of their stay on the stroke unit; this is being supported by detailed recorded keeping by the Clinical Site Management team of the reasons why stroke patients were admitted elsewhere

(Action complete)

- Daily notification of required repatriations and any outlying stroke patients to the Clinical Operations Centre, post board round; discussion at 12.30 bed meeting (Action complete)
- 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 (Action complete)
- The Jubilee weekend resulted in the clinic being closed for four days – plans were put in place to open the TIA clinic during the August bank holiday weekend, to reduce the effect of the bank holiday weekend; North Bristol Trust provided this service out-of-hours, and all calls were appropriately diverted to them
- The team is reviewing whether an e-referral or Choose & Book service would be more appropriate to reduce the risk of fax machine failure and paper-based referrals (Ongoing – work is underway with the Primary Care Trust and our own Information Management & Technology (IM&T) department; an NHS.net account is now being set-up to receive electronic referrals)
- Incidents of GPs referring late or via the wrong route are being feedback to individual GPs via the Primary Care Trust (ongoing)

Progress against the recovery plan:

Performance against the 24 hour TIA treatment standard is just below the 60% national standard year to date. The implementation of a system for receiving electronic referrals is expected to improve performance against this standard. Performance against the 90% stay standard is expected to improve with the improvements in emergency access and the actions being taken to protect stroke beds.

QUALITY

Q 18. EXCEPTION REPORT: Number of patient complaints as a proportion of all activity.	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The number of complaints received by the Trust and either managed by a formal or informal resolution process in agreement with the complainant. This excludes concerns raised and immediately dealt with by front line staff. This is expressed as a percentage of activity derived from patient attendances.

Performance in the period, including reasons for the exception:

In August 2012 the number of patient complaints as a percentage of activity was 0.4%. The Trust received 158 complaints which is a decrease from the previous month and is also similar to the number of complaints received in August 2011.

The number of complaints received decreased in the Division of Surgery, Head & Neck where complaints reduced from 93 in July to 71 in August and is the lowest number of complaints received in this Division since April 2012. Although the highest number of complaints continues to be about the delay or cancellation of appointments at Bristol Eye Hospital and failure to answer phones, these have halved to 12 from 24 in July 2012. The second highest number of complaints continues to relate to delays and cancellations within the Trauma & Orthopaedic Department at Bristol Royal Infirmary (9), although this has decreased from 17 received in July. The number of complaints regarding cancellation or delayed surgery in Lower Gastro-Intestinal Surgery continues to remain high at 9 in August, although this is a slight decrease from the 11 recorded in July. There were no other trends or concerns identified.

The Division of Medicine has an increase in the number of complaints for August to 29 from 20 in July. There were also increases in the Divisions of Women's & Children's (to 21 from 14) and in Diagnostics & Therapies (to 6 from 3). The only noticeable trend was for Women's & Children's where complaints about the Central Delivery Suite rose from 1 in July to 5 in August.

The Division of Specialised Services had the same number of complaints as last month (19).

Recovery plan, including expected date performance will be restored:

The staffing issues in the Ophthalmology and Trauma & Orthopaedics Outpatient Departments 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 were filled by the end of July. The expected improvement in the number of complaints

QUALITY

received is now starting to show.

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:

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

Performance has improved as expected by September 2012 although further monitoring of this situation is being undertaken.

QUALITY

Q19. EXCEPTION REPORT: Percentage of complaints resolved within Local Resolution Plan timescale	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

August 2012 performance was 94.8%, which equates to four breaches of timescale for this month. Performance is still below the Trust standard, although has slightly improved in percentage terms since last month. The reasons for each individual breach are as shown below

Medicine

- One breach of timescale related to the late receipt of the complaint response from the Division and the other related to a complaint where amendments to the initial response were subsequently required.

Women's & Children's

- Late receipt of final response letter from the Division and then amendments to the initial response were subsequently required.

Facilities & Estates

- Late receipt of final response letter from the Division and then amendments to the initial response were subsequently required.

Recovery plan, including expected date performance will be restored:

- The 2012/2013 work plan identifies objectives for further collaborative working between the Corporate and Divisional complaints teams to ensure that this target is consistently achieved. The objectives include the corporate team drafting response letters to less complex complaints, freeing up time for divisional staff to investigate and draft more complex complaint responses. Quarterly review meetings will also be held with Divisional complaints staff from October 2012, to identify and address issues which are arising and affecting ability to achieve this target.
- Each individual breach has been discussed with the relevant Divisional Complaints Co-ordinator.
- Performance is discussed and monitored at the Patient Experience Group, chaired by the Chief Nurse.
- Training by the Corporate Team with key Divisional staff who undertake investigations and write response letters will be rolled-out on a

QUALITY

quarterly basis from September 2012, to improve the quality of investigations and responses. Training and support is also being provided through a one hour session on the Supervisory Sisters Programmes being run in October 2012.

1.6 SUPPORTING INFORMATION

1.6.1 EXAMPLE OF LEARNING FROM COMPLAINTS

Summary of Complaint One

A patient received a letter confirming her appointment at Bristol Eye Hospital on 12th March. Shortly afterwards, she received a further letter advising that her appointment had been cancelled and rearranged for two weeks later, on 28th March. There was no explanation as to why the appointment had been cancelled. The patient subsequently received a further letter, advising her that as she had failed to attend her appointment on 12th March, another appointment had been made for 28th March. She felt that this letter was slightly "threatening", stating that this was the final appointment she would be offered. She then telephoned the hospital to discuss the mix up and was offered no explanation or apology.

Furthermore, the patient had asked for her appointment to be made in the afternoon as she has to rely on a friend to transport her to the hospital. Although the first appointments had been made for the afternoon, the one she actually had to attend, on 28th March, was made for 9.45am and this caused both the patient and her friend a great deal of inconvenience.

Investigation

The investigation found that:

- The appointment on 12th March should not have been cancelled and the hospital could not ascertain why a cancellation letter was sent;
- As the appointment was cancelled on the system, a re-book letter was generated, rearranging the appointment on 28th March.

Individual Learning

- Staff in the department have now been fully trained on the new computer system which will keep much better records of why appointments are cancelled and re-booked.
- The patient's concerns have been shared with the booking team to help staff improve processes and understand the impact of the current process on patients.

Organisational Learning

- As part of the Trust-wide Productive Outpatients programme, all outpatient processes at Bristol Eye Hospital are being reviewed.
- It is planned that all appointments are booked with patients over the telephone, in order that a convenient time can be agreed with the patient.

QUALITY

- Through Productive Outpatients, the Bristol Eye Hospital is focusing on slot utilisation and cancelled appointments to increase efficiency and reduce patient complaints. The initial focus is on Glaucoma and Retinal clinics as these make up the majority of the hospital's outpatient activity.

Summary of Complaint Two

A patient made a complaint and described how he attended an appointment the Bristol Haematology & Oncology Centre for radiotherapy treatment. After having a cannula inserted in the x-ray room, a nurse attached a phial containing "radiation" to the cannula and all staff left the room. He then heard a voice over a speaker system advising that they were about to inject the contents of the phial. However, when they did so, the patient felt this shoot up his arm "like a bullet", causing him to scream in pain. The nurses re-entered the room and without speaking to or reassuring the patient. They removed the cannula and shut down the machinery. He was then told that they would see him again two weeks later to commence his radiotherapy. The patient never received an explanation for what had happened and was left with a burn that extended up his arm from his fingers to his elbow.

Following his radiotherapy treatment he was seen by his consultant, some eight weeks after the initial incident. The consultant looked at the burn and stated that he had never seen a reaction like this. The patient had always been an independent and proud man, yet ever since the first appointment where his arm was burnt, he had gone rapidly downhill, he needed help washing, shaving and dressing himself and did no socialise any more. He told his wife that if he had known the effect this treatment was going to have on him, he never would have agreed to it.

Investigation

The investigation found that:

- The patient and his wife should have received a full explanation as to what had happened, at the time of the incident;
- The incident during which the patient's arm was burnt was during a planning scan, which is used by the doctor to plan the area where the radiotherapy will be delivered. As part of this scan, as is normal practice, the patient was injected with contrast media, a type of dye, to show the various blood vessels and other parts of the body.
- A questionnaire, completed by the Radiographer before the scan, has been in place since January 2012. Unfortunately, this was not in place at the time and the procedure was not fully explained to the patient before it took place.
- The complaint response explained to the patient that the contrast media is not radioactive. However, we were unable to provide a definitive explanation for the reaction the patient experienced.
- A review by a consultant confirms that the right treatment was given and in the right area. Regular scans were taken during the radiotherapy treatment and confirm that treatment was in the right place.
- The contrast media used in no way compromised the patient's treatment and the radiotherapy was delivered to the right area. Sadly, the type of tumour the patient was suffering from does not always respond to radiotherapy.

Individual Learning

QUALITY

- The Radiographers offered their apologies that they did not explain what was happening to the patient or offer him any reassurance or comfort him at the time. They acknowledged that they should have provided this reassurance and have used this as a learning point for discussion within the team.

Divisional Learning

- A questionnaire was introduced in January 2012. Whilst completing this with the patient, the Radiographer talks to the patient about the contrast media and the scan and asks questions about allergies, asthma and heart or kidney problems. The Radiographer also explains that the contrast media can cause a strange sensation, like a hot flush.
- As a direct result of this complaint, all staff have been reminded of the importance of fully explaining procedures to patients and providing reassurance and comfort when patients experience discomfort during a procedure.

WORKFORCE

2.1 SUMMARY

The Trust has selected a range of key workforce indicators. The indicators below target this month are sickness absence, workforce numbers, bank and agency usage, and statutory and mandatory training.

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

2.2 EXCEPTION REPORTS

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

- Sickness absence – red rated against target
- Workforce numbers – red rated against budgeted numbers
- Bank and agency usage – red rated against target

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 4.2% in August compared with 4.4% in the previous month, but remains over the target, which in August was 3.1%. All Divisions are red rated except Women's & Children`s. Reasons for absence are 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 & Facilities)	Estates & Facilities
Absence August 2011	3.7%	1.8%	4.9%	3.4%	3.3%	4.0%	3.6%	5.5%
Target August 2012	3.1%	1.8%	3.6%	3.0%	2.8%	3.5%	2.8%	5.0%
Absence August 2012	4.2%	2.7%	4.5%	3.8%	4.6%	3.9%	3.7%	6.4%
Cumulative absence August 2012	4.2%	2.7%	4.7%	4.3%	4.3%	3.8%	3.5%	6.2%

Recovery plan, including expected date performance will be restored:

Changes to the Supporting Attendance Policy have been agreed by Industrial Relations Group, which will support managing attendance.

Diagnostic & Therapies

The target for August 2012 is exceptionally low (1.8%) because the monthly target reflects last year's achievement. Work continues to closely monitor sickness. Services with higher than the Divisional cumulative target for sickness are closely monitored, and performance is reviewed at monthly review meetings.

Diagnostic & Therapies sickness absence rate for August is 0.1% lower than last month; however the cumulative achievement year to date at 2.7% is above the cumulative target of 2.5%. The achievement of 2.5% sickness for 12/13 remains a challenging stretch target.

WORKFORCE

Medicine

There has been a decrease in absence across all the main causes during the month, with the exception of Genitourinary and gynaecological disorders.

The HRBP (Human Resources Business Partner) /senior management team continue to review those top 10 areas with highest sickness within month, to provide support and escalation as necessary, and regular meetings continue to ensure consistency and actions are implemented.

Significant work has been undertaken in August to increase referral rates to the staff well-being advisors, which did prove successful and referrals were significantly increased. In addition, one to one work continues with areas with high sickness and employees with complex ongoing health conditions or poor attendance histories.

Absence management sessions to be run through supervisory ward sister sessions and specialty manager training programmes. These will be run following the successful attendance at a recent ward sister meeting by a Staff Well-being Advisor which enabled proactive discussions to take place identifying areas of improvement.

Specialised Services

Divisional Employee Services representative continues to hold regular meetings with key managers to review all workforce metrics, with a particular recent focus on sickness absence.

The HRBP and Employee Services Representative will be holding a sickness absence workshop in September 2012 for all managers in the Division, with a view to addressing these themes, and any further issues which are raised. **Deadline – 28th September 2012**

In addition, the Division has identified the top 5 highest areas for sickness absence, which include CICU (Cardiac Intensive Care Unit), CCU (Coronary Care Unit), BHOC (Bristol Haematology & Oncology Centre) outpatients and BHOC Administrative Services. The Divisional Employee Services representative has reviewed these areas with the HRBP and has developed a plan of action with each individual manager as part of the ongoing HR review meetings process. This action plan will be updated with outcomes from the workshop as identified above. Deadline – **28th September 2012**

HRBP to undertake further investigation into causes of absence, particularly around stress and anxiety which has increased recently. The results of this work will be fed back to the September Divisional Board. **Deadline – 28th September 2012**

Surgery, Head & Neck (SHN)

The project looking at specific area with high sickness was launched at the beginning of the month and the first round of returns are being analysed and targeted support will follow in the areas requiring it. The second round is due to take place next week. **Review – October 2012**

Levels of sickness absence relating to stress/anxiety/depression have increased for the third consecutive month and represents 28% of the Division`s total calendar days lost in August, whereas other reasons for sickness which have been high in the Division in recent months have all decreased. As well as the support provided by the Safety Team and Employee Services, some analysis is about to commence to look at a better breakdown of the reasons for sickness under this category – this will involve managers being asked to specify whether the reason for the individual's absence was work related

stress, bereavement, personal circumstances (i.e. marriage, debt, divorce) or a mental health condition. **Review – October 2012**

Estates & Facilities

Facilities & Estate`s new HR business partner has now met with operational managers individually, to go through current sickness, to ensure that all the appropriate actions are being taken to expedite return from work, and to ensure that the policy is being followed and absences followed up.

Progress against recovery plan: See above.

WORKFORCE

W2. EXCEPTION REPORT: Workforce Numbers	RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development

Description of how the standard is measured: Workforce numbers in Full Time Equivalent (FTE) compared with targets set by Division for 2012/13

Performance in the period, including reasons for the exception:

Workforce numbers including bank and agency increased by 1.7% compared with July 2012, 2.6% above budgeted workforce numbers for August 2012.

	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Estates & Facilities)	Estates & Facilities
August 2012	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE
Workforce Numbers (including bank and agency)	7259.56	912.80	1104.48	776.95	1652.72	1432.21	655.84	724.56
Budgeted Numbers	7072.05	913.59	970.28	758.05	1599.65	1427.12	684.16	719.20
variance target +/-	-187.51	0.79	-134.20	-18.90	-53.07	-5.09	28.32	-5.36

Whilst the overall numbers increased, the net change in staff employed by UH Bristol increased by only 6.75 FTE. Most of the increases were in medical staffing, particularly in junior doctors. In Specialised Services, there was an increase in cardiology juniors of 5.00 FTE, and 2.83 Cardiology consultants. Surgery Head & Neck increased medical staffing by 5.87 FTE, of which 4.38 FTE was in Ophthalmology.

Recovery plan, including expected date performance will be restored:

Failure to achieve the target for workforce numbers was the result of increased bank and agency usage; the recovery plan is covered in the bank and agency section, see Exception Report W3 below.

Progress against recovery plan:

WORKFORCE

See bank and agency section below.

W3. EXCEPTION REPORT: Bank & Agency compliance	RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development

Description of how the standard is measured: Bank and agency usage in Full Time Equivalent (FTE) compared with targets set by Divisions for 2012/13

Performance in the period, including reasons for the exception:

Bank increased by 74.5 FTE and agency by 41.5 FTE in August 2012 compared to July 2012, 34.3% above target compared with 9.0% above the previous month. This increase in bank and agency usage is also the reason for the red rated target for workforce numbers (see table above). However it should be noted that some of the increased agency usage this month is the result of delays in receiving and processing invoices from a key agency provider for theatre and ITU (Intensive Therapy Unit) nursing.

Bank and Agency (FTE)	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Estates & Facilities)	Estates & Facilities
Actual August 2011	388.5	0.0	108.0	38.3	66.2	65.1	76.2	34.7
Actual August 2012	459.6	27.8	142.9	43.1	123.6	78.7	13.9	29.6
Target August 2012	301.9	20.7	71.2	31.9	59.1	56.9	34.7	27.5
Variance from target	34.3%	25.3%	50.2%	26.1%	52.2%	27.8%	-149.3%	6.9%

Recovery plan, including expected date performance will be restored:

Diagnostic & Therapies

The increased use is due to pressures in:

- Radiology – backlog reporting has required the services of a medical locum
- Laboratory Medicine – administrative and clerical staff to prepare for the CPA (Clinical Pathology Accreditation) inspection
- Radiology – temporary administrative staff prior to the implementation of Voice Recognition

WORKFORCE

- Administrative staff (general) to assist with Medway implementation

Reductions will occur by next month, as the medical locum in radiology finishes at the end of September. There will also be a lower requirement for administrative/bank and agency next month due to the completion of the CPA inspection, the Medway work, and the appointment to the new administrative structures in radiology as a result of Voice Recognition implementation.

Medicine

At the end of August, the flexible capacity was re-opened in full, resulting in a delay in reducing bank usage. The growth in bank and agency is largely the result of the requirement to meet the 4 hour and other performance targets, and includes the use of agency doctors, including provision of cover of vacancies in Emergency Nurse Practitioners. Nursing bank has also been widely used across the Emergency Department and the Medical Assessment Unit. This is likely to continue throughout September. There was also a significant Registered Mental Nurse (RMN) agency cover requirement on specific wards; such individual "spikes" in required cover by RMNs are unavoidable. However, options Trust-wide are being reviewed to consider how alternatives to agency can provide RMN cover. There was also bank usage resulting from the recruitment/redeployment into vacancies resulting from the nurse transformation programme; this process is now complete and this should be evident by the next board report due in October.

Specialised Services

Medical agency juniors in haematology and cardiology reduced from 5 FTE in July to 2.6. The reduction of usage of medical agency is the result of two nurse practitioners now being fully trained and scheduled into cardiac rotas to cover Junior Medical duties in the BHI (Bristol Heart Institute). Nursing bank usage in the division has increased during the month due to a combination of factors. There has been an increase in the complexity of patients in CICU (Cardiac Intensive Care Unit) combined with high sickness. Across the Division there has also been a higher proportion of patients with other conditions such as obesity and dementia which increased the nursing requirement. In addition, the new shift patterns result in a longer shift to fill in the event of absence, and annual leave has been taken which was allocated a year in advance based on 2011/2012 establishment. Going forward the annual leave has been adjusted to reflect the new establishment.

Surgery, Head & Neck (SHN)

The apparent increased use in theatre agency nursing is the result of delayed processing of invoices in the Bank Office. Systems have been put in place to prevent this recurring. There was also an increase of nursing bank usage from 44 FTE last month to 60 FTE. 10 of this was in ITU, where staffing levels are currently under review, and 12.5 FTE was the result of covering sickness absence across the Division, due to increased levels of sickness this month. Ward sisters are in the process of revising their rotas to work within the allocated budget, and are also working across wards to reallocate staffing to reduce bank and agency spend. These actions should take effect by the next report.

Women's & Children's

WORKFORCE

The issues this month have been as follows:

- High midwifery use, partly due to covering two suspended staff, and short term and long term sickness, which is being managed pro-actively, and vacancy cover – recruitment is underway.
- High use in Gynaecology due to sickness cover.
- High use in NICU (Neonatal Intensive Care Unit), as new staff appointed but working supernumerary/not started yet, in Children's Emergency Department mainly due to maternity leave cover, and across BRHC (Bristol Royal Hospital for Children) due to high dependency patients on wards.
- High use for junior doctors due to increase in number of vacancies in August 2012. Doctors started in September 2012, which will alleviate this problem.
- High agency use due to difficulty in accessing bank

The recovery plan includes a transformational programme which has just been initiated to improve partnership working with the Trust Staff Bank and the Children's Hospital to transform use of temporary staffing within this area. It is anticipated that this will result in improved fill rates and reduced agency usage.

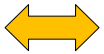
Divisional Vacancy Control Panel now approve posts when the Ward Manager knows member of staff is leaving, but has not received written resignation. This ensures that replacements can be recruited with as little delay as possible.

Progress against recovery plan: As above

2.3 SUPPORTING INFORMATION

2.3.1a Statutory and mandatory training

An overview of key topic areas is shown below for the period September 2011 to August 2012.

Statutory and Mandatory	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul- 12	Aug-12	Aug 12 Movement*
Induction	85%	90%	89%	87%	84%	87%	87%	85%	92%	93%	92%	86%	
Health & Safety	86%	87%	85%	83%	91%	92%	91%	91%	92%	92%	92%	94%	
Infection Control	83%	81%	80%	80%	88%	88%	88%	89%	90%	89%	89%	87%	
Manual Handling	77%	78%	78%	76%	75%	73%	75%	74%	72%	76%	74%	70%	
Fire Safety Training	45%	46%	48%	51%	56%	58%	58%	58%	57%	50%	51%	52%	
Violence & Aggression L2	91%	91%	90%	90%	89%	90%	89%	89%	89%	90%	89%	88%	
Child Protection, Level 1	88%	88%	89%	89%	88%	89%	89%	89%	89%	88%	88%	84%	
Child Protection, Level 2	79%	79%	83%	84%	57%	57%	59%	62%	62%	64%	65%	64%	
Child Protection, Level 3	82%	82%	82%	83%	63%	64%	65%	62%	61%	61%	61%	59%	
Child Protection, Level 4	90%	93%	92%	92%	71%	73%	75%	73%	73%	72%	77%	70%	
Safeguarding Adults Level 1	56%	71%	81%	81%	77%	73%	74%	74%	82%	77%	76%	75%	
Safeguarding Adults Level 2	46%	50%	91%	91%	95%	95%	75%	76%	77%	77%	79%	79%	
Safeguarding Adults Level 3	60%	72%	100%	100%	95%	100%	78%	79%	81%	82%	85%	86%	

* Movement relative to July 2012

2.3.1b Action plans for Essential Training

The table below includes both regulatory and statutory training with action plans.

Area	Target	NHSLA Target	Essential Training Category	Compliance End Aug 2012	Key actions to improve compliance
Blood Transfusion		95% NHSLA	Regulatory	60%	Business case approved to provide administrative staff to enter data on to At Learning. Staff to commence mid-September.
Child Protection Level 1	80% 90% Stretch		Statutory	84%	Level 1 training will continue to be delivered as part of the Trust Corporate Induction programme.
Child Protection Level 2	80% 90% Stretch		Statutory	69%	Recovery plan in place to achieve target of 90% compliance by the end of 2012. This will require a minimum of 200 staff to attend training per month.
Child Protection Level 3	80% 90% Stretch		Statutory	59%	New requirements increase training from 2 to 4 hours, primarily affect Women's & Children's Division. Recovery plan in place to achieve target of 90% compliance by the end of 2012.
Child Protection Level 4	80% 90% Stretch		Statutory	70%	New requirements increase training from 2 to 4 hours, primarily affect Women's & Children's Division. Recovery plan in place to achieve target of 90% compliance by the end of 2012.
Consent		95% NHSLA	Regulatory	50%	Business case approved to provide administrative staff to enter data on to At Learning. Staff to commence mid-September.
Equality and Diversity			Mandatory	25%	Trust planning to roll out Living the Values training to all staff.
Falls Prevention		95% NHSLA	Regulatory	83%	Business case approved to provide administrative staff to enter data on to At Learning. Staff to commence mid-September.
Fire Safety	80% 90% stretch		Statutory	52%	Managers asked, via SDG (Service Delivery Group), to ensure sessions are attended.
Food Safety Level2	80% 90% Stretch		Mandatory	86%	Regular letters to managers showing non-compliance of their staff on a monthly basis. Time between examination and results can be 6 weeks causes fluctuation in monthly figures
Health and Safety	80% 90% Stretch	95% NHSLA	Statutory	94%	Additional Risk Management awareness training for senior managers is being delivered which also counts as Health & Safety update. Revised NHSLA (NHS Litigation

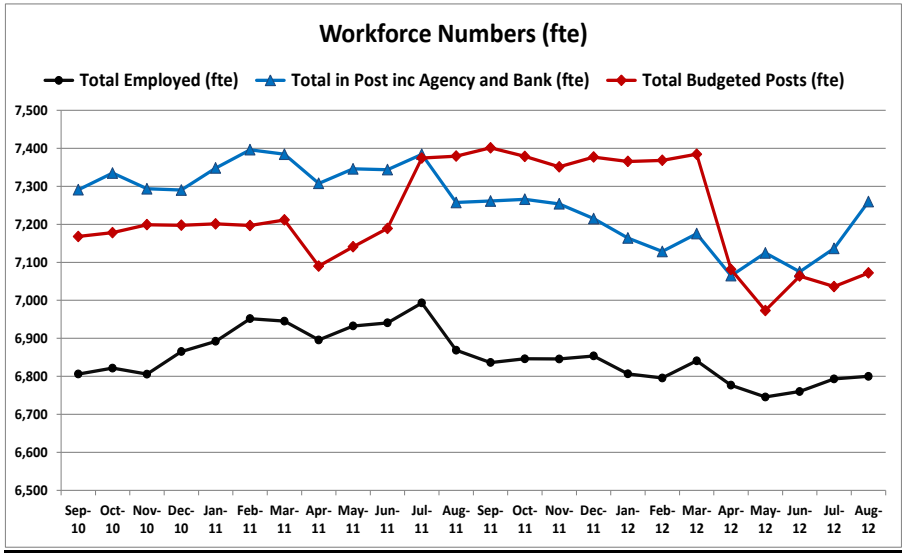
WORKFORCE

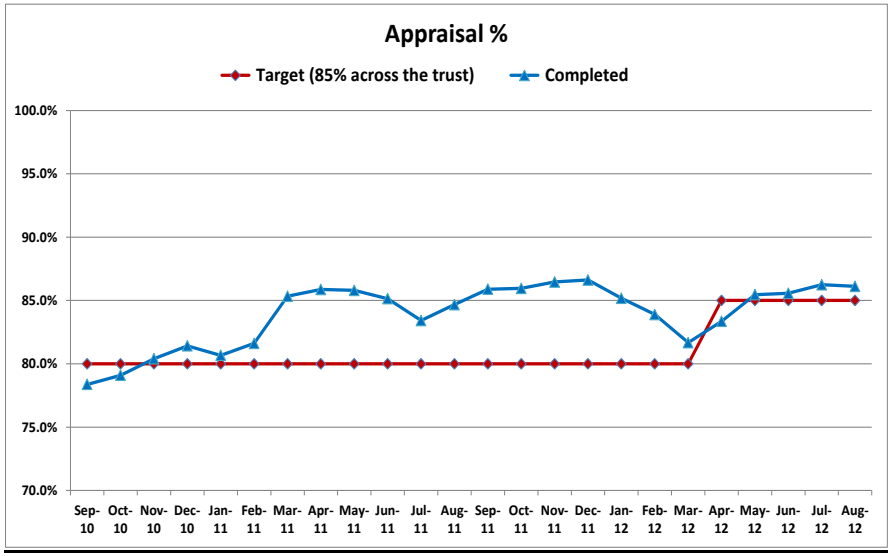
					Authority) training topics require a compliance rate of 95% or progress towards this level to be demonstrated at assessment in September 2013.
HR Update		95% NHSLA	Mandatory	40%	Target audiences not accurately identified on AT-Learning due to difficulties of identifying manager's names
Incident Reporting		95% NHSLA	Regulatory	54%	Business case approved to provide administrative staff to enter data on to At Learning. Staff to commence mid-September.
Induction	80% 90% Stretch	95% NHSLA	Statutory and Regulatory	86%	New Induction Policy approved to ensure compliance figures and non-attendance are followed up.
Infection Control	80% 90% Stretch	95% NHSLA	Statutory And Regulatory	87%	Divisions to review the list of non-attendees. To achieve level 3 NHSLA for hand hygiene compliance must reach and maintain 95%
Information Governance	80% 90% Stretch	95% IG Toolkit	Mandatory	79%	Divisions to review weekly list of non-compliant staff and address. Booklet is available on DMS (Document Management Service), so that staff can print and complete.
Malnutrition screening	80%		Regulatory	82%	Target to 80% achieved.
Manual Handling	80% 90% Stretch	95%NH SLA	Statutory	70%	Target Audiences and Learning Pathways under review
Medical Devices		95% NHSLA	Regulatory		Not recorded on At-Learning. Business case approved to provide administrative staff to enter data on to At Learning. Staff to commence mid-September.
Medicines Management		95% NHSLA	Regulatory	41%	Business case approved to provide administrative staff to enter data on to At Learning. Staff to commence mid-September. Investigations underway to record completions done by E Learning on AT-Learning.
New Starters Orientation	80% 90% Stretch	95% NHSLA	Regulatory	65%	Work being undertaken to chase outstanding Induction Checklists for the past 12 months. Meetings to be held with PGME on recording of and process for Dr's Specialty Induction (included in these figures).
Pressure Ulcer Prevention		95% NHSLA	Regulatory	35%	Pressure Ulcer Prevention is not being entered onto AT-Learning. Business case approved to provide administrative staff to enter data on to At Learning. Staff to commence mid-September.
Resuscitation	75%		Mandatory	87%	A Training Needs Analysis has been carried out to ascertain which Resuscitation training clinical staff need to attend. Resuscitation has set a realistic Target of 75% as there is no Target specified by any regulatory group
Safeguarding Adults Level 1	80% 90% Stretch		Statutory	75%	The Safeguarding Children Steering Group has agreed a detailed action plan, including: • Sufficient training sessions for all levels of training.
Safeguarding Adults Level 2	80% 90% Stretch		Statutory	79%	• Training dates will be re advertised through Connect and flyers to be sent to wards.

WORKFORCE					
Safeguarding Adults Level 3	80% 90% Stretch		Statutory	86%	• Promotion of the 'Professional Practice log' for Level 3 target audience. • Bulletin to be placed on Newsbeat. • Additional sessions will be delivered across the Trust. • Senior level Management to facilitate the release of staff to attend training • Compliance reports will be sent to Heads of Division / Training monthly.
Venous thrombo-embolism		95% NHSLA	Regulatory	48%	Venous Thromboembolism Target Audiences need to be identified. This is due to a lack of administration staff. Business case approved to provide additional administrative staff. Staff to commence mid-September.
Violence and Aggression (V&A)	80% 90% Stretch	95% NHSLA	Mandatory	88%	2012 V&A training planned delivery should maintain or improve current compliance. V&A is included in every Induction as well as every clinical/non-clinical update programme. Special updates are also provided upon request if instructor time/resources allow. Instructors have been willing to work on weekends or after hours if necessary. A review of the target audiences for Levels 1 and 2 of V&A will be undertaken soon to see if any tighter focus can be achieved.
Workstation Assessment	80% 90% Stretch		Statutory	80%	Target audiences identified and training provided with Manual Handling.

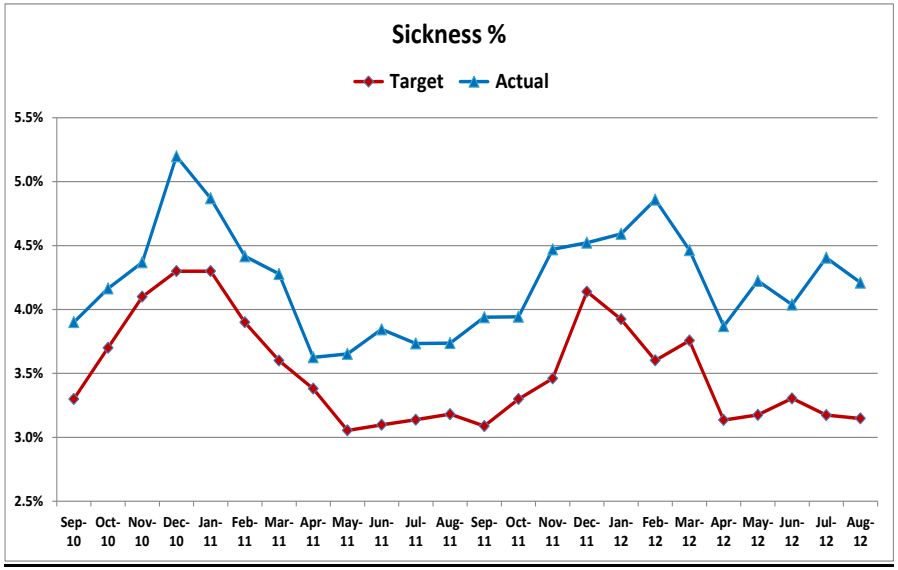
2.3.1c Summary

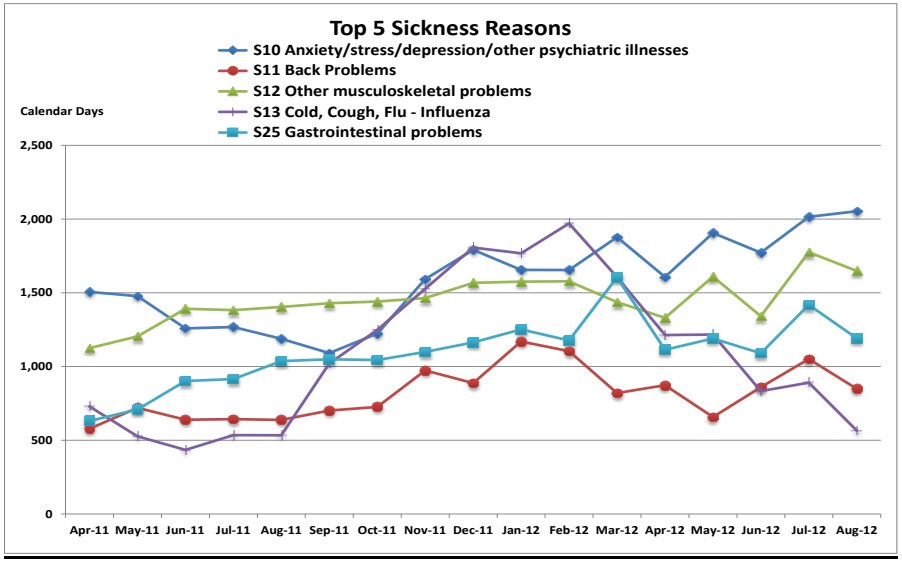
This report provides an outline of the Trust's position against key workforce standards for the month of August 2012, and year to date performance for 2012/13, for workforce numbers, appraisal rates, sickness rates, top five causes of sickness absence, bank and agency usage.

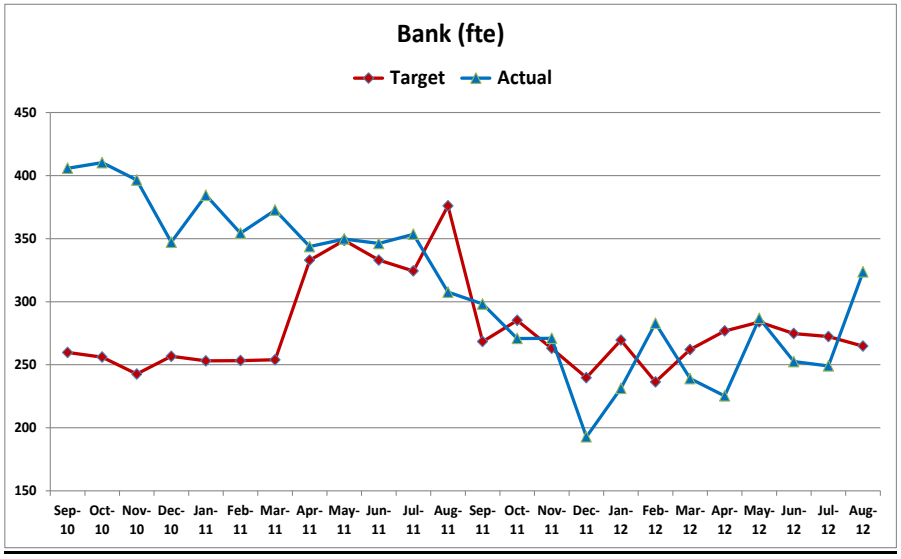


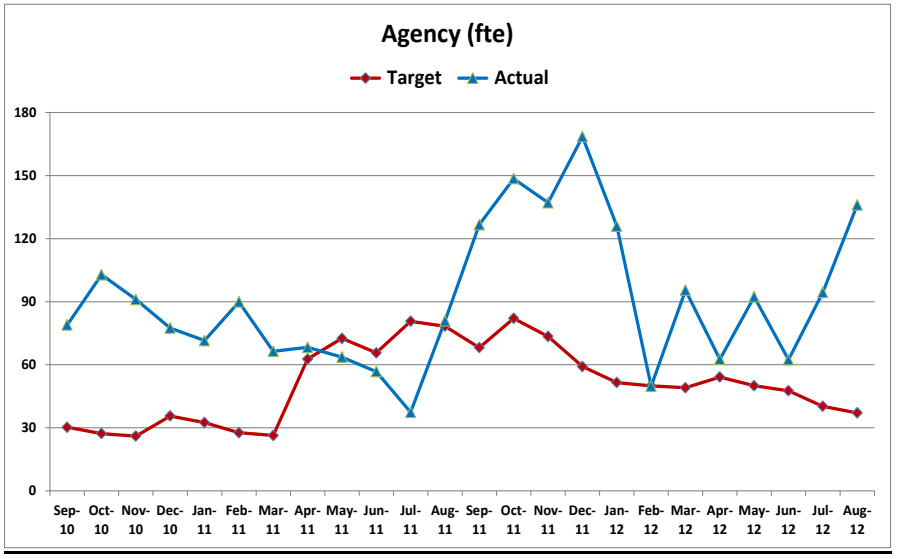


WORKFORCE


Sickness %
Target
Actual
5.5%
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
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 Jul-12 Aug-12

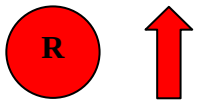
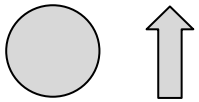
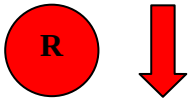
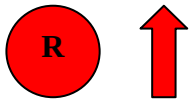
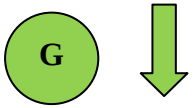

Top 5 Sickness Reasons
S10 Anxiety/stress/depression/other psychiatric illnesses
S11 Back Problems
S12 Other musculoskeletal problems
S13 Cold, Cough, Flu - Influenza
S25 Gastrointestinal problems
Calendar Days
2,500
2,000
1,500
1,000
500
0
Apr-11 May-11 Jun-11 Jul-11 Aug-11 Sep-11 Oct-11 Nov-11 Dec-11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


Bank (fte)
Target
Actual
450
400
350
300
250
200
150
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 Jul-12 Aug-12


Agency (fte)
Target
Actual
180
150
120
90
60
30
0
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 Jul-12 Aug-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 (September 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 increased by 1.7% compared with July 2012, 2.6% above budgeted workforce numbers for August 2012. This compares with July 2012, when workforce numbers were 1.4% above budget.	See summary and exception report
Turnover		Rolling turnover (with exclusions) increased to 10.8%.	See summary
Sickness		Sickness reduced by 0.2 percentage points compared with July 2012 across the Trust, 1.1 percentage points above the monthly target for 2012/13.	See summary and exception report
Bank/Agency		Bank increased by 74.5 FTE and agency by 41.5 FTE in August 2012 compared to July 2012, 34.3% above target compared with 9.0% above in the previous month.	See summary and exception report
Appraisal		Trust wide appraisal rates for all staff were 86.1%, and therefore achieved the stretch target of 85% which was introduced in April 2012. Divisional rates were: Diagnostic & Therapies, 85.1%, Medicine 86.2%, Specialised Services 85.2%, Surgery Head & Neck 85.1%, Women's & Children's 85.0%, Trust Services 90.6%, and Estates & Facilities 88.4%.	See summary
Statutory and mandatory training		Key topic areas of main statutory and mandatory training, average percentage reduced in compliance compared to March 2012, continuing to achieve over 80%.	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	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Aug 12 Planned
Budgeted Posts (FTE)	7379.3	7401.1	7378.4	7351.1	7376.8	7365.3	7368.1	7384.3	7081.2	6973.2	7063.9	7036.2	7072.1	7224.5
Total Employed (FTE)	6868.9	6836.4	6846.4	6845.8	6853.7	6806.7	6795.7	6841.0	6776.8	6745.7	6760.1	6793.3	6800.0	6674.4
Sickness Rate (%)	3.7%	3.9%	3.9%	4.5%	4.5%	4.6%	4.9%	4.5%	3.9%	4.2%	4.0%	4.4%	4.2%	3.1%
Bank (FTE) Admin & Clerical	67.3	99.3	60.7	71.8	50.6	60.8	70.1	61.4	54.1	68.3	55.3	65.3	81.8	71.2
Bank (FTE) Ancillary Staff	13.6	23.5	81.7	10.2	12.9	15.0	15.5	12.9	12.8	14.9	12.9	11.8	14.4	6.8
Bank (FTE) Nursing & Midwifery	225.4	163.4	118.3	177.6	123.3	152.1	197.3	164.7	158.2	203.6	184.3	171.1	227.4	171.5
Agency (FTE) Admin & Clerical	6.4	6.9	7.4	4.6	5.5	13.5	4.5	5.2	6.4	11.8	5.4	8.7	16.9	2.9
Agency (FTE) Ancillary Staff	62.1	78.6	95.1	84.8	110.2	63.4	36.3	34.6	30.0	20.0	22.9	25.3	17.5	19.1
Agency (FTE) Nursing & Midwifery	7.6	9.7	24.6	22.2	30.0	26.7	0.0	37.6	32.4	40.3	30.8	45.5	77.8	6.1
Overtime	40.4	65.3	62.7	81.1	64.9	72.2	76.6	89.1	83.8	70.0	70.9	67.8	74.4	39.6
Appraisal (%)	84.7%	85.9%	86.0%	86.5%	86.6%	85.2%	83.9%	81.7%	83.4%	85.5%	85.6%	86.2%	86.1%	85.0%
Rolling Average Turnover (all reasons) (%)	14.4%	15.2%	15.1%	15.3%	15.7%	16.5%	16.2%	16.8%	17.0%	17.0%	17.2%	19.9%	17.6%	
Rolling Average Turnover (with exclusions) (%)	8.6%	8.8%	8.8%	9.1%	9.3%	9.5%	9.8%	10.3%	10.4%	10.4%	10.5%	10.4%	10.8%	
Vacancy Rate (%)	6.9%	7.6%	7.2%	6.9%	7.1%	7.6%	7.8%	7.4%	4.3%	3.3%	4.3%	3.5%	3.8%	

- 'Turnover' measures the number of leavers expressed as a percentage of the average number of staff in post in the defined period. 'Vacancy' measures the number of vacant posts as a percentage of the budgeted establishment.
- The Sickness Rate is expressed as a percentage of total whole time equivalent (FTE) staff in post

ACCESS STANDARDS

3.1 SUMMARY

The following section provides a summary of the Trust's performance against key national access standards at the **end of August 2012**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 2)***, and/or the ***month***. 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 (15)	**Underachieving (4)**
- 31-day diagnosis to treatment cancer standard - *subsequent drug* - 31-day diagnosis to treatment cancer standard – *subsequent radiotherapy* - 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 - A&E Time to Treatment - A&E Time to Initial Assessment (ambulance arrivals) (95th percentile) - 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) – *local target not achieved* - A&E Maximum waiting time (4-hours) – *national standard being achieved, local stretch target of 98% not being met* - 31-day diagnosis to treatment cancer standard - *first treatment* - 31-day diagnosis to treatment cancer standard - *subsequent surgery*
Failing (4)	**Not reported/scored (0)**
- Last-minute cancelled operations - 28-day readmission – *a date for re-admission within 28 days of cancellation* - 62-day referral to treatment cancer standard – *GP referred* - 62-day referral to treatment cancer standard – *Screening referred*	

*Please note: Performance for the cancer standards is reported by all trusts in the country two months in arrears. The current cancer performance figures shown include the final figures reported for July, and the draft figures for August. Indicators are shown as being **failed** where the required standard is not achieved for the quarter to date. Indicators are shown as being **underachieved** if there has been a failure to achieve the national target in the previous month, but the quarter is currently being achieved, or where a local standard is not being met.*

3.2 ACCESS DASHBOARD

Access Standards - dashboard

	Target	Thresholds Green	Thresholds Red	Previous YTD	Year to date (YTD)	Month Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Quarterly performance Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	88%	95.4%	95.8%	93.4%	94.2%	96.7%	98.1%	94.0%	96.6%	97.1%	96.7%	96.5%	94.6%	95.3%	Cancer standards report two months in arrears	97.0%	96.1%	95.9%	95.3%
	Cancer - Symptomatic Breast (cancer not suspected) in Under 2 Weeks	93%	88%	98.7%	95.9%	100.0%	93.6%	95.3%	97.7%	100.0%	98.4%	95.7%	96.1%	97.3%	95.7%	94.0%		96.8%	97.7%	96.5%	94.0%
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	93%	97.1%	96.3%	99.1%	98.1%	97.5%	98.1%	99.1%	98.4%	99.2%	99.5%	98.4%	92.1%	95.3%		97.9%	98.9%	96.7%	95.3%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	93%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	99.7%	100.0%	100.0%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	89%	98.1%	95.5%	98.3%	93.6%	94.5%	100.0%	93.3%	96.4%	98.2%	100.0%	98.2%	85.4%	98.0%		96.0%	95.9%	94.7%	98.0%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	89%	99.7%	99.6%	98.9%	99.0%	99.5%	100.0%	99.5%	96.9%	99.1%	99.5%	99.4%	99.4%	100.0%		99.5%	98.5%	99.4%	100.0%
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	80%	85.2%	87.4%	87.7%	88.1%	88.2%	89.3%	89.3%	87.7%	87.4%	92.8%	90.8%	83.1%	83.3%		88.4%	88.1%	89.1%	83.3%
	Cancer 62 Day Referral To Treatment (Screenings)	90%	85%	94.2%	92.4%	95.2%	88.1%	100.0%	100.0%	96.2%	100.0%	92.9%	100.0%	100.0%	87.5%	81.8%		95.3%	96.2%	95.9%	81.8%
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	95.1%	96.9%	94.9%	94.4%	94.7%	87.0%	91.9%	93.6%	93.8%	100.0%	100.0%	88.6%	100.0%		91.7%	93.1%	96.7%	100.0%
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	85%	92.2%	92.2%	91.9%	91.2%	91.2%	90.6%	91.8%	91.4%	91.2%	91.2%	93.2%	91.5%	91.8%	92.1%	91.0%	91.4%	92.1%	92.0%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	90%	98.2%	96.2%	97.7%	97.8%	97.2%	98.0%	97.6%	97.6%	98.0%	97.9%	96.8%	95.9%	95.8%	95.3%	97.6%	97.7%	96.8%	95.6%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	87%	Not reported	92.2%	Target not in effect							92.2%	92.2%	92.1%	92.4%	92.2%	Not reported		92.2%	92.3%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	98.0%	94.3%	97.1%	95.4%	97.1%	94.5%	94.1%	91.5%	92.0%	93.4%	91.9%	95.7%	95.3%	95.3%	95.6%	92.5%	93.6%	95.3%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	59	120	13	14	12	13	12	48	30	120	196	15	13	13	13	24	151	13
	A&E Time to treatment decision (median) - in minutes	60	60	19	60	18	19	17	21	19	24	26	30	69	62	61	50	19	23	53	55
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	1.5%	2.1%	1.9%	2.0%	1.9%	1.8%	1.8%	1.5%	1.6%	1.1%	2.1%	2.6%	2.4%	2.3%	1.9%	1.6%	2.0%	2.4%
	A&E Left without being seen	5%	5%	1.0%	2.6%	1.1%	1.3%	0.6%	0.9%	0.8%	1.1%	1.3%	2.2%	5.0%	2.4%	1.5%	1.7%	0.9%	1.1%	3.3%	1.6%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	0.99%	1.07%	0.31%	0.90%	0.89%	0.85%	0.88%	0.96%	0.76%	1.08%	1.59%	0.94%	0.77%	0.96%	0.88%	0.87%	1.21%	0.86%
	28 Day Readmissions	95%	85%	93.6%	88.2%	96.1%	100.0%	92.0%	93.9%	95.2%	92.0%	86.8%	84.4%	88.2%	88.0%	87.8%	93.0%	94.0%	91.0%	87.2%	90.2%
	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%	83.5%	85.5%	97.1%	85.7%	77.3%	70.4%	86.1%	90.4%	81.1%	89.7%	81.8%	88.2%	83.3%		87.8%	86.4%	86.5%	83.3%
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	89.0%	93.6%	94.3%	90.5%	86.4%	100.0%	88.9%	94.2%	91.9%	96.6%	84.8%	97.1%	95.2%		91.2%	92.0%	92.7%	95.5%
	Infant Health - Mothers Initiating Breastfeeding	76.3%	74.5%	76.1%	80.0%	73.8%	78.2%	77.1%	76.5%	77.3%	74.7%	76.0%	74.2%	80.7%	81.7%	80.7%	80.1%	77.3%	76.0%	78.8%	80.6%

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
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:

- Last-minute cancelled operations ↑ (up from 0.77% in July to 0.96 % in August)
- 28-day readmission standard ↑ (up from 87.8% in July to 93.0% in August)
- 31-day diagnosis to treatment (first treatment) cancer standard ↑ (up from 92.1% in June to 95.3% in July)
- 31-day diagnosis to treatment (subsequent surgery) cancer standard ↑ (up from 85.4% in June to 98.0 % in July)
- 62-day referral to treatment (screening referred) cancer standard ↓ (down from 87.5% in July to 81.8 % in August)

Please note the above performance figures only show the final reported position and do not show the draft August performance against the cancer standards.

3.4 EXCEPTION REPORTS

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

1) Last-minute cancelled operations
2) 28-day readmission
3) Cancer 62-day referral to Treatment – GP referred
4) Cancer 62-day referral to Treatment - Screening referred

ACCESS STANDARDS

A1-A2. EXCEPTION REPORT: Last-minute cancellation and 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 54 last-minute cancellations (LMCs) of surgery in **August** (0.96% of operations) which is above the national standard of 0.8%. The main reasons for cancellations in the month were as follows:

- 31% of cancellations (17 cancellations) were due to an emergency patient being prioritised on the day
- 20% (11 cancellations) were due to surgeons being unavailable to operate
- 9% (5 cancellations) were due to another clinically complicated patient being in theatre, with a resulting lack in theatre time
- 7% (4 cancellations) no ward bed being available

Of the 54 cancellations, 18 were day-cases and 36 were inpatients (33% 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, which is more likely to impact inpatient than day-case procedures. Levels of surgical emergency admissions have been high in recent weeks which explains the high levels of cancellations due to an emergency patient needing to be prioritised on the day.

The number of ward-bed related cancellations was low this month (7% of cancellations), which mirrors the improvement in patient flow and the achievement of the A&E 4-hour 95% standard.

Six of the 11 cases of a surgeon not being available were within Ophthalmology, and Dermatology. In the case of the Ophthalmic surgeon, his list of three cases had to be cancelled due to his wife going into labour.

In August 93.0% of patients cancelled in the previous month were readmitted within 28 days of the cancellation. This is below the national standard of 95%, but a significant improvement on recent months.

Three patients were not able to be re-booked within 28 days of the cancellation of their surgery. The reasons for these were as follows:

- 1 patient was clinically complex, and could not be accommodated on a theatre list within 28 days due to other patients on the surgeon's list

being more urgent

- 1 patient was offered another date for their operation, but had to be cancelled again because of more urgent patients needing to be operated on
- 1 patients required a specific surgeon to undertake the operation, and the surgeon was on leave during the month, limiting capacity to re-book

The critical success factors in achieving the 28-day readmission standard are:

- Reducing the number of last-minute cancellations that need to be re-booked
- Robust management of the re-booking process
- Ensuring good level of bed availability so that patients aren't cancelled again, or delayed due to ongoing difficulties with capacity in the month we are attempting to re-book

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*):

- Escalation of all LMCs not re-booked within 7 days of cancellation (ongoing)
- Monthly validation of all potential LMCs re-established, to ensure we are not inappropriately reporting last-minute cancelled operations, or failures to re-admit within 28 days, and that we understand the reasons for cancellations (Ongoing)
- 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 was approved by the Surgical Executive in August; this is now being trialled in Maxillo Facial
- 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*)
- Productive Operating Theatres is undertaking a programme of work in Cardiac Theatres, which is aimed at reducing cancellations both before and on the day of surgery
- Implementation of the Optimising Use of Beds work-steam will continue – with the aim of balancing bed capacity and demand for beds
- Ongoing implementation of 4-hour and Winter Resilience plans, the actions from which should reduce cancellations related to bed availability

Progress against the recovery plan:

The Trust achieved the 0.8% national standard for last-minute cancellations in July. But the national standard wasn't achieved in August. The reduction in the levels of cancelled operations in July helped to improve the 28-day readmission rate, although the 95% standard was not quite achieved. Maintaining a low level of bed-related cancellations remains critical to the achievement of both the 0.8% national standard, but also the

ACCESS STANDARDS
readmission of patients within 28 days.

ACCESS STANDARDS

A3-A4. EXCEPTION REPORT: 62-day referral to treatment for GP and screening referred patients	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients with confirmed cancers treated within 62 days of referral, as a percentage all cancer patients treated during the period under that standard. There are separate targets for GP and screening referred patients.

Monitor measurement period: Quarterly, as part of a combined 62-day cancer standards (weighted 1.0)

Performance during the period, including reasons for exceptions:

62-day GP referred

During July 83.3% of patients were treated within 62 days of urgent referral by their GP against the 85% national target. Twenty-three patients were not treated within the standard in the month. The main reasons for breaches of standard in the month were (in order of frequency):

- Patient choice to delay
- Late referral from other provider / delays at other providers
- Delayed outpatient appointment
- Medical deferral
- Complex patient/diagnostic pathway (e.g. multiple additional tests required, referred to more than one tumour site)
- Administrative issues
- Elective capacity

The top two causes, of patient choice and delays at other providers, accounted for over half of the breaches, although in accountability terms the impact on performance was less, as we share the breach with the other provider.

62-day screening referred

During July 81.8% of patients were treated within 62 days of referral from one of the three national screening programmes against the 90% national target. Three patients were not treated within the standard in the month, the reasons for which were:

- Patient choice to delay outpatient appointment or diagnostic test (one breast patient; one colorectal patient)
- Diagnostic delay, which resulted in a further week's delay to Multi-Disciplinary Team discussion (one breast patient)

There are a number of factors that have contributed to the deterioration in performance across these two standards. High levels of patient choice over the summer months has had a significant impacted on pathways in the period, both in terms of local patients and late referrals from other providers.

This has particularly affected screening pathways, where patients are not exhibiting symptoms and therefore are more likely to elect to delay invasive diagnostics. There has been a much higher number of late referrals from other trusts in the quarter compared to last quarter, many of which are lung patients. This may be related to the recent lung cancer awareness campaign.

High levels of emergency demand has impacted patient flow, particularly around availability of Intensive Therapy Unit (ITU)/High Dependency Unit beds, which has in turn led to cancellations. The period has also seen a higher number of administrative related issues, which is likely related to the recent gaps within the MDT (Multi-Disciplinary Team) co-ordinator and wider cancer services team due to vacancies and long-term sick leave Some of these gaps have since been filled, with others due to start in October/November. Additional posts are also under consideration to provide greater resilience within the team, whilst a review of administrative support for cancer services is undertaken.

Some areas have experienced unforeseeably sharp increases in demand, particularly Upper GI Hepato-biliary (HPB), which has led to capacity problems. There have also been a higher volume of specialist surgeon-specific procedures which reduces the flexibility possible around scheduling. There were also some delays in template biopsies being undertaken, again due to capacity constraints. The issues were escalated and have since been resolved. However, this did impact some urology pathways.

Recovery plan, including expected date performance will be restored:

The actions being taken to ensure continued quarterly achievement of the 62-day standard for GP and screening referred patients are detailed below. *Please note: actions completed in previous months have been removed from the following list*:

- Additional operating sessions are being planned as required
- Additional support to recruit to a supernumerary band 4 MDT co-ordinator and an additional band 2 clerical support for the team has been agreed, and recruitment is underway; band 2 support currently in place from the Administrative & Clerical bank
- A tool is being developed which will help identify urology patients referred to University Hospitals Bristol from other trusts for a urology outpatient appointment, prior to surgery at North Bristol Trust; this will help to ensure the MDT Co-ordinator for the tumour site is made aware of these patients earlier in their referral (end of September)
- Letters continue to be sent to referring trusts when a referral is received after day 46 in the pathway
- A locum endoscopist will be appointed to meet increasing demand for gastro-intestinal endoscopies, and help reduce the risks associated with an expected increase in demand due to the autumn bowel cancer awareness campaign (end of October)
- Additional equipment for undertaking liver surgery has been purchased to improve hepato-biliary capacity (Order placed – equipment should arrive before the end of September)
- Additional ad hoc hepato-biliary operating sessions are being planned as required (Ongoing)
- Divisions of Surgery, Head & Neck and Specialised Services continue to use capacity flexibly, to try to meet demand for high care/intensive therapy unit beds (Ongoing)
- A review of demand for high care/intensive therapy unit beds will be undertaken as part of the refresh of the long-term bed capacity model (end October)

ACCESS STANDARDS

- A&E 4-hour improvement plan continues to be implemented to reduce cancellations of surgery on the day (Ongoing)

Progress against the recovery plan:

August's draft performance against the 62-day GP referred standard is above the national target (at 85.9% against the 85% standard). August's draft performance against the 62-day screening standard is at the 90% national standard (90.0%).

It is still possible for both standards to be achieved, although achievement is considered to be at risk for the 62-day screening. Actions continue to be taken to restore compliance with these standards within the current quarter, and to significantly reduce identified risks to non-achievement in quarter 3.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 06 – Histopathology Action Plan Update

Purpose

To brief the Board on progress in implementing the Trust's Histopathology Action Plan and the reporting arrangements both internally and externally.

Abstract

The Histopathology Action Plan 2012-13 is managed within operational management structures of UHBristol and NBT. Assurance is provided both through the normal governance structures of the organisations and by regular 3 monthly reports directly to the Medical Directors. There will be exception reporting if required.

The plan is being reported to South Gloucestershire and Bristol Joint Health Overview and Scrutiny Committee on19 September 2012

The first of the 3 monthly reports is due to be presented to the D&T Board on 25 September with a copy to the medical director.

The majority of the Action Plan is on time with evidence available as required.

The only issues for which there is a slight delay is the agreed work plan for specialist teams, finalising job plans for all consultants and having a fully implemented IT solution so that consultants can access the Ultra system from across the city.

Dr Pitcher will be providing updates to the HOSC on these issues and they will form part of his first report as described above.

Recommendations

The Trust Board is asked to **note** the report.

Executive Report Sponsor or Other Author

Sponsor – The Medical Director, Sean O'Kelly

Author – Head of Division, Diagnostics and Therapies, Lis Kutt.

Appendices

- Appendix A – Histopathology Inquiry Revisit Action Plan V16

North Bristol NHS Trust

University Hospitals Bristol NHS Foundation Trust

HISTOPATHOLOGY ACTION PLAN 2012-13 – ARISING FROM THE INQUIRY REVISIT

Version	Date	Reviewer	Comment
Version 11	2012.06.19	Rob Pitcher	Amended following discussions with Lis Kutt and Sean O'Kelly
Version 12	2012.06.20	Rob Pitcher	Further information added and date amended following discussion with Sean O'Kelly
Version 13	2012.07.25	Rob Pitcher	Updated for Divisional Board UHB, NBT and BCPF
Version 14	2012.08.30	Rob Pitcher	Monthly update
Version 15	2012.09.05	Lis Kutt	Monthly update reformatted
Version 16	2012.09.19	Rob Pitcher	Updated for UHBristol Board and Joint Bristol and South Glos HOSC

Ref No	Actions	Timescale	Responsible person/body	Progress	Complete	Evidence
Section Lead:	**Original Inquiry action plan: while 43 of the 44 of the actions from the initial action plan developed from the recommendations of the Histopathology Inquiry have been completed there is one outstanding where further work is required. This is also referred to in the further work identified by the inquiry team during their revisit.**					
	Develop Service Structure and Proposition for integrated cellular pathology service	(Expected October 2012; see item 2.0 below)	Proposition: Rob Pitcher. Decision: NBT and UHBristol Trust Boards	• These issues are being considered as part of the wider Pathology Services Review being led by NHS Bristol. • The Clinical Lead for Cellular Pathology is also the clinical lead for Severn Pathology		

Ref No	Actions	Timescale	Responsible person/body	Progress	Complete	Evidence
Section Lead:	The Inquiry team revisited Bristol on the 29th February and the 1st March and recommended focus on a number of issues. The following actions are intended to take the identified issues forward. Their overarching recommendation is to keep up the momentum of change and improvement.					
1.0 Resolve the staffing issues in breast histopathology as soon as possible and repatriate to NBT the work currently outsourced						
1.1	Recruit to vacant posts at NBT	Sept 2012	Rob Pitcher	3 candidates offered posts following interviews in May 2012. All 3 have now started	Y	Y
1.2	Develop expertise of existing consultant with an expressed interest leading to independent reporting	Sept 2012	Rob Pitcher	Currently in progress with participation in the breast EQA scheme, exposure to breast work and attendance at specialist meetings	N	
1.3	Develop plan for repatriating work	Aug 2012	Rob Pitcher	Plan agreed and repatriation commenced	Y	Y
2.0 Make the decision about the future of pathology services in Bristol as soon as possible with diagnostic reliability and clinical effectiveness as dominant criteria to enable histopathology to operate as a unified service						
2.1	NBT to develop detailed proposal for a consolidated pathology service under the aegis of the Bristol and Weston Pathology Review	October 2012	NBT Pathology Board	As proposed lead provider NBT has a project developing this proposal. This includes the provision of a central laboratory for cellular pathology The external advisory panel in July agreed good progress had been and was supportive of proposal. Further work being undertaken before Trust Boards in November	N	

Ref No	Actions	Timescale	Responsible person/body	Progress	Complete	Evidence
3.0 Fully implement the introduction of sub-specialty teams						
3.1	Identify teams and members	July 2012	Rob Pitcher	Teams and members identified	Y	Y
3.2	Finalise 2012-13 work programmes for each team	July 2012	Rob Pitcher	Draft work programmes have been produced for majority of teams	N	Y
3.3	Implementation of work programmes	September 2012	Rob Pitcher	Further discussions have taken place but this will not be complete across all sub-specialties and across NBT and UHBristol in July - revised date of completion by end of September 2012. This is due to a combination of new staff starting and absence of key team members.	N	
4.0 Continue the review of MDTs to ensure that the teams are functioning reliably and effectively across the city.						
4.1	Continue audit of 'deferred' patient discussions at MDTs at both Trusts. Report results to relevant internal meetings. Follow up any issues that arise from the audit.	Ongoing	Dany Bell (NBT) &Hannah Marder (UHB)		Y	Service Delivery Group performance reports
4.2	Cancer Manager at UHB to continue attending NBT Cancer Committee. Medical Director NBT to continue attending UHB Cancer Board.	Ongoing	Dany Bell (NBT) &Hannah Marder (UHB)		Y	Minutes from meetings

Ref No	Actions	Timescale	Responsible person/body	Progress	Complete	Evidence
4.3	Cross-city meetings to continue.	Ongoing	Dany Bell (NBT) &Hannah Marder (UHB)		Y	Minutes from meetings
4.4	Continue monitoring of MDT attendance, sharing results with managers	Ongoing	Dany Bell (NBT) &Hannah Marder (UHB)		Y	Audits of member attendance
5.0 Implement and audit the agreed procedure for double reporting.						
5.1	Modify the existing protocol in the light of guidance from the RCPath	July 2012	Rob Pitcher	Guidance issued in August in draft form	N	
5.2	Harmonise categories of work where double reporting is mandated across both NBT and UHBristol	June 2012	Rob Pitcher	Categories identified	Y	Double reporting.msg BCPF minutes June 2012

Ref No	Actions	Timescale	Responsible person/body	Progress	Complete	Evidence
5.3	Introduce a general rule that all first diagnoses of malignancy are double reported with some documented exceptions	Sept 2012	Rob Pitcher	Depends on successful recruitment	N	
5.4	Audit adherence to the revised protocol	2012-13	Rob Pitcher	Included in audit programme	N	
6.0 Keep consultant staffing under review						
6.1	Review consultant staffing on an annual basis	Sept 2012	Rob Pitcher	Completed for current year	Y	Y
6.2	Include as part of the annual report and take forward any proposed changes through Trust process	July 2012	Rob Pitcher	A new consultant post has been agreed in each Trust and a Consultant Senior Lecturer has been appointed at the UoB with 4 clinical sessions	Y	Y
6.3	Ensure annual job planning process is completed	Sept 2012	Rob Pitcher	Progress with job planning has slipped due to problems with analysing workload information. This work is now underway in August and September with executive review of completed job plans at UHBristol to take place on 26th October 2012.		Consultant work diaries Consultant workload

Ref No	Actions	Timescale	Responsible person/body	Progress	Complete	Evidence
7.0 The histopathologists should confine their practice to areas of specialist competence proven by quality assurance and audit.						
	Policy on Specialist Reporting: Approach to diagnoses outside ones field of expertise	Mar 2012	Rob Pitcher	This is agreed	Y	Policy doc
	EQA participation	Annually March 2013		Monitored	Y	Y
	Specialist team audits	Annually March 2013		Correlation audit to compare the reporting of the original biopsy sample with reporting of the resection specimen post surgery Correlation audit to compare the results of cytology with the results of subsequent biopsies from the same site		
8.0 Continue to develop the network for paediatric and perinatal pathology with Oxford and Southampton.						
8.1	Identify and progress areas of practice in the network where benefits can be realised	October 2012	Craig Platt	• Audit results for microbiology in stillbirths have been shared with Southampton who have done similar audit • Further meeting of network planned for		

Ref No	Actions	Timescale	Responsible person/body	Progress	Complete	Evidence
				November		
9.0 Fund further upgrading of the BRI Department. We recognise that it is important to keep in mind the longer term schemes likely to be required following the Bristol Pathology Review.						
9.1	Fund and develop hot reporting rooms with microscopes and networked computers at BRI	Sept 2012 – Linked transfer of Breast, Urology and H&N services which is due Spring 2013	Lisa Galvani	Planned works involve creation of accommodation for audit clerks and visiting Consultants from NBT. Works including fitting out the rooms with equipment and the decoration of offices has now been completed.	N	
9.2	Fund and develop hot reporting rooms with microscopes and networked computers at NBT	Sept 2012	NBT lead	The conversion is now complete with only the offices now requiring fitting out	N	

Ref No	Actions	Timescale	Responsible person/body	Progress	Complete	Evidence
9.3	Provide access to each Trust's Ultra system from all reporting consultants computers at both NBT and UHBristol	June 2012	Mark Orrell, Wayne Tainton, John Siggins	Several issues have been identified in trying to provide this however, an interim solution has been identified in principle	N	
9.4	Support is required from IT at both NBT & UHBristol to roll out interim solution through departments	Sept 2012	IMT lead NBT & Andrew Hooper UHB	Continuing IT technical problems have delayed the roll out of the identified solution above A temporary workaround is to have a single computer that can access other Ultra system; this has been implemented at UHBristol. A similar workaround is required at NBT.	N	

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 07 – Safeguarding Annual Report
Purpose
To brief the Board on the Trust's Safeguarding initiatives and achievements for the reporting year 2011-2012.
Abstract
The requirement to safeguarding children and adult's remains central to all the trust activities, underpinned statutory requirements. Safeguarding activity continues to be monitored externally through the Care Quality Commission (CQC) and the NHS Commissioners as well as internally through existing governance structures and the adult and children's steering groups, chaired by Alison Moon as Executive Lead for Safeguarding. There are two areas of concern for compliance with the CQC Outcome Seven (Safeguarding): safeguarding training compliance and restraint policy and training. An action plan is in place to address these concerns which will continue into the next reporting period. More trust staff have now completed safeguarding training than ever before, and this is resulting in an increasing awareness of potential risk factors and reflected in the year on year increase in safeguarding referrals and advice being sought from the safeguarding leads.
Recommendations
The Board is recommended to **note** the report.
Report Sponsor
Alison Moon, Chief Nurse
Other Author
Carol Sawkins, Nurse Consultant Safeguarding Children (Named Nurse) Anne Berry, Safeguarding Adults Lead.
Appendices
• Appendix A – Safeguarding Annual Report

University Hospitals Bristol NHS
NHS Foundation Trust

SAFEGUARDING ANNUAL REPORT

APRIL 2011 – MARCH 2012

Prepared by:

Carol Sawkins
Safeguarding Children Nurse Consultant (Named Nurse)

And

Anne Berry
Safeguarding Adults Lead

CONTENTS

Preface for Safeguarding Annual Report

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

The Annual Report for 2011/12 demonstrates continued energy and focus in addressing this responsibility. The challenges are significant for our staff to ensure they are always alert to those patients in our care who may be vulnerable. 2011/12 has been a very busy year in safeguarding terms and there are many examples of exemplar practice. Our staff need to be competent and confident in their approach to safeguarding, keeping the individual at the heart of what they do. We need to pay special attention to those who for whatever reason may not have a strong voice and above all we need to treat people in our care with kindness and compassion.

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

Alison Moon
Executive Lead for Safeguarding / Chief Nurse

1. Introduction

This annual report relates to the period 1st April 2011 to 31st March 2012 and will cover both Adult and Children's Safeguarding. The safeguarding of our patients is best-addressed under one trust agenda underpinned by the 'Think Family' approach, although both areas continue to retain specific specialist teams with individual areas of responsibility.

This joint approach supported the Regulatory Framework developed by the Care Quality Commission in which 'safeguarding' is considered as a specific outcome. This reporting period has seen both fields of safeguarding remain an area of high priority, both locally and nationally, with several high profile cases including Winterbourne View, focusing public attention on the requirement to protect all vulnerable members of our society from harm.

Over the past year the safeguarding arrangements within all areas of the trust have continued to be strengthened, with a particular focus on ensuring our staff receives safeguarding training. We know that staff who are trained within the area of safeguarding are more likely to identify and support a vulnerable person so it is important to us that training has taken place. Work plans are in place which follow a joined up approach viewing safeguarding as a continuum from the unborn baby until older age. The safeguarding agendas are underpinned by the trusts values in particular the strong culture of both multi agency and multi-disciplinary working reflecting the aim of 'Working together' and 'Respecting everyone' being a core value to all aspects of safeguarding.

2. Key Safeguarding Achievements of 2011/12.

During this reporting period significant progress has been made with both the safeguarding adults and children's work plans and objectives, which are detailed within the main body of this report. Key achievements are summarised below:

- Significant progress has been made across the Trust in relation to the amount of safeguarding training that has been delivered, for both adults and children, with more staff than ever before having completed the appropriate level of training.
- Increased staff awareness of their safeguarding responsibilities is clearly demonstrated by the year on year increase in the number of safeguarding referrals

being made by staff to Social Care, as well as advice and supervision being sought through the safeguarding teams.

- The Safeguarding teams have contributed to a number multi-agency Serious Case reviews in a timely manner and evaluation of the reports has been very positive.
- To support safeguarding, caring for people with learning difficulties has remained high on the agenda, and achieved some excellent results with interagency working. The addition of easy read leaflets this year, specifically for this group of service users enhances and supports the patient journey and their experience of hospital.
- The Dementia Standards work has also contributed to safeguarding with the implementation of dementia champions, and the 'This is me' document which focuses on the person behind the medical condition, being fully utilised across the trust.
- Independent Domestic Violence Advisers are now fully integrated with both safeguarding teams and have made a significant contribution in providing a specialist support to high-risk victims of domestic abuse and their children.
- The 'Think Family' principle continues to underpin both the children's and adults safeguarding objectives and is promoted through safeguarding training.
- The development of an evidence based Infant Safeguarding Assessment Tool for use within the Children's Emergency Department.

3. Brief overview of National and Local Safeguarding drivers.

The Mental Capacity Act 2005 (MCA) was introduced in April 2007 and fully implemented by October 2007. The MCA assists to underpin the principles of safeguarding vulnerable people.

Deprivation of Liberty Safeguards come within the scope of the MCA, and was introduced through an amendment of the Mental Health Act in 2007, giving a wider definition of mental disorder, to include as an example people with a learning disability. The Deprivation of Liberty Safeguards applied to all hospitals and care homes from 2009.

Other key legislation which is routinely considered throughout the safeguarding process is the Domestic Violence, Crime and Victims Act 2004, Human Rights Act 1998, Youth Justice and Criminal Evidence Act 1999, Mental Health Act as amended 2007, and the Sexual Offenders Act 2003.

In January 2010, the Government announced its response to the 2008 safeguarding consultation, which included:

- National leadership through an Inter-Departmental Ministerial Group (IDMG) on Safeguarding Vulnerable Adults.
- New legislation to put local safeguarding adult's boards on a statutory footing.

- A programme of work including the development of new multi-agency guidance.

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

Safeguarding children, young people and the unborn baby, remains 'everyone's responsibility' (Laming 2009); and for all trust employees, no matter what their role or responsibility. This requirement is further underpinned by the statutory responsibilities outlined in the Children Act 2004 and within Working Together to Safeguard Children 2006/2010.

In June 2010 the Secretary of State for Education commissioned the Munro Review of Child Protection to consider what helps professionals to make the best judgements to protect vulnerable children and to consider how child protection systems can be improved. The review was completed in May 2011 and the Government has endorsed the fifteen recommendations of the final Munro report, and a plan currently being developed to guide implementation of these changes in practice. The recommendations aim to reduce the amount of bureaucracy surrounding the current safeguarding process as well as the prescriptive nature of the guidance, for example with specified timeframes for the completion of initial and core assessments, thereby allowing practice to be guided by local guidance and the individual professional judgement.

The recommendations will include a complete review of the guidance 'Working Together to Safeguard Children' which currently includes detailed statutory guidance for all agencies. There are likely to be significant implications for front-line practitioners resulting from the anticipated much reduced and less constrained version. This will have consequence for the way in which practitioners work together both across agencies and across regions.

The importance of safeguarding vulnerable patients whilst in our care continues to underpin all the Trusts values and health care activities. This includes recognising that staff who may have no direct contact with children may be caring for a parent with behaviours which may impact on their ability to care for a child. Although there may be some fundamental differences within the law, which underpins both adults and children's safeguarding, it is important to appreciate that safeguarding, should be viewed as a whole, very much following a 'Think Family' agenda. This can be managed successfully together in an organisation where appropriate experts are overseeing policy and practice.

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

The Trust Board continues to hold ultimate accountability for ensuring that safeguarding responsibilities are met, supported by the Safeguarding Steering Groups, which are chaired by the Chief Nurse as Executive Lead for Safeguarding. This includes the internal governance of all safeguarding activities across the trust. Safeguarding activities continue to be directed on a day-to-day basis by teams of well-established and experienced professionals.

The full structure of the Trust's safeguarding arrangements for 2011/12 is detailed in Appendix One.

The Trust safeguarding activities are also monitored externally, both nationally and locally, through the commissioning and regulating arrangements, including by the Care Quality Commission, Monitor, Safeguarding Boards and NHS Bristol through a set of Commissioning Standards for safeguarding.

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

The Trust continues to have in place Safeguarding Children and Adult polices and procedures to guide staff through their contractual responsibilities to protect vulnerable patients, which includes, for example guidance on information sharing, making a referral and how to a mange professional differences of opinion. These polices and procedures are based on current National and local guidance and are reviewed regularly.

5. Summary of Key Safeguarding Activities within UHBristol 2011/12

The previous annual report (2010/11) highlighted the need for the safeguarding of children and adults to be fully embedded into all trust activities; this has been reflected both through the work plans of both safeguarding steering groups and the trusts commitment to achieve safeguarding training compliance targets.

Monitoring of safeguarding activity forms part of the trust governance arrangements and is reported quarterly to the safeguarding steering groups, and also includes data required by commissioning contracts. Compliance with the Care Quality Commission Outcome Seven is also monitored quarterly through the Regulatory Compliance Group, with additional scrutiny from the Clinical Quality Group. Also in this reporting period governance arrangements have become more robust in that all relevant incident forms

are now reviewed by the relevant safeguarding leads to identify any gaps, patterns or trends, which were identified as an objective for 2011/12.

The requirement to ensure that communication channels are fully embedded within the trust, including the dissemination of safeguarding information was also highlighted in the previous annual report. All divisions are now represented at both the children and adults trust safeguarding boards and have the responsibility for the dissemination of information through their Divisional Boards. Specific training on safeguarding has been received by the Patient Support and Complaints team, and there is now an overview of any complaints which may suggest safeguarding issues by both the Safeguarding Leads.

Further work will be required in the next reporting period to fulfil one of the outstanding objectives from 2011/12:

- To improve transitional care arrangements to ensure that the service user and the parent /guardian are provided with the necessary information prior to the child becoming an adult.

A detailed summary of the key activities for this reporting year, according to these commissioning standards, is detailed within the data below.

5.1 Safeguarding Training.

The provision and delivery of safeguarding training for both children and adults remains a key priority for both safeguarding teams, with the requirement that all staff are provided with the appropriate level of training according to their role and responsibilities. The aim of the safeguarding training is to ensure that every member of staff is aware of their safeguarding roles and responsibilities, that they recognise abuse and know what to do about it, as the minimum requirement.

Level One Safeguarding awareness training for both adults and children continues to be mandatory for all new starters and as such is included within the Trust Corporate induction. Other levels of safeguarding training are delivered to staff groups according to their specific roles and responsibilities, detailed within the Safeguarding Training Matrixes.

Compliance with all levels of training is robustly monitored within the Trust as well as being fundamental to the Care Quality Commission standards and review. Throughout this reporting period a robust plan has been in place, agreed by the Safeguarding Steering Groups to support the delivery of safeguarding training across the trust. However improvement with all levels of safeguarding training compliance continues to be an area of concern for the trust, which will be considered in more detail later in this report.

Within the wider remit of safeguarding two further areas have been addressed at the end of this reporting year. The Prevent strategy, which is the term used to describe part of the government's anti-terrorism strategy, and Clinical Holding, which sits within the restraint requirements of CQC Outcome 7 regulations. Whilst both these areas have been considered and action plans put in place, outcomes will be provided within the 2012/13 annual report.

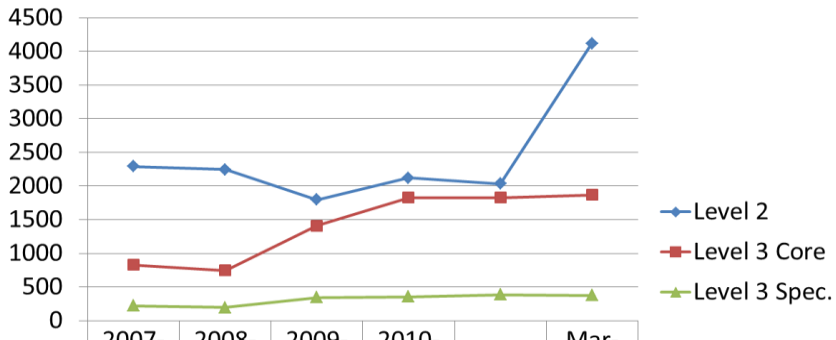
The training data management system known as At- Learning, which provides the trust with training compliance reports, has had some reporting challenges throughout this period due to an association with the Trust ESR system. However much work has taken place to address these issues and it is hoped that more accurate data will now allow for effective reporting.

5.1.1 Safeguarding Children Training Data:

This reporting period has seen the on-going plan to fully incorporate the recommendations of the Intercollegiate Roles and Competencies for Health Care Staff (September 2010). The final stage in this process was the inclusion of all clinical staff into the Level 2 target audience, resulting in a significant increase in the target audience from 2033 to 4117 staff, highlighted below in table One. The safeguarding children training matrix has also been reviewed for the fourth consecutive year, incorporating these recommendations.

As anticipated these changes have had a major impact on the compliance reporting throughout this reporting period. The Trust has remained committed to improve compliance and working towards achieving the aims and objectives of the training recovery plan to be fully achieved by the end of 2012.

Table One: Number of staff required to complete Safeguarding Children Training.

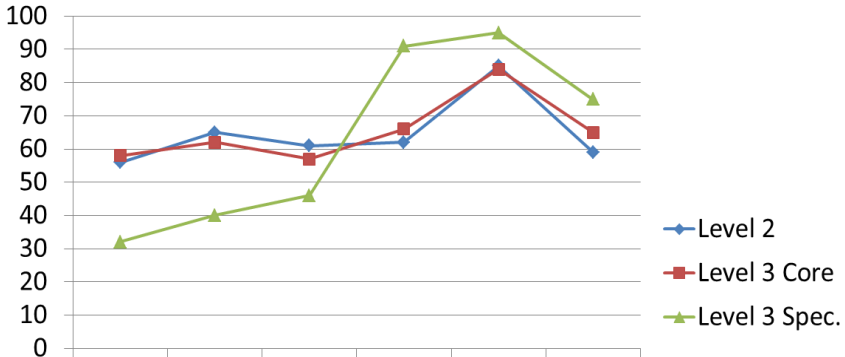


	2007-08	2008-09	2009-10	2010-11	Dec-11	Mar-12
Level 2	2289	2244	1796	2121	2033	4117
Level 3 Core	829	744	1412	1826	1828	1868
Level 3 Spec.	219	197	344	355	385	374

Table One demonstrates how the changes recommended by the 'intercollegiate Roles and Competencies for Heath Care Staff (2010) has resulted in a further significant increase in the number of staff who now require safeguarding training at Level 2.

This final change in the target audience resulted in a significant adverse effect on level 2 training compliance from January 2012, detailed below in Table Two. This had however been anticipated and a robust recovery plan was immediately put into place. This reporting period also saw changes, to the update requirements for all staff in the Level 3 target audience (primarily within the Women's and Children's Division), increasing from three yearly to yearly, which have also had a negative impact on training compliance.

Table Two: Annual Percentage Compliance rates for Safeguarding Children Training.



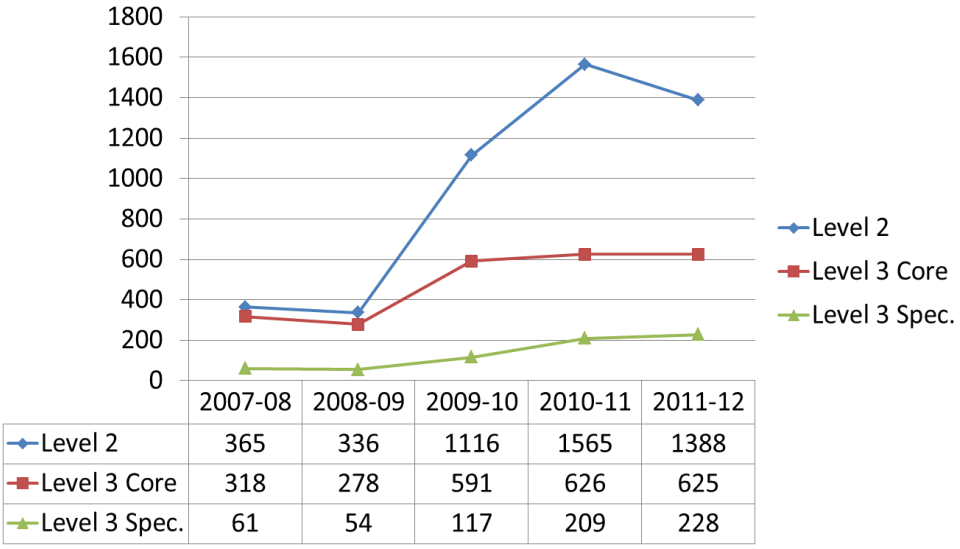
	2007-08	2008-09	2009-10	2010-11	Dec-11	Mar-12
Level 2	56	65	61	62	85	59
Level 3 Core	58	62	57	66	84	65
Level 3 Spec.	32	40	46	91	95	75

Table Two highlights the impact of the changes in the target audience on the percentage compliance rates

The resulting drop in safeguarding children training compliance alongside the associated recovery plans were reported both to the Care Quality Commission and NHS Bristol as lead Commissioners, with a target set for the end on 2012 to re-achieve compliance. Compliance with the 2012 plan continues to be monitored internally on a monthly basis at the Service Delivery Group, as well as being reported externally as previously described.

However despite the drop in the training compliance rates it is significant that the number of staff who have now completed safeguarding training has seen a further year on year increase, as detailed below in table three. In practice this means that an increased number of trust employees are better able to recognise signs of abuse and more importantly feel more confident in knowing what action to take if they have a concern. This is also reflected in the year on year increase in the number of safeguarding children referrals made to children's social care (see table 3)

Table Three: Number of staff receiving Safeguarding Children Training.



	2007-08	2008-09	2009-10	2010-11	2011-12
Level 2	365	336	1116	1565	1388
Level 3 Core	318	278	591	626	625
Level 3 Spec.	61	54	117	209	228

Table Three highlights the year on year increase in the numbers of staff completing training. Level One awareness training continues to be delivered to all new starters as part of the corporate induction programme

5.1.2 Safeguarding Adults Training Data.

Safeguarding adult training has progressed considerably from 2010. Table 1 demonstrates the increase in compliance throughout this reporting period. At quarter 4 the trust target of 80% rose internally to 85%. The start of the year January 2012 reflected a non-compliant situation, in part due to our increasing the compliance target, but also the apparent jump in level 1 target audience. A recovery plan was put in place to regain compliance during 2012.

Quarter 4 of 2011/12 also included the recording of volunteer training, which had not been formally recorded previously; this was in part due to our At Learning data system not recognising volunteers, bank or agency staff on the data base previously.

Table Four: Safeguarding Adults training compliance 2011/12

	Quarter 4 2010/11	**Quarter 1 2011/12**	**Quarter 2 2011/12**	**Quarter 3 2011/12**	**Quarter 4 2011/12**
Level 1	**39%**	**57%**	**71%**	**80%**	**74%**
Level 2	**8%**	**17%**	**52%**	**95%**	**76%**
Level 3	**28%**	**43%**	**70%**	**100%**	**78%**
Volunteer training compliance from Q4.					**77%**

5.2 Inter- Agency and Inter -Professional Working:

National Guidance and local guidance as well as inter-agency standards set out the framework within which the planning, implementation and monitoring of safeguarding work should take place. The key structure in this framework is a multi-agency partnership that leads to the development of professional trust and established working relationships, which underpins effective working together, and information sharing at a local level.

The potential safeguarding risk for children resulting from the fragmentation of information across several sets of health record remains a significant area of concern for the trust. Lord Laming recognised this as a safeguarding risk and originally recommended in 2003 that health professionals in one location should be working from a single record. This risk has also be reflected in the findings of local Serious Case reviews.

Since 2003 specific mitigating actions have been introduced by the safeguarding children team and the Divisions, which include the introduction of the specific 'green' Safeguarding Communication and Chronology' paperwork and highlighting awareness and risks through the safeguarding children training. Electronic safeguarding alerts which 'flag' all children in the three neighbouring authorities who are subject to a Child protection Plan remain in place. The Children's Hospital notes should be recognised at the child's central set of notes to which any additional sets of notes should communicate.

The safeguarding children's team have been considering these risks through the introduction of the new electronic record system 'Medway' and progress will be expected within the next reporting period. However the current risks surrounding the potential existence of 'multiple sets of children's notes' will remain on the trust risk register, and this will continue to be regularly monitored through the Safeguarding Children Steering Group and reported upwards.

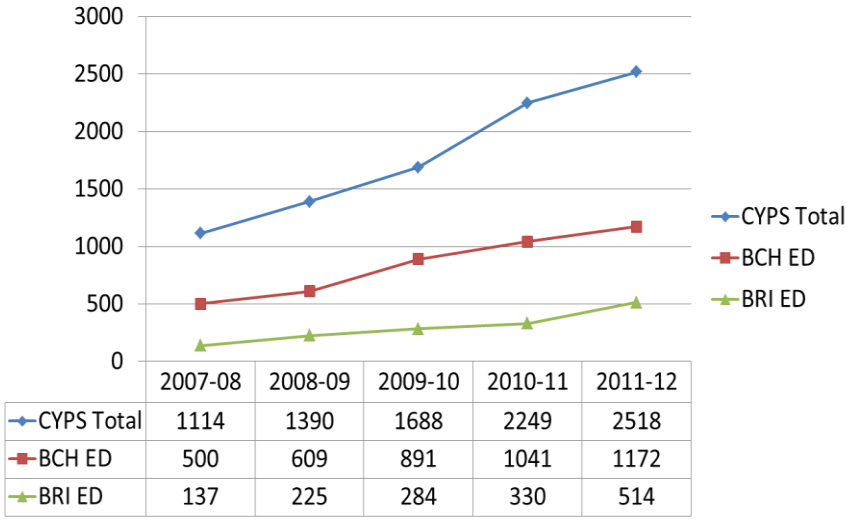
Safeguarding Children's pathways have been developed to guide best practice between professionals, out-lining roles and responsibilities in key areas including the Paediatric Intensive Care Unit and both the Children's and Adults Emergency Departments.

A selection of data in relation to partnership working is detailed below.

5.3 Safeguarding Children Activity Data

The ability to recognise safeguarding risks to the unborn baby, children and young person and to know 'what to do' next is an essential component of the Trust's mandatory safeguarding training. It is of note that there is a continuing level of direct correlation between the increased numbers of staff trained per year to the increased number of safeguarding children referrals made to Children's Social Care, as detailed in table five below.

Table Five: Referrals made to Children's Social Care



	2007-08	2008-09	2009-10	2010-11	2011-12
CYPS Total	1114	1390	1688	2249	2518
BCH ED	500	609	891	1041	1172
BRI ED	137	225	284	330	514

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

This increased staff awareness of their safeguarding roles and responsibilities have also had a significant year on year impact in the number of contacts made to the Safeguarding Children Team by staff asking for help, support and advice, detailed in table six below.

Table Six: Safeguarding advice given by the Child Protection Team

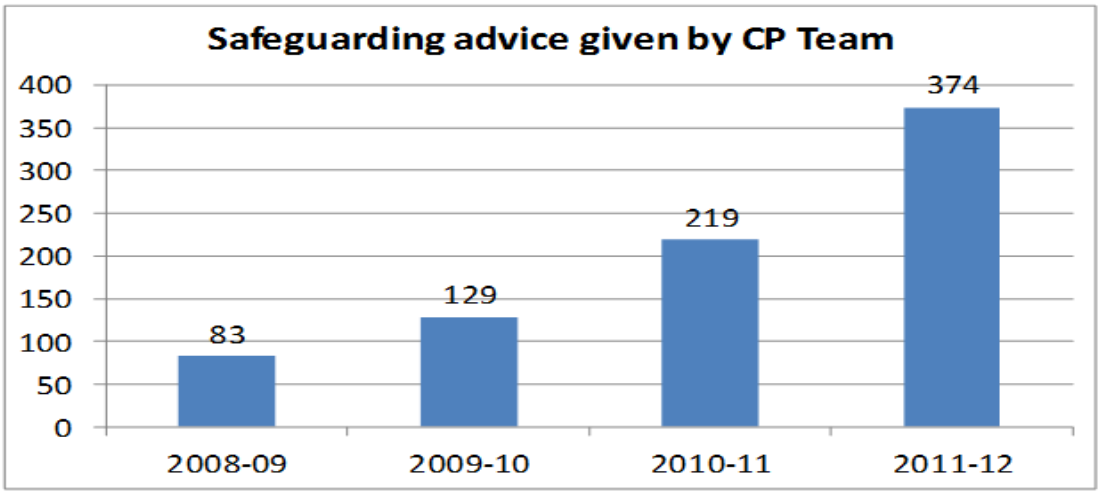


Table Six demonstrates the year on year increase in the number of contacts made to the child protection team requesting advice and support with the management of safeguarding cases.

The safeguarding children team also provide safeguarding supervision to practitioners who are responsible for managing their own case loads, primarily the Paediatric Clinical Nurse Specialists and Community Midwives, The provision of safeguarding supervision for staff, both on an ad-hoc and regular basis, is frequently noted to be essential to support staff in effectively protecting children from harm, especially when they are managing complex and challenging cases (Sidebotham et al 2010). There continues to be a year on year increase (detailed below in table seven) in the number of cases discussed at formal supervision sessions, this could be suggested to be a positive reflection both of increased awareness of the safeguarding risks and of the value that staff are now placing on the supervision provided by the Safeguarding Team and will continue to be monitored.

Table Seven: Provision of Safeguarding Supervision by the child protection team

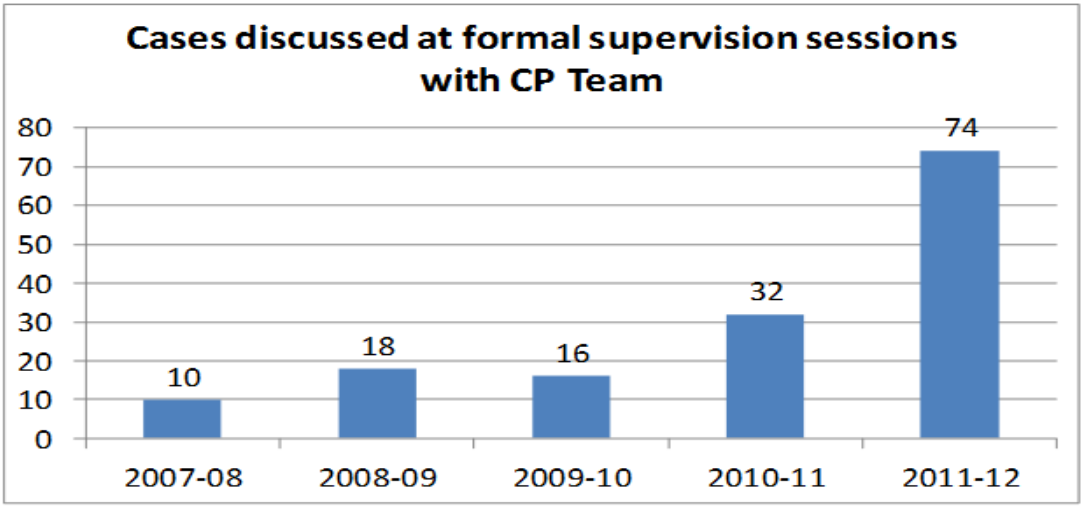


Table Seven demonstrates the year on year increase in the amount of formal supervision sessions provided by the child protection team to support staff managing their own caseloads, for example Paediatric Clinical Nurse Specialist.

5.4 Safeguarding Adults Activity Data

As part of interagency partnership working it is vital that our internal systems allow for joint working. From the recent quarter four data which signifies the number of safeguarding referrals and subsequent investigations, we can identify that training in this area has had a significant impact on staff awareness.
Pressure sores (grade 3 and 4) reporting has also increased the number of alerts made regarding potential neglect. The majority of these alerts are raised by the hospital to high light community acquired pressure sores, however there have been four alerts made in this reporting period regarding hospital acquired pressure sores. As part of the learning from these investigations a Tissue Viability group has been established, chaired by the Deputy Chief Nurse which aims to ensure that the Trust has a whole systems approach to managing both pressure areas and the safety of our patients.

Table eight: Comparison of Numbers of Referrals 2010/11 and 2011/12

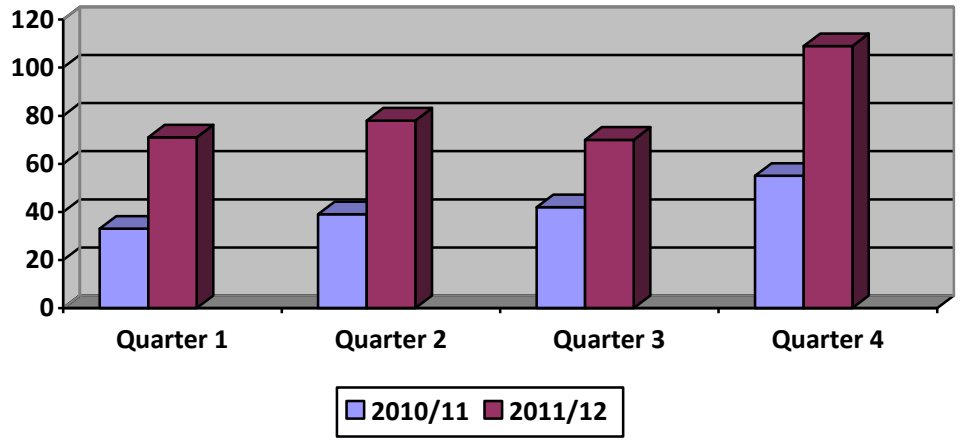


Table nine: Safeguarding Adult Referrals April 11 to March 12 by Month

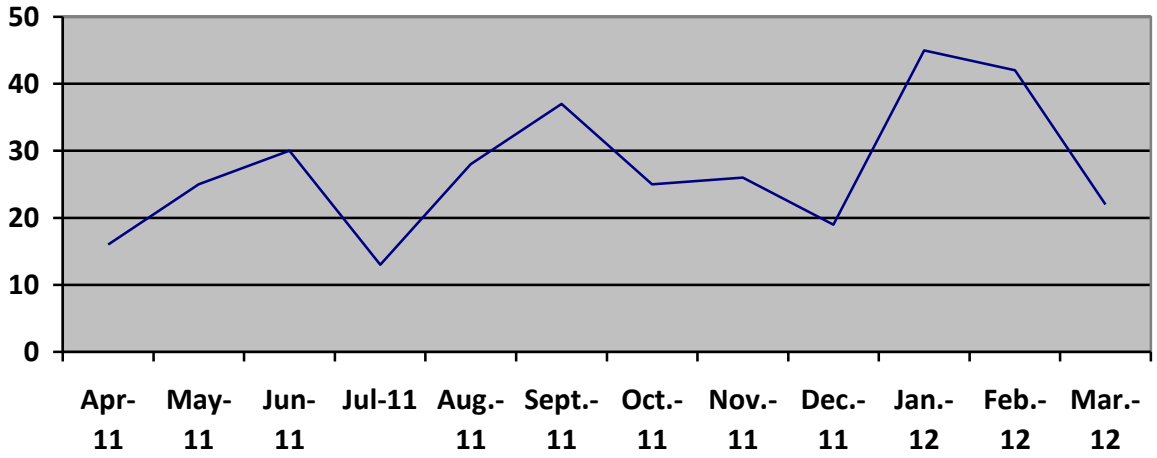


Table nine provides an overview of the number of referrals made to the safeguarding adult team from within the trust on a monthly basis. All referrals are investigated and progressed in partnership with either children's or adult social services and where appropriate the police. In some instances, depending on the nature of the alleged abuse, the police would be the initial investigators. The expectation is that the number of safeguarding adult referrals will increase in the next reporting period, as a result of an increased staff awareness of risk factors, resulting from safeguarding training.

Table ten: Safeguarding Adult referrals by Category April 11 to March 12

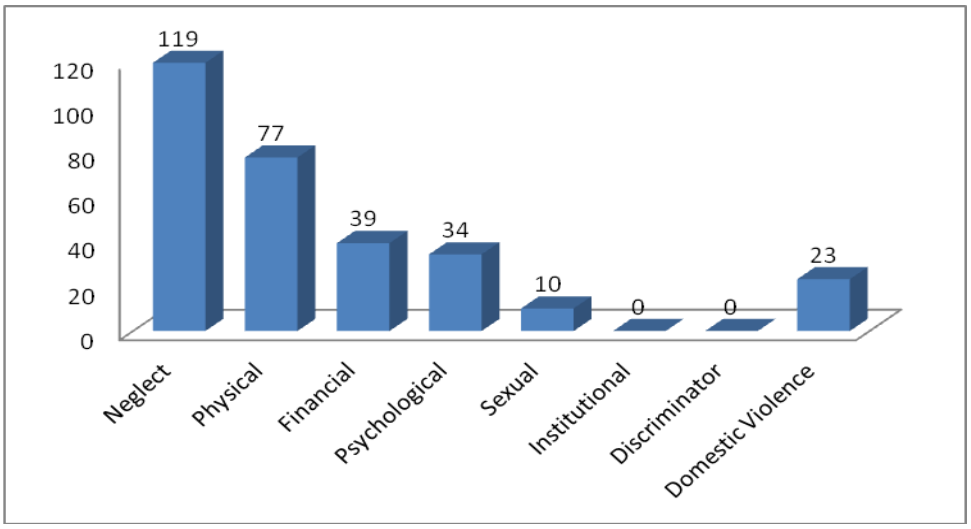


Table ten provides us with the presenting concern. The seven categories named are nationally agreed categories of adult abuse. It may be the case that during the investigation other cause groups arise. This information is shared with social service departments through our usual referral pathway, and provided to the Bristol Safeguarding Adults Board.

5.4.1 Deprivation of Liberty Safeguards

The Mental Capacity Act 2005, covering England and Wales, provides a statutory framework for acting and making decisions on behalf of people who lack capacity to make those decisions for themselves. The Deprivation of Liberty Safeguards were new provisions introduced in 2009 to ensure that the most vulnerable people in our society would be protected where a best interest decision might be made to remove someone's liberty for care and treatment. Within this process hospitals and care homes are classified as Managing Authorities, which are required to make applications to deprive patients to Supervisory Bodies, which are often Local Authorities or Primary Care Trusts.
The Trust has delegated the managing authority responsibilities to the Safeguarding Adult team, which have a responsibility to apply for authorisations, monitor the deprivation, and ensure that a Care Quality Commission report is provided to them at the time.

Table eleven: Number of Deprivation of Liberty Requests made to Supervisory Body. April 11 to March 12

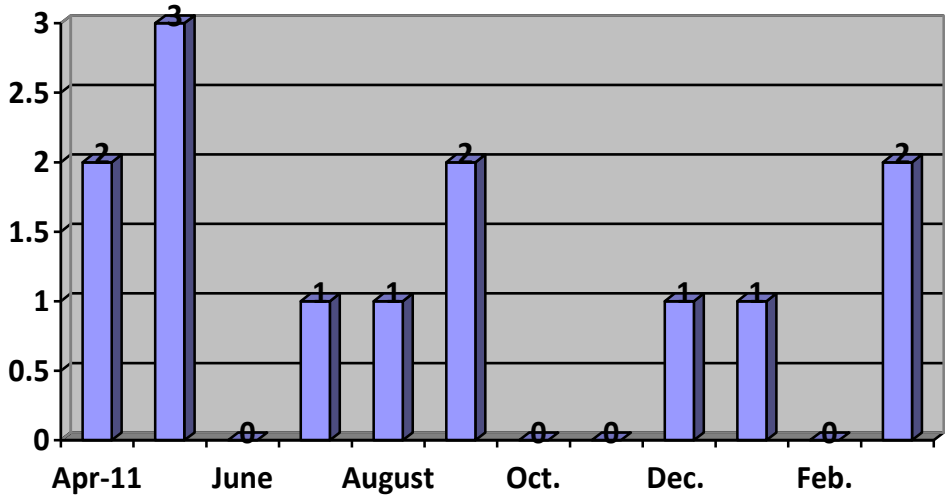


Table eleven indicates thirteen referrals for 2011/12, which is slightly higher than for 2010/11. The number of referrals being granted a Deprivation has also increased, as four were not granted in 2010/11, against two not being granted for 2011/12. This would suggest that more appropriate referrals are being made by the safeguarding team. In relation to other trusts in Bristol these figures would appear to be consistent.

5.5 Safeguarding performance monitoring and quality assurance

The trust has in place a robust performance management framework through which safeguarding activities are monitored both internally and externally, this includes:

- Quantitative safeguarding children data reported quarterly to Bristol and South Gloucestershire Local Safeguarding Children Boards and NHS Bristol as a part of compliance with the 'Safeguarding Children: Standards for providers of health services' (2011-12).

- In this reporting period the trust has submitted Individual Management Reviews for three local Serious Case reviews as well as contributing towards local two internal case reviews. The trust Safeguarding Children Steering Group will monitor the implementation of the action plans developed following each of these cases reporting to the responsible Local Safeguarding Children Boards

- Completion of annual Children Act 2002 Section 11 self-assessment.

- Safeguarding training evaluations.

- Monitoring of allegations, complaints and clinical incident forms by the safeguarding leads for further actions to be taken as well as the identification of possible patterns and trends.

- A staff safeguarding awareness exercise completed on several wards across the trust for both children and adults.

- Robust annual audit work plans, for both safeguarding children and adults, are monitored quarterly through the safeguarding steering groups. Examples from the work plan are detailed below and follow up actions will be included into the safeguarding children audit work plan for 2012-2013.

5.5.1 Safeguarding Children Audit Activity

A selection of the safeguarding children audit activity is detailed below:

- Midwifery Information Sharing Audit:

Following the Serious Case Review of Child M (Bristol Safeguarding Children Board, 2010), an action plan was formulated by UH Bristol with recommendations for practice, including completion of a quality assurance audit to confirm that social concerns highlighted during pregnancy are effectively transferred from the mothers maternity records into the babies main hospital notes and that the UHB safeguarding communication and chronology is completed.

A retrospective sample of mothers with social concerns was obtained for January and February 2011. The baby's notes were then pulled and the results showed that social information was transferred into the babies' notes in 74% of cases. Although this was a positive result for a first audit it has highlighted an area for improvement which will be considered in the next reporting period.

- Audit of information sharing between the Children's Emergency Department and the Primary Care Teams

Since 2006 Bristol has undertaken regular audits to review the effectiveness of information sharing between the Children's Emergency Department and the Primary Care Team. The original report highlighted a lack of consistency of information sharing across the city between acute to primary care and between members of the primary health care team. Subsequent audits have indicated improvements.

The target is 100% compliance with the process of effective information sharing between these services. This year's audit demonstrated that 97% of Children's Emergency Department discharge information was cascaded to Health Visitor or School Health Nurse within the specified time frame. The audit will be repeated next year for on-going quality assurance.

- Safeguarding Infants Audit of Emergency Department Practice.

Infancy, defined according to the National Institute for Health and Clinical Excellence (NICE) as being: 'aged less than one year' is frequently reported to be the most vulnerable period of childhood with a greater risk of harm. In a study of 189 serious case reviews, detailed in the most recent biennial review, 45% were infants with a significantly high proportion of these being very young babies, nearly 30% were aged under 3 months at the time of the incident and half of these were under 1 month (Brandon et al 2009). An audit of current safeguarding infant practice in the Children's Emergency Department was therefore completed.

From reviewing these results it appears that overall compliance with the key recommendations contained within the NICE maltreatment guidance, when to consider and suspect abuse or neglect was good. However for a dedicated Children's Emergency Department with a high level of paediatric expertise there is room for improvement.

A standardised safeguarding approach was needed for the assessment of infants under the age of twelve months with specified presentations, an assessment which could incorporate the best practice guidance detailed within the NICE maltreatment guidance and other sources of evidence base practice recommendations. The Nurse Consultant for Safeguarding Children has therefore developed evidence based 'Safeguarding Infant Assessment Tool' which will be piloted and implemented in the next reporting period.

5.5.2 Safeguarding Adults Audit Activity

As part of the 2011/12 Annual Audit Plan, as approved by the Audit Committee, Internal Audit undertook a review of the Safeguarding Adults system within the Trust. The overall objective of this review was to provide assurance that the Trust had implemented a sound system of internal control surrounding the Safeguarding Adults system.

The objectives of the review were to provide assurance that:

- The Trust has provided staff with sufficient information, guidance and support to allow them to successfully execute their responsibilities regarding Safeguarding Adults
- Staff are trained to be confident and competent in carrying out the Safeguarding Adults responsibilities
- Staff are compliant with the 'No Secrets' Safeguarding Adults Multi-Agency Policy and procedures when a concern regarding a possible vulnerable adult is raised
- Accurate record keeping is maintained when an alert has been made and that the monitoring surrounding the alerts is robust
- Appropriate reporting arrangements at an Executive Level are in place
- Correct procedures are followed when accusations of abuse are made against members of staff
- All staff are aware of the appropriate procedures to use when restraining vulnerable adults
- Processes are in place within the Trust's Emergency Department for dealing with patients who present with possible domestic violence concerns
- The Trust effectively communicates with external agencies.

Good Practice

The audit found that the Trust has the relevant policies and inter-agency relationships in place to ensure that staff are aware of current issues and practices thus enabling them to successfully execute their responsibilities. This is endorsed by a safeguarding training matrix and the Trust's At-Learning training monitoring system.

Safeguarding reports are produced, and accurate record keeping of any safeguarding issue is monitored through the safeguard system which is regularly updated. Much work has been undertaken in the Emergency Department to support victims of Domestic

Abuse, as well as their children, including referrals directly to the Multi-Agency Risk Assessment Conferences.

Issues for Further Action

At the time of the audit (summer 2011) training compliance was at 10.6%, with a target of 80% by end October 2011. ***The training compliance for adults is now above 80% 2011***
The trust disciplinary policy did not acknowledge the need to contact the safeguarding leads where a staff member was the alleged perpetrator. ***Policy change and training has now addressed this 2011.***

The Trust is piloting training sessions for restraint training and once these have been evaluated then the Trust will then be in a robust position to:
a) Have a restraint training matrix that accurately reflects the staff needs,
b) Have an agreement as to the significant financial resource this will require implementing the training across both Trusts. ***Matrix and training in place 2011/12.***

Accordingly, it was the view of Internal Audit that the overall assurance opinion on the design and operation of controls relating to Safeguarding Adults within the Trust was Amber. However since this time all actions and recommendations have been completed**.**

- **Mental Capacity Act & Deprivation of Liberty Safeguards Audit**

The following Mental Capacity Act audit was commissioned to appreciate if staff knowledge and awareness of the Act had improved since safeguarding adult training had become part of the essential training matrix. Whilst the overall results had shown an improvement on the previous year, the outcome also demonstrated where more detailed information was required for clinicians assessing capacity and recognising when a deprivation may be occurring. This information has been used to inform the training packages used for staff.

CLINICAL AUDIT SUMMARY FORM

On completion, please return to the appropriate Clinical Audit Facilitator (see www.uhbristol.nhs.uk/clinicalaudit)

Your Details: Audit Lead

Name: Dr Gerald Tobin	Division: Geriatric Medicine	
Position / Job Title: Consultant	Specialty: Geriatric Medicine	
Email: Gerald.Tobin@UHBristol.nhs.uk	**Tel: 07813846036**	**Bleep:**

Title: Audit of staff understanding of Mental Capacity Act 2005 Deprivation of Liberty Safeguards

Brief summary of results:
Standard 1: Members of staff have an awareness of the Mental Capacity Act **~93% compliance**
Standard 2: Members of staff have an awareness of the Deprivation of Liberty Safeguards **~86% compliance**
Standard 3: Members of staff know that Deprivation of Liberty Safeguards is one of the appropriate pieces of legislation to deprive someone of their liberty **~93% compliance**
Standard 4: Members of staff can identify when Deprivation Liberty Safeguards should be considered **~68% compliance**
Standard 5: Members of staff know the criteria for assessing capacity **~39% compliance**
Standard 6: Members of staff know the process of initiating Deprivation of Liberty **~79% compliance**
Standard 7: Members of staff know what happens following a request for Deprivation of Liberty Authorisation **~50% compliance**

Areas of good practice (good results against standards):
Good practice in staff knowledge of Mental Capacity Act, Deprivation of Liberty Safeguards and when these are applicable
Good practice in making appropriate clinical judgement on a patient's capacity.
Good practice in staff awareness of the process of initiating Deprivation of Liberty

Areas where improvement is needed (poor results against standards):

Improvement is needed in staff awareness of when Deprivation of Liberty Safeguards should be considered
Improvement is needed in staff awareness of the formal criteria for assessing capacity
Improvement is needed in staff awareness of what happens following a request for Deprivation of Liberty Authorisation

Proposals for change:

Did the audit confirm good practice? Yes / No

Did the audit identify areas where there is need for improvement? Yes / No

If YES, please complete the action plan overleaf

Audit report completed? Yes / No Date of report/last report: September 2011

5.6 Midwifery and the unborn baby

The Named Midwife for child protection continues to be supported in her role by a child protection supervisor and a 0.10 wte Band 7 midwife, and safeguarding supervision for community midwives dealing with complex child protection cases is now established.

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

A major concern for the midwifery service continues to be the lack of timely child protection plans in place for unborn babies. Some progress is being made through the continuing multi- agency discussions between the Named Midwife for child protection and the hospital and locality social work teams to improve the situation.

5.7 Safeguarding and Domestic Violence

The need to protect both children, including the unborn baby and adult from the risks and consequences of domestic violence remains a key priority for the safeguarding teams. The prevalence, characteristics and the associated risks for both adults and children are highlighted as part of the 'Think Family' approach through safeguarding training.

An important positive development in this reporting period has been the introduction of two Independent Domestic Violence Advisors (IDVA's) into the Emergency Department at Bristol Royal Infirmary in April 2011, as part of a pilot project. The IDVA's primary role has been to engage with complex, high-risk cases, in which the individuals may be at high risk of serious harm and suicide. High-risk victims are offered the opportunity to stay overnight within the department in order to enhance their safety and to allow engagement with an IDVA.

By the end of 2011 the IDVA service had received referrals for 215 victims, 39 % of which were assessed as being at high risk of further domestic abuse. A total of 177 children were also identified as living in these households, placing them at risk of significant harm. All of the children were therefore referred to the Hospital Social Work Team for further assessments. The IDVA's continue to provide support to the victims for a number of weeks after the Emergency Department attendance, for example providing safety planning advice. A care pathway has also been developed between the IDVA’s, social care and the adult safeguarding team which enable all domestic violence referrals to be linked into the main data and information sharing safeguarding arena. This process enables social care to provide on-going support to service users who fall outside the IDVA’s remit.

The Safeguarding Children’s team continue to engage fully with the process of Multi-Agency Risk Assessment Conferences (MARAC) which shares information about the risk of serious harm or homicide to people experiencing domestic abuse and their children, these meetings are held once a month for the south of Bristol. Prior to the implementation of the IDVA project the Emergency Department had made 11 referrals to a MARAC, since their introduction in April 2011, 70 referrals have been made by the IDVA's to MARAC, a significant increase.

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

5.8 Learning Disability Research Studies and Confidential Inquiry

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

Since then, successive Mencap reports, such as Treat me right 2004; Death by Indifference 2007; reporting on the care of people with learning disabilities have recommended a confidential inquiry. The tipping point came with the report by Sir Jonathan Michael 2008, regarding the care that people with learning disabilities receive from the NHS. The government accepted the findings of the report and committed to implementing its recommendations, which included the establishment of a Public Health Observatory for Learning Disabilities, and of a time limited Confidential Inquiry into premature deaths of people with learning disabilities.

The Inquiry Team provided by the University of Bristol, has been part of a three year study into premature deaths within an NHS institution. The Trust has been contributing to this study throughout this reporting period with a total of fourteen patient investigations discussed, and learning points incorporated into daily practice. Two cases are summarised as an example.

- Case 1 involved a service user attending the ED department with raised Calcium levels. The service user received treatment and was discharged; some days later they attended another hospital with hypercalcaemia and later died. The investigation highlighted an issue with both our recording and communication, as we were unable to advise why we had not corrected the calcium levels in this clinical situation, and we could not find any evidence to suggest we conveyed this to the GP.
  Following this case the Consultant confirmed that they had instituted an electronic discharge system, which is forwarded automatically to the GP. Furthermore the e-Dis system allows pathology results to be imported directly into the discharge report, thereby reaching the GP with both reliability and accuracy.

- Case 2 involved a service user who had complex health conditions over a number of years, and the care home, with involvement from GP and family had formulated an end of life care plan. During a seizure, which was resolved the GP was called for laboured breathing. That evening the service user became more unwell and the care home staff called 999 as there was a delay with the out of hours GP. On arrival the service user was found to be in a pre-arrest situation, but staff were made aware of the DNAR and end of life care plan. Following discussion with family the service user was kept comfortable and died peacefully 24 hours later.
  This case highlights good practice by staff to acknowledge the rights of vulnerable people to decide on their plan of care. It also highlights staff inclusion of family at a difficult time.

5.9 Safeguarding Resourcing Committee

The Safeguarding Resourcing Committee, chaired by the Head of Resourcing, is now fully established with representation from adults and children safeguarding, the trust bank office, human resources and volunteer services. Terms of Reference and a work plan have also been finalised. The committee's purpose is to ensure that the trusts safeguarding responsibilities, for example the safe recruitment and selection of staff including bank, locum and agency are met. The committee raises matters of concern directly to the adult and children's steering groups

In this reporting period work has focused on ensuring that bank, locum, agency practitioners and volunteers have completed the required level of safeguarding training. Further quality assurance will take place in the next reporting period to ensure that the accurate training records are available for bank staff and that the training completed by locum staff is of a suitable quality and includes local guidance.

6. Child Death Overview Panel (CDOP)

The Trust continues to be fully engaged with the Child Death Review Process led by James Fraser as the Designated Doctor and Paediatric Intensive Care Consultant

The Child Death Overview Panel is an example of effective partnership working across agencies which provide a rigorous overview of all child deaths in or from the West of England, with the overall aim to improve outcomes for children by identifying areas for reducing the risk of preventable deaths.

The panel reviewed 126 child deaths in this reporting period, 42% of the children who died had a chronic long-term illness. Modifiable factors contributing to death which may relate to social, parenting or service factors were thought to be present in 32% of cases. In 87% of cases factors intrinsic to the child, the medical or surgical condition with which they presented was thought to provide a full and complete explanation for the death. There were no cases where factors relating to services accounted for the death.

Full details of the key findings from the Child Death Overview Panel have been published in a separate report. (West of England Child Death Overview Panel. Annual Report 2011).

7. Care Quality Commission (CQC) Outcome Seven

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

This standard is monitored quarterly within the trust via the Regulatory Compliance Group. Two main areas of concern were identified:

- Compliance with both safeguarding children and adults training and as previously discussed a robust recovery plan has been agreed with the CQC with the requirement to achieve the specified compliance targets by the end of 2012

- Restraint procedures, implementation and training. A scoping exercise, based upon clinical incident reporting, has been completed to identify clinical areas across the trust where methods of restraint/clinical holding were more frequently implemented to deliver clinical care. The trust then collaborated with North Bristol NHS Trust on the implementation of a clinical holding training programme with a private provider 'Positive Options'. Following which three members of staff were trained to be trainers to deliver training to the identified high risk areas. This training programme will continue until the end of 2012 and a plan will be developed in the next reporting period to take this work forward.

8. Conclusions

Whilst there are many pieces of legislation, policy and guidance from multi agencies in the area of safeguarding, the principles of empowerment, protection, prevention, proportionality, partnership and accountability remain the same for all. In order to ensure that the trust continues to demonstrate learning from experience, and improving standards for vulnerable children and adults the following recommendations are asked to be considered for 2012/13.

Achieving these objectives in 2012 /2013 will be challenging for the Trust, both divisionally and corporately. Progress will be monitored through the Safeguarding Steering Groups, and compliance with the Care Quality Commission Outcome standards will also be monitored. Areas of concern or poor progress will be highlight through the Trusts internal governance arrangements as well as being entered on the Trust risk register.

9. Recommendations and Key objectives for 2012/13

- To continue to follow the training recovery plan as set out, with continued support from all Divisions to achieve safeguarding compliance across the Trust.
- To continue to develop a work plan for restraint polices procedures and training which incorporates clinical holding, within the essential training matrix to ensure that compliance impacts positively on our CQC requirements, as well as patient safety.
- To support the government's anti-terrorism strategy 'Prevent' by developing a robust training and awareness plan.
- To promote Transitional Care arrangements for all specialists from Children's to Adult Services with a safeguarding perspective.

- To pilot and implement evidence based ‘Safeguarding Infants Assessment Tool’ for use by practitioners within the Emergency Department.
- To continue to monitor the potential safeguarding children risks resulting for multiple sets of notes across the trust.
- To review and update the Trust three year Learning Difficulties Strategy.
- To appoint a Dementia Lead Nurse to progress the dementia standards across the Trust.
- To continue to play our part in Serious Case Reviews and any action specific recommendations identified.
- To action recommendations made following Bristol and neighbouring Local Authority Ofsted /CQC inspections, both announced and unannounced.

Appendix 1

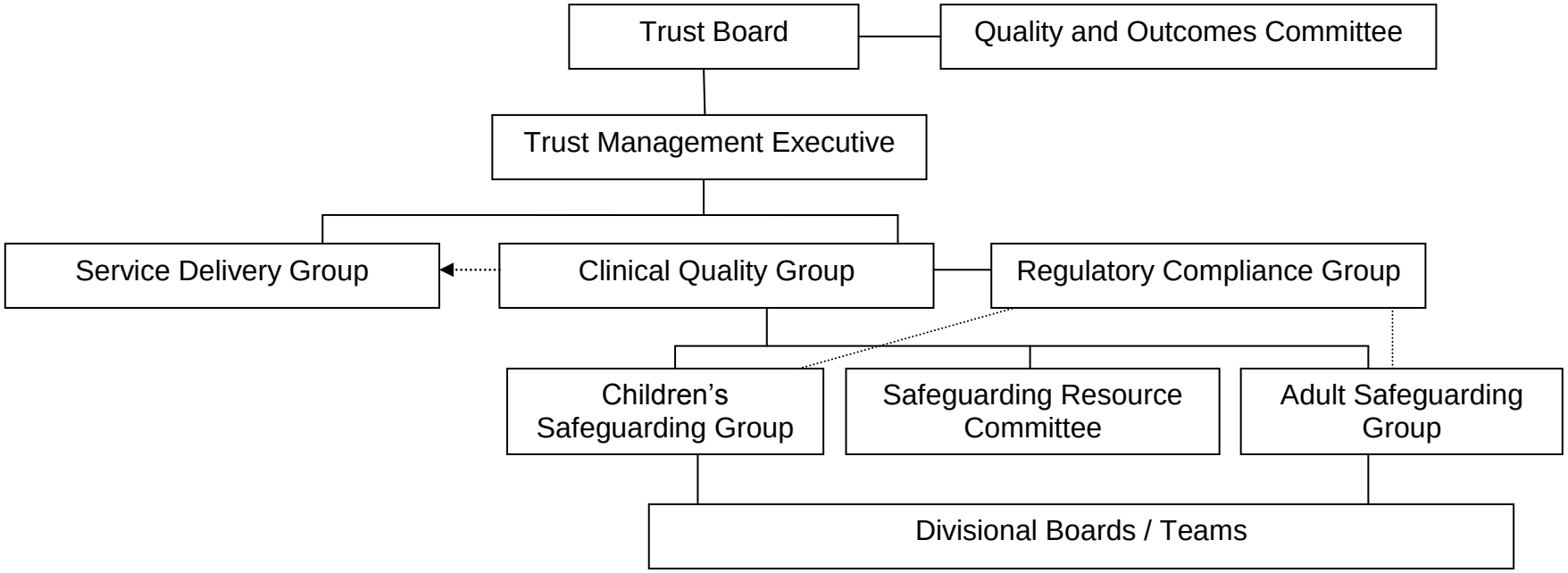
Safeguarding Arrangements: Organisational Chart 2011/12

Bristol Safeguarding Children's Board

Bristol Safeguarding Adults Board

External Arrangements

Internal Arrangements



University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 08a - Committee Chairs' Reports – Finance Report
Purpose
To report to the Board on the Trust's financial position and on related financial matters which require the Board's attention.
Abstract
The summary income and expenditure statement shows a surplus of £1.460m for the five months to 31st August 2012. This represents an adverse performance of £0.929m when compared with the Annual Plan projected surplus for the period. The Trust's Financial Risk rating is unchanged at 3 (actual 2.90). Pay budgets have a cumulative overspending of £2.933m – an increase of £1.127m in August. Expenditure has risen in August on directly employed, bank and agency staff. CRES shortfalls account for £1.324m of the overspending to date. Cash releasing efficiency savings total £9.368m to date and equate to 80% of plan for the period. The rate of savings over the remainder of the year is projected to increase to deliver savings of £23.127m, or 83% of the original plan.
Recommendations
To note the financial position for the 5 months to 31 August 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
			24 September 2012		

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £1.460m for the five months to 31st August 2012, a favourable movement of £0.865m in the month. The Annual Plan projected surplus for the period is £2.389m so the results represent slippage against the Plan of £0.929m. The operating surplus (EBITDA[1]) at £13.221m equates to 91% of the Annual Plan projection for the 5 month period. 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 surplus of £1.460m does include a number of one-off items which have improved the position year to date (including VAT reclaim £0.298m and reviews of old creditors £0.343m).

Considerable validation has now taken place on data quality from the new Medway PAS / EPR system. The Trust is now largely satisfied with the activity data being reported, as are Commissioners. Reviews are naturally continuing as part of the normal SLA monitoring process.

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. This generates an overspending against divisional budgets which now totals £3.702m. Detailed information and commentary for each Division is to be considered by the Finance Committee.

Divisional Variances	Variance to 31st July	Variance this month	Variance to 31st August	Memorandum CRES Variance
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(1,836)	(1,127)	(2,963)	(1,324)
Non Pay	(976)	91	(885)	(2,156)
Operating Income	483	157	640	2
Income from Activities	(219)	(275)	(494)	(272)
Totals	**(2,548)**	**(1,154)**	**(3,702)**	**(3,750)**

It can be seen that the non achievement of savings within the CRES programme is a significant feature on the expenditure lines. However CRES only accounts for £1.3m of the £3.0m overspending on the pay heading which is the primary driver of the unfavourable variance to date.

Pay budgets have a cumulative overspending of £2.963m – an increase of £1.127m in August. . The increase in the level of overspending in August is a major disappointment. There are a number of reasons for such a high level of spending this month. First of all the absolute cost of directly employed staff has risen when compared with the July pay bill with an increase of £0.318m recorded in August. In addition, bank staff costs have increased month on month by £0.246m. Of this increase £85k relates to an increase in the accrual to cover the cost of unsocial hours payments

[1] Earnings Before Interest Depreciation Taxation and Amortisation

and £0.161m relates to increased usage of the Trust's Bank Staff service. For July and August the actual usage of agency staff is broadly unchanged but the financial position has been adversely affected by a backlog of invoices (£0.245m) having been presented and paid. Assurance has been given that there are no further aged invoices for payment other than those included within the established system of recording by the Bank Office and notified to Finance each month.

A further concern is the increasing adverse variance on pay CRES schemes up from £0.848m to July to £1.323m to the end of August. For a number of clinical areas the previously agreed 'Conroy Review' revised staffing and rostering arrangements have not yet been implemented. Payments for overtime and waiting list initiatives reduced in August to an average similar to the monthly average paid in the first quarter.

Non pay budgets show a cumulative adverse variance of £0.885m, an improvement of £91k in the month. Slippage on non-pay CRES schemes of £2.157m to date is embedded within this position.

Operating Income budgets show a favourable variance of £0.640m, an improvement of £0.157m in the month. Notable favourable variances were achieved in August Diagnostic and Therapies (£97k), Medicine (£44k) and Surgery, Head and Neck (£35k).

Income from Activities shows a cumulative under-performance of £0.494m, an adverse movement in the month of £0.275m. The area of greatest concern is within the Surgery, Head and Neck Division which has an under achievement to date of £0.630m. Further information on income from activities is provided to the Finance Committee under agenda item 5.2 Contract Income and Activity Report.

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

	£'000
Energy Inflation	227
Revision of Provider to Provider inflation	139
European Working Time Directive	129
Barth Syndrome	98
Clinical Systems Implementation Programme	78
RHCN Reproductive Health and Care of Newborn	77
CQUINs	74

3. Cash Releasing Efficiency Savings

The achievement of cash releasing efficiency savings headline message is that August has seen delivery of CRES savings of £9.368m to date. This equates to 80% of the Plan for the first five months of 2012/13. 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 August report reflects an adverse variance of £3.750m year to date on the CRES programme. Actual savings of £9.368m represents slippage of £2.296m when compared with profiled planned savings for the first five months of £13.118m. The adjustment to bring CRES plans on to a 1/12ths basis adds a further £1.454m to the reported non achieved CRES to date.

The table shown below summarises divisional CRES performance for the five months to 31st August together with the current projections for the year.

	Diagnostic and Therapies	Medicine	Specialised Services	Surgery, Head and Neck	Women's and Children's	Estates and Facilities	Trust Services	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Plan to 31st August	1,312	2,411	1,929	3,333	2,310	669	1,154	13,118
Actual	1,227	1,557	1,414	1,609	2,048	538	975	9,368
Variance – Fav / (Adverse)	(85)	(854)	(515)	(1,724)	(262)	(131)	(179)	(3,750)
Represented by:								
Slippage etc	37	(276)	(386)	(1,425)	(98)	(22)	(126)	(2,296)
/12ths Phasing	(122)	(578)	(129)	(299)	(164)	(109)	(53)	(1,454)
Plan for Year	2,605	4,590	4,588	7,086	4,830	1,377	2,546	27,622
Forecast Outturn								
Recurring	2,269	4,118	3,571	4,054	3,700	1,161	2,094	20,967
Non Recurring	326	54	446	86	871	169	208	2,160
Totals	2,595	4,172	4,017	4,140	4,571	1,330	2,302	23,127
Variance – Fav / (Adverse)	(10)	(418)	(571)	(2,946)	(259)	(47)	(244)	(4,495)
Full Year Effect of Forecast Outturn	2,135	4,457	3,943	4,421	3,235	1,042	2,049	21,282
Recurring shortfall c/fwd into 2013/14	(470)	(133)	(645)	(2,665)	(1,595)	(335)	(497)	(6,340)
Recurring savings for 2013/14 CRES Plan	-	-	-	-	-	-	-	-

CRES achievement to date at 80.3% of plan results in slippage of £2.3m. The forecast outturn has as its underlying assumption that CRES will be delivered at 86.2% of plan over the remainder of the year to secure savings of £23.1m and slippage for the year of £4.5m. The level of pick-up in CRES delivery is an important determinant in the Trust's financial performance for 2012/13.

The main area of concern is in Surgery, Head & Neck which accounts for 66% of the Trust shortfall on CRES for the year.

4. Income

For the months of April – July contract income is broadly in line with Plan. Activity was higher than Plan in July leading to an over-performance of £0.45m, offset by an under-performance on contract penalties / rewards of £0.48m. On a cumulative basis (to July 2012) contract income is £1.10m higher than Plan – this includes the balance of the 2011/12 over-performance of £1.07m.

Clinical Income by Worktype	**Plan**	**Actual**	**Variance**
	£'m	£'m	£'m
Accident & Emergency	3.93	3.87	(0.06)
Emergency Inpatients	23.92	23.50	(0.42)
Day Cases	10.01	10.10	0.09
Elective Inpatients	15.69	15.80	0.11
Non-Elective Inpatients	9.94	10.70	0.76
Excess Bed days	2.55	2.81	0.26
Outpatients	21.85	20.45	(1.40)
Bone Marrow Transplants	2.77	2.66	(0.11)
Critical Care Bed days	12.18	12.06	(0.12)
PbR Exclusions / NICE	12.99	13.75	0.76
Contract Penalties / Rewards	0.40	(0.01)	(0.41)
Other	17.25	17.82	0.57
Sub-Totals	**133.48**	**133.51**	**0.03**
2011/12 Estimate v Actual	-	1.07	1.07
Totals	**133.48**	**134.58**	**1.10**

5. Expenditure

In total, Divisions are shown as overspent by £3.702m for the five months to 31st August. The position for each Division, together with comparable results with CRES accounted for on the Divisional Phased Plan basis, is summarised below:

Division	**CRES on 1/12ths profiling**		**CRES on Phased Plan**	
	Variance to 31st August Favourable / (Adverse)	Memorandum CRES Variance to 31st August	**Variance to 31st August Favourable / (Adverse)**	**Memorandum CRES Variance to 31st August**
	£'000	£'000	£'000	£'000
Diagnostic and Therapies	229	(85)	351	37
Medicine	(698)	(854)	(120)	(276)
Specialised Services	(260)	(515)	(131)	(386)
Surgery, Head and Neck	(2,228)	(1,724)	(1,929)	(1,425)
Women's and Children's	(638)	(262)	(474)	(98)
Facilities and Estates	(48)	(131)	61	(22)
Trust Services	73	(40)	126	13
Other Services	(132)	(139)	(132)	(139)
Totals	**(3,702)**	**(3,750)**	**(2,248)**	**(2,296)**

The table below summarises the changes in financial performance August for each of the Trust's management divisions. Further analysis of the variances by pay, non-pay and income categories is given at Appendix 2.

	Cumulative Variance to 31st July Fav / (Adv)	Variance for August Fav / (Adv)	Cumulative Variance to 31st August Fav / (Adv)
	£'000	£'000	£'000
Diagnostic and Therapies	195	34	229
Medicine	(326)	(372)	(698)
Specialised Services	(230)	(30)	(260)
Surgery, Head and Neck	(1,454)	(774)	(2,228)
Women's and Children's	(633)	(5)	(638)
Estates and Facilities	(47)	(1)	(48)
Trust HQ	52	21	73
Trust Services	(105)	(27)	(132)
Totals	**(2,548)**	**(1,154)**	**(3,702)**

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

	2012/13	Year to date
	£'000	£'000
Diagnostics and Therapies	86	36
Medicine	355	148
Specialised Services	794	331
Surgery, Head & Neck	1,050	437
Women's and Children's	272	113
Totals	**2,557**	**1,065**

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 £2.228m, an overspending of £0.774m in the month when compared with the July position of £1.454m adverse. 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		(1,086)	358	99	(476)	(1,105)
CRES	Slippage	(370)	(842)	-	(213)	(1,425)
	/12ths phasing	(123)	(71)	-	(105)	(299)
	Sub Totals	**(1,579)**	**(555)**	**99**	**(794)**	**(2,829)**
Adj re	Non Recurring Support	-	437	-	-	437
	March 2012 Income	-	-	-	164	164
Variance to 31st August		**(1,579)**	**(118)**	**99**	**(630)**	**(2,228)**

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

Pay budgets have a cumulative overspending of £1.579m. Within the overspending is the impact of CRES slippage of £0.370m, the prior year shortfall of £0.610m relating to non-achieved CRES on pay headings in the Surgery, Head and Neck Division and other cost pressures and net overspendings on management budgets of £0.476m. 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 £0.118m to date. The non pay column in the above table shows that this includes management budget underspendings to date of £0.358m 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 £0.630m. The under-performance is a combination of lower than planned activity for services directly managed by the Division such as day cases / short stay elective work and follow up out-patients together with a loss of income on under-performing specialties managed by other Divisions. The Division is implementing plans to catch-up on the slippage against elective activity service agreements. Operating Income budgets have a favourable variance of £99k to date.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £0.638m, an overspending of £5k 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	(628)	113	(9)	(171)	(695)
CRES Slippage	(7)	(106)	6	9	(98)
/12ths phasing	-	(164)	-	-	(164)
Sub Totals	**(635)**	**(157)**	**(3)**	**(162)**	**(957)**
Adj re Non Recurring Support	-	113	-	-	113
March 2012 Income	-	-	-	206	206
Variance to 31st August	**(635)**	**(44)**	**(3)**	**44**	**(638)**

Pay budgets are overspent by £0.635m – an overspending of £0.195m in the month. The overspending relates in the main to the use of agency doctors to cover vacancies, waiting list initiative payments made to consultants together with higher than planned costs of nursing and midwifery staff.

Non pay budgets show a cumulative overspending of £44k – an improvement of £0.308m in August. The improvement relates to a catch up in billing for BMT donor charges, lower than planned Cochlear implants and other ENT procedures undertaken at a third party hospital. The Division is also benefitting from slippage on service developments and the Operating Plan support funding.

Two Divisions are now 'amber / green' rated. The Specialised Services Division moves from 'amber / red' and the Division of Medicine loses its 'green' rating.

The **Division of Medicine** reports an adverse variance of £0.698m for the five months to 31st August, a deterioration of £0.372m when compared with the adverse variance to 31st July of £0.326m. The deterioration in the financial position this month is almost entirely due to the cost of

actions taken to avoid a breach of performance targets with additional expenditure incurred on medical and nursing staff.

	Pay	Non Pay	Operating Income	Income from Activities	Totals
	Fav / (Adv)	Fav / (Adv)	Fav / (Adv)	Fav / (Adv)	Fav / (Adv)
	£'000	£'000	£'000	£'000	£'000
Operating Services Variance	156	(453)	233	(133)	(197)
CRES Slippage	(234)	(60)	(7)	-	(301)
/12ths phasing	(496)	(57)	-	-	(553)
Sub Totals	**(574)**	**(570)**	**226**	**(133)**	**(1,051)**
Adj re Non Recurring Support	-	331	-	-	331
March 2012 Income	-	-	-	22	22
Variance to 31st August	**(574)**	**(239)**	**226**	**(111)**	**(698)**

The Division has significant overspendings on pay headings (£0.340m) as agency doctors have been engaged to alleviate pressures to patient flow and the 4 hour access target. In addition nursing bank staff have been widely used and supplemented by the use of agency nursing staff to staff additional bed capacity.

Non-pay budgets are cumulatively overspent by £0.239m after an increase of £0.108m in the month mainly as a result of higher drug expenditure and the cost of ward moves.

Small underspendings have been recorded against income from activities (£32k) and operating income budgets (£44k) in the month.

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £0.260m, an adverse movement of £30k 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)	Fav / (Adv)	Fav / (Adv)	Fav / (Adv)	Fav / (Adv)
	£'000	£'000	£'000	£'000	£'000
Operating Services Variance	(450)	159	114	79	(98)
CRES Slippage	92	(515)	-	37	(386)
/12ths phasing	(113)	(16)	-	-	(129)
Sub Totals	**(471)**	**(372)**	**114**	**116**	**(613)**
Adj re Non Recurring Support	-	331	-	-	331
March 2012 Income	-	-	-	22	22
Variance to 31st August	**(471)**	**(41)**	**114**	**138**	**(260)**

Pay budgets show a cumulative overspending of £0.471m. Arrears of pay relating to rota compliance for junior doctors were paid in August at a cost of £92k. There will a need to meet pay protection costs whilst these people remain in post. The balance of 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 overspending of £41k to date – an improvement of £65k in the month. Operating Income budgets show a favourable variance to date of £0.114m – this relates to clinical trials income and pay recharges at the BHOC. Income from Activities shows a favourable net variance of £0.138m, an improvement of £78k in the month. Favourable variances are noted against Cardiology EP activity to reduce the waiting list backlog and Cardiac Critical Care. Cardiac Surgery activity is higher (130 bed days) than contract

plan to date. In the BHOC Radiotherapy has moved in month from over performing against contract of £44k to an underperformance year to date of £12k due to reduced activity. Oncology has improved £36k in month improving it's underperformance to £8k due to a coding correction in outpatients. Activity is being reviewed in this area to ensure Medway coding is mapping through correctly into income. Haematology is offsetting these areas by over performing £205k year to date. There continues to be a significant under-achievement on private patient activity / income within the BHI.

The remaining three divisions are green rated.

The **Diagnostic and Therapies Division** reports a cumulative underspending of £0.229m. Pay expenditure is greater than Plan with a £0.180m adverse variance. Non pay budgets are operating within Plan and report a favourable variance of £0.161m to date. Operating Income is £0.152m ahead of Plan and Income from Activities is £96k greater than Plan. The Division continues to work on cost control measures and its CRES programme to ensure delivery of the projected surplus of £0.281m for the year.

The Facilities and Estates Division reports an overspending to date of £48k, an adverse movement of £1k in the month. The phasing of the CRES plan contributes £121k to this adverse position.

Trust Headquarters Services report an in-month underspending of £21k and a cumulative underspending of £73k.

6. Financial Risk Rating

The Trust's overall financial risk rating, based on results to 31st August is 3. The actual financial risk rating is 2.90 (July = 2.90) which rounds up to 3. There have been improvements in four of the metrics this month. The liquidity ratio metric records a small reduction. The actual value for each of the 5 metrics is given in the table below together with the bandings for each metric. Further information showing performance to date compared with the Annual Plan projections is given at Appendix 6.

	31st August 2012		
Metric	Metric Result	Metric Score	Weighted Average Score
EBITDA			
Margin	6.0%	3	0.75
Plan achieved	90.7%	4	0.40
Net Return on Financing	1.06%	3	0.60
I&E surplus margin	0.66%	2	0.40
Liquidity ratio (days)	20.4 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.

7. Capital Programme

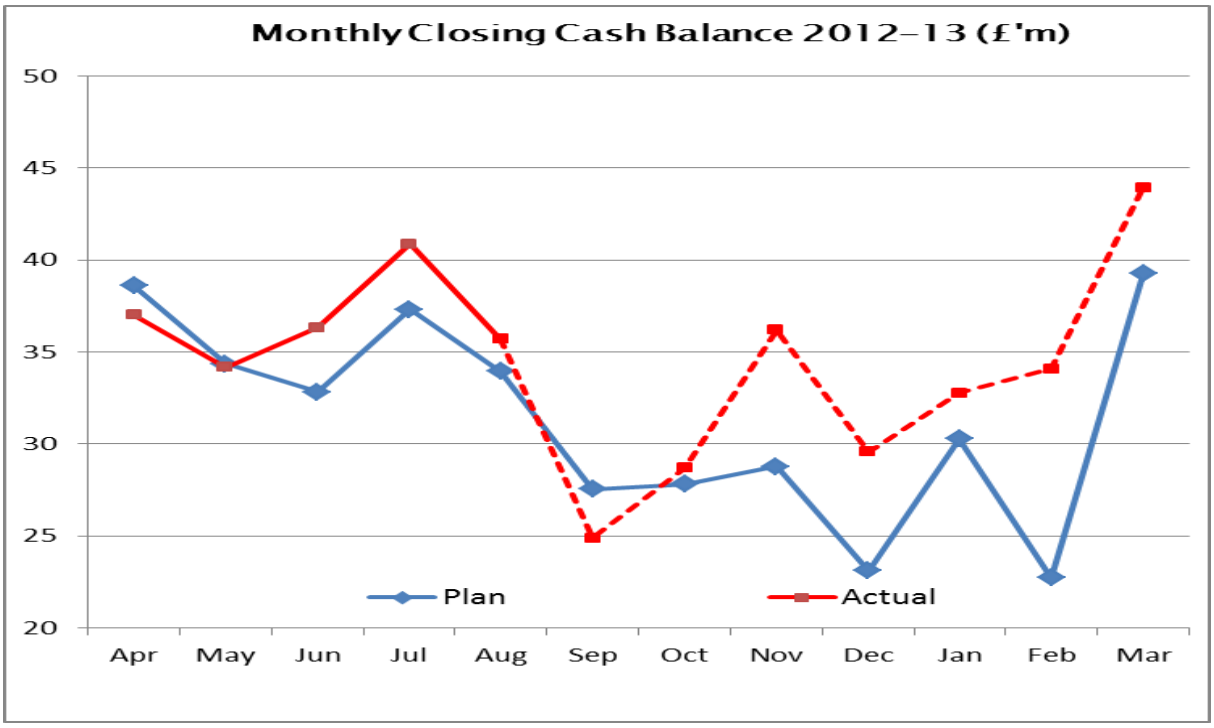
A summary of income and expenditure for the five months to 31st August is given in the table below. Expenditure for the period of £22.507m is £2.971m less than the current Plan.

Plan for Year		5 Months Ended 31st August 2012		
		Plan	Actual	Variance Favourable / (Adverse)
£'000		£'000	£'000	£'000
	Sources of Funding			
238	Donations	238	184	(54)
18,125	Retained Depreciation	7,244	7,244	-
49,950	Prudential Borrowing	-	-	-
7,695	Sale of Property	5,845	1,000	(4,845)
5,109	Cash balances	12,151	14,079	1,928
81,117	**Total Funding**	**25,478**	**22,507**	**(2,971)**
	Expenditure			
(54,123)	Strategic Schemes	(18,179)	(15,912)	2,267
(9,063)	Medical Equipment	(1,894)	(1,767)	127
(5,518)	Information Technology	(2,511)	(2,385)	126
(1,911)	Roll Over Schemes	(611)	(688)	(77)
(3,234)	Refurbishments	(789)	(639)	150
(10,134)	Operational / Other	(1,494)	(1,116)	378
2,866	Anticipated Slippage	-	-	-
(81,117)	**Total Expenditure**	**(25,478)**	**(22,507)**	**2,971**

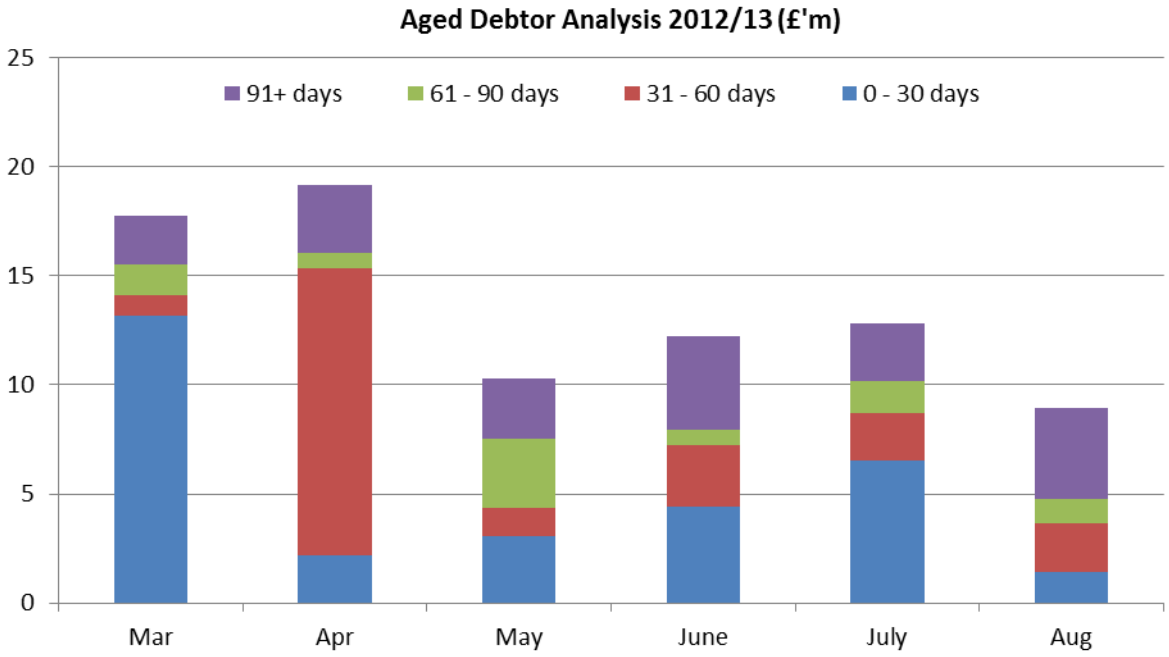
The Finance Committee is provided with further information on this under agenda item 6.

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

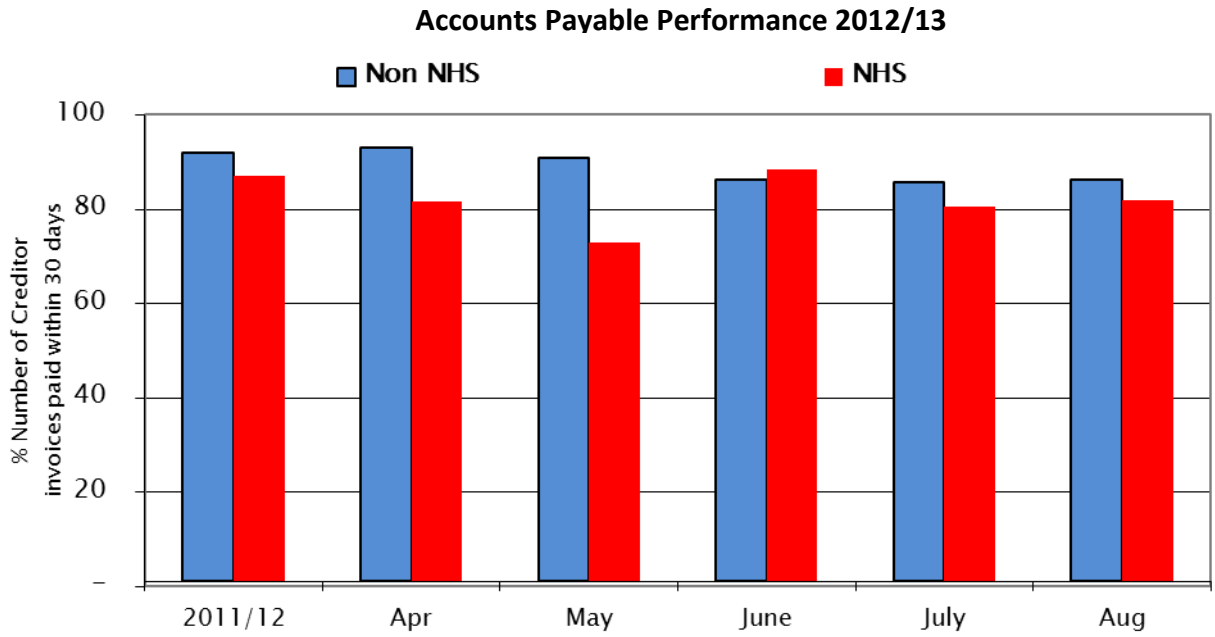
Cash - The Trust held a cash balance of £35.695m as at 31st August. The graph, shown below, sets out the current forecast for month end cash balances to March 2013.



Debtors - The total value of invoiced debtors has decreased by £3.908m during August to a closing balance of £8.921m. The total amount owing is equivalent to 6.7 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In August the Trust achieved 82% and 86% compliance against the Better Payment Practice Code for NHS and Non NHS creditors.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Monthly analysis of pay expenditure 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 August 2012- Summary Income & Expenditure Statement

Approved Budget / Plan 2012/13	Heading	Position as at 31st August Plan	Actual	Variance Fav / (Adv)	Actual to 31st July
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
410,186	From Activities	172,581	172,039	(542)	136,826
111,925	Other Operating Income	47,116	47,814	698	37,256
522,111	Sub totals income	**219,697**	**219,853**	**156**	**174,082**
	Expenditure				
(300,652)	Staffing	(126,056)	(129,035)	(2,979)	(102,576)
(175,273)	Supplies and services	(76,730)	(77,597)	(867)	(61,548)
(475,925)	Sub totals expenditure	**(202,786)**	**(206,632)**	**(3,846)**	**(164,124)**
(10,591)	**Reserves** Reserves	(2,336)	-	2,336	-
(10,591)	Sub Total Reserves	**(2,336)**	-	**2,336**	**-**
35,596	**EBITDA**	**14,575**	**13,221**	**(1,354)**	**9,958**
6.82	**EBITDA Margin - %**		**6.01**		**5.72**
350	Fixed asset impairments	(1)	(1)	-	-
(83)	Reserves	(425)	-	425	-
-	Profit/ loss on sale of asset	-	-	-	-
(19,451)	Depreciation & Amortisation	(7,714)	(7,714)	-	(6,122)
226	Interest Receivable	94	95	1	72
(387)	Interest payable on leases	(161)	(161)	-	(129)
(1,000)	Interest payable on loans	-	-	-	-
(9,551)	PDC Dividend	(3,979)	(3,980)	(1)	(3,184)
5,700	**NET SURPLUS / (DEFICIT)**	**2,389**	**1,460**	**(929)**	**595**

Appendix 2

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

Approved Budget / Plan 2012/13	Division	Total Net Expenditure / Income to Date	Position as at 31st August [Favourable / (Adverse)] Pay	Non Pay	Operating Income	Income from Activities	Total Variance to date	Memorandum CRES Variance to Date	Cumulative Variance to 31st July
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements								
403,862	Service Agreements	168,190	–	–	47	(48)	(1)	–	2
–	Overheads	–	–	–	–	–	–	–	55
39,593	NHSE Income	16,527	–	–	7	–	7	–	6
443,455	**Sub Total Service Agreements**	**184,717**	**–**	**–**	**54**	**(48)**	**6**	**–**	**63**
	Clinical Divisions								
(42,650)	Diagnostic & Therapies	(17,318)	(180)	161	152	96	229	(85)	195
(57,847)	Medicine	(24,840)	(574)	(239)	226	(111)	(698)	(854)	(326)
(65,008)	Specialised Services	(27,228)	(471)	(41)	114	138	(260)	(515)	(230)
(87,370)	Surgery Head & Neck	(38,028)	(1,579)	(118)	99	(630)	(2,228)	(1,724)	(1,454)
(86,784)	Women's & Children's	(36,373)	(635)	(44)	(3)	44	(638)	(262)	(633)
(339,659)	**Sub Totals (1)**	**(143,787)**	**(3,439)**	**(281)**	**588**	**(463)**	**(3,595)**	**(3,440)**	**(2,448)**
	Corporate Services								
(6,154)	Trust Hq	(2,606)	72	(118)	84	–	38	8	32
(5,203)	Human Resources	(2,066)	103	(67)	(26)	–	10	(15)	8
(6,659)	Imt	(3,142)	178	(166)	5	–	17	(3)	6
(4,978)	Finance	(2,084)	82	(53)	(21)	–	8	(29)	6
(31,378)	Facilities And Estates	(13,657)	(32)	31	(42)	(5)	(48)	(132)	(47)
(53)	Community	(11)	–	11	–	–	11	–	9
(7,867)	Misc Support Services	(5,989)	52	(204)	30	(26)	(148)	(139)	(110)
(29,002)	Capital Charges	(11,693)	–	–	–	–	–	–	–
4,872	Research & Innovation	2,389	21	(38)	22	–	5	–	(4)
(86,422)	**Sub Totals (2)**	**(38,859)**	**476**	**(604)**	**52**	**(31)**	**(107)**	**(310)**	**(100)**
(426,081)	**Sub Totals (1) and (2)**	**(182,646)**	**(2,963)**	**(885)**	**640**	**(494)**	**(3,702)**	**(3,750)**	**(2,548)**
–	**Skills for Health**	4	**(16)**	18	4	–	6	–	13
(426,081)	**Totals I & E**	**(182,642)**	**(2,979)**	**(867)**	**644**	**(494)**	**(3,696)**	**(3,750)**	**(2,535)**
	Reserves								
(11,674)	General	(615)	–	3,376	–	–	2,761	–	1,405
(11,674)	**Sub Total Reserves**	**(615)**	**–**	**3,376**	**–**	**–**	**2,761**	**–**	**1,405**
5,700	**TRUST TOTALS**	**1,460**	**(2,979)**	**2,509**	**698**	**(542)**	**(929)**	**(3,750)**	**(1,067)**

Analysis of pay spend 2011/12 and 2012/13

Division		2010/11	2011/12					2012/13								2010/11	2011/12
		Total £'000	Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Total £'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	5,741	5,797	28,734	5,747	5,491	5,651
	Bank	2,076	496	524	521	514	2,055	176	209	190	575	183	226	984	197	173	171
	Agency	654	182	128	162	315	786	71	125	126	322	102	171	596	119	55	66
	Waiting List initiative	304	73	42	16	27	158	18	2	5	25	16	10	51	10	25	13
	Overtime	91	14	11	7	12	45	6	4	3	13	4	3	20	4	8	4
	Other pay	62,798	16,219	16,274	16,333	16,736	65,562	5,627	5,494	5,509	16,630	5,507	5,582	27,719	5,544	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	5,812	5,992	29,369	5,874	5,494	5,717
	Variance Fav / (Adverse)	(32)	(346)	(263)	(138)	(51)	(798)	(76)	(200)	(93)	(369)	(71)	(195)	(635)	(127)	(3)	(66)
Medicine (incl Central Services 11/12)	Pay budget	41,745	11,034	10,900	10,938	11,340	44,213	3,720	3,763	3,671	11,154	3,598	3,613	18,365	3,673	3,479	3,684
	Bank	3,434	845	758	689	775	3,067	276	305	293	874	297	365	1,537	307	286	256
	Agency	559	157	141	113	309	720	1	93	61	155	34	100	289	58	47	60
	Waiting List initiative	315	30	4	26	43	103	2	17	9	28	11	18	57	11	26	9
	Overtime	69	25	15	16	15	70	5	6	5	16	7	5	28	6	6	6
	Other pay	38,883	10,318	10,094	10,041	10,162	40,616	3,470	3,399	3,369	10,238	3,325	3,464	17,027	3,405	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	3,674	3,953	18,938	3,788	3,605	3,715
	Variance Fav / (Adverse)	(1,515)	(341)	(111)	54	36	(363)	(34)	(58)	(66)	(158)	(76)	(340)	(574)	(115)	(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	5,752	5,629	28,086	5,617	5,512	5,676
	Bank	2,100	450	525	497	497	1,969	158	193	177	528	191	250	969	194	175	164
	Agency	1,206	121	95	175	189	580	39	79	65	183	121	235	539	108	101	48
	Waiting List initiative	1,209	304	50	220	140	714	30	26	10	66	76	71	213	43	101	60
	Overtime	152	22	35	40	46	142	10	17	17	43	16	10	69	14	13	12
	Other pay	61,071	15,784	16,096	15,921	16,682	64,482	5,619	5,518	5,475	16,612	5,654	5,609	27,875	5,575	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	6,058	6,175	29,665	5,933	5,478	5,657
	Variance Fav / (Adverse)	410	(265)	146	192	157	230	20	(637)	(110)	(727)	(306)	(546)	(1,579)	(316)	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	2,896	2,928	14,488	2,898	2,816	2,945
	Bank	1,049	230	265	241	208	945	68	73	67	208	71	116	395	79	87	79
	Agency	654	243	293	245	382	1,163	60	31	74	165	76	48	290	58	55	97
	Waiting List initiative	537	138	86	127	72	423	42	32	19	93	22	5	120	24	45	35
	Overtime	20	3	4	6	14	27	3	3	3	9	3	3	15	3	2	2
	Other pay	32,290	8,283	8,362	8,219	9,212	34,077	2,814	2,772	2,831	8,417	2,817	2,905	14,139	2,828	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	2,989	3,078	14,959	2,992	2,879	3,053
	Variance Fav / (Adverse)	(760)	(262)	(398)	(198)	(432)	(1,290)	(40)	(120)	(68)	(228)	(93)	(151)	(471)	(94)	(63)	(108)

Analysis of pay spend 2011/12 and 2012/13

Division		2010/11	2011/12					2012/13								2010/11	2011/12
		Total £'000	Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Total £'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	2,997	3,100	15,635	3,127	3,077	3,105
	Bank	544	144	108	129	130	510	38	38	33	109	31	44	184	37	45	43
	Agency	389	73	46	63	101	284	(3)	32	23	52	22	59	132	26	32	24
	Waiting List initiative	156	37	27	28	41	133	0	31	12	43	18	6	67	13	13	11
	Overtime	264	68	49	67	96	280	20	31	27	77	24	21	123	25	22	23
	Other pay	35,515	8,915	9,029	8,965	8,954	35,863	3,060	3,079	3,101	9,240	3,043	3,026	15,309	3,062	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	3,137	3,156	15,815	3,163	3,072	3,089
	Variance Fav / (Adverse)	61	(116)	22	119	165	189	(19)	18	17	16	(139)	(56)	(180)	(36)	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	1,610	1,567	7,802	1,560	1,559	1,583
	Bank	483	93	75	72	84	323	28	31	27	86	18	27	132	26	40	27
	Agency	1,300	351	380	312	364	1,407	91	118	119	329	123	111	563	113	108	117
	Waiting List initiative	7	2	0	0	0	2	0	0	0	0	0	0	0	0	1	0
	Overtime	1,160	286	250	308	294	1,138	120	87	84	292	112	108	512	102	97	95
	Other pay	15,591	3,912	4,021	3,906	3,989	15,828	1,304	1,326	1,312	3,942	1,331	1,355	6,627	1,325	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	1,584	1,601	7,834	1,567	1,545	1,558
	Variance Fav / (Adverse)	165	13	80	57	144	294	(10)	(18)	5	(22)	25	(35)	(32)	(6)	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	2,133	2,284	10,810	2,162	2,230	2,240
	Bank	609	115	157	(11)	13	275	0	(2)	(14)	(16)	(15)	(8)	(40)	(8)	51	23
	Agency	209	9	53	83	96	240	7	18	6	30	19	18	68	14	17	20
	Waiting List initiative	7	(1)	0	0	0	(1)	0	0	0	0	0	0	0	0	1	(0)
	Overtime	108	16	17	23	83	139	17	29	13	59	11	6	76	15	9	12
	Other pay	26,087	6,532	6,832	6,617	5,890	25,871	2,150	1,908	2,050	6,108	2,019	2,072	10,198	2,040	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	2,034	2,088	10,302	2,060	2,252	2,210
	Variance Fav / (Adverse)	(257)	(302)	189	416	55	358	43	89	80	212	99	197	509	102	(21)	30
Trust Total (excl Skills for Health)	Pay budget	289,972	72,870	74,510	74,678	76,559	298,617	25,211	24,200	24,865	74,276	24,727	24,917	123,921	24,784	24,164	24,885
	Bank	10,295	2,373	2,413	2,137	2,221	9,144	744	846	774	2,364	775	1,021	4,160	832	858	762
	Agency	4,971	1,136	1,136	1,154	1,755	5,181	266	498	473	1,237	498	743	2,477	495	414	432
	Waiting List initiative	2,535	583	209	417	323	1,532	92	108	55	255	143	110	508	102	211	128
	Overtime	1,864	434	380	466	560	1,841	181	176	152	509	177	157	843	169	155	153
	Other pay	286,411	69,963	70,708	70,003	71,626	282,299	24,044	23,496	23,646	71,186	23,695	24,013	118,895	23,779	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	25,288	26,044	126,883	25,377	24,325	25,000
	Variance Fav / (Adverse)	(1,928)	(1,619)	(335)	502	73	(1,380)	(116)	(925)	(234)	(1,275)	(560)	(1,126)	(2,962)	(592)	(161)	(115)

Key Issue	RAG	Executive Summary	Table
Service Level Agreement Income and Activity	G	Activity was higher than Plan in July leading to an over-performance of £0.45m, offset by an under-performance on contract penalties / rewards of £0.48m. On a cumulative basis (to July 2012) contract income is £1.10m higher than Plan – this includes the balance of the 2011/12 over-performance of £1.07m. A&E Attendances at 37,836 are 636 **lower** than planned. The average number of daily attendances is 310. Emergency activity at 12,297 is 0.6% or 77 spells **lower** than planned. Non Elective activity at 5,532 is 4.2% or 221 spells **higher** than planned. Elective activity at 4,714 is as per Plan. Day case activity at 13,069 is 3.5% or 471 spells **lower** than planned. Outpatient Procedure activity at 7,945 is 13.2% or 1,205 spells **lower** than planned. New Outpatients activity at 43,579 is 2.1% or 943 attendances **lower** than planned. Follow up Outpatient activity at 94,176 is 10.2% or 10,737 attendances **lower** than planned. An income analysis by commissioner is shown at Table INC 2. Information on clinical activity by Division, specialty and patient type is provided in table INC 3.	INC 1
Income and Expenditure	R	The reported surplus for the 5 months to 31st August is £1.460m. This is £0.929m adverse to Plan. The EBITDA surplus of £13.221m equates to 90.7% of the Annual Plan target for the period. Total income to date of £219.853m is £0.156m greater than Plan. This includes a proportion (5/12ths) of the residual over performance relating to 2012/13 at £1.07m. Expenditure at £206.632m is greater than Plan by £3.846m, this reflects higher than planned expenditure in a number of areas and slippage to date on CRES plans. Financing costs are broadly in line with Plan.	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 five months to 31st August total £9.368m, a shortfall of £2.296m (July £1.583m) against divisional plans. The 1/12th phasing adjustment adds a further £1.454m to the total cumulative shortfall to date of £3.750m. The forecast outturn is for savings to total £23.127m of which £2.16m is non-recurring. The reduction in the non-recurring element of the CRES programme reflects the reclassification of CQUINs income as recurring savings, previously reported as a non-recurring saving.	I&E 4a – 4b
Statement of Financial Position & Treasury Management	G	The cash balance on 31st August was £35.695m. This is £1.649 lower than the forecast value. Income was lower than anticipated due to a further delay in the receipt of Skills for Health income (£3.213m) and offset by higher than planned Non-SLA NHS income. Payments were marginally lower than planned (£0.264m). Capital expenditure and Skills for Health expenditure slipped by £1.560m and £0.438m respectively but both are expected to catch up over the rest of the year. Payments to traders were £0.666m higher than expected as work continued on ensuring the Divisions authorise the backlog of invoices for payment. NHS payments were £0.879m higher than planned because of work to reduce balances over 90 days old. The balance on Invoiced Debtors has decreased by £3.908m in the month to £8.921m. The invoiced debtor balance equates to 6.7 debtor days. Creditors and accrual account balances total £76.386m although £8.205m relates to deferred income. Invoiced Creditors - payment performance for the year to date for Non NHS invoices and NHS invoices within 30 days was 88% and 81% respectively.	BS 1 BS 2 BS 3 BS 4
Capital	G	Expenditure for the five months to 31st August totals £22.507m - this is £2.971m less than profiled for the period. The significant variances reflect slippage on Strategic Schemes (£2.267m) and Operational Capital (£0.378m).	
Financial Risk Rating	A	The Trust's overall financial risk rating using the results for the five months to 31st August 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 £0.515m or 0.30% of total patient related income. This is well below the Trust's Private Patient Cap of 1.1%.	

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

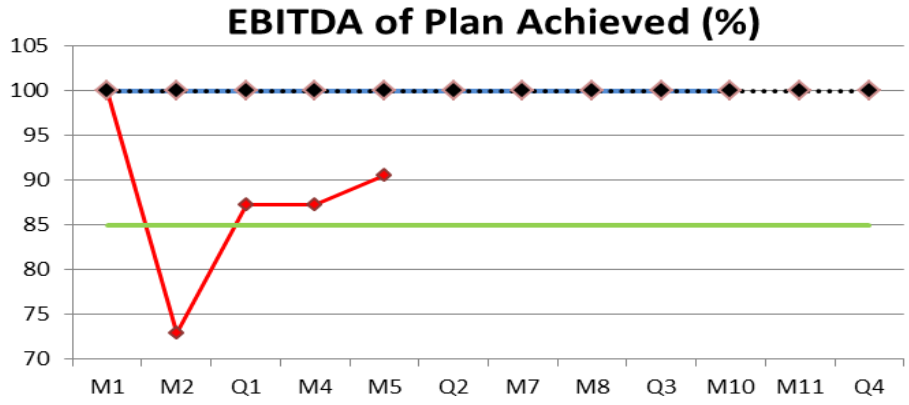
Finance Report August 2012 - Risk Matrix

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	High	8.0	
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 @ 0.30% of patient related income remains well within the Trust's Cap of 1.1%.
1623	Risk to UH Bristol of fraudulent activity.	Low	-	Local Counter Fraud Service in place. Pro active counter fraud work. Reports to Audit Committee.	PM	Low	-	
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 – August 2012 Performance

1. Financial Risk Rating

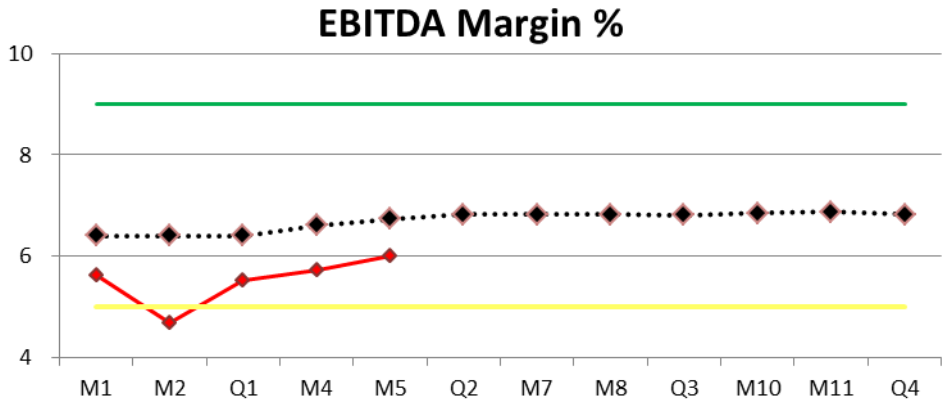
The following graphs will show performance against the 5 Financial Risk Rating metrics. The 2012/13 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 5 (blue line)**; **FRR 4 (green line)** and **FRR 3 (yellow line)**.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

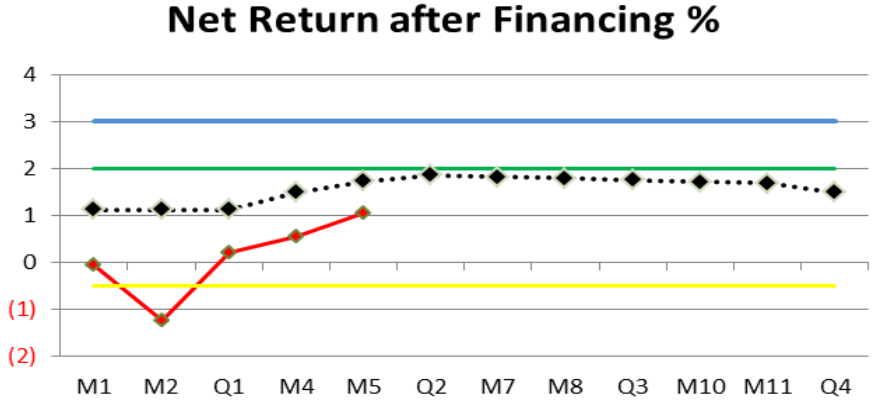


An EBITDA of £13.221m was achieved. This equates to 90.7% of the Annual Plan projection of £14.575m.

EBITDA Achievement of 90% of Plan earns a metric score of 4.

The EBITDA Margin of 6.0% for the 5 months to August achieves a metric score of 3. This is less than the Annual Plan forecast of 6.73% to date.



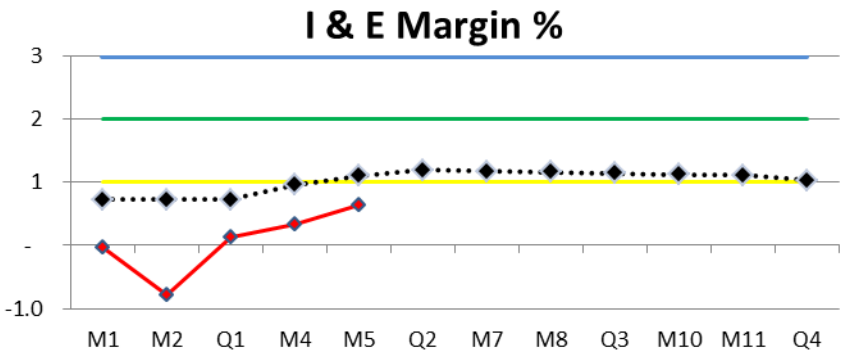


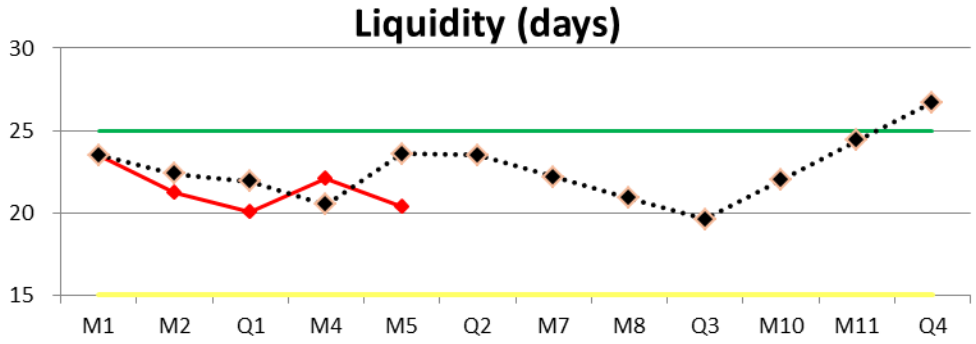
The Net Return on Financing for the 5 months is 1.06%. The result earns a metric score of 3.

Annual Plan = 1.73% to date.

The 2012/13 Annual Plan Income and Expenditure surplus margin is 1.10% to date.

The Income and Expenditure surplus margin for the period is 0.66%, a metric score of 2.





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

The actual liquidity ratio for August is 20.4 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 five months to 31st August.

2. Prudential Borrowing Limit

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

Prudential Borrowing Limit Performance	Monitor Ratio Tier 1	31st August 2012	Projection – March 2013
Minimum Dividend Cover	>1x	3.6x	3.6x
Minimum Interest Cover	>3x	86x	25x
Minimum Debt Service Cover	>2x	59x	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

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 09 – Foundation Trust Constitution

Purpose

To present changes required by the Health and Social Care Act 2012 (the Act) by 01 October 2012 to the Trust Board of Directors for **approval,** for onward submission to Monitor for final approval and adoption by the Trust.

Abstract

The Act makes a number of changes which require reflection in Foundation Trust Constitutions. These changes are being phased-in through "commencement orders", the first and second of which come into force on 01 October 2012 (Statutory Instruments 2012/1319 and 2012/1831).

Monitor requires foundation trusts to carry out the following actions:

- prepare the relevant changes to their constitution;
- secure the internal approvals required for constitutional changes, i.e. Membership Council and Trust Board of Directors approval; and,
- submit to their revised Foundation Trust Constitution for Monitor approval.

Monitor has asked that foundation trusts do not make any other constitutional changes as part of this update.

These amendments concern the following:

- The continuation of the body corporate known as Monitor;
- Changes from the "Board of Governors" to the "Council of Governors";
- Requirement for the principal purpose (i.e. provision of goods and services for the health service in England) to be stated in the Constitution;
- Introduction of the new legal duty to ensure that income of NHS funded goods and services is greater than income from other sources;
- Introduction of additional oversight and scrutiny by the Council of Governors over activities generating non-NHS income; and
- Replacement of HM Treasury with Secretary of State as regards giving guidance over foundation trust accounts.

For the time being, it remains Monitor's duty to approve Constitution amendments. As a result, Monitor has requested that FTs carry out the following actions as soon as possible (whilst there is no express timetable stated in the bulletin for carrying out these actions, the implication is that they will be carried out in readiness for 01 October 2012).

The amendment of this Constitution may be put to Monitor on the basis of an approval by the Board of Directors which shall first have consulted the Membership Council on each such proposal. The changes set out in the attached presentation were considered by the Membership Council at the Annual Members' Meeting on 20 September.

Recommendations
The Board is recommended to **approve** the requisite changes, as set out in the presentation, for onward submission to Monitor for final approval.
Executive Report Sponsor or Other Author
Sponsor – Chief Executive, Robert Woolley Author – Trust Secretary, Charlie Helps
Appendices
• Appendix A – Summary of Changes to the Foundation Trust Constitution

Revisions to Foundation Trust Constitution - 01 October 2012

Statutory Instruments

2012/1319 and 2012/1831

Revision 1

- The continuation of the body corporate known as Monitor

"Monitor"	is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.

Revision 2

- Changes from the “Board of Governors” to the “Council of Governors”

“Council of Governors” throughout

~~MEMBERSHIP COUNCIL~~COUNCIL OF GOVERNORS – COMPOSITION

12.1 The Trust shall have a ~~Membership Council~~Council of Governors which shall comprise both Elected and Appointed Governors.

12.2 The composition of the ~~Membership Council~~Council of Governors shall be as specified in Annex 4.

12.3 The members of the ~~Membership Council~~Council of Governors, other than the Appointed Governors, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency.

12.4 The number of Governors to be elected by each constituency or, where appropriate, by each class of each constituency is specified in Annex 4.

~~MEMBERSHIP COUNCIL~~COUNCIL OF GOVERNORS – ELECTION OF GOVERNORS

13.1 Elections for elected members of the ~~Membership Council~~Council of Governors shall be conducted in accordance with the Model Election Rules.

Revision 3

- Requirement for the principal purpose (i.e. provision of goods and services for the health service in England) to be stated in the Constitution

Principal Purpose

3. **PRINCIPAL PURPOSE**

3.1 The principal purpose of the Trust ~~shall be~~is the provision of goods and services for the purposes of the health service in England.

3.2 The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The trust may provide goods and services for any purposes related to—

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

Revision 4

- Introduction of the new legal duty to ensure that income of NHS funded goods and services is greater than income from other sources
- See “Principal Purpose” above

Revision 5

- Introduction of additional oversight and scrutiny by the Council of Governors over activities generating non-NHS income

37. ANNUAL REPORT, ~~AND~~ FORWARD PLANS AND NON-NHS WORK

37.1 The Trust shall prepare an annual report and send it to Monitor.

37.2 The Trust shall give information as to its forward planning in respect of each financial year to Monitor.

37.3 The document containing the information with respect to forward planning (referred to ~~referred to at paragraphs 33.1.5 and 37.2~~ above) shall be prepared by the Directors.

37.4 In preparing the document, the Directors shall have regard to the views of the ~~Membership Council~~Council of Governors.

37.5 Each forward plan must include information about –

37.5.1 The activities other than the provision of goods and services for the purpose of the health service in England that the trust proposes to carry on, and

37.5.2 the income it expects to receive from doing so.

37.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 37.5.1 the Council of Governors must –

37.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the trust of its principal purpose or the performance of its other functions, and

37.6.2 notify the directors of the trust of its determination.

~~37.4~~37.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the trust voting approve its implementation.

Revision 6

- Replacement of HM Treasury with Secretary of State as regards giving guidance over foundation trust accounts

Secretary of State

36. **ACCOUNTS**

36.1 The Trust ~~shall~~ must keep proper accounts and proper records in relation to the accounts~~in such form as Monitor may with the approval of HM Treasury direct~~.

~~36.1~~36.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

~~36.2~~36.3 The accounts are to be audited by the Trust's auditor.

~~36.3~~36.4 The Trust shall prepare in respect of each Financial Year annual accounts in such form as Monitor may with the approval of the ~~HM Treasury~~Secretary of State direct.

~~36.4~~36.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

Sundry

- Definitions

"the 2006 Act"	means the National Health Service Act 2006;
"the 2012 Act"	means the Health and Social Care Act 2012

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 10 – Quality and Outcomes Committee Terms of Reference

Purpose

To present an amendment to the Terms of Reference of the Quality and Outcomes Committee for **approval** by the Trust Board of Directors.

Abstract

In agreement with the Chairman, the Quality and Outcomes Committee recommends that the committee meets in advance of each meeting of the Trust Board of Directors at which the Quality and Performance report is to be considered. This is to enable the committee to give due consideration to the Quality and Performance Report so as to discharge the duties set out in the Terms of Reference effectively.

Recommendations

The Board is recommended to **approve** the following amendment on page 7 of 8:

8. Frequency of Meetings

8.1. The Committee shall meet in advance of each meeting of the Trust Board of Directors at which the Quality and Performance Report is to be considered ~~every second month~~, and at such other times as the chair of the Committee shall require.

No other amendments to the Terms of Reference are recommended.

Executive Report Sponsor or Other Author

Sponsor – Trust Secretary, Charlie Helps

Author – Trust Secretary, Charlie Helps

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11 – Register of Applications of the Trust Seal
Purpose
To report applications of the Trust Seal.
Abstract
Standing Orders for the Trust Board of Directors stipulates that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing. The Register at Appendix A includes all applications of the Trust Seal in the Financial Year 2012-2013 to 03 September 2012.
Recommendations
The Board is recommended to **note** the Register of Seals.
Executive Report Sponsor or Other Author
Sponsor – Chief Executive Author – Trust Secretary
Appendices
• Appendix A – Register of Applications of the Trust Seal 2012-09-03

Reference Number	Date	Description of Document Sealed	Signatory 1	Signatory 2
662	06/03/2012	Deed of variation of lease and underlease relating to Sam's House, Royal Fort Road.	Paul Mapson	Robert Woolley
663	09/03/2012	Agreement relating to Internal Refurbishment and alterations to create Sleep Unit and Medical Physics, Levels 4 and 5, Old Building, Bristol Royal Infirmary between UH Bristol and Ian Williams Contractor.	Paul Mapson	Robert Woolley
664	09/03/2012	Revised deed of variation of lease and underlease relating to Sam's House, Royal Fort Road.	Paul Mapson	Robert Woolley
665	19/03/2012	Revised deed of variation of lease and underlease relating to Sam's House, Royal Fort Road.	Robert Woolley	Paul Mapson
666	20/03/2012	Freehold Sale Agreement relating to Brentry Laundry and Central Processing Unit, Brentry Hospital, Charlton Road between UH Bristol and Pie Minister Limited.	Robert Woolley	Paul Mapson
667	20/03/2012	Lease relating to land and premises at Charlton Road, Westbury-on-Trym, Bristol between UHBristol and Pie Minister Limited.	Robert Woolley	Paul Mapson
668	20/03/2012	Stage 3 design fees relating to BHOC Project with Laing O'Rourke.	Robert Woolley	Paul Mapson
671	02/04/2012	License to under-let in relation to part of South Bristol Community Hospital in respect of acute services.	Robert Woolley	Paul Tanner
672	02/04/2012	License to under-let in relation to part of South Bristol Community Hospital in respect of dental services.	Robert Woolley	Paul Tanner
673	13/04/2012	Novation Agreement relating to Contract for Provision of Soft Facilities Management Services at South Bristol Community Hospital	Robert Woolley	Paul Mapson
674	13/04/2012	Overarching Agreement relating to South Bristol Community Hospital	Robert Woolley	Paul Mapson
675	09/07/2012	Lease relating to the canteen and store room at Level 1, BDH, between UHB and R.J. Holland (x2).	Paul Mapson	Robert Woolley
676	09/07/2012	Lease relating to coffee shop, BCH and store room, between UHB and R.J.Holland (x2)	Paul Mapson	Robert Woolley
677	09/07/2012	Engrossment relating to the disposal of Bristol General Hospital: Transfer 1 (x2)	Paul Mapson	Robert Woolley
678	09/07/2012	Engrossment relating to the disposal of Bristol General Hospital: Transfer 1 (Velindra Access) x2	Paul Mapson	Robert Woolley
679	09/07/2012	Engrossment relating to the disposal of Bristol General Hospital: Additional Payment Deed (x2)	Paul Mapson	Robert Woolley
680	09/07/2012	Engrossment relating to the disposal of Bristol General Hospital: Legal charge (x2)	Paul Mapson	Robert Woolley
681	09/07/2012	Engrossment relating to the disposal of Bristol General Hospital: Deed of Subordination and Priorities (x3)	Paul Mapson	Robert Woolley
682	17/07/2012	Sale of Land between 76-88 Horfield Road aka Horfield Road Triangle	Robert Woolley	Paul Mapson
683	18/07/2012	106 Unilateral Undertaking for £30,000 in relation to Highway Works in Association with the Planning Application for the Oncology Centre	Robert Woolley	Paul Mapson
684	25/07/2012	Bristol General Hospital disposal: Transfer 1 document	Paul Mapson	Robert Woolley
685	25/07/2012	Bristol General Hospital disposal: Supplemental Agreement	Paul Mapson	Robert Woolley
686	25/07/2012	Bristol General Hospital disposal: Deed of Assignment of Asbestos Reports	Paul Mapson	Robert Woolley
687	25/07/2012	Bristol General Hospital disposal: Legal Charge	Paul Mapson	Robert Woolley
688	15/08/2012	Lease of Kiosk premises at Bristol Royal Infirmary between UHB & Costa	Robert Woolley	Paul Mapson
689	03/09/2012	Deed of Priorities - Land at Charlton Road, Brentry	Deborah Lee	Paul Mapson
690	03/09/2012	TR1 - Land at Charlton Road, Brentry	Deborah Lee	Paul Mapson
691	03/09/2012	Additional Payment Deed - Land at Charlton Road, Brentry	Deborah Lee	Paul Mapson
692	03/09/2012	Legal Charge - Land at Charlton Road, Brentry	Deborah Lee	Paul Mapson

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 12 – Loan Facility Agreements – Conditions Precedent
Purpose
To obtain the Board's approval of the Conditions Precedent of the loan facility agreements and to authorise the Director of Finance to act on its behalf in this matter.
Abstract
The Trust Board has previously approved proposals to take out term loan facility agreements with the Secretary of State for Health through the Department of Health Foundation Trust Financing Facility. The Loan Facility Agreements require a copy of a resolution of the board of directors to the Conditions Precedent. The report provides summary information of the Agreements.
Recommendations
• the terms and transactions of the Finance Documents and resolving that it execute the Finance Documents to which it is a party; • authorises the Director of Finance to execute the Finance Documents to the agreement; and • authorises the Director of Finance, on behalf of the Board, to sign and / or despatch all documents and notices (including any Utilisation Request) to be signed and / or despatched by it under or in connection with Finance Documents to which it is a party.
Report Sponsor
Director of Finance, Paul Mapson.
Other Author
Head of Finance, Paul Tanner.
Appendices
Appendix 1 – Extract of Loan Agreement, Schedule 1 Conditions Precedent

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
			24 September 2012		

Loan Facility Agreements – Conditions Precedent

The Trust Board has previously approved proposals to take out term loan facility agreements with the Secretary of State for Health through the Department of Health Foundation Trust Financing Facility.

Facility Agreements are in place as follows:

Purpose	£'m
Welcome Centre *[Repayable over 19 years from September 2013 @ an interest rate of 1.73%]*	4.95
BRI Redevelopment and Centralisation of Specialist Paediatrics *[Repayable over 16½ years from June 2015 @ an interest rate of 4.81%]*	70.00
Total	**74.95**

It is anticipated that the loan of £4.95m for the Welcome Centre scheme will be drawn down in full in 2012/13. The drawdown of the BRI Redevelopment and Centralisation of Specialist Paediatrics is available in 2012/13 and 2013/14. The working assumption is that up to £45m may be drawn down in 2012/13 with the balance of £25m required in 2013/14. The Trust is working to reduce the amount drawn down this year to reduce the amount of interest charges payable.

An extract of Schedule 1 – Conditions Precedent is attached as Appendix 1. Copies of the Loan Agreements are available on request.

Recommendations

It is recommended that the Trust Board approves:

- the terms and transactions of the Finance Documents and resolving that it execute the Finance Documents to which it is a party;
- authorises the Director of Finance to execute the Finance Documents to the agreement; and
- authorises the Director of Finance, on behalf of the Board, to sign and / or despatch all documents and notices (including any Utilisation Request) to be signed and / or despatched by it under or in connection with Finance Documents to which it is a party.

SCHEDULE 1

CONDITIONS PRECEDENT

1. Authorisations

1.1 A copy of the constitutional documents of the Borrower.

1.2 A copy of a resolution of the board of directors of the Borrower:

(A) approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(B) authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf; and

(C) authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.

1.3 A specimen of the signature of each person authorised by the resolution referred to in paragraph 1.2.

1.4 A certificate of the Borrower (signed for and on behalf of the Borrower) confirming that borrowing the Facility Amount would not cause the Prudential Borrowing Limit to be exceeded.

1.5 A certificate of an authorised signatory of the Borrower certifying that each copy document relating to it specified in this Schedule 1 and provided to the Lender is correct, complete and in full force and effect as at a date no earlier than the date of this Agreement.

2. Financial Information

The Original Financial Statements of the Borrower.

3. Finance Documents

3.1 This Agreement (original).

3.2 The original or certified copy (as the Lender shall require) of any Finance Document not listed above.

4. General

4.1 A copy of any other Authorisation or other document, opinion or assurance which the Lender considers to be necessary or desirable in connection with the entry into and performance of the transactions contemplated by any Finance Document or for the validity and enforceability of any Finance Document.

4.2 Evidence that the fees, costs and expenses then due from the Borrower pursuant to Clause 13 (*Costs and expenses*) have been paid or will be paid by the first Utilisation Date.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 13 – Partnership Programme Board Report
Purpose
To provide the Board with an update on matters considered at the August 2012 meeting of the University Hospitals Bristol (UH Bristol) and North Bristol NHS Trust (NBT) Partnership Programme Board.
Abstract
The Partnership Programme Board meets on a bi-monthly basis and considers matters of relevance to the partnership agenda between University Hospitals Bristol and North Bristol NHS Trust with the aim of promoting highly effective joint working between the partner trusts for the benefit of patients and staff within the two organisations. A summary of the key issues discussed is provided to the Board, for information.
Recommendations
The Board is recommended to **receive** the highlight report of the recent Partnership Programme Board.
Report Sponsor
The Chief Executive, Robert Woolley.
Report Author
The Director of Strategic Development, Deborah Lee.
Appendices
• Appendix A – Partnership Programme Board Summary August 2012.

North Bristol NHS Trust
University Hospitals Bristol NHS Foundation Trust

The Partnership Programme Board

Held on Tuesday 14th August

Key Points Summary

Mental Health Liaison

Both Trusts are working together, with partners in mental health provision and commissioning, to produce a service specification to support the development of mental health support to patients in need, who are being cared for in either of the acute Trusts; this will include patients who present both to the Accident and Emergency Department and those who are cared for in our wards and other settings.

It is intended to go to market tender for a service provider subject to the business case securing support.

Macmillan Partnership Bid

The two Trusts, along with other partners, were successful in securing funds from Macmillan Cancer Support to enable improvements in the cancer pathway for our patients. The two trust Cancer Boards will retain oversight of the project going forward. Feedback from Macmillan confirmed that it was the partnership nature of the Bristol bid that had secured the funding above others applicants.

Academic Health Science Network (AHSN)

The Board was briefed on the progress towards the establishment of a West of England AHSN as part of the national approach to ensure that all providers of NHS funded care are members of an accredited AHSN by the end of 2013. The goal of the AHSN will be to increase the pace and scale of improvements in the delivery of healthcare through the effective identification, early adoption and rapid spread of what we collectively identify as “the right things for patients”.

The putative West of England AHSN is aiming to be licensed by April 2013. University Hospital Bristol is currently the sponsoring organisation for the West of England application which encompasses providers, commissioners, higher education and industry partners from Wiltshire, Swindon, Gloucestershire, Bristol, North Somerset and South Gloucestershire.

Non-clinical Support Services

The Board has sponsored a piece of joint work across the two Trusts to explore the option of creating a single Central Sterile Supplies Service to ensure effective, affordable instrument decontamination is available in both the medium and long term. External support for the work has been commissioned and an option appraisal will be presented to the PPB in the Autumn.

Acute Service Integration

The Partnership Programme Board received an update following the resolution by Trust Boards in July to do further work to develop an Outline Business Case for the creation of a single acute services organisation for Bristol.

Standing Reports By Exception

Updates were received from all leads on the on-going service transfers. Key issues and milestones noted were:

Pathology – The production of the Business Case had been delayed by two months and was not now expected until December 2012. Furthermore, the bid to access national capital had not been successful which in turn now requires the Clinical Model Option 2 to be developed further; this option sees the partial consolidation of three pathology disciplines at Southmead and the consolidation of Cellular Pathology on the BRI site.

Centralisation of Paediatrics – Risk to theatre staff recruitment noted with actions to mitigate agreed.

Tri-service Transfer – The transfer had not proceeded through the final assurance gateway but would

be tested for preparedness to proceed again, at the end of September when it was hoped that the gateway would be GREEN rated. It was noted that staff consultation must commence by mid-November for the transfer to proceed as planned.
NBT Highlight Report Steve Webster, Director of Finance would be leaving the Trust in January 2013 and NBT intend to proceed to a substantive appointment. Sue Jones (Yeovil) had started in her post as Interim Director of Nursing, Mike Brooks has been appointed to Interim Head of IM&T and Sasha Karakusevic, former Director of the HIEC has been substantively appointed to the Chief Operating Officer post and will commence at the end of September.
UH Bristol Highlight Update Monitor had signed off the UH Bristol Annual Plan whilst noting the risks to A&E performance. The benefits of joint working, to both Trust urgent care performance, was noted.
Chair Rotation In line with the Boards Terms of Reference, the Chair will pass to Stephen Hughes at NBT and a meeting will be convened to agree the forward work programme and partnership priorities.

Attendees	**Apologies**
NBT	**UHB**
Marie-Noelle Orzelle, Chris Burton, Harry Hayer	Emma Woollett
UHB	**NBT**
Robert Woolley, Iain Fairbairn (Chair) Deborah Lee, Alison Moon, John Moore,	Stephen Hughes, Robert Mould

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 14 – Electronic Prescribing – Southern Trusts' Collaborative Business Case

Purpose

To brief the Board on the Trust's membership of the South Acute Programme Electronic Prescribing Collaborative and the associated Outline Business Case and seek approval of the current approach.

Abstract

The Trust's Clinical System Strategy includes a specific intention to deploy Electronic Prescribing and Medicines Administration (EPMA) as part of its Implementation Programme. Following the production of a local Outline Business Case (OBC) for Electronic Prescribing and Medicines Administration (EPMA) earlier this year, UH Bristol has now elected to join an initiative being run in the South by the Department of Health Informatics Directorate (DHID, formerly NHS Connecting for Health).

The South Acute Programme aims to disburse funding that was unallocated during earlier initiatives (National Programme for IT and the more recent ASCC procurement route) through seven collaborative groups of acute Trusts, each group seeking to purchase a different system or combination of system functions (see attached summary). UH Bristol has subscribed to EPMA Group A, which includes Salisbury, Poole, Royal Bournemouth and Christchurch, Southern Healthcare, Portsmouth, Royal Surrey and ourselves.

Since joining the collaboration in May 2012, UH Bristol has participated in the production of an Outline Business Case that covers the needs of all member trusts, expressing the Case as a 'typical' trust whilst allowing us to extrapolate our own much larger figures for local information. The EPMA Group's OBC has been developed by members of the group assisted by an external consultancy company (Apira) within the time-scales stipulated by DHID. Once all collaborative OBCs have been completed they will be represented in an over-arching OBC that will be presented to the Cabinet Office later in the Autumn so that decisions on funding can be consolidated.

The expectation is that, subject to some limitations, all vendor costs will be funded for the first four years of the supply contract.

The Draft Outline Business Case and Time-scales

Whilst the EPMA Group draft OBC was reviewed and approved in principle by the DHID programme team, subsequent review by a DoH Business Case assurance representative introduced a further round of changes and requirement for detail not usually expected in an outline case. Further work has therefore been done and an 'interim' draft was been submitted at the end of August in accordance with the plan.

A summary of the OBC has been provided as further background but the overall collaborative OBC is based upon a total investment of £18.7M, with return on investment of £36.5M together with a substantial improvement in patient safety relating to medicines management. It should be noted that the figures for investment and RoI relate to the case for the whole collaborative Group and UH Bristol is not yet convinced that these figures are accurate or achievable at this scale,

hence the requirement for further local work to refine our own case. The CSIP programme director will be pleased to provide a more detailed briefing for individual members if requested.

Richard Caves, Chief Information Officer (West) for NHS South of England, has written to the Trust asking for confirmation from the Board that the Trust is committed to meeting the time-scales of the initiative and approves the approach to the OBC. The Trust responded positively to this letter on 3 September 2012. Other collaborative groups have been less successful in meeting the time-scales for their own OBCs, with the result that the schedule that DHID required us to commit to has already slipped by one month.

Next Steps

The project team is confident that the EPMA Group, led by Salisbury, has the wherewithal to meet its obligations with DHID so that the final version of the OBC can be submitted to the Cabinet Office at the end of September, with an expectation that central evaluation will be completed by the end of the year and a requirements gathering exercise and subsequent procurement launched in February 2013.

UH Bristol's project team will continue to support the collaboration whilst maintaining a cautious view of some of the claims expressed in the OBC and the requirements of the initiative as a whole. Particular issues to note are:

- All members of the Group will be required to procure the same solution
- There is a bias towards the two main pharmacy supplier solutions (JAC and Ascribe), although these are not proven to be the most appealing
- UH Bristol is the only Group member fielding a clinician user as a part of its team (Peter Murphy). Other members are involving only pharmacy leads.
- The OBC is, necessarily, focussed on the financial aspects of the initiative but we feel that there should be more emphasis on direct patient safety and quality of care and will develop this separately
- We do not believe that the figures underpinning the return on investment (used in many recent EPMA business cases) are sufficiently reliable and favour more conservative estimates that are still likely to demonstrate a positive return.

However, the availability of substantial funding for vendor costs and a compelling case for improved safety and quality of care makes it important that we maintain our participation through the next stages of Business Case through to procurement.

Recommendations

For discussion and **approval**.

NHS South of England has written to the Trust asking for confirmation from the Board that the Trust is committed to meeting the time-scales of the initiative and approves the approach to the Outline Business Case (OBC). The Trust's response is contained in appendix B. A summary of the OBC can be found in appendix C. The Board is asked to approve the approach.

It is further recommended that the Trust should remain part of this collaboration as long as the associated procurement holds out the potential to provide a value-for-money Electronic Prescribing solution that also fits in with the Trust's Clinical Systems Strategy.

Executive Report Sponsor or Other Author

Sponsor – Finance Director, Paul Mapson

Author – Steve Gray, interim CSIP Programme Director.
Appendices
Appendices: • Appendix A – South Acute Programme EPMA – Richard Caves – 03 September 2012 • Appendix B – SAcP – groupings and steering group information – August 2012 • Appendix C – Summary of the South Acute Programme Outline Business Case for Electronic Prescribing and Medicines Administration.

Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
	12 September 2012				

Appendix A

South Acute Programme (SAcP)

SAcP Collaborative groupings – as of August 2012

Group A	SC&W EPMA	Group B	Sussex Strategic Network	Group C	South Devon Informatics
Trusts	Salisbury, Poole, Royal Bournemouth and Christchurch, Southern Healthcare, Portsmouth Royal Surrey, UH Bristol	Trusts	Queen Victoria Hospital NHS Foundation Trust, East Sussex, Healthcare NHS Trust, Western Sussex Hospitals NHS Trust	Trusts	South Devon Healthcare, Torbay and South Devon Care Trust, WAST, Rowcroft Hospice, and Southern Devon GP Practices (via Commissioners)
Products	EPMA (Best of Breed)	Products	ePrescribing, Clinical Docs, Order Comms, Clinical Portal (Integrated)	Products	ePrescribing, (Best of Breed)
Group D	**Kent SAcP Collaborative**	**Group E**	**GLNDY**	**Group F**	**EDM**
Trusts	Dartford and Gravesham, Medway, East Kent , Maidstone	Trusts	Gloucestershire, Northern Devon Yeovil District Hospital	Trusts	Frimley Park. Ashford and St Peters Heatherwood & Wexham
Products	PAS+, ePrescribing, Clinical Portal, Maternity (Best of Breed)	Products	PAS+, ePX, Clinical docs, Order Comms, Clinical portal Theatres, A&E, Maternity (integrated)	Products	Clinical Documentation/EDM (Best of Breed)

Confidential

University Hospitals Bristol NHS
NHS Foundation Trust

Appendix B

Our Ref: RW/SG

03 September 2012

Trust Headquarters
Marlborough Street
Bristol
BS99 1YF

Richard Caves South
West House Blackbrook
Park Avenue Taunton
TA1 2PX

Direct line number: 0117 342 3720
Email: Robert.woolley@uhbristol.nhs.uk
Website: www.uhbristol.nhs.uk

Dear Richard

Ref: South Acute Programme – Trust Board level Approval of Electronic Prescribing Collaborative Outline Business Case

Thank you for your letter of 9 August 2012 regarding the South Acute Programme in which we are participating in the Electronic Prescribing Collaboration.

I can confirm that, subject to our review of the Collaborative's Outline Business Case that is due for submission at the end of August in preparation for the Southern Programme for IT Board, we will include an agenda item at our September Trust Board asking for approval of the approach being taken by the Trust in respect of the Collaborative OBC. It is not possible to actually approve the OBC as it contains no Trust specific information.

I can also confirm that University Hospitals Bristol NHS Foundation Trust is committed to working within the timeline in Annex A of your letter although I note that once the Collaborative OBC has been submitted at the end of August there appears to be little practical input for our team prior to the start of the procurement. I should point out that the Collaborative's OBC has previously been submitted to the South Acute Programme, who subsequently required that significant changes should be made to it. We await the reworked document.

Yours sincerely

Robert Woolley
Chief Executive Officer

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

POSITIVE ABOUT DISABLED PEOPLE

Appendix C

Summary of the South Acute Programme Outline Business Case for Electronic Prescribing and Medicines Administration

The following is a high-level summary of the more detailed Outline Business Case (OBC) for Electronic Prescribing and Medicines Administration (EPMA) and is based on the abstracts used to brief the Steering Group of the South Acute Programme, which is being operated by the Department of Health Informatics Directorate and NHS South of England. Tables are therefore 'snapshots' from the slides used and have not been separately formatted for this summary.

Background

Collaborative Group A for EPMA consists of seven Trusts in South West and South Central:

- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH)
- Poole Hospital NHS Foundation Trust (PHT)
- Portsmouth Hospitals NHS Trust (Port)
- Salisbury NHS Foundation Trust (SFT)
- Southern Health NHS Foundation Trust (SHFT)
- Royal Surrey County Hospital NHS Trust (RSCH)
- University Hospitals Bristol NHS Foundation Trust (UHB)

Scope

The scope of the procurement is for an EPMA system that will interface to an existing Pharmacy Stock Control system and provide a complete end to end paperless prescribing and administration system covering all prescribing and medicines administration activities (with the exception of chemotherapy) across all specialties including mental health, paediatrics, maternity, ITU and community services, etc.

The Outline Business Case is based upon a total Collaborative investment of £18.7M, with return on investment of £36.5M together with a substantial improvement in patient safety relating to medicines management.

[Note: the figures for investment and RoI relate to the case for the whole collaborative Group and UH Bristol is not yet convinced that these figures are accurate of achievable, hence the requirement for further local work].

The Strategic Case (SC)

National Drivers

- The Department of Health's new Information Strategy highlights a number of priority areas, the first of which is "Medicines management, for safer, more effective care".
- **Essential:** EPMA has been identified by Connecting for Health (CfH) as a core service for all Trusts in England. A comprehensive report published in 2009 concluded that "ePrescribing is essential for any provider organisation to thrive in healthcare".

- **Clinical 5:** The Department of Health has highlighted e-prescribing as one of the five features central to clinicians' requirements of a strategic hospital IT system.

Strategic Risks

The EPMA solution will address the following Strategic Risks

- Transcribing errors
- Lost prescription charts
- Omitted medication
- Omitted or delayed doses
- Medication being wrongly administered
- Lack of complete medication history
- Poor communication of medication data to GPs

Strategic Benefits

And achieve the following Benefits

- Reduced prescribing errors
- Reduced administration errors and omissions
- Reduction in prescribing time for clinicians
- Access to improved medication histories 24 by 7, and across departments
- Reduced pharmacy intervention time, allowing increased direct care contributions from Pharmacy staff
- Application of Clinical Decision support
- Access to accurate and timely data for analysis, audit and research purposes
- Improved communication to GPs on medication
- Increased efficiency of supply chain
- Reduced stationery and storage costs
- Enhanced reputation of Trust
- Increased opportunities for research income
- Increased opportunities for CQUIN incentives
- Increased income from new business and from tariffed activity under PbR

The Economic Case (EC)

Short List of options (following a more diverse long list)**:**

A: Do nothing

B: Do minimum: Adapt existing systems and processes to achieve some of the desired benefits and mitigate the risks

C: Procure EPMA as an individual Trust

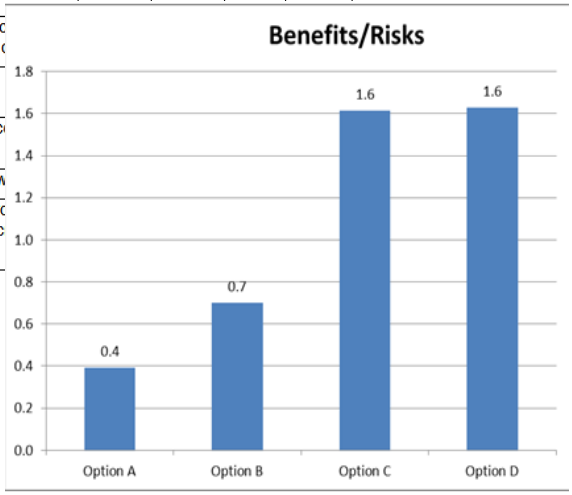
D: Procure EPMA as a collaborative

Evaluation

Short listed options scored by benefits and risks:
[Note, following are abstracts for illustration only]

Weighting	Benefits	Score A	Score B	Score C	Score D
5	Reduces medication errors (prescribing)	1	2	4	5
5	Reduces medication errors (administration)	1	2	5	5
4	Reduced prescriber time (legibility and re-writing which frees clinician time)	1	2	5	5
4	Easy access to history, Visible history 24 by 7				
4	Reduce interve allowing increa care contributic Pharmacy staf				

Weighting	Risks	Score A	Score B	Score C	Score D
4	Reputational damage from impact of prescribing errors	4	4	2	2
3	Consent processes found inadequate	3	3	2	1
3	Loss of business to competitors	4	3	2	2
3	High transparency c - demands cultural c				
3	Escalating and uncontrollable drug				
4	Escalating insuranc legal costs				
3	Increasing clinical w				
4	Increasing untowarc incidents with presc factors				



The Financial Case (FC)

Aggregated Costs

Expenditure item	Anticipated source of funding	Seven year total (£)
Capital		
Vendor costs, including initial implementation and licencing costs	DH	2977240
Trust side IT costs, eg. Local integration	Trust	700000
Revenue		
Vendor costs, including ongoing maintenance and licencing costs	DH / Trust	3585655
Trust side project implementation costs, including procurement and project management	Trust	2563156
Trust side Business as Usual costs, including system administration and user support	Trust	8909681
Total Capital Costs		3677240
Total Revenue Costs		15058492
Total expenditure (£)		**18735732**

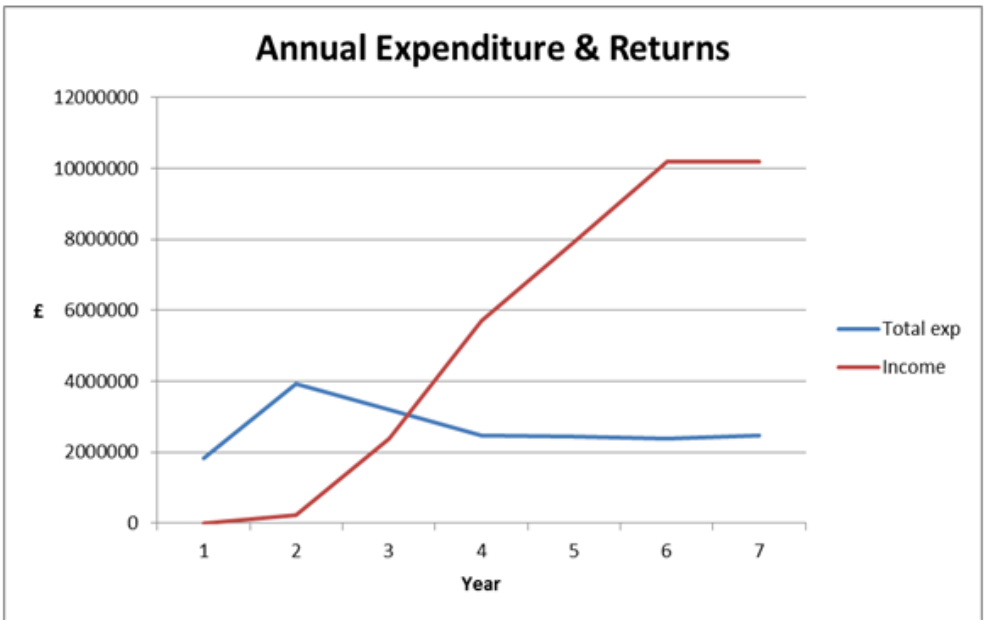
Return on Investment

Ref.	Item	Seven year total (£)
1.1.1	Reduction of paper	113,492
1.1.4	Overall drug costs (excluding cancer treatments)	1,0768,970
1.1.6	Avoided (re)admissions	8,717,575
1.1.11	Incident management costs	103,797
1.1.12	Reduction in length of stay	1,642,352
1.2.1	Rewriting charts	1,642,388
1.2.4	Pharmacy journeys	530,967
1.2.5	Audit time	502,351
1.3.2	Research income (surplus)	493,405
1.3.4	Commissioning incentives (CQUIN)	12,075,000
	Total savings and revenue (£)	**36,590,302**

Annual Expenditure and Return

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
Total expenditure	1822100	3928044	3196236	2463669	2458102	2393588	2473993	18735732
Savings/income	0	225888	2388804	5698448	7917616	10179524	10180024	36590302

Table 11



The Commercial Case (CC)

Market Analysis

Suppliers	Advantages	Disadvantages
JAC, Ascribe	Proven in Acute and Mental Health environment Dedicated EPMA system	Potential lack of flexibility Project needs to be robustly managed Capacity of these suppliers may become stretched as demand rises following the end of the National Programme
System-C, Cerner, iSoft, PICS	Well established commercially	Lack of flexibility Higher relative cost May not be available as stand-alone module
Cambio, Galileo	Potential to develop solution in line with requirements Potential cost savings Higher expected demand for EPMA solutions may drive development of these new entrants to the UK market	Not yet proven in UK Unlikely to be able to develop product within required timescale

Procurement strategy: OJEU Restricted Tender (Competitive Dialogue is discouraged)
Contract Strategy: Individual contracts between trusts and supplier(s); Internally hosted (by each trust); Software and maintenance contract

The Management Case (MC)

Implementation Plan (based on seven concurrent deployments)

Phase	Timescale	Notes
Procurement	Quarter 1-2	OJEU tender, select supplier, identify funding sources
Preparation	Quarter 3-6	Award contract, appoint project team, complete infrastructure upgrade
Testing and configuration	Quarter 4-8	Full interface testing and User Acceptable Testing and rules configuration.
Pilot	Quarter 7-8	Small number of users in one or two locations: e.g. 1 inpatient ward, 1 outpatient clinic
Review	Quarter 9	Review benefits and processes
Phase 2	Quarter 10-11	Extend use to further inpatient wards and outpatient clinics
Phase 3	Quarter 12-13	Extend use to further inpatient wards and outpatient clinics
Phase 4	Quarter 14-28	To include all wards and clinics

Governance will be determined by the South Acute Programme.

Risks

Risk	Impact	Mitigation
Lack of adequate infrastructure and mobile devices to support full implementation of EPMA	Lack of easy access to a reliable IT system can lead to disenchantment, poor engagement and use of system	Ensure that IT infrastructure is fit for purpose
Lack of internal resources for on-going support	EPMA implementation unlikely to succeed and be sustainable without dedicated support posts	Approved budget needs to include dedicated staff costs
Perception that EPMA system is Pharmacy-led, and not suited to clinical requirements	May lead to gaps in requirements specified and have adverse impact on clinical engagement	Ensure clinical sponsorship and engagement at an early stage
Lack of integration with existing systems	Benefits will not be fully realised if systems are not genuinely integrated	Supplier contract must specify detailed integration requirements
Lack of user engagement	Uptake and use of EPMA system will be inconsistent	Ensure early engagement with all users, with high level of support

Changes to be applied before completion end of September

- Adapting the commercial case to be compliant with the template from DoH Business Case Assurance *(new requirement introduced since our draft was completed)*
- Full evaluation of the long-listed options in the Economic Case *(although these are self-evident)*
- Base-lining the benefits for the case and creating SMART objectives *(not be possible to do this properly in the Outline Case)*
- Augmenting the management case with more detail relating to governance and implementation.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 15 – Results of Quarter 1 Compliance Framework Monitoring Exercise

Purpose

To brief the Board on the assigned Monitor risk rating for Quarter 1 of the 2012/2013 financial year.

Abstract

Compliance with targets, national priorities and Care Quality Commission registration conditions is a requirement of the Trust's terms of Authorisation. This report sets out governance and financial risk ratings assigned to the Trust by Monitor, the Foundation Trust regulator, following their review of performance in Quarter 1 of the 2012/2013 financial year.

Monitor has confirmed that based on their analysis, the Trust's ratings for Q1 were:

- Financial risk rating - 3
- Governance risk rating - AMBER-RED

The Trust has been assigned an Amber-Red governance risk rating for Q1 which reflects that it has failed to meet its C. Difficile trajectory and the Accident and Emergency 4 hour wait target.

Monitor advises that should the Trust fail to meet its C. Difficile trajectory for three consecutive quarters or fail the Accident and Emergency 4 hour wait target in Q2, its governance risk rating may be overridden to Red by Monitor in line with the procedures set out in the Compliance Framework and considered for escalation for potential significant breach of its terms of Authorisation.

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

Recommendations

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

Executive Report Sponsor or Other Author

Sponsor – Chief Executive

Author – Trust Secretary

Appendices

- Appendix A – Monitor's Executive Summary of the Q1 results

University Hospitals Bristol NHS FT
Q1 2012-13 reporting executive summary

Monitor
Independent Regulator of NHS Foundation Trusts

Risk ratings

Financial Risk Rating:

12/13 Plan:	YTD	FY		YTD Actual:	Q1
	3	3			**3**

Governance Risk Rating:

12/13 Plan:	AMBER-GREEN		YTD Actual:	AMBER-RED
Declared Risks:	• 4 Hour A&E target		**Breaches:**	• C. Difficile and 4 Hour A&E target

2012/13 Authorised limits

Long term borrowing	£152.4m	Working Capital Facility	£37.5m	Private Patient Income	1.1 %

Comments

- FRR 3 delivered at Q1 which is line with plan (unrounded 2.9). Trust delivered an EBITDA margin of 5.5% compared to planned 6.4%. Trust expects EBITDA in Q2 to be in line with plan year to date and has £2.7m headroom to an FRR 2.
- Trust has breached A&E 4 hour wait 95% and its C Difficile trajectory in Q1 2012/13.

Financial summary

£m	Q1 only			Year to date		
	Plan	Actual	Variance	Plan	Actual	Variance
Op. Rev for EBITDA	**128.8**	**130.4**	**1.6**	**128.8**	**130.4**	**1.6**
Pay	(76.9)	(76.8)	0.0	(76.9)	(76.8)	**0.0**
PFI Op. expense	0.0	0.0	0.0	0.0	0.0	**0.0**
All other Op. costs	(43.6)	(46.4)	(2.7)	(43.6)	(46.4)	**(2.7)**
EBITDA	**8.2**	**7.2**	**(1.0)**	**8.2**	**7.2**	**(1.0)**
Operating Surplus	**3.4**	**2.6**	**(0.8)**	**3.4**	**2.6**	**(0.8)**
Surplus after tax	**0.9**	**0.2**	**(0.8)**	**0.9**	**0.2**	**(0.8)**
EBITDA %	6.4 %	5.5 %	-0.9 %	6.4 %	5.5 %	**-0.9 %**
CapEx	(15.9)	(12.3)	3.6	(15.9)	(12.3)	**3.6**
Net cash flow	(8.7)	(5.0)	3.6	(8.7)	(5.0)	**3.6**
Cash & Equiv	**32.8**	**36.4**	**3.6**	**32.8**	**36.4**	**3.6**
FRR Liquidity days	21.9	20.1	(1.8)	21.9	20.1	**(1.8)**
CIP% Op. Ex less PFI	4.6 %	3.4 %	-1.2 %	4.6 %	3.4 %	**-1.2 %**
Net current assets	6.4	4.4	(2.0)	6.4	4.4	**(2.0)**
Borrowing	**11.0**	**6.1**	**(5.0)**	**11.0**	**6.1**	**(5.0)**

Key risks	Action taken / committed	Gaps and residual concerns
• **Service performance failure.** • Trust failed to meet A&E 4 hour target in Q4 11/12 and Q1 12/13 (92.5% and 93.6% respectively vs. 95% target). • Trust has breached its Q1 C Difficile trajectory with 16 cases vs. 14. *NB: Q1 Monitor target is 25% of full year target.*	• Trust has engaged external support from DH IST and expects to demonstrate sustainable compliance from Q2 2012/13. There remain significant external risks affecting the delivery of this target including high levels of emergency demand, patient acuity linked to an increase in admission volumes of more elderly patients and discharges delayed by outside agencies; these factors remain difficult to predict & mitigate. Despite failure at Q1 12/13, Trust performance in June tracked above 95% and Trust expects to meet the target in Q2 2012/13. • Trust does not consider the full year C.Difficile target to be at risk however did take further action at the end of June to ensure compliance from Q2 onwards.	• Trust will be considered for escalation if it fails to meet the A&E target twice in 12 month period and then fails the target in subsequent 9 month period. Therefore a further failure in 2012/13 will result in the Trust being considered for escalation.
• **Achievement of challenging CIP programme.** Trust underperformed against its Q1 CIP target by 25% (£5.8m target, delivered £4.4m). • Trust has failed to achieve CIP targets over the last three years - 77%, 83% and 81% for 9/10, 10/11 and 11/12.	• At Q1, the unidentified CIPs for the full year amounted to £3.7m. The Trust has an on-going in-year process for reviewing CIP delivery and generating new schemes with 11 cross cutting Trust work streams focussing on various categories of expenditure and efficiencies in specific areas.	• Failure to achieve planned CIPs may erode the Trust's financial position, headroom to FRR 2 and may impact the Trust's ability to deliver its over-arching approach to service transformation.
• **Financial risks.** >5% of debtors over 90 day financial indicator triggered.	• Appropriate provisions have been made for potential bad debts. • Trust continues to actively attempt to reduce debtor balances and will participate in NHS South of England initiative to clear balances in Oct-Dec, although continues to forecast high levels triggering this specific FRI during 2012/13.	• This FRI has been triggered for ninth consecutive quarters.
• **Corporate and clinical governance**. Review into Histopathology services at the Trust identified various governance concerns.	• Trust has reported that it remains focussed on concluding the implementation of the recommendations arising from the Histopathology Inquiry and associated governance matters.	• No material concerns at this stage.

Next steps • **Continue quarterly monitoring.**

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 27 September 2012 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 16 – Results of Monitor Annual Plan Review

Purpose

To inform the Board of the outcome of Monitor's assessment of the Trust's Annual Plan 2012/13

Abstract

Monitor employs a two-step approach to the assessment of Foundation Trust Annual Plans. All Foundation Trust Annual Plans are subject to a first-step review, with selected Annual Plans being subject to further review where concerns persist following initial review.

This Trust's Annual Plan for 2012/13 has not been selected for further review and the regulatory approach will be executed through the established quarterly monitoring meetings. However, Monitor have noted that they believe there to be a significant risk to delivery of the plan in relation to the A&E standard and have taken the opportunity to remind the Trust of the importance of ensuring that delivery of cost improvement actions does not erode the quality of care.

Finally, the feedback notes the value of comprehensive planning over three years; the development of a Medium Term Operating Plan is already in-hand.

Recommendations

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

Executive Report Sponsor or Other Author

Sponsor – Chief Executive, Robert Woolley

Author – Trust Secretary, Charlie Helps

Appendices

- Appendix A – APR 12/13 Letter
- Appendix B – APR 12/13 Executive Summary

Previous Meetings

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

4 Matthew Parker Street
London
SW1H 9NP

T: 020 7340 2400
F: 020 7340 2401
W: www.monitor-nhsft.gov.uk

31 July 2012

Mr Robert Woolley
Chief Executive
University Hospitals Bristol NHS Foundation Trust
Trust HQ
Marlborough Street
Bristol
BS1 3NU

Dear Mr Woolley

2012/13 Annual Plan Review

I am writing to you in relation to the 2012/13 Annual Plan Review (APR). The purpose of Monitor's review is to assess whether NHS foundation trusts are effectively planning for the future while maintaining and improving quality. This enables Monitor to make a more informed judgement about future risks to compliance with a Trust's terms of Authorisation.

Under the APR process all NHS foundation trusts are subject to a two day high-level review of the annual plans submitted to Monitor at the start of June. Following this scrutiny Monitor determines, on a trust by trust basis, the appropriate regulatory approach for the year. The regulatory approach may involve one or more of the following:

- Continued quarterly monitoring;
- Enhanced monitoring;
- Formal visit by Monitor;
- Further internal work by Monitor; and
- Suggested further work for the Trust to commission.
- In addition where concerns have been identified Monitor may, during the period from late July to early October, instigate a more detailed review that focuses on aspects of risk identified during the first stage.

For your information I enclose a summary of our analysis of your Trust's Annual Plan. This summary reflects the work done by Monitor during June and early July and as a consequence subsequent discussions which may have taken place are not reflected. It is important to note that Monitor's review process assesses but does not endorse Trusts' plans.

Risk Ratings

We have now completed the two day review on your 2012/13 Annual Plan, and your Trust has the following annual risk ratings for 2012/13 as submitted in your return to Monitor:

Financial Risk Rating	3
Governance Rating	AMBER-GREEN

These ratings will be published on Monitor's website in early August. We would emphasise that these risk ratings are the Foundation Trust's own risk ratings and as such are never adjusted by Monitor. We will also publish on our website, under your entry in the Public Register of NHS foundation trusts, the components of the strategic plan that your Trust submitted that were highlighted as for publication including a summary of financial plans in a similar format to that published last year, new 2012/13 Schedule 2 (Mandatory Goods and Services), Schedule 3 (Mandatory Education and Training) and Schedule 5 (Limit on Borrowing).

Monitor will continue to assess the risks to the Trust's compliance with its terms of Authorisation through the returns provided by you as part of the normal quarterly monitoring process which commences with the review of quarter one in August 2012. We will publish an update to the risk ratings at this time.

Outcome of Annual Plan Review

University Hospitals Bristol NHS Foundation Trust has not been selected for an in-depth review. It should be noted that our review has identified significant risks to the delivery of the plan, but Monitor has chosen to undertake a more in-depth understanding of plans through on-going regulatory process with respect to its potential to trigger escalation during 12/13 for A&E. The Trust most recently failed Q4 11/12, Q1 12/13 (and has also demonstrated a mixed performance for A&E since authorisation). We acknowledge that the Trust does believe it will return to sustainable compliance in Q2 12/13 and is working with DH IST (and Newton Europe Ltd) to address the underlying issues. The Trust has not been selected for an in-depth review on this basis.

It is important that the Trust Board continues to monitor the risks to compliance with its terms of Authorisation and takes appropriate mitigating action where necessary. Recognising the significant level of Cost Improvement programmes (CIPs) that need to be delivered across the Health Sector, all Trust Boards should assure themselves that where CIPs are being implemented their impact is being assessed on a on-going basis such that the quality of services is being maintained and improved and that the Trust can continue to deliver safe services sustainably.

Trusts planning to breach indicators

Please note that Monitor does not take action in respect of planned breaches. As a result Trusts planning to breach indicators or deliver sub-standard FRR and GRR ratings over the plan period should not assume that Monitor will not escalate these matters if and when they occur.

Quality of Planning

Our review of Trusts' plans has identified that in many cases while Trusts plan prudently for year 1 of their APR submission planning for years 2 and 3 appears less rigorous with Trusts simply rolling forward the same plan. This is not best practice and we believe Trusts should be considering plans equally across all three years despite more detail being required for the first year. Going forward this approach to APR submissions may be considered a governance risk.

Next steps

As in previous years, Monitor intends to publish a summary of findings from the Annual Plans that have been submitted which will include aggregated information from all NHS foundation trusts and the emerging themes from our review. We intend to publish the information contained in this document during August 2012.

Please note that your Prudential Borrowing Limit is currently being calculated and approved and will be published on the Monitor website at the end of August.

If you have any queries in relation to any of the above, please contact me by telephone on 020 7340 2466 or by email (Rupinder.Singh@monitor-nhsft.gov.uk) at the earliest opportunity.

Yours sincerely

Rupinder Singh
Senior Compliance Manager

cc: Dr John Savage, Chairman
Dr Sean O'Kelly, Medical Director
Mr Paul Mapson, Finance Director

University Hospitals Bristol
APR 12/13 executive summary

Monitor
Independent Regulator of NHS Foundation Trusts

Risk ratings

Financial Risk Rating:

2012/13:	Q1	Q2	Q3	FY		2013/14	2014/15
	3	3	3	**3**		**3**	**4**

Governance Risk Rating:

Self-certified rating	AMBER-GREEN	**Risk(s) identified**	• A&E target (breached in Q4 11/12 and Q1 12/13).

Prospective 12/13 Limits:

Long term borrowing limit	*To be published*	Working capital facility	£37.5m	Private patient income	1.1%

Financial plan summary

£m	2011/12 Actual		2012/13 Plan	2013/14 Plan	2014/15 Plan
Total revenue	**531.6**		**521.4**	**514.1**	**535.7**
Pay	-317.3		-307.5	-297.3	-306.6
PFI operating expense	0.0		0.0	0.0	0.0
Other costs	-179.6		-177.9	-178.7	-187.5
EBITDA	**34.3**		**35.6**	**37.9**	**41.4**
Surplus	**9.0**		**5.7**	**7.5**	**-4.1**
EBITDA %	6.5%		6.8%	7.4%	7.7%
CIP %OpEx less PFI	4.2%		4.6%	4.1%	4.0%
CAPEX	-39.1		-80.8	-63.3	-30.1
Net cash flow	-11.5		-2.2	-10.2	3.8
Cash & Equiv	**41.5**		**39.3**	**29.0**	**32.8**
Liquidity days	25.7		26.7	22.7	26.6
Net current assets	12.5		5.6	-1.0	5.7
Borrowing	**6.1**		**55.9**	**80.4**	**79.9**

Annual Plan Review Summary

- The Trust is planning to achieve an FRR 3 for 12/13 and 13/14. Excluding contingency, the Trust has c.£10m of headroom to an FRR 2 in year 1.
- Major investment: BRI development (phase 3 & 4) agreed – risk assessed by Monitor as FRR 3, green/amber. Funding of £70m secured. Construction has begun.

Key risks	Action taken / committed	Gaps and residual concerns
• Major investment. Delivery of 'significant' capital scheme (Bristol Royal Infirmary & specialist paediatrics).	• This investment has been risk assessed by Monitor as it met the 'significant' reporting threshold. Risk rated Amber-Green/FRR 3. £70m secured from the National Loan Fund. 1st drawdown due this year to coincide with construction initiation for Phase 3 & 4.	• No material concerns at this stage. Trust should update Monitor if the business case fundamentals adversely change.
• A&E 4 hour target declared at risk. Performance against the A&E 4-hour standard has been both historically and more recently inconsistent.	• Trust has engaged external support (DH IST) and expects to demonstrate sustainable compliance from Q2 2012/13. There remain significant external risks affecting the delivery of this standard including high levels of emergency demand, patient acuity linked to an increase in admission volumes of more elderly patients and discharges delayed by outside agencies; these factors are considered difficult to predict & mitigate. • Despite failure at Q1 12/13, Trust performance in June tracked above 95%.	• Trust will be considered for escalation should it fail to meet the A&E target twice in 12 month period and then fails the target in subsequent 9 month period i.e. given Q112/13 was failed, a further failure in 12/13 will result in the Trust being considered for escalation.
• Achievement of challenging CIP programme. The Trust has failed to fully achieve its CIP targets over the last three years – 77%, 83% and 81% for 9/10, 10/11 and 11/12 respectively.	• Trust believes it has planned prudently and therefore has contingency, which could be deployed to address any CIP slippage. • Responsibility for the delivery of the CIP programme sits with the Trust's Programme Steering Group which meets monthly to review progress by Divisions and reviews both financial savings and risks including clinical risks and quality. CIP performance is also reported monthly and is subject to scrutiny by the Trust's Finance Committee.	• Failure to achieve CIPs will likely erode the Trust's financial position/ headroom to FRR 2. • Pay related CIPs were underachieved in 2011/12, with a significant % of planned CIP's dedicated to pay again – a residual concern exists and should be monitored.
• Inquiry's report into histopathology services at the Trust identified various concerns.	• The Trust has reported that it continues to implement its action plan to address the Inquiry's recommendations and related governance matters. • CQC's recent follow up inspection has not identified any areas of non-compliance.	• Trust should report to Monitor by exception where it experiences material issues or delay in addressing the Inquiry's recommendations.
Next steps	• **Continue quarterly monitoring.**	